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City of Westminster

Committee Agenda

Title:	**Health & Wellbeing Board**
Meeting Date:	**Thursday 18th September, 2014**
Time:	**4.00 pm**
Venue:	**Rooms 3 & 4 - 17th Floor, City Hall**

Members:

Councillor Rachael Robathan	Cabinet Member for Adults & Health
Dr Ruth O'Hare	Central London Clinical Commissioning Group
Councillor Danny Chalkley	Cabinet Member for Children's Services
Councillor Barrie Taylor	Minority Group
Meradin Peachey	Tri-Borough Public Health
Liz Bruce	Tri-borough Adult Social Care
Andrew Christie	Tri-borough Children's Services
Dr Naomi Katz	West London Clinical Commissioning Group
Janice Horsman	Healthwatch Westminster
Jackie Rosenberg	Westminster Community Network
Dr David Finch	NHS England

Members of the public are welcome to attend the meeting and listen to the discussion Part 1 of the Agenda

Admission to the public gallery is by ticket, issued from the ground floor reception at City Hall from 3.30pm. If you have a disability and require any special assistance please contact the Committee Officer (details listed below) in advance of the meeting.

An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter. If you require any further information, please contact the Committee Officer, Andrew Palmer:

Tel: 020 7641 2802
Email: apalmer@tiscali.co.uk

Corporate Website: www.westminster.gov.uk

Note for Members: Members are reminded that Officer contacts are shown at the end of each report and Members are welcome to raise questions in advance of the meeting. With regard to item 2, guidance on declarations of interests is included in the Code of Governance; if Members and Officers have any particular questions they should contact the Head of Legal & Democratic Services in advance of the meeting please.

AGENDA

PART 1 (IN PUBLIC)

1. MEMBERSHIP

To report any changes to the Membership of the meeting.

2. DECLARATIONS OF INTEREST

To receive declarations of interest by Board Members and Officers of any personal or prejudicial interests.

3. MINUTES AND ACTIONS ARISING

I) To agree the Minutes of the meeting held on 19 June 2014.

II) To note progress in actions arising.

4. BETTER CARE FUND PLAN 2014-16 REVISED SUBMISSION

To consider the requirement to revise and resubmit the Better Care Fund Plan which was previously agreed by the Health & Wellbeing Board.

5. CLINICAL COMMISSIONING GROUP CONTRACTING INTENTIONS 2015/16

I) Central London Clinical Commissioning Group.

II) West London Clinical Commissioning Group

6. PRIMARY CARE COMMISSIONING

To consider how NHS England (NHSE) perform their responsibilities for the commissioning and quality assurance of primary care services.

7. MEASLES, MUMPS AND RUBELLA (MMR) VACCINATION IN WESTMINSTER

To review the position of the measles, mumps and rubella vaccination (MMR) in Westminster.

8. PHARMACEUTICAL NEEDS ASSESSMENT

To review the progress being made by the Pharmaceutical Needs Assessment Task and Finish Group.

9. WORK PROGRAMME

To consider issues for the Work Programme for 2014-15.

10. ITEMS ISSUED FOR INFORMATION

To provide Board Members with the opportunity to comment on items that have been previously circulated for information:

- Joint Strategic Needs Assessment Review
- Tri-Borough Learning Disabilities Action Plan
- Health & Wellbeing Engagement Strategy

11. ANY OTHER BUSINESS

Peter Large
Head of Legal & Democratic Services
10 September 2014

Dates of future meetings:

- Thursday 20 November 2014
- Thursday 22 January 2015
- Thursday 19 March 2015
- Thursday 21 May 2015

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CITY OF WESTMINSTER

DRAFT MINUTES

WESTMINSTER HEALTH & WELLBEING BOARD
19 JUNE 2014
MINUTES OF PROCEEDINGS

Minutes of a meeting of the **Westminster Health & Wellbeing Board** held on Thursday 19 June 2014 at 4.00pm at Westminster City Hall, 64 Victoria Street, London SW1E 6QP

Members Present:
Chairman: Councillor Rachael Robathan, Cabinet Member for Adult Services & Health
Minority Group Representative: Councillor Barrie Taylor
Director of Public Health: Eva Hrobonova (acting as Deputy)
Tri-Borough Executive Director of Children's Services: Andrew Christie
Tri-Borough Executive Director of Adult Social Care: Cath Attlee (acting as Deputy)
Clinical Representative from the Central London Clinical Commissioning Group:
Kiran Chauan (acting as Deputy)
Clinical Representative from the West London Clinical Commissioning Group:
Dr Naomi Katz
Representative of Healthwatch Westminster: Janice Horsman
Chair of the Westminster Community Network: Jackie Rosenberg
Representative for NHS England: Dr Belinda Coker (acting as Deputy)

Also in Attendance:
Councillors Barbara Arzymanow and Iain Bott.

1. MEMBERSHIP

1.1 Apologies for absence were received from Councillor Danny Chalkley (Cabinet Member for Children & Young People), Dr Ruth O'Hare (Central London CCG) and Liz Bruce (Tri-borough Director of Adult Social Care). Kiran Chauan and Cath Attlee attended as Deputies for Ruth O'Hare and Liz Bruce respectively. Apologies for absence were also received from Meradin Peachey (Director of Public Health) and Dr David Finch (NHS England), with Eva Hrobonova and Dr Belinda Coker attending as their Deputies.

1.2 The Chairman welcomed Louise Proctor (Central London CCG) and Simon Tucker (West London CCG); and also welcomed Councillor Iain Bott (Deputy Cabinet Member for Adults & Health) and Councillor Barbara Arzymanow (Adults, Health & Public Protection Policy & Scrutiny Committee).

2. DECLARATIONS OF INTEREST

2.1 No declarations were received.

3. MINUTES AND ACTION TRACKER

3.1 **Resolved**:

3.1.1 That the minutes of the meeting held on 24 April 2014 were approved for signature by the Chairman.

3.1.2 That progress in implementing actions and recommendations agreed by the Board be noted.

4. WHOLE SYSTEMS INTEGRATED CARE UPDATE

4.1 At its last meeting on 24 April, the Board received an update on progress in the work being undertaken by Westminster's CCGs to develop a model of working and local priorities as part of the Whole System Integrated Care Pioneer Programme (Minute 7). Kiran Chauhan (Central London CCG) now introduced the model of integrated provision that was being developed, which would seek to address strategic issues and combine work streams to avoid duplication.

4.2 Over the last 9 weeks, the vision for Whole Systems Integrated Working had been developed in consultation with Adult Social Care and a wide range of partners and stakeholders at steering groups and workshops. The CCG had made good progress in patient engagement, and had taken strategic needs and cost information into account in identifying outcomes and determining how the new model of care could have the most impact. It was proposed that the new model would be based on localities, with GP practices being grouped into 'villages', and with the creation of the new role of Care Co-ordinator, who would have immediate access to data relating to the history of individual patients.

4.3 The Whole System plans had received a positive response, for the number of people who had been engaged, and for reflecting what the people of Central London wanted from a model of care. The proposals had also been endorsed by health and social care commissioners and providers, and by service users and third sector organisations.

4.4 Marina Muirhead (Project Lead for Whole Systems Integration, Central London CCG) informed the Board that the CCG was now in the second phase of the planning process, which would take place between June and October. Development during this phase would include:

- providing access to accurate, real time patient data across the system;
- costing the new model of care and identifying where savings could be made to provide funding;
- agreeing budgets to be pooled; and

- agreeing the list of contracts that were affected.

4.5 Simon Tucker (West London CCG) updated the Board on the development of the Whole Systems model for the West London CCG, which was being produced following an extensive co-production exercise with the Central London CCG. Members noted that there were three elements to the West London model:

- GP hubs where care planning was focussed by a Care Co-ordinator with a GP accountable for every person;
- a central co-ordination team with a single point of access who would ensure that patients, carers and front line professionals are able to obtain appropriate referrals quickly; and
- two integrated care hubs, with an integrated care team having access to advice and intermediate care for patients whose conditions are not stable and who may need extra support.

4.6 The West London model sought to enable professionals to have a shared vision, and work in a joined-up way with the person at the centre. The model would also seek to improve quality of life, with care plans being shaped to individual needs minimising time away from home. Simon Tucker highlighted the importance of people having trust in the services they received, with a single named accessible co-ordinator who could provide continuity in and out of hours and in different settings of care. The Board noted that the model also included two Whole Systems projects, which were centred on the health needs of people over 75 and on mental health.

4.7 The Board commented on the reduction in available resources to meet the ongoing increase in an aging population, and highlighted the importance of community knowledge and support, and the value of the contribution made by the third sector community in health outcomes. Members also commented on the need for the third sector to be taken into account in care plans; and suggested that there was a need for Registered Social Landlords to be engaged in the Whole Systems process.

4.8 Members discussed the monitoring role of the Health & Wellbeing Board, and suggested that difficult or contentious issues should be referred to the Board in addition to progress reports.

4.9 Full business cases for the Whole Systems proposals would be submitted to the Board in the autumn.

4.10 **Resolved:** That progress in the development of Whole Systems Integrated Care be noted.

5. CHILDHOOD OBESITY

5.1 Eva Hrobonova (Deputy Director of Public Health) presented the findings of the Tri-Borough Obesity Prevention and Healthy Weight Services' Review, together

with the programme of actions designed to halt and reverse the rising trend in childhood obesity. Levels of childhood obesity in Westminster were high, and the Board noted that nearly a quarter (23.6%) of Reception children were overweight or obese, with this figure rising to almost two fifths of children (39.4%) in year 6.

5.2 The Board acknowledged that childhood obesity presented a major challenge to health and wellbeing, which increased the risk of premature mortality in adults. Problems relating to overweight, obesity and physical inactivity also tended to start in childhood, and often disproportionately affected disadvantaged socio-economic groups. Evidence suggested that multi-disciplinary action was fundamental to supporting changes in the behaviour of individuals and families, and local authorities were now uniquely placed to influence both the commissioning and provision of family weight management services that were needed in order to halt and reverse the rising trend in obesity.

5.3 As the first part of the re-commissioning process, Public Health had carried out a review of current Public Health service provision together with a consultation exercise, to map activities that contributed to the prevention of child obesity and to identify gaps in services. Evidence suggested that the main influence on people's weight was their environment.

5.4 The Board discussed commissioning intentions, and highlighted the value of child health and public health programmes in providing an opportunity for patterns of behaviour to be changed at an early stage. Members suggested that three or four real opportunities for change or improvement were identified and concentrated upon for delivering specific gains.

5.5 The Board also received the draft report of the Childhood Obesity Task Group from Councillor Iain Bott, who was Chairman of the Group. The key messages of the report had been that diet was crucial, and that people needed to eat less. The report commented on the need to avoid sugar, particularly in drinks, and recommended the creation of obesity care pathways. Current provision needed to be expanded, and the Board acknowledged the critical role of children's centres and schools, with school based interventions aiming to give young people the cognitive ability to deal with obesity. The report also suggested that many families were not aware that they had an issue, and recommended that support be provided through GPs, dentists and family healthcare workers, with parents being further incentivised through measures such as 'money off' vouchers for healthy food.

5.6 The Board commended the findings of the report, and acknowledged the importance of establishing a whole Council approach which would engage all Council departments and stakeholders in the creation of an easy and supportive environment, where children could eat and live more healthily. Members also commented on the need for a national media campaign to change attitudes, and for planning and licensing services to influence and reduce the number and placement of fast food shops near schools.

5.7 Members discussed whole population behaviour change, and agreed that messages needed to made at community level, being tailored for specific cultural groups who may not consider being overweight as a problem, and being interesting and fun in order to engage young people. Members also suggested that recommendations were Borough specific, and implemented in a localised community setting through Wards with potential support from Ward budgets.

5.8 Members discussed the value of exercise facilities, and expressed concern that there was a lack of specific provision for children and young people under 18. The Board noted that Public Health were looking to develop and commission a bespoke programme similar to Weight Watchers, as soon as a provider had been confirmed. Other issues discussed included the popularity of cooking as part of the school curriculum and at the Stowe Centre, and encouraging people to grow their own food.

5.9 **Resolved:**

1) That the review of childhood obesity prevention services and plans for commissioning childhood obesity prevention and intervention services be noted;

2) That the findings and recommendations of the draft report of the Childhood Obesity Task Group be endorsed;

3) That the development of a whole Council partnership approach to preventing childhood obesity be noted; and

4) That a further report be submitted to a future meeting of the Westminster Health & Wellbeing Board by the local authority and health partners, providing an update on progress in the processes and engagement for preventing childhood obesity.

6. THE HEALTH & WELLBEING STRATEGY

6.1 The Board received reports on progress made over the past six months in the delivery of the five Priorities of the Westminster Health & Wellbeing Strategy.

6.2 <u>Priority One: Every child has the best start in life</u>

6.2.1 Andrew Christie (Tri-Borough Executive Director of Children's Services) reported that a comprehensive plan for the delivery of Priority One would be produced in the near future. Members noted that there had been a delay in obtaining data on MMR immunisation from NHS England, and that it was anticipated that a paper on MMR would be brought to the next meeting of the Board. Members commended the work and research of the BME Health Forum, and highlighted the need to ensure that recommendations were implemented.

6.3 Priority Two: Young people are enabled to have a healthy adulthood.

6.3.1 Andrew Christie also provided an update on progress in the delivery of Priority Two, and commented that the Children's Trust Board had expressed concern that the quality of inpatient provision and transition from child and adolescent services was poor. The Board noted that the Children and Adolescent Mental Health Service (CAMHS) continued to provide a good service, and that young people were being encouraged to engage in positive activities and to choose to live a healthy lifestyle. Members also noted that there was a shortfall in Troubled Family referrals, and asked that GPs be informed of the availability of the service.

6.4 Priority Three: Supporting economic and social wellbeing and opportunity.

6.4.1 The Board received an update on the delivery of Priority Three from Tom Harding (Senior Policy Officer), who reported encouraging progress with a range of services having been commissioned to support people with issues relating to mental health, learning disabilities or physical disabilities. Support for employment and people on long term benefit was to be recast over the forthcoming year, and would operate on an area based model for tackling long-term unemployment, including groups which were difficult to reach. Analysis had suggested that employers also needed to act as mentors, and proposals were being developed for a work place co-ordinator to join the existing team of brokers and to work with employers. Other issues being taken forward included increasing the capacity of social enterprise schemes and the healthy workplace charter.

6.4.2 The Board commented on the importance of people continuing to receive support once they had found employment, and highlighted the need for this to be recognised by Government agencies. Members also commented on the work of the Public Service Reform Group in looking at people with mental health issues, and discussed long-term worklessness and the role of the local authority in the pathway to employment.

6.5 Priority Four: Ensuring access to appropriate care at all times.

6.5.1 Kiran Chauan (Central London CCG) provided an update on progress in delivering Priority Four. Work was in progress to establish integration programmes between hospitals and Primary Care to overcome data sharing issues and associated risks. Measures to provide extra care for Children and avoid planned and unplanned hospital admissions were also moving forward, and the CCGs were working with hostels to avoid people going to A&E due to substance misuse. The Board noted that the number of people in Westminster attending A&E was going down, and agreed that this would be added as a performance indicator.

6.5.2 Dave Eastwood (Interim Head of Community Protection) provided an update on progress in taking forward the recommendations and actions which had been proposed by the Homeless Health Task and Finish Group, and set out in the report 'Sleeping Rough in Westminster: Health, Wellbeing and Healthcare". The Board noted that although the Homeless Health Group had been very successful, problems remained in obtaining real-time information that was needed for data

matching from A&Es and GPs, who had many different databases. Members noted that input from Adult Social Care was needed for the homeless case conferences based in the two homeless GP practices, to ensure that there were co-ordinated community services working together to prevent admissions and to ensure successful discharges.

6.6 Priority Five: Supporting people to remain independent for longer

6.6.1 The Board received an update from Cath Attlee (Tri-Borough Adult Social Care) on the indicators and targets that had been given in Priority Five. Members noted that the main focus of activity had been the development of the Better Care Fund Plan, and ensuring alignment with the CCG 2-5 year trajectories and Adult Social Care Medium Term Plan. Proposals relating to readmissions, health related quality of life and addressing isolation through health related activities also continued to be developed, and Dementia services were being reviewed in light of the national strategy.

6.7 Members suggested that a briefing note setting out details of the five Priorities of the Health & Wellbeing Strategy, and their Priority Leads, be circulated to all Members of the City Council.

6.8 **Resolved**:

1) That progress in the delivery of the five Priorities of the Westminster Health & Wellbeing Strategy be noted; and

2) That a further update on progress be submitted to the Westminster Health & Wellbeing Board in six months.

7. NHS HEALTH CHECKS UPDATE AND IMPROVEMENT PLAN

7.1 Christine Mead (Behaviour Change Commissioner, Tri-Borough Public Health) presented the outcomes of the 2013-14 NHS Health Check, which was a national risk assessment and prevention programme that helped people take action to avoid, reduce or manage their risk of developing health problems. The Board noted that the Department of Health had set targets for 20% of the eligible population to be invited for Health Checks each year, on the basis that the entire eligible population would then have a Health Check every five years. Between 50-75% of those invited are expected to attend a Health Check each year.

7.2 Christine Mead reported that during 2013-2014, Health Checks had been delivered to 9.7% of eligible residents in Westminster, against a target of 10%. Data indicated that Health Checks were useful, and the Board noted that the new target was for delivery to be raised from 10% to 20% of eligible residents by 2015-16; with the proportion of people being checked who were older and at higher risk also being increased.

7.3 Key areas for improvement had included working closely with CCGs to raise the delivery of Health Checks in all practices and to support communication and training for motivational interviewing; and to increase the uptake in the community through expanding delivery by health trainers, and by making them available to residents at pharmacies. The Board noted that GP practices had the option whether to carry out Health Checks, and acknowledged the need for the NHS to know if they were not being offered so alternative arrangements could be made.

7.4 The Board considered ways in which referral systems could be made more effective, and suggested that they could be shaped to relate more to local communities, with vulnerable communities being specifically targeted. Members commended the work of the community based Health Trainers service; and suggested that health care assistants were not in the best position to carry out Health Checks as they had less authority than GPs.

7.5 The Board discussed the effectiveness of the Patient Outcome Data (POD) system, which sought to provide consistency of delivery, referrals and monitoring. Members expressed concern that the need to have real time data together with issues relating to the processes of the POD system could put GPs at potential risk, and highlighted the importance of effective monitoring to ensure that referrals were followed up.

7.6 **Resolved:**

1) That the delivery of a plan to improve the offer and take-up of NHS Health Checks within Westminster be supported; and

2) That Westminster's Public Health team work with the Clinical Commissioning Groups to identify ways of improving the effectiveness of Health Checks, with a further report on progress being submitted to a future meeting.

8. THE ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH

8.1 Eva Hrobonova (Deputy Director of Public Health) presented the key messages from the Annual Public Health Report, which reviewed the health of people who lived in Westminster; identified local public health priorities; and described current projects designed to improve the health and wellbeing of local people.

8.2 The Board noted that compared to the rest of the country, people living in Westminster were relatively healthy. Although overall life expectancy in Westminster was at or higher than the national average for both men and women, there were significant differences between different communities and between affluent and deprived areas. The report highlighted the need to ensure that people had equal access to health care services, and that they were supported to make healthy choices and were protected against risks to their health.

8.3 The report suggested that health inequalities could be reduced by a focused effort across all services that affected health and wellbeing, which would need to include

leisure, education, employment, housing and planning. The Board acknowledged that giving every child the best start in life was crucial to reducing health inequalities. Health agencies also needed to consider how people could be helped to address multiple rather than individual behaviours, as unhealthy lifestyle choices tended to cluster together; with people who smoked being more likely to drink too much alcohol or to use drugs, and to have poor diets and be inactive.

8.4 Members commented on inequalities that were linked with poverty, and noted that children who lived in poverty were at greater risk of health and social problems later in life; which ranged from obesity, heart disease and poor mental health, to low educational achievement and employment status. Members also suggested that public health initiatives for Westminster should focus on the local community, rather than on a Tri-borough overview.

8.5 **Resolved:** That the Annual Report of the Director of Public Health be noted.

9. JOINT STRATEGIC NEED ASSESSMENT WORK PROGRAMME

9.1 Colin Brodie (Public Health Services) invited the Board to approve the Joint Strategic Need Assessment (JSNA) work programme for 2014/15. The JSNA Steering Group had met on 29 April to consider possible areas for deep-dive JSNA, and had suggested that the issues of childhood obesity, older people and housing, and dementia were three priority areas to be developed into formal applications, as they affected large populations and related to clear commissioning decisions. Members noted that other potential topics could be developed into JSNA deep-dives at a later date, or be addressed in other ways as new priorities emerged.

9.2 The Board requested that the implications of language creating a barrier to successful health outcomes be considered as a further JSNA application.

9.3 Colin Brodie also provided an update on progress in the Pharmaceutical Needs Assessment, and the Board noted that the sending of questionnaires was dependent upon NHS England providing details of community pharmacies.

9.4 **RESOLVED**: that the issues of ‘Childhood Obesity’, ‘Dementia’ and ‘Older People’s Housing Needs’ be included in the 2014/15 Work Programme for detailed Joint Strategic Need Assessments.

10. WORK PROGRAMME

10.1 The Board reviewed its Work Programme for 2014-15.

10.2 Members discussed the agenda for the forthcoming meeting on 18 September, and suggested that the commissioning strategy and capacity of GP services be considered at a future meeting.

11. ITEMS ISSUED FOR INFORMATION

11.1 No papers had been circulated for information since the last meeting of the Westminster Health & Wellbeing Board on 24 April 2014.

12. TERMINATION OF MEETING

12.1 The meeting ended at 6.05pm.

CHAIRMAN _____ DATE _____

WESTMINSTER HEALTH & WELLBEING BOARD
Actions Arising

Meeting on Thursday 19th June 2014

Action	Lead Member(s) And Officer(s)	Comments
Whole Systems		
Business cases for the Whole Systems proposals to be submitted to the Health & Wellbeing Board in the autumn.	Clinical Commissioning Groups.	In progress.
Childhood Obesity		
A further report to be submitted to a future meeting of the Westminster Health & Wellbeing Board by the local authority and health partners, providing an update on progress in the processes and engagement for preventing childhood obesity.	Director of Public Health.	In progress
The Health & Wellbeing Strategy		
A briefing note setting out details of the five Priorities of the Health & Wellbeing Strategy, and their Priority Leads, to be circulated to all Members of the City Council.	Senior Policy & Strategy Officer.	In progress
A further update on progress to be submitted to the Westminster Health & Wellbeing Board in six months.	Priority Leads.	In progress.
NHS Health Checks Update and Improvement Plan		
Westminster's Clinical Commissioning Groups to work with GPs to identify ways of improving the effectiveness of Health Checks, with a further report on progress being submitted to a future meeting.	Clinical Commissioning Groups	In progress.
Joint Strategic Needs Assessment Work Programme		
The implications of language creating a barrier to successful health outcomes to be considered as a further JSNA application.	Public Health Services Senior Policy & Strategy Officer.	In progress.

Meeting on Thursday 26th April 2014

Action	Lead Member(s) And Officer(s)	Comments
Westminster Housing Strategy		
The consultation draft Westminster Housing Strategy to be submitted to the Health & Wellbeing Board for consideration in the autumn.	Strategic Director of Housing	In progress
Child Poverty Joint Strategic Needs Assessment Deep Dive		
A revised and expanded draft recommendation report to be brought back to the Health & Wellbeing Board in September.	Strategic Director of Housing Director of Public Health.	In progress
Tri-borough Joint Health and Social Care Dementia Strategy		
Comments made by Board Members on the review and initial proposals to be taken into account when drawing up the new Dementia Strategy.	Matthew Bazeley Janice Horsman Paula Arnell	In progress
Whole Systems		
A further update on progress to be brought to the Health & Wellbeing Board in June.	Clinical Commissioning Groups	Completed

Meeting on Thursday 27th February 2014

Action	Lead Member(s) And Officer(s)	Comments
Central and West London Clinical Commissioning Groups: Strategic and Operational Planning 2014/15–2018/19		
The CCGs agreed to provide the Board with updates on dementia figures over the course of the forthcoming year. The Board agreed that the issues of Dementia and Care Planning should be discussed in more detail at the next meeting on 24 April.	Clinical Commissioning Groups	Completed. Completed.
Better Care Fund Plan		
The Board requested that more structured detail be provided on the process for the governance of the Plan, and on how decisions would be referred to the Health & Wellbeing Board.	Liz Bruce Cath Attlee	In progress

Meeting on Thursday 12th December 2013

Action	Lead Member(s) And Officer(s)	Comments
Integration Transformation Fund (Better Care Fund)		
The Board noted that although the national deadline for lodging the submission was 14 February 2014, it was hoped that this could be extended to enable the final document to be submitted to the Board for approval at its next meeting on 27 February. Prior to the next meeting, Board Members agreed to forward any comments or feedback on the draft submission to the Tri-borough Executive Director.	All Members of the Board	Completed.
The Mental Health and Wellbeing of Children and Young People in Westminster		
The Board agreed to establish a Task and Finish Group that could: i) look in more detail at the mental health and emotional needs of children and young people and parental mental health on a Tri-borough basis; ii) seek to identify any unmet need; and iii) consider how services should be arranged and commissioned in the future to achieve improved outcomes for Children and Young People. An initial meeting would be arranged between the Senior Policy Officer for Health & Wellbeing and the Children's Department to prepare a list of issues relating to mental health and young people, also liaising with CCGs and the Cabinet Member for Children & Young People.	Dr Ruth O'Hare Chris Swoffer	In progress Stakeholder launch completed First Meeting of Task and Finish Group – 8th April 2014
The Health & Wellbeing Strategy		
Members acknowledged the value of each Priority having a Board sponsor, who could provide support in driving delivery and by helping to build relationships with other organisations that may be involved. The Board agreed that sponsors for each item, together with achievable three-year targets, should be identified by the next meeting in February 2014.	All Members of the Board *Priority Leads*: Andrew Christie Tom Harding Roz King Cath Attlee	Board sponsors identified
Homeless Health Report		
The Board asked to receive an update on the recommendations set out in the report of the Task and Finish Group at its meeting in April 2014, and suggested that the report and recommendations be referred to the appropriate Policy & Scrutiny Committee.	Cllr Rachael Robathan (Chairman) Senior Policy & Strategy Officer.	Completed.

Joint Strategic Needs Assessment Update		
The Board discussed the 2014/15 JSNA Work Programme, and suggested that a JSNA be made of Childhood Obesity, which could seek to identify any new characteristics and formulate a more effective way forward.	Director of Public Health JSNA Steering Group	In progress.
Members agreed that the findings of a JSNA on housing for older people should be taken into account in Westminster's Housing Strategy.	Sue Atkinson (Interim Director of Public Health) JSNA Steering Group	Completed.
Members commented on the implications of Westminster's residents being unable to speak English, and agreed that this could be considered as part of a wider piece of work around access to services.	JSNA Steering Group	A JSNA application will be put together for discussion by the Steering group
Business Planning		
It was acknowledged that children's oral health was at a high level in elective surgery, and it was agreed that the Board would be provided with a briefing on oral health.	Eva Hrobonova (Public Health)	Completed.
The Central London and West London Clinical Commissioning Groups would return to the next meeting of the Board in February 2014, with a final draft of their commissioning intentions, so that a formal statement may be provided on whether they had taken proper account of the Westminster Health & Wellbeing Strategy.	Dr Ruth O'Hare Dr Naomi Katz	Completed.

City of Westminster

Westminster Health & Wellbeing Board

Date:	**18th September 2014**
Classification:	**Public**
Title:	**Better Care Fund Plan 2014-16 Revised Submission**
Report of:	**Liz Bruce, Executive Director Adult Social Care and Public Health**
Wards Involved:	**All**
Policy Context:	Development of an integrated Better Care Fund Plan is a requirement of the Department of Health and the Department for Communities and Local Government. Funding allocations to the Local Authority and to the local NHS in 2014-16 are dependent on agreement between the parties on the BCF Plan. In addition, the programme of work is consistent with the stated vision and objectives of the partners within the Westminster Health and Wellbeing Board, and is a mechanism for delivering the outcomes and efficiencies required from Better City, Better Lives.
Financial Summary:	The Better Care Fund brings together a number of existing funding sources, plus a small amount of new money. The Council contribution in 2015-6 is expected to be around £26m. CLCCG contribution in 2015-16 is expected to be around £42m. WLCCG contribution is around £10m in 2015-16. The Plan anticipates recurrent savings of around £15m across tri-borough partners by the end of 2015-16, if targets are fully achieved. These figures are still subject to revision prior to final resubmission.
Report Author and Contact Details:	**Cath Attlee, Whole Systems Lead, Tri-borough** **telephone 07903956961** **email cattlee@westminster.gov.uk**

1. Executive Summary

1.1 This paper reports on the requirement on the Health and Wellbeing Board to resubmit the Better Care Fund (BCF) Plan, which was previously agreed by the Health and Wellbeing Board in March 2014 and submitted to the Department of Health (DH) in April.

1.2 The plan is currently being revised but is not yet ready for presentation to the Board. However, it has to be submitted on 19th September. It is anticipated that the revised plan will be available either shortly before, or to be tabled at the Board meeting on 18th September.

1.3 The report explains that the plan contains some additional material and revision following further guidance and a revised template from DH and the Department for Communities and Local Government (DCLG).

1.4 The key changes relate to the Pay for Performance and Risk Sharing arrangements which mitigate the risk of local areas failing to achieve the key target of reduced emergency admissions, but reduce the investment in integrated care, and potentially increase the risk to social care.

2. Key Matters for the Board's Consideration

2.1 The Health and Wellbeing Board is recommended to note the requirement for resubmission and, once the final plan has been made available, to approve the revised BCF Plan for submission to NHS England by 19th September.

3. Background

3.1 The BCF is "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities". A national allocation of £3.8bn was announced in the summer of 2013 for this purpose.

3.2 The BCF does not come into full effect until 2015/16, but an additional £200m was transferred to local government from the NHS in 2014/15 (on top of the £900m already planned) and it is expected that Clinical Commissioning Groups (CCGs) and local authorities will use this year to transform the system. Consequently, a two year plan for the period 2014/16 had to be put in place by March 2014.

3.3 The BCF will support the aim of providing people with the right care, in the right place, at the right time, including expansion of care in community settings. This will build on CCG Out of Hospital strategies and local authority plans expressed locally through the Community Budget and Pioneer programmes.

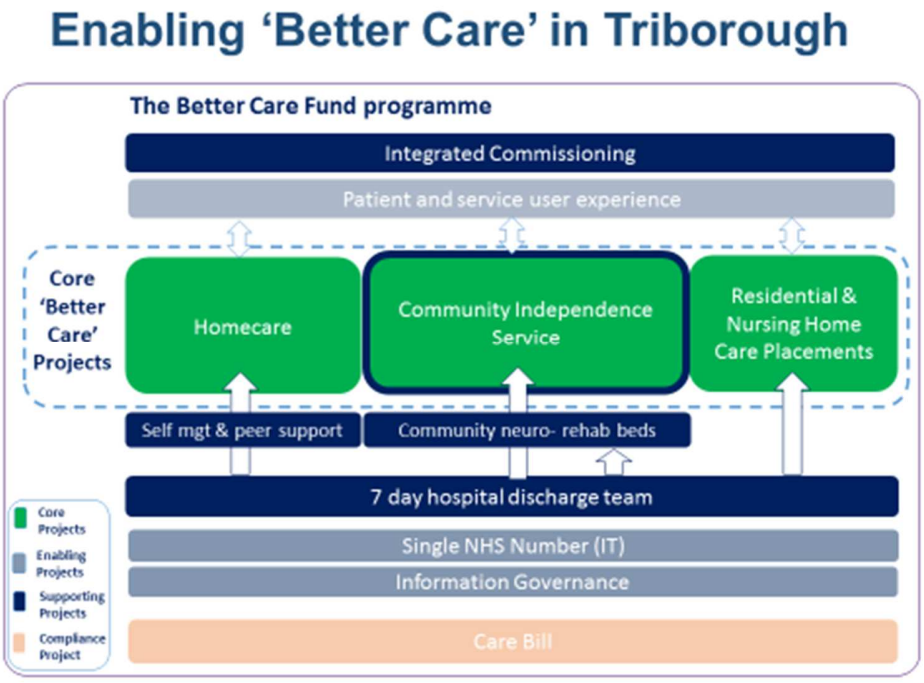
3.4 The development of an integrated BCF Plan is a requirement of the DH and the DCLG. Funding allocations to the Local Authority and to the local NHS in 2014-

16 are dependent on agreement between the parties on the BCF Plan. In addition, the programme of work is consistent with the stated vision and objectives of the partners within the Westminster Health and Wellbeing Board, and is a mechanism for delivering the outcomes and efficiencies required.

3.5 The Better Care Fund Plan was developed within the existing Whole Systems partnership between the local authority and the NHS, with service providers and with service user and carer representatives including HealthWatch, and reflects the shared aspirations for integrated care.

4. Requirement for Resubmission

4.1 The Health and Wellbeing Board approved the Better Care Fund Plan 2014-16 in March 2014 and the Plan was subsequently submitted to NHS England on 4th April. A summary of the BCF schemes is captured in the diagram below.



4.2 The Tri-borough BCF Plan was considered of good quality by NHS England (NHSE), the Local Government Association (LGA), DH and DCLG, and the three authorities were among a small number approached in July to be "fast-track" BCF authorities, providing a further example to other authorities of how an acceptable BCF Plan could be developed (although this offer was declined). The plan was rated 2nd nationally following more detailed work on finance and metrics and external assurance.

4.3 Other parts of the country, however, were not able to submit satisfactory plans. In addition concerns were expressed, particularly by the hospital sector, about the arrangements for local risk sharing and pay for performance. A key ambition

of the BCF is reducing pressures arising from unplanned admissions to hospital. There was a lack of confidence in the ability of CCGs and local authorities to deliver the necessary changes to achieve this ambition within the timescale and, consequently, a fear that funding would be transferred from the NHS to local authorities but that acute activity would continue unabated.

4.4 Consequently, in July 2014, Health and Wellbeing Board Chairs received letters from the DH and the DCLG announcing some changes to the BCF Programme. The changes related to the Pay for Performance and Risk Sharing arrangements which commence in 2015-16.

4.5 Each area has been asked to demonstrate how the BCF Plan will reduce emergency admissions, as a clear indicator of the effectiveness of local health and care services in working better together to support people's health and independence in the community.

4.6 A proportion of the performance allocation (the local share of the national £1bn performance element of the £3.8bn fund) will be payable for delivery of a locally set target for reducing emergency admissions (they suggested at least 3.5% reduction). The balance of the allocation will be available upfront to spend on out of hospital NHS commissioned services, as agreed by the Health and Wellbeing Board. This provides greater assurance to the NHS and mitigates the risk of unplanned acute activity. If the target for reducing admissions is not met, a proportion of the £1bn funding will remain with the NHS and not transfer to the BCF for joint use.

4.7 The reduction in unplanned admissions indicator will be the only indicator underpinning the pay for performance element of the BCF. Hospital providers are being asked to confirm agreement with the proposed reduction in non-elective activity.

5. The Revised Better Care Fund Plan

5.1 On 25th July NHSE and the LGA sent Health and Wellbeing Board Chairs revised BCF guidance and planning and templates for completion and submission by 19th September 2014. The revised BCF Plan is in preparation and will follow later, for approval by the Health and Wellbeing Board. The key changes from the BCF Plan previously approved by the Health and Wellbeing Board are as follows:

- Target reduction of around 3.5% in total emergency admissions (replaces the previous metric of approximately 5% reduction in avoidable emergency admissions). Funding linked to achievement of this target will be released by the CCG into the pooled budget on a quarterly basis, depending on performance, starting in May 2015, based on Q4 performance in 2014-15.

- The remainder of the £1bn national fund (the performance element of the £3.8bn) will be released to the CCG upfront in Quarter 1 in 2015-16.

5.2 If the locally set target for reduction in emergency admissions is achieved, all of the funding linked to performance will be released to the Health and Wellbeing Board to spend on BCF activities. Achievement will be measured against the total figure for the whole area, not just against those activities within the BCF Plan.

5.3 It should be noted that if the target is not achieved, the remaining performance money will not leave the local area, it will remain with the CCG to compensate for unplanned acute activity or spend on NHS commissioned services, in consultation with partners on the Health and Wellbeing Board.

5.4 The system is designed to mitigate the financial risk to the CCG, whilst at the same time providing flexibility to deliver schemes that reduce acute activity. The revised arrangements need to be taken into account in both CCG and Local Authority planning for 2015-16.

5.5 Local authorities nationally have expressed concerns at the changes which step back from the core purpose of promoting locally led integrated care and reduce the resources available locally to protect social care and prevention initiatives.

5.6 However, within the Tri-borough area there is confidence that the target level of reduction in emergency admissions can be achieved so that the maximum level of allocation will be transferred to the BCF pooled budget for integrated services.

5.7 The NHS commissioned services can include NHS spend on those services currently commissioned by the local authority on behalf of the NHS or commissioned jointly through s75 agreements, which form a significant element in the Tri-borough BCF.

5.8 There is, however, a risk to Adult Social Care from these changes and the position will need to be monitored closely through the year to assess progress against target and the impact of any shortfall in the pooled budget on integrated services. A reduction in emergency admissions is likely to lead to an increased use of social care which needs to be funded.

5.9 The revised plan will provide additional material in relation to the following areas:

- **The case for change** – analysis and risk stratified understanding of where care can be improved by integration, which has informed the key BCF workstreams of community independence services including reablement and 7 day working.

- **A plan of action** – a clear evidence based description of the delivery chain which will support a reduction of emergency admissions, developed with all local stakeholders and aligned with CCG, local authority, provider and whole system strategies.

- **Strong governance** – confirmation of local management and accountability arrangements and description of tracking arrangements to monitor the impact of interventions, take action to address slippage, and robust contingency plans and risk sharing arrangements across providers and commissioners locally.

- **Protection of social care** – this reflects existing funding transferred via s256 from NHS England for current levels of work. The level of protection of social care identified for Westminster in 2014-15 is £4.736m plus £122k identified for implementation of the Care Act; in 2015-16 £4.676m plus £625k for the Care Act.

- **Alignment with acute sector and wider planning** – evidence of alignment with the NHS two-year operational plans, five year strategic plans, and plans for primary care as well as the local authority. Evidence is provided that providers are engaged in the BCF programme and have understood the impact of the plan on their services.

5.10 In addition the revised BCF Plan will set out in more detail the amount of funding going into carer support and the nature of that support.

6. Consultation

6.1 The revised BCF template seeks evidence of provider engagement in the development of the BCF programme and understanding of the impact which BCF changes would make to activity. Discussions have been held with major providers, acute and community, during June-September to increase their awareness of the detailed BCF programme. The strategic plans already agreed with local hospitals include a significant shift of work into the community and a reduction in emergency admissions.

6.2 Shaping a Healthier Future (SaHF) and the Out of Hospital Strategies set out the plan to reconfigure hospital services to focus on the needs of patients. These plans have been developed and consulted upon, with local authority, acute, community and mental health services and other local stakeholders fully engaged. The plans contained in the BCF are consistent with SaHF plans to shift work to community / primary care settings.

6.3 Acute Trusts are aware of the Better Care Fund and its intention to strengthen and harmonise the approach to community care and confidence in out of hospital provision, particularly through links to the Urgent Care Boards. The CCGs currently have risk sharing arrangements in place with local acute providers relating to activity reductions, and these would be maintained. Arrangements for further engagement at Chief Executive level prior to plan re-submission are in progress. There will also be further engagement with all providers over the coming months to involve them in co-design of in depth solutions facing the health and social care economy in Tri-borough.

6.4 The BCF draws on the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessments across all boroughs, informed by patient and service user feedback. The approach to developing the BCF is characterised by co-design and co-delivery, supported by extensive stakeholder engagement, including with clinicians, other CCGs and local authorities, provider organisations and national bodies.

7. Financial Implications

7.1 A summary of the financial implications included in the original BCF Plan is in the table below. In 2015-16 the minimum value required of the BCF Pooled Budget is £47.836m and the Tri-borough authorities are proposing around £210m. Of this, around £26m will come from Westminster City Council and around £42m from CLCCG. WLCCG contribution to Westminster (for QPP) will be around £10m. **These figures will be refined prior to resubmission.**

7.2 It is estimated that the programme will contribute to the delivery of around £15m in savings across Tri-borough partners by the end of 2015/16, if targets are fully met, as shown in the table below. **This figure will be refined prior to resubmission**.

7.3 We have constructed and are finalising a detailed financial and activity model which demonstrates the linkages and flows of costs and benefits across health and social care as a result of the new proposed ICR/CIS. The model is based on current data and agreed assumptions of the technical working group. At the core of this, is the new Integrated Crisis Response / Community Independence Service and the linkages between that service, homecare and residential and nursing home placements.

7.4 The model will enable the local authority and CCGs to take an informed view over the different pressures and costs of redesigning core components of our of hospital care and the subsequent shift in activity and flows of people in order to come to a mutually beneficial agreement over the impacts and associated reimbursements. **This is required to provide reassurance to the local authorities that social care will not be negatively impacted by the BCF.**

7.5 The revised BCF Plan includes figures based on current estimates of costs and savings. These are continually being refined and it is anticipated that revised proposals will be submitted periodically through 2014-15 as the detailed modelling of the integration work is undertaken.

Tri-borough Better Care Fund Financial Summary (July 2014)

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 '000	Minimum contribution (15/16) '000	Actual contribution (15/16) '000	Anticipated Benefit
Westminster City Council	Y	*28,765*	*1,379*	*26,252*	4,896
Royal Borough of Kensington and Chelsea	Y	*22,946*	*874*	*22,004*	
London Borough of Hammersmith and Fulham	Y	*49,720*	*1,052*	*47,781*	
Central London CCG	N	*26,171*	*13,553*	*42,768*	3,366
West London CCG	N	*15,811*	*17,830*	*39,746*	3,572
Hammersmith and Fulham CCG	N	*12,630*	*13,148*	*31,923*	3,873
BCF Total		**156,043**	**47,836**	**210,474**	**15,707**

Actual savings will be tracked by borough or, where at tri-borough level, will be pro-rated by population. Our intention is for the local authorities to hold the pooled budget, but the pooling agreement will recognise that each scheme will be led by the most appropriate commissioner, either LA or CCG.

8. Legal Implications

8.1 The DH and the DCLG have established a multi-year fund, confirmed in the Autumn Statement, as an incentive for councils and local NHS organisations to jointly plan and deliver services, so that integrated care becomes the norm by 2018. A fund will be allocated to local areas in 2015/16 to be put into pooled budgets under Section 75 joint governance arrangements between CCGs and Councils. A condition of accessing the money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

8.2 Legislation is needed to ring-fence NHS contributions to the Fund at national and local levels, to give NHS England powers to assure local plans and performance, and to ensure that local authorities not party to the pooled budget can be paid from it, through additional conditions in Section 31 of the Local Government Act 2003, which will allow for the inclusion of the Disabled Facilities Grant.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:
Cath Attlee, Whole Systems Lead, Tri-borough
telephone 07903956961

email cattlee@westminster.gov.uk

BACKGROUND PAPERS:

Tri-borough Better Care Fund Plan Resubmission September 2014
Tri-borough Better Care Fund Plan – March 2014
Tri-borough BCF Finance and Outcomes Spreadsheet March 2014

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City of Westminster

Westminster Health & Wellbeing Board

Date:	**18 September 2014**
Classification:	**Public**
Title:	**Central London CCG Contracting Intentions 2015/16**
Report of:	**Managing Director of Central London Clinical Commissioning Group**
Wards Involved:	**All except Queen's Park and Paddington**
Policy Context:	**Healthcare**
Financial Summary:	**N/A**
Report Author and Contact Details:	Kiran Chauhan, Deputy Managing Director, Central London CCG Email: kiran.chauhan4@nhs.net

1. Executive Summary

1.1 Central London CCG is currently in the process of developing its Contracting Intentions for 2015/16, which will be issued to providers in October 2014. Attached is an overview of the approach being taken by the CCG in developing these intentions.

2. Key Matters for the Board's Consideration

2.1 The Health and Wellbeing Board is requested to review and comment on the attached overview of the Central London CCG Contracting Intentions for 2015/16.

3. Background

3.1 The CCGs are currently developing their commissioning plans for 2015/16. This year, two documents will be produced:

- A document known as Contracting Intentions, for which the specific audience is provider organisations. This will be circulated to providers in early October 2014.

- A public and stakeholder facing document, which will be made available by December 2014.

3.2 The 2015/16 Contracting Intentions will have two main angles:

- The delivery of the key NWL strategic priorities, including patient empowerment, primary care transformation, Whole Systems Integration and service reconfiguration.
- Responding to local issues, gaps and priorities.

3.3 At present, the CCG is using the attached slide pack as an overview of the key strategic themes and the local priorities within them. In September, the Contracting Intentions will be drafted and signed off by the Governing Body, prior to circulation to providers in early October.

4. Legal Implications

4.1 N/A

5. Financial Implications

5.1 N/A

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

Kiran Chauhan, Deputy Managing Director, Central London CCG
Email: kiran.chauhan4@nhs.net

APPENDICES:

Appendix1: An overview of the Central London CCG's approach to developing its 2015/16 Contracting Intentions is attached.

NHS
Central London
Clinical Commissioning Group

Westminster Health and Wellbeing Board 18 September 2014

Contracting Intentions for 2015/16

Developing commissioning intentions

NHS
Central London
Clinical Commissioning Group

Key points about developing the intentions this year:

- A move away from the 'annual' approach to intentions – we will engage with staff and patients but will draw on the all the work we have done through the year
- Providers are the specific audience in the first instance - more 'contracting intentions' than 'commissioning intentions' – by September
- Two angles: what do we need to do this year to:
  - Progress the delivery of our 'big ticket' strategic plans?
  - Respond to local issues?
- A separate public facing document will be produced for the end of the year

Developing commissioning intentions

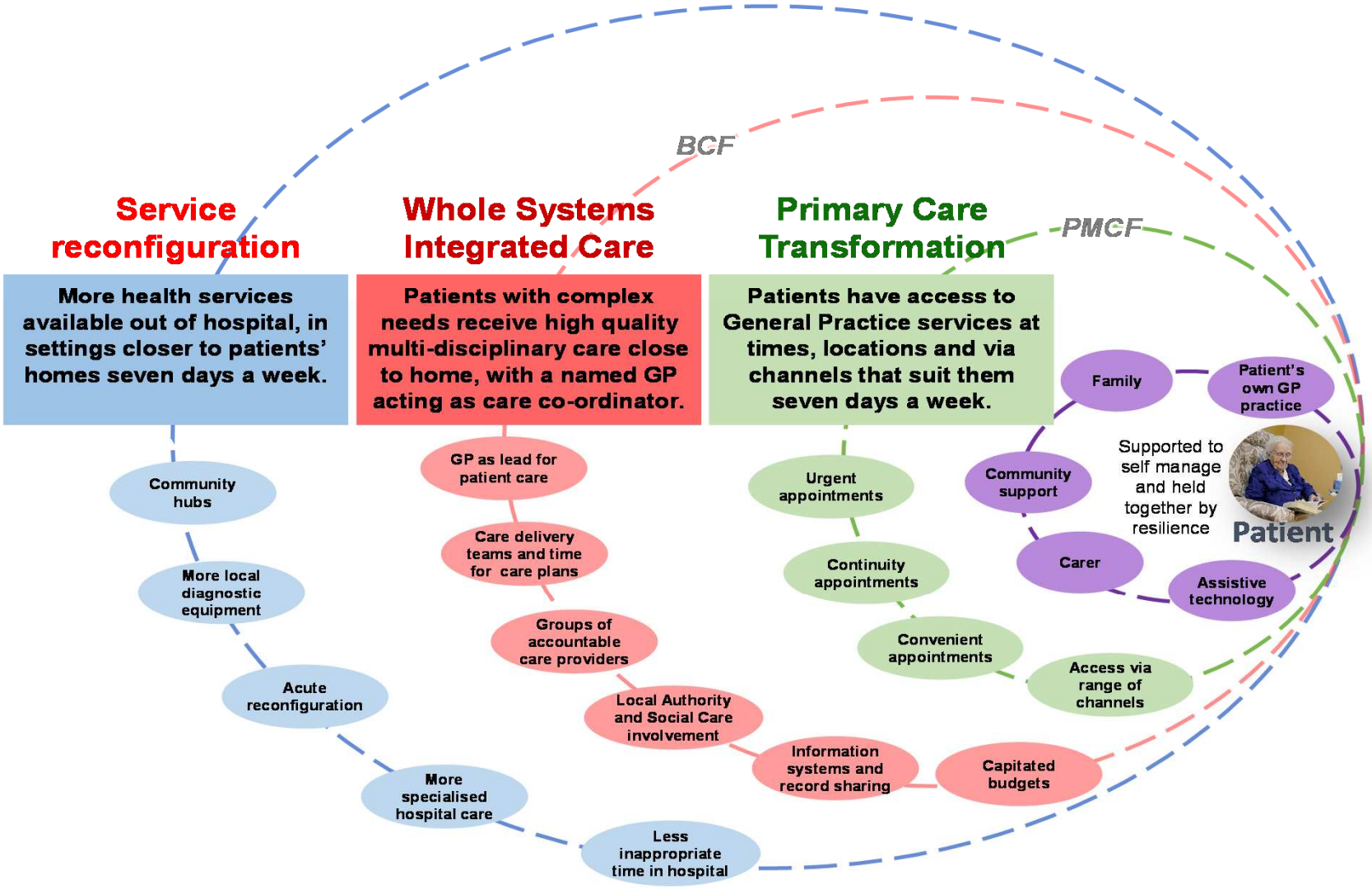
NHS
Central London
Clinical Commissioning Group

Today we will …

- Share the headlines for this year
- Have a discussion and gather some feedback on:
  - Whether there are any gaps
  - Whether there are current programmes we need to do more with
  - Whether there are priorities that are not adequately covered
- Set out the next steps & timescales

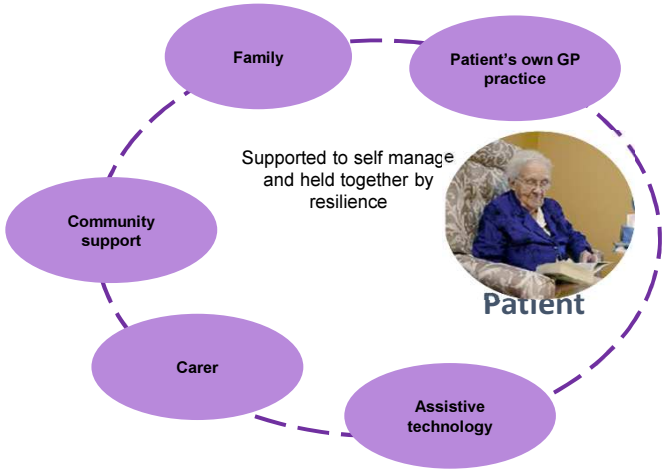
Strategic Priorities

NHS
Central London
Clinical Commissioning Group



Patient Empowerment

NHS
Central London
Clinical Commissioning Group



What will help delivery?

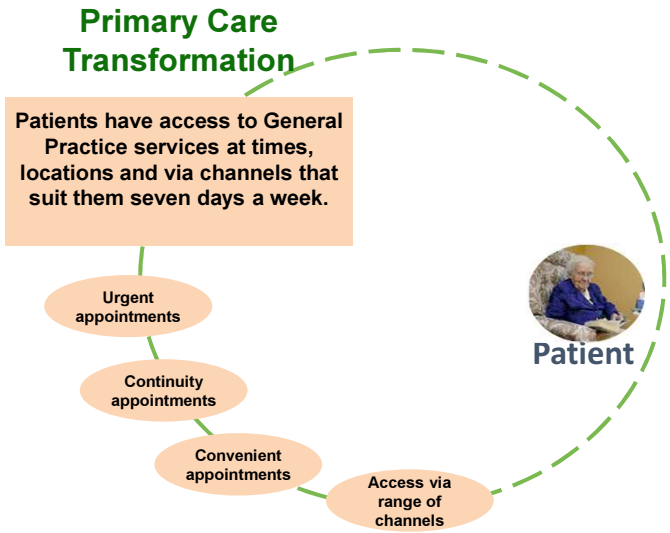
- Lay person group established
- Co-design and co-production

Deliverables 2015/16 (Central)

- Continue to commission the Expert Patient Programme (EPP)
- Introduce an online version of the EPP
- Strengthen the choices available to patients to support self-management through the Better Care Fund
- Better understanding of the current gaps in transport services
- Ensure providers produce quarterly patient experience reports
- Work collaboratively with Health and Social Care organisations to embed patient and carer experience
- Continue to implement the 360 action plan
- Continue to work with the User Panel to strengthen how the CCG engages with local patients and communities
- Investigate opportunities to increase support available to patients with a communications barrier
- Village Asset and Needs Assessment

Primary Care Transformation

NHS
Central London
Clinical Commissioning Group



What will help delivery

PM Challenge Fund

- Network development
- New legal entities
- 7 day working

Out of Hospital contracts

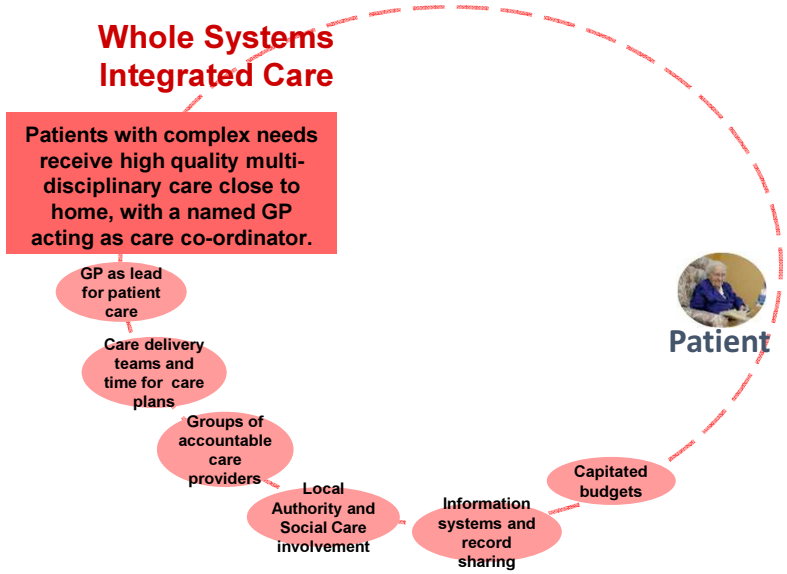
Workforce

Deliverables 2015/16 (Central)

- Invest in primary care services to support SAHF
- Increase access to primary care through increasing Skype and assisted technology
- Increase capacity at evenings and weekends
- Ensure patients on multiple medications have a medication review
- Review patients whose outcomes do not match their medications
- Increase compliance through using hybrid homecare workers and other care professionals to identify possible issues
- Review discharge medication for patients following an inpatients stay to minimise medication conflicts

Whole Systems Integrated Care

NHS
Central London
Clinical Commissioning Group



What will help delivery?

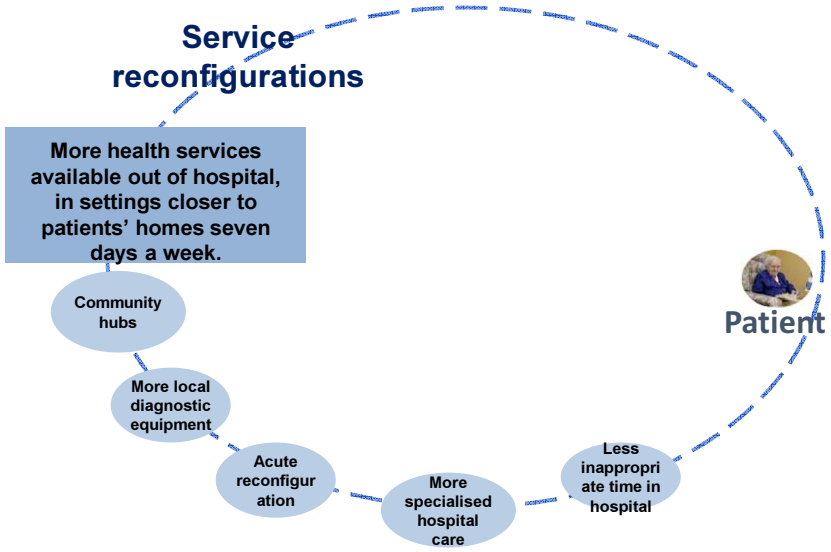
- Better Care Fund
- Joint governance arrangements
- Pooled budgets
- Integrated community recovery services
- Joint homecare tenders
- QIPP
- Workforce
- WSIC enabling infrastructure OOH hubs

Deliverables 2015/16 (Central)

- Re-designed Crisis Response/Community Independence service
- Strengthening primary care through integration and alignment with other key services
- Deliver outstanding primary care
- Adopt WSIC model of care in village setting and identify care provision for other patients
- Children/young persons multi-disciplinary team in all villages
- Implement method for self reported wellbeing, using patients' life priorities in their care plan
- Falls provision/geriatrician input into villages
- Deliver all H&WB strategy actions
- Deliver an integrated physical and mental health service supporting homeless patients
- Commission a targeted intermediate care facility linked to local hostel provision to support patients with discharge from hospital/avoiding admission.
- Support peer advocacy with Groundswell.
- Rationalise existing care planning services
- Deliver care plans for those that need them which are shared via the single system with agreed care professionals, patients and care co-ordinators.
- Support those patients who are diagnosed with a long term condition through education and information to manage their LTC and stay well

Service Reconfigurations (1 of 2)

NHS
Central London
Clinical Commissioning Group



What will help delivery?

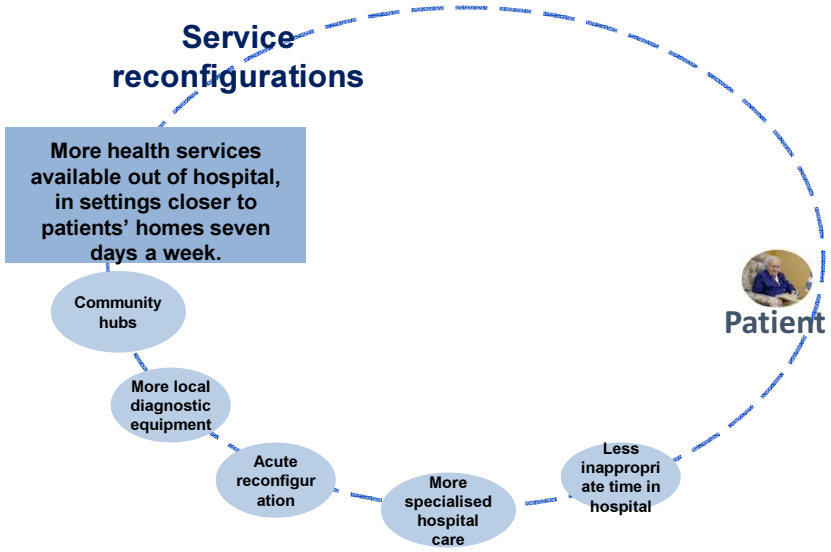
- 7 day working
- Mental health transformation
- Local Hospital Business Cases
- Major Hospital Business Cases
- Out of Hospital Strategies
- Clinical standards
- QIPP

Deliverables 2015/16 (Central)

- Review provision of end of life care
- Expand Connecting Care for Children to cover all villages and develop services in childrens centres
- Start programme to refurbish and refit existing care homes
- Quantify future care home need and work with LA to increase capacity
- Work with the LA to mobilise the hybrid workers, working with homecare to link into WSIC.
- Improve outcomes for mothers and babies especially in hard to reach groups
- Identify areas that a WSIC approach may benefit troubled/complex families
- Reviewing provision for 15-17 year olds and transitioning to adult services, jointly with LA
- Implementation of personal budgets
- Work with the Local Authority to implement childhood obesity reduction strategy
- Implementation follow through to mobilise the St Mary's UCC contract using the Shaping a Healthier Future specification
- Re-procurement of 111 service
- Potential extension of out of hours service for opted out practices if service not re-procured

Service Reconfigurations (2 of 2)

NHS
Central London
Clinical Commissioning Group



What will help delivery?

- 7 day working
- Mental health transformation
- Local Hospital Business Cases
- Major Hospital Business Cases
- Out of Hospital Strategies
- Clinical standards
- QIPP

Deliverables 2015/16 (Central) Mental Health & Learning Disabilities

- Continued implementation of Primary Care Plus pilot and formal tendering of future service
- Continue to commission levels of capacity to achieve targets for IAPT and put in place plans for future commissioning based on outcome of work across the 8 CCGs
- Continue to improve liaison psychiatry services
- Continue to deliver national targets on dementia
- Improve the resources available in the community for perinatal mental health
- Continue to implement training on suicide prevention.
- Continue work on urgent care assessment and care pathway re-design
- Implement the outcomes of the Parental Mental Health/Health & Wellbeing Board workstreams working groups
- Improve CAMHS provision, especially in respect of out of hours access, behavioural support, equality of access and looked after children pathway
- Improve services for people with learning disabilities, including services for those with dual diagnosis, the range of services available, independent living

Developing commissioning intentions: What are our key local issues?

NHS
Central London
Clinical Commissioning Group

What are the gaps in service/local pathway priorities we want to address?

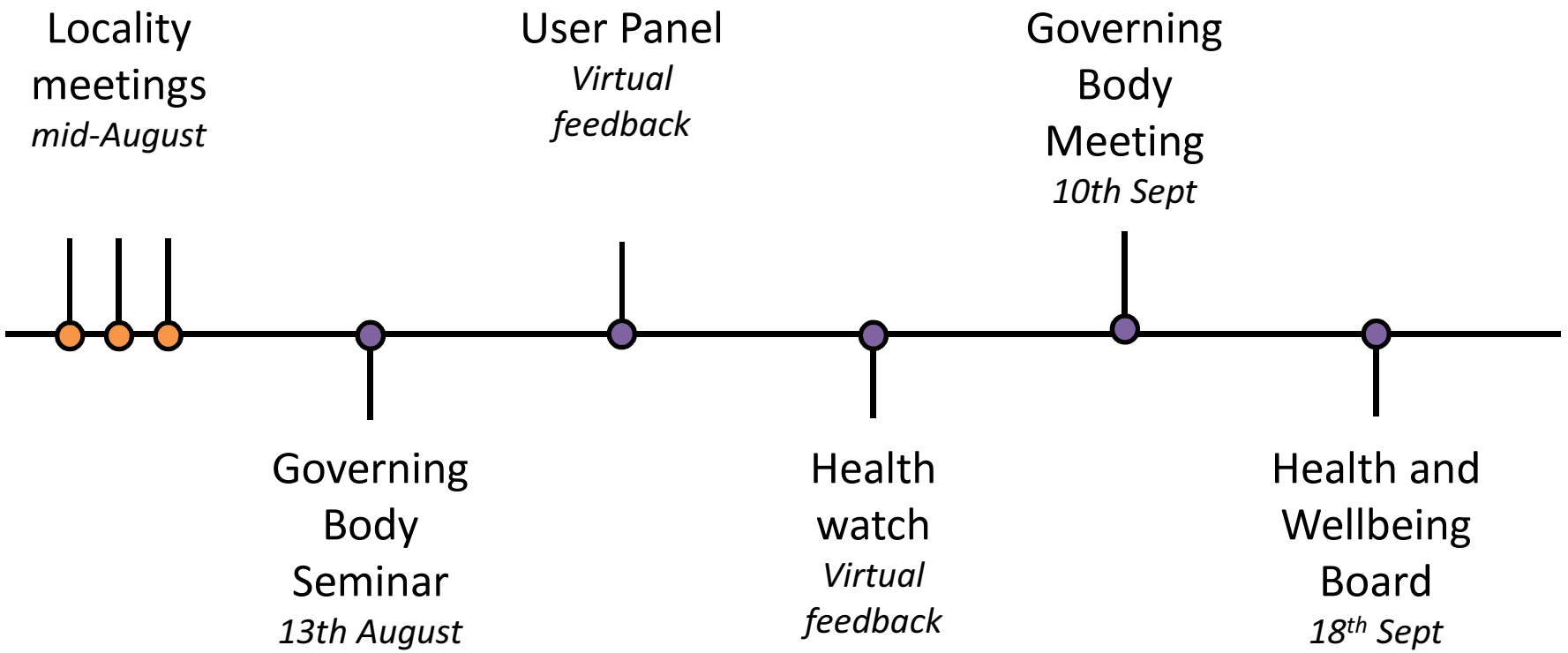
- Child health. Do we need to do more in respect of:
  - maternity, given current provider performance on key indicators
  - **child and adolescent mental health)**
  - **childhood obesity) Joint with partner agencies**
  - **childhood dental care)**
  - complex families

On prevention are we doing enough in respect of:

- falls
- **sexual health – joint with partner agencies**
- mental health investment

We have a plan to engage with stakeholders in developing our commissioning plans…

NHS
Central London
Clinical Commissioning Group



Next steps

NHS
Central London
Clinical Commissioning Group

Timescale	Action
August	Draft intentions developed through work with stakeholders
September	Draft document reviewed by Governing Body
	Draft contracting intentions share with the public at AGM
End September	Sign-off final version in line with delegated authority from the Governing Body
October	Contracting intentions shared with providers
October – December	Develop public facing document describing our intentions

City of Westminster

Westminster Health & Wellbeing Board

Date:	18 September 2014
Classification:	Public
Title:	West London CCG Contracting Intentions 2015/16
Report of:	Managing Director of West London Clinical Commissioning Group
Wards Involved:	Queen's Park and Paddington
Policy Context:	Healthcare
Financial Summary:	N/A
Report Author and Contact Details:	Katie Beach, Head of Strategic Planning, West London CCG Email: katie.beach@inwl.nhs.uk

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4. Legal Implications

4.1 N/A

5. Financial Implications

5.1 N/A

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

Katie Beach at katie.beach@inwl.nhs.uk

APPENDICES:

Appendix1: An overview of the West London CCG's approach to developing its 2015/16 Contracting Intentions is attached.

ITEM: 5b1

NHS
West London
Clinical Commissioning Group

West London CCG Contracting Intentions 2015/16

Westminster Health and Wellbeing Board

18 September 2014

Approach to developing CIs

NHS
West London
Clinical Commissioning Group

- Providers are the specific audience for contracting intentions in the first instance – due to be circulated by 1 October

- Two angles:
  - Delivery of 'big ticket' strategic plans
  - Responding to local issues

- Responding to PPE feedback received throughout the year

- A separate public facing document will be produced for the end of the year

Timeline

NHS
West London
Clinical Commissioning Group

Timescale	Action
August	• Draft intentions developed through work with stakeholders • Engagement with CLSs, Governing Body and PPE groups
September	• Engagement with Health and Wellbeing Boards • Draft document refined • Draft document shared with Governing Body and other stakeholders for input • Plans shared with public at AGM
End September	• Sign-off final version in line with delegated authority from the Governing Body
October	• Contracting intentions shared with providers
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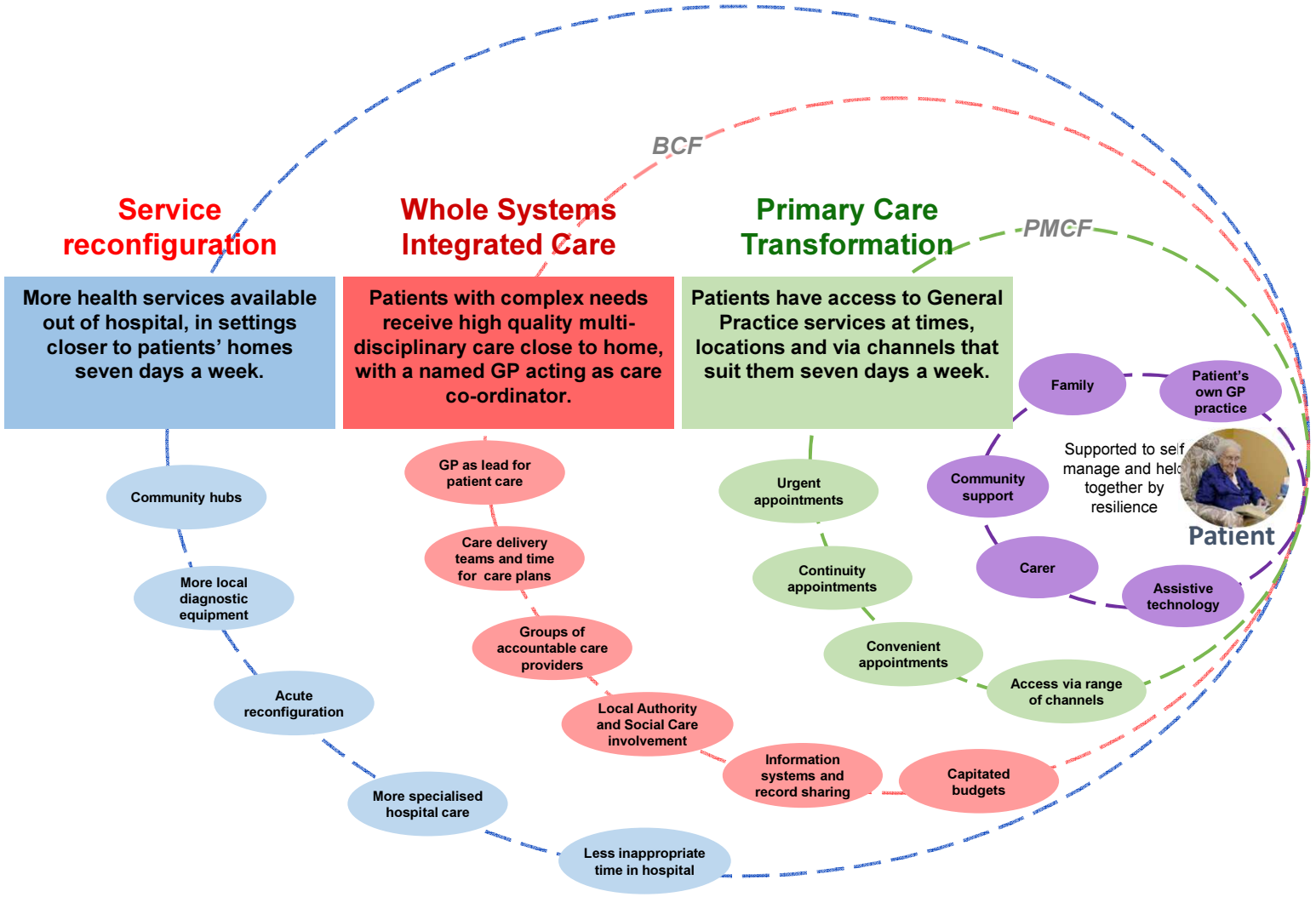
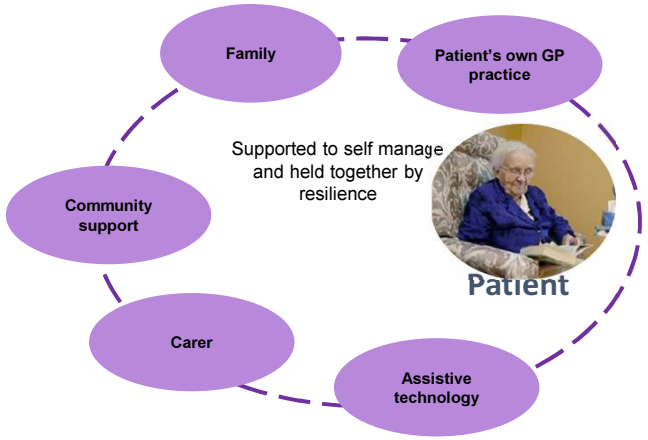
Strategic Priorities

NHS
West London
Clinical Commissioning Group



Patient Empowerment

NHS
West London
Clinical Commissioning Group



Enablers

- Lay person group established
- Co-design and co-production
- Better Care Fund

Deliverables 2014/15

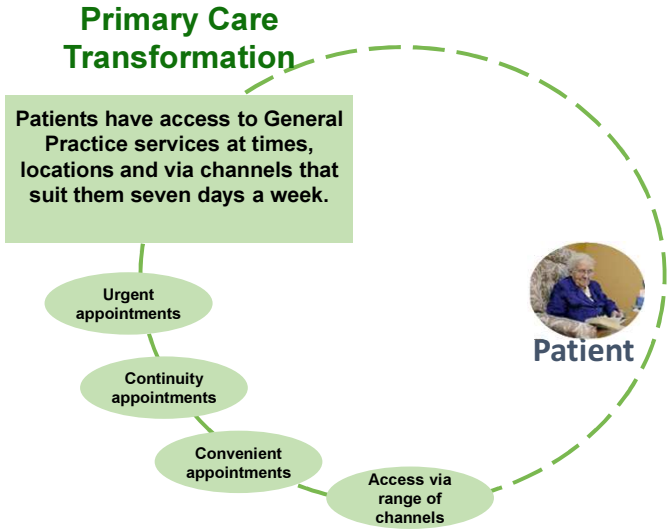
- Design of Better Care Fund patient experience and self management programmes
- Primary Care Navigators to be rolled out
- Expert Patient Programme tender
- Patient and Public Engagement grants bidding process to be complete and projects to launch in Q3
- Launch of health roadshows and health mentoring
- Continued support to Patient Participation Groups, including creating PPG forums at Commissioning Learning Set and CCG level
- Carer Primary Care Navigator project implemented to improve identification of carers in Primary Care
- Carer Hospital Discharge project implemented to treat carers as expert partners in care
- Personal health budgets for Continuing Healthcare patients

Deliverables 2015/16

- Mobilisation of new Expert Patient Programme
- Continuation of Patient and Public Engagement grants commissioned in 2014/15
- Continuation of health roadshows and health mentoring
- Continuation of support to Patient Participation Groups
- Better Care Fund patient experience and self management programmes to be piloted/commissioned
- Embed Learning Disability into existing engagement processes by making them fully accessible
- Widening of patient/customer groups who will be offered Personal Health Budgets
- Anyone who would benefit from a Personal Health Budget has a 'right to ask'

Primary Care Transformation

NHS
West London
Clinical Commissioning Group



Enablers

- Prime Minister's Challenge Fund
- Federation development
- New legal entities
- 7 day working
- Out of Hospital contracts
- Workforce

Deliverables 2014/15

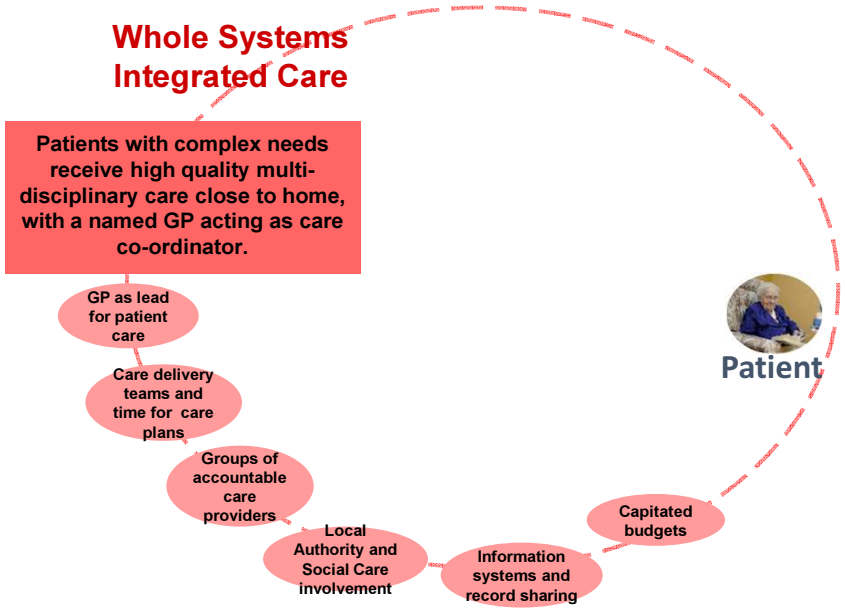
- Commission out of hospital services at federation level
- Federation(s) established
- Federation(s) to agree their delivery plan for 2014/15 (including organisations development requirements)
- Initial business change in place in primary care (e.g. online appointment booking / email consultations etc)
- Models of federated service delivery agreed

Deliverables 2015/16

- 7 day/week primary care services in operation in practices within federation(s)
- A range of consultation methods available to patients (telephone/email/Skype)
- Out of hospital contracts commissioned from federation(s) achieving full population coverage
- Shared electronic patient records
- Patients accessing their records online

Whole Systems Integration

NHS
West London
Clinical Commissioning Group



Enablers

- Better Care Fund
- Joint governance arrangements
- Pooled budgets
- Integrated community recovery services
- Joint homecare tenders
- Workforce
- Whole Systems Integrated Care enabling infrastructure Out of Hospital hubs (St Charles)

Deliverables 2014/15

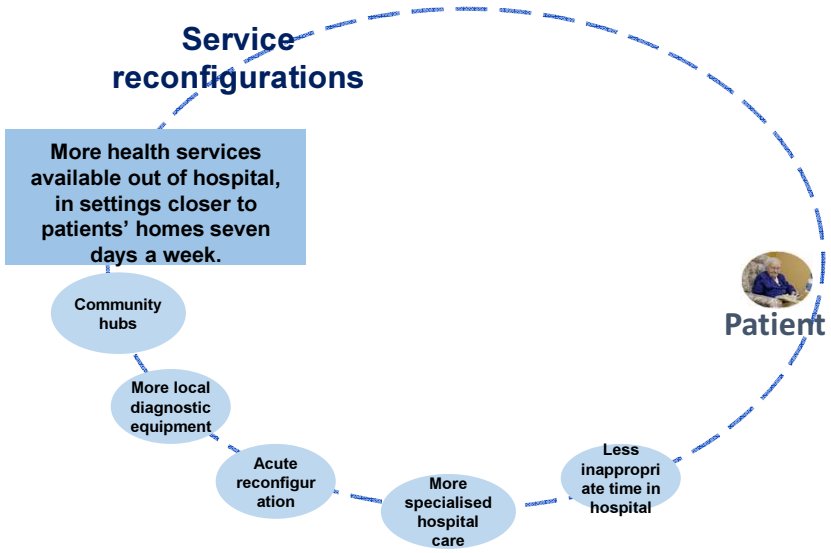
- Undertake co-production and develop models for older adults and patients with long-term mental health needs
- Develop business cases and implementation plans
- Trial new ways of working and organisational development
- Provide linked dataset with local capitation values and analysis
- Create provider and commissioner dashboards
- Agree NWL-frameworks for new commissioning and provider vehicles
- Provide costing tool for new models of care
- Older adults' support team pilot
- New Community Independence Service specification to be agreed

Deliverables 2015/16

- New models of care in place for older adults and patients with long-term mental health needs
- 7-day services in operation
- Health and social care commissioners holding multi-provider 'accountable care partnerships' to account for delivery of population health outcomes
- New payment model in operation
- 7 day Community Independence Service in operation, including single point of access
- Older adults' team in operation

Service Reconfigurations

NHS
West London
Clinical Commissioning Group



Deliverables 2014/15

- Complete baseline self-assessment against 10 clinical standards for 7-day services (all acute Trusts with partners)
- Agree priorities and sequence for implementation of 7 day standards across the non-elective pathway/develop action plan
- Achieve priority standards for 14/15 (including as per 7 day CQUINs)
- Integrated mental health emergency pathway in place
- Planned care procurements (respiratory, cardiology, ophthalmology, dermatology, diagnostics)
- Design of model for urgent care provision at St Charles
- Initiation of procurements for 111, GP Out of Hours and Chel West Urgent Care Centre
- Children's hub pilots

Enablers

- 7 day working
- Mental health transformation
- Local Hospital Business Cases
- Major Hospital Business Cases
- Out of Hospital Strategies
- Clinical standards

Deliverables 2015/16

- Achieve agreed priority 7-day clinical standards for 15/16, including those included within the national acute contracts
- Mental health and wellbeing strategy
- Activity shift into community for planned care procurements undertaken in 14/15
- Procurements for musculo-skeletal and potentially gynae and urology
- Procurement and mobilisation of 111 service, GP Out of Hours service and Chel West Urgent Care Centre
- ?Procurement and mobilisation of new model for urgent care at St Charles
- Mental health programmes, including shifting settings, urgent assessment and care, psychiatric liaison, Improving Access to Psychological Therapies and dementia
- Children's hubs evaluation

Alignment to local needs (1)

NHS
West London
Clinical Commissioning Group

West London CCG priority area	Examples of West London CCG schemes	Alignment to RBKC and Westminster JSNAs and Health and Wellbeing Strategies
Integration	• Whole Systems Integrated Care programme for patients aged over 75 • Putting Patients First (care planning and case management) • Redesign of Community Independence Service • 7 day working across health and social care, including 7 day discharge • Sharing patient records (SystmOne)	RBKC has Health and Wellbeing Strategy themes for making better use of resources to improve outcomes, as well as safe and timely discharge from hospital. Westminster has Health and Wellbeing Strategy themes for ensuring access to appropriate care at the right time and supporting people to remain independent for longer. These themes are supported by the CCG's plans to work with partners to achieve integration and 7 day working across health and social care.
Mental health	• Development of Whole Systems Integrated Care programme for patients with long-term mental health needs • Continuing focus on referral into Improving Access to Psychological Therapy (IAPT) services and IAPT recovery • Continuing focus on improving rates of dementia diagnosis	RBKC had the highest population with severe and enduring mental illness known to GPs in 2012/13 and Westminster had the 4th highest population. Common mental illness affects 1 in 6 people at any one point in time. Dementia prevalence will increase significantly over the next decade. The CCG's local schemes support improvements in services in all of these areas. RBKC has a Health and Wellbeing Strategy theme related to accessible and flexible mental health/substance misuse services, which is supported by West London CCG's work in these areas.

Alignment to local needs (2)

NHS
West London
Clinical Commissioning Group

West London CCG priority area	Examples of West London CCG schemes	Alignment to RBKC and Westminster JSNAs and Health and Wellbeing Strategies
Planned care and long-term conditions	• Redesign and procurement of community services for cardiology and respiratory • Review and potential procurement of the MSK community service • Procurement of a community ophthalmology service • Self management schemes being reviewed through the Better Care Fund	Cardiovascular disease and COPD are amongst the most common causes of premature death in both RBKC and Westminster. MSK disorders have a significant impact on quality of life. The CCG has firm plans to commission services closer to home in these areas. Patient engagement in self-management schemes has tended to be poor in both RBKC and Westminster. The Better Care Fund presents an opportunity to ensure these schemes are reviewed and commissioned to support need.
Children	• Roll out and review of multi-disciplinary children's hubs (Connecting Care for Children) • Review and pre-procurement of out of hours Child and Adolescent Mental Health Services (CAMHS), along with implementation of outcomes from national CAMHS review	The JSNAs and Health and Wellbeing Strategies for both RBKC and Westminster identify children's services, and supporting children to have the best start in life, as priorities.
Primary Care	• Prime Minister's Challenge Fund initiatives, including improved access and 7 day working • Commissioning of Out of Hospital contracts (for services such as diabetes care, mental health and end of life care) to ensure population coverage and equity	The JSNA for RBKC identifies that levels of satisfaction with GP practices are better than London and England averages. For Westminster, satisfaction levels are similar to London averages but lower than England averages. Improvement in patient satisfaction with GP practices and ensuring consistent services are available across the CCG areas are key priorities for the CCG.

Any questions?

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City of Westminster

Westminster Health & Wellbeing Board

Date:	**18th September 2014**
Classification:	**Public**
Title:	**Primary Care Commissioning**
Report of:	**NHS England (London Region)**
Wards Involved:	**All**
Policy Context:	**Health**
Financial Summary:	**None**
Report Author and Contact Details:	Karen Clinton, Health of Primary Care North West London, NHS England (London Region) Karen.clinton@nhs.net

1. Executive Summary

1.1 This report provides detail on how NHS England (NHSE) perform their responsibilities for primary care commissioning and when decisions are made that relate to primary care, how the impact on the local health and care system is taken into account.

2. Key Matters for the Board's Consideration

2.1 The Westminster Health and Wellbeing Board is asked to note the information provided by NHS England in the attached report about the commissioning and quality assurance of primary care services and consider:

a.) how the Health and Wellbeing Board should seek to support and influence primary care commissioning to ensure it reflects local need, when exercising their role in providing local system leadership;

b.) whether the Health and Wellbeing Board should work with NHSE and West London CCG (WLCCG) to monitor and improve the quality of primary care; and

c.) how to maximise the opportunities that might be available through the introduction of co-commissioning of primary care services between NHSE, West London Clinical Commissioning Group and Central London Clinical Commissioning Groups.

3. Background

3.1 Primary care services are many people's first point of contact with the NHS. The main source of primary health care is general practice, but primary care also includes dental practice, community pharmacy and high street optometrists.

3.2 The Health and Social Care Act 2012 made a number of changes to the way that primary care is commissioned. Since April 2013, NHSE has been solely responsible for the commissioning of primary care services. Clinical Commissioning Groups have a responsibility to help improve the quality of primary care services.

3.3 Health and Wellbeing Boards, as local system leaders, should develop strong relationships with NHSE to help ensure that primary care services within their area align with the needs of residents and local system change.

3.4 The attached report from NHS England sets out more information about how primary care commissioning is undertaken by NHS England and what future changes might look like. It also set out how NHS England engages with the local health and care system and what work will be underway in 2014/15.

3.5 The Health and Social Care Information Centre suggests that around 90% of patient interaction is with primary care services. As such, access to good quality, primary care is absolutely central to improving the health outcomes for our local population and to the deliverability of our key local system change programmes such as Shaping a Healthier Future, whole systems integration and the Better Care Fund Plan.

3.6 The attached report at Appendices 2 and 3 provide information on the current quality of primary care services in Westminster.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

Karen Clinton, Health of Primary Care North West London,
NHS England (London Region)

Karen.clinton@nhs.net

APPENDICES:

1. A Slide Presentation from NHS England: London Primary Care Commissioning
2. A report from Tri-borough Adult Social Care Business Intelligence on acute and GP services within the City of Westminster
3. A slide presentation from Primary Care Commissioning.

London Primary Care Commissioning

Plan on a page 2014/15 onwards

NHS England

Vision

Primary care services that consistently provide excellent health outcomes to meet the individual needs of Londoners

Form

Objective One
Co-ordinated Care

Objective Two
Proactive Care

Objective Three
Accessible Care

Function

Objective Four
Collaborative models of delivery

Quality Standards and Outcomes
- Ensuring consistency of service across London
- Performance management

Premises
- Making best use of the assets available
- Borough based strategic planning to inform investment decisions

Workforce
- Ensure the services we commission maintain a diverse workforce that supports collaborative 24/7 working

Technology
- Joined up working that meets the needs of patients
- Integrated systems and better data sharing

Commissioning and contracting
- Managing the provider landscape
- Redesigning incentives
- Primary care contract that delivers national consistency which enables programme of change in local context

Stakeholder engagement
- Ensuring ongoing engagement of patients, healthcare providers and other key stakeholders in service design and programme of change

Change management
- Organisation design
- Clinicians and organisations collaborating to deliver integrated care for patients

Governance arrangements
- Overseen by the Primary Care Programme Board
- Borough based accountability – via the SPGs?

Success criteria
- Enables effective delivery of out of hospital care
- Demonstrable improvement in:
  - Outcome standards across all London CCGs
  - Public confidence in NHS England's ability to address and act upon poor quality (premises, clinicians, systems)
- Ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances.
- Primary care system that prevents ill health and supports healthy lifestyle choices
- Patients and stakeholders are at the heart of commissioning decisions

High level risks to be mitigated
- Information governance – linking IT systems across different organisations involved in the pathway.
- Engagement with key stakeholders will be crucial to ensuring the success of this strategy
- Finance – investment required to support the transformational change over the next 5-7 years

Six High-Level National Objectives

General practice will play a much stronger role, as part of a more integrated system of out-of-hospital care. It will need to work on a more systematic, collaborative basis with community health services, social care, voluntary/community organisations, community pharmacy and other partners.

Six underlying objectives for general practice:

1. **Proactive co-ordination of care** (or anticipatory care), particularly for people with long term conditions and more complex health and care problems.
2. **Holistic care**: addressing people's physical health needs, mental health needs and social care needs in the round.
3. Ensuring **fast, responsive access to care** and preventing avoidable emergency admissions and A&E attendances.
4. Promoting health and wellbeing, **reducing inequalities and preventing ill-health** and illness progression at individual and community level.
5. **Personalising care** by involving and supporting patients and carers more fully in managing their own health and care.
6. Ensuring consistently **high quality and value of care**: effectiveness, safety and patient experience.

Commissioning Primary care for the local systems in London

- Currently NHS England (NHSE) is solely responsible for commissioning primary care services. However we don't do this in isolation and we have an agreed process of consultation which takes into account local stakeholders.

- NHSE London primary care does not work to a single strategy for primary care commissioning. We have an agreed framework for improving primary care performance and for decision making around commissioning and decommissioning of services but the final decisions about commissioning are made within the context of the local health economy. For North West London (NWL) this means taking account of Shaping a Healthier Future (SaHF) and NHSE officers work closely with CCGs to ensure commissioning decisions support the SaHF ambitions.

- Co-commissioning with CCGs will formalise this arrangement and ensure primary care commissioning has a cohesive and transparent framework from which to make commissioning decisions. The development of co commissioning sits with the CCGs as they must decide what level of responsibility they wish to take on. NHSE will work with CCGs to develop the governance around their chosen model.

Model for decision making when a practice closes.

Over recent years on average the number of practices that close their contracts in NWL has been 4-5 each year (less than 1 per borough). With the current emphasis on improving the quality of primary care and the significant shift in demand that primary care providers are dealing with it is possible that this number could increase. Funding from practices that close is always recycled back into primary care but this can be done in one of two ways either of which can be right for a specific practice population.

1. Dispersal of the list
2. Procurement

A range of factors is taken into account when making the final recommendation, these include

- The views of all stakeholders (patients, OSC, health-watch, CCGs and others as identified, although the patient views are always paramount)
- Local out of hospital strategy, including the ned to co-locate services etc (for NWL this is SaHF)
- Condition and quality of available estate
- Quality and capacity of provision nearby
- Any unique needs of the local population
- Any other specific local issues, for example the impact of the decision on other local practices.

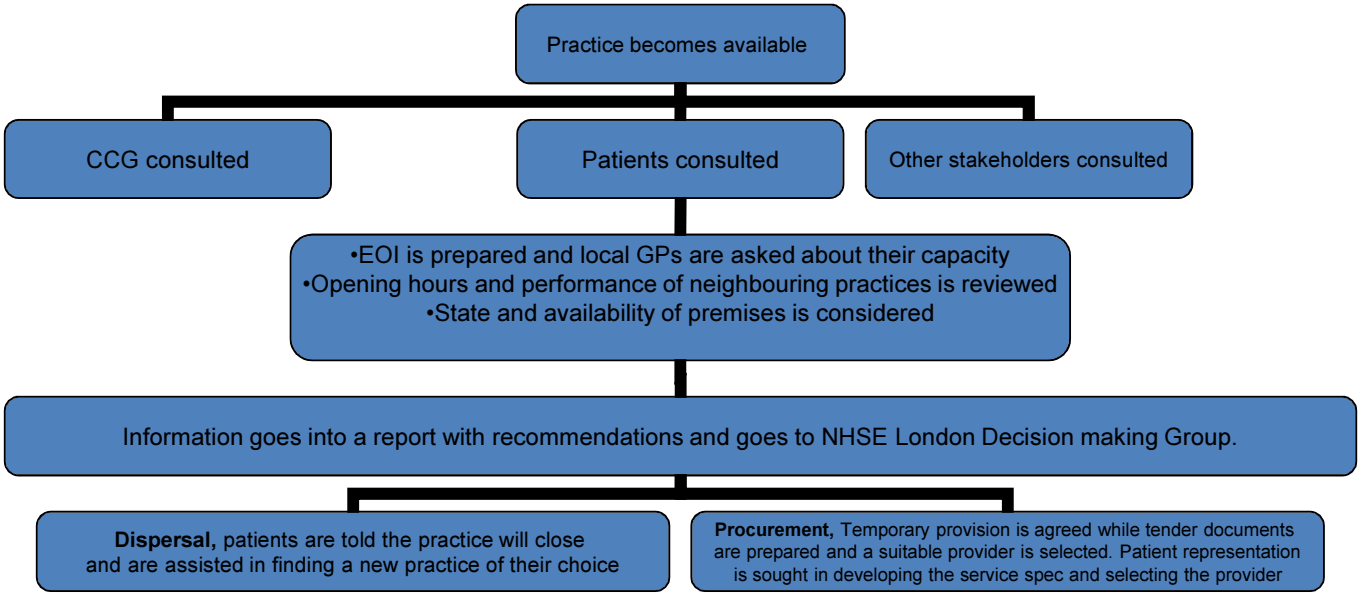
There is a nationally agreed standard around the time given to consult after which a paper is presented to the London Primary Care Decision Making Group (DMG) with recommendations.

Commissioning a GP Practice.

New contacts can only be let when a current practice contract becomes available. There are two options when this happens, to disperse the list or procure a new contract. There are benefits to both and both options are considered within the context of other available provision and local need.

Dispersal: Often small practices are not able to offer patients the full range of services that are available in larger practices and opening hours are less flexible. By dispersing the list neighbouring practices are able to expand and the extra funding that follows the patient can support the development of more comprehensive services in these practices.

Procurement: This would be the option of choice when the list is too large to safely disperse, the neighbouring practices have no capacity to expand or there are unique needs of a specific population that need addressing.



Payment mechanisms for GPs

There are three contract types available for the provision of GP services:

1. GMS: this is the national contract and is predominantly funded by the patient list, practices are paid a fixed price for the number of patients they have on their list (circa £66). This is nationally agreed each year. In addition practices are reimbursed for certain infrastructure such as IT and premises. Finally practices can increase their income by providing extra services usually called 'enhanced' services such as minor surgery. GMS contracts have no end date and only become vacant if the partner/s retires or relinquishes their contract. The contract holder must be a GP.
2. PMS: this contract is locally negotiated and again the main source of funding is the patient list. However the price per patient is agreed based on local factors to recognise the particular needs of the population. In NWL this price ranges from £65 to £135. PMS contracts usually have additional KPIs to recognise local need. These contracts have the opportunity for additional funding as above. Again there is no end date to these contracts but NHSE is able to give notice to terminate or vary these contracts if required. The contract holder does not need to be a GP although GPs must be employed in the practice.
3. APMS: this contract is also locally negotiated and has similarities to the PMS contract in terms of how they are funded. However infrastructure costs are normally wrapped up into the price. APMS contracts are tendered with an end date (normally 5-10 years depending on the service) and also frequently have additional services that would be offered to the wider population. An example would be a practice that also had a walk in centre. The contract holder does not need to be a GP although GPs must be employed in the practice.

Personal Medical Services (PMS) reviews (currently on hold awaiting national decision)

Nationally we said…	**1. NHS England will seek to align PMS contracts with local emerging primary care strategies arising from discussions informed by 'a call to action' to achieve better access and better outcomes for patients, and offering best value for money** **2. NHS England will be engaging with PMS practices and their representatives to seek to agree the best way forward for PMS contracts, taking into account the results of the desktop review and contract disaggregation exercise undertaken by area teams in August 2013**
In London this means:	1. Review of all PMS contracts for size and volume to align to national process. The preferred model is for larger / federated PMS contractors to bring benefit and economies of scale 2. Once reviewed, PMS contracts should be aligned to ensure consistency of service and access. The premium will be aligned to the London 'standards'.

Locally in North West London this means… **Ensuring any premium is also offered to GMS practices to create parity.** **Ensuring any premium deducted from higher rate practices is reinvested into primary care in NWL.**	
Inner – Central, West London, Hammersmith & Fulham, Hounslow, Ealing	60 PMS contracts Average £95.29 per weighted patient Previous reviews: Hounslow in 2010 – a range core requirements and optional premium services introduced KCW reviewed premium enhanced services introduced

Alernative Provider Medical Services (APMS)

Nationally we said…	**1. NHS England will be engaging with APMS practices and their representatives to seek to agree the best way forward for APMS contracts, whilst understanding the impact of closures of these centres on patients and on choice and competition.**
In London this means:	1. London Region is systematically reviewing its time limited APMS contract portfolio which includes 73 primary medical services and 24 GP Led Health Centres. 2. The review is being undertaken with CCGs in the case of GP Led Health Centres, in recognition of the shared commissioning responsibility and London Region intends uncouple the unscheduled care element of these contracts. 3. The result of these reviews is that contracts will either continue, or be re-procured, renegotiated or terminated, as appropriate. 4. London, in collaboration with NHS England National Primary care Support Team, is developing a standard APMS contract. This will include a standard specification, price per weighted patient and KPIs for London. Once complete, this will be used to ensure consistency across new APMS contracts within London – both in terms of quality and access to services. 5. Any significant changes to services , both in terms of access and services provided will be subject to appropriate consultation and engagement of key local stakeholders and Equality Impact Assessments
Locally in NWL this means:	The re commissioning of APMS contracts in NWL must be aligned with the SaHF programme. We have a schedule of when contracts are due for renewal and work closely with the CCGs to decide what is required before going out to the market.

Improving performance

- There is a rolling programme to tackle the bottom 10% of practices in London as defined by the quality Outcome Framework (QOF), High Level Indicators (HLI) and the GP Outcome Standards (GPOS)
- Under these measures 39 practices across NWL have been identified for review.
- The Primary care performance team are working with practices to develop improvement plans.
- Exit strategies will be developed for those practices not able to improve
- Close liaison with CCGs to ensure any market opportunities this creates reflects SaHF strategic and transformation plans
- There is a London wide quality and governance system to ensure consistent approach across London
- There is a 5 year aspiration to raise the number of achieving and higher achieving practices in line with or better than the national average.

Premises

Nationally we said…	**1. We are developing a strategic framework to support joint work with healthcare providers, CCGs, local authorities and other community partners to ensure that local strategies for out-of-hospital care include appropriate strategies for premises development.** **1. NHS England will work with other commissioners and with healthcare providers and premises providers (including NHS Property Services Ltd, Community Health Partnerships and LIFT companies) to promote more effective use of current primary care estate, including ways to improve utilisation of current properties. NHS England will seek to develop an abatement policy to ensure that payments made under the GP rent and rates scheme appropriately support primary medical services; understanding the range of non-core services currently reimbursed under the Premises Directions and how these should be managed in the future.**
Locally in London this means:	1. NHS England will need to work with partners, including healthcare providers, CCGs, Local Authorities and community partners to develop the premises required to deliver the primary care element of out of hospital strategies 2. In 14/15, this will require scoping around the needs for premises across the London region, taking into account the future changes planned for primary care and the out of hospital agenda. This will include an assessment of the space required, in what location and with what equipment to deliver the strategy. It should also link to facilities requirements and potential IT solutions, to provide a single premises strategy for the future of primary care 3. Additional consideration will need to be given to the best way to procure space, both within an expensive property market in London and the long term risks associated with building and maintaining property.
For NWL this means:	For NWL our proposal is to work with CCGs and NHSPS to agree a 5 year premises estates strategy which will be managed via a steering group acting as a gateway for schemes going to FIPA.

The benefits of working with H&WBB

The Health and Wellbeing Board, may like to consider:

1. How the Health and Wellbeing Board should seek to support and influence primary care commissioning to ensure it reflects local need, when exercising their role in providing local system leadership

1. How the Health and Wellbeing Board can work with NHSE and CCGs to monitor and improve the quality of primary care

2. How to maximise the opportunities that might be available through the introduction of co-commissioning of primary care services between NHSE and CCGs

City of Westminster

Westminster City Council

Acute Health Care and General Practice

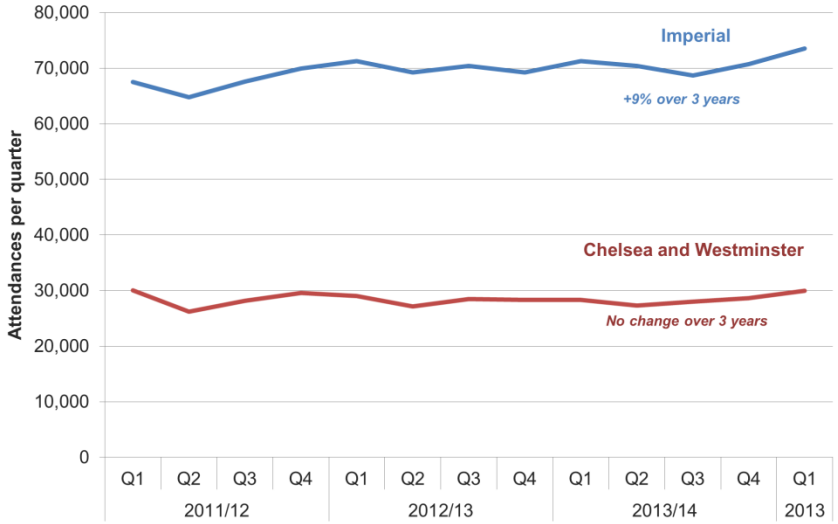
Performance Summary - Westminster

Tri-Borough Adult Social Care Business Analysis Team
james.hebblethwaite@lbhf.gov.uk

18th July 2014

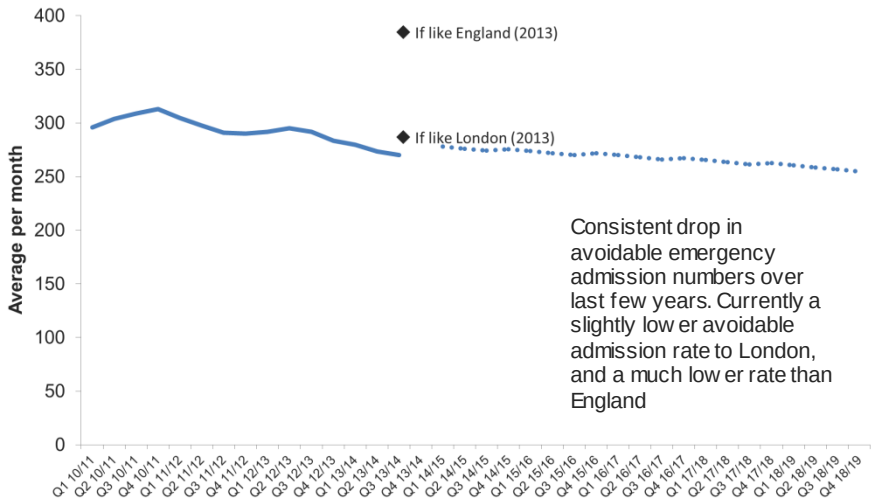
ACUTE HEALTH CARE SUMMARY – WESTMINSTER

Total A&E and Minor Injuries Unit attendances, number by Trust by quarter

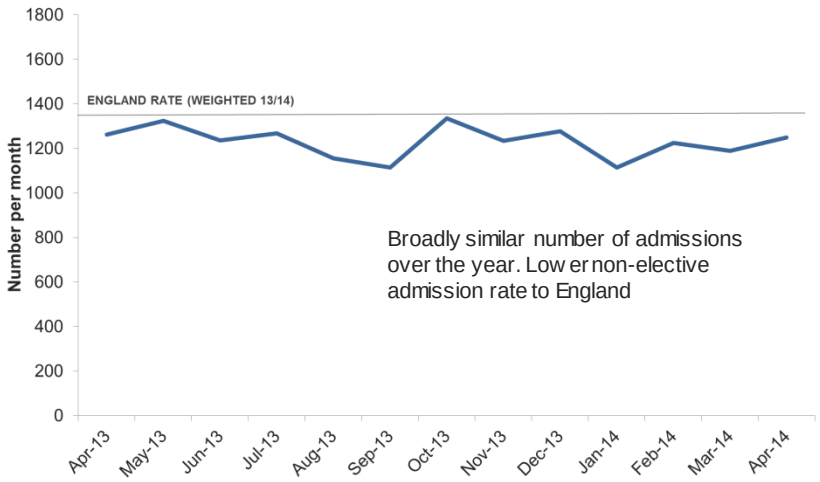


Avoidable emergency admissions (average number per month)

annual data rolling forward quarterly – with Better Care Fund 5 year indicative target

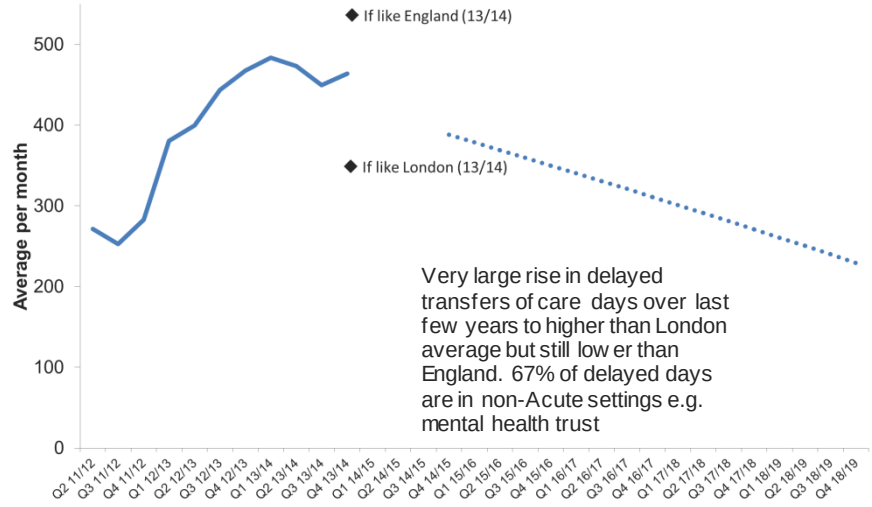


Non-elective admissions for Central London CCG, number by month (FFCEs)



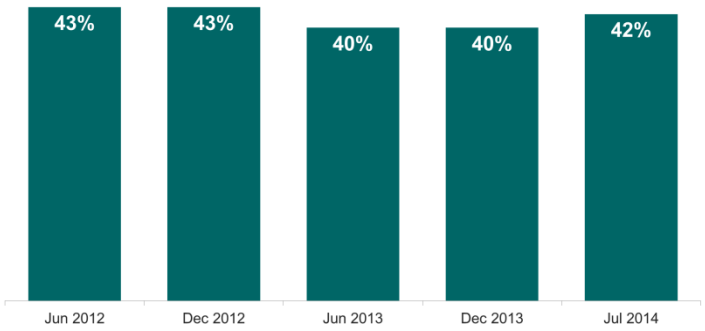
Delayed transfers of care (average days per month)

annual data rolling forward quarterly – with Better Care Fund 5 year indicative target



GP ACCESS AND QUALITY SUMMARY – WESTMINSTER

GP Patient Survey – **Very satisfied** with GP surgery/health centre, over time



There was a slight drop in the proportion of patients in the **CCG area** who are very satisfied with their GP surgery in 2013 but satisfaction appears to be rising again

Summary of GP Access and Quality

In the period to March 2013, Westminster patients reported better access to the practice by phone than average for London and England. They were more able to get an appointment 2 days in advance and had higher satisfaction in opening hours than London, but not England.

Local patients were more satisfied with their practice than average for London, but not England, and were also more likely to recommend it to a friend. The level of satisfaction with the quality of consultation was better than London, but still short of the England average. However, they had a higher likelihood of seeing their preferred doctor than London and England averages.

The proportion of people feeling supported in managing their long-term condition was better in the CCG than London and close to England, but satisfaction with GP out-of-hours services was comparatively low. Practice clinical achievement was much lower than average in 2012/13.

Find more information here:
Selected GP Patient Survey data, as presented on the **My Health London** website: http://www.myhealth.london.nhs.uk/
GP Patient Survey data used in NHS Outcomes Framework, on the **NHS IC Indicator Portal**: https://indicators.ic.nhs.uk/webview/
Quality and Outcomes Framework data on GP clinical points achieved on Health & Social Care Information Centre website: http://www.hscic.gov.uk/qof

Summary GP Access and Quality Indicators

GP Survey - Access Source: My Health London website (March 2013 data)	**West**	**London**	**England**
Found it easy to get through on the **telephone**	**87.0%**	74.9%	77.7%
Able to get an appointment with a doctor more than **two full weekdays** in advance	**88.7%**	87.0%	90.4%
Satisfied with GP practice **opening hours**	**81.2%**	79.4%	82.7%
GP Survey - Satisfaction Source: My Health London website (March 2013 data)	**West**	**London**	**England**
Level of satisfaction with the **quality of consultation** at the GP practice (composite measure)	**605**	602	628
Able to see a **preferred** doctor	**62.1%**	54.4%	60.7%
Would **recommend** the GP surgery or health centre to someone who has just moved to your local area	**79.4%**	76.7%	81.3%
Overall satisfaction with the care at the GP surgery or health centre	**83.8%**	82.1%	86.7%
GP Survey - Support Source: NHS IC Indicator Portal (2012/13 data)	**CL CCG**	**London**	**England**
% of people feeling supported to **manage their long term condition**	**64.3%**	59.4%	65.6%
% reporting a good experience with **GP out-of-hours service**	**59.1%**	62.9%	70.2%
QOF GP quality of care Source: HSCIC website (2012/13 data)	**CL CCG**	**London**	**England**
% of total points achieved for **clinical domain** - Quality and Outcomes Framework (QOF)	**89.1%**	94.0%	95.4%

Better than London and England
Between London and England
Worse than London and England

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NHS Central London (Westminster) CCG Primary Care Data Analysis

melissa.cottington@nhs.net
gary.williams3@nhs.net

18th August 2014

Purpose of this report

- To present NHS Central London (Westminster) CCG analysis with an overview of Primary Medical Services:
- Primary Medical Services (including)
- General Practice Outcome Standards (GPOS) and General Practice High Level Indicators (GPHLI)
- National GP Patient Survey (GPPS)
- Quality and Outcomes Framework (QOF)

GLOSSARY OF TERMS

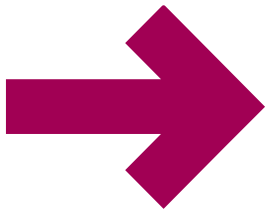
The General Practice Outcome Standards (GPOS) and General Practice High Level Indicators (GPHLI) represent the minimum patients can expect to receive from general practice and form part of a suite of products designed to support and improve primary care in London, covering areas such as screening, diagnosis and patient experience.

The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The survey is sent out to over a million people across the UK. The results show how people feel about their GP practice.

The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. QOF was introduced as part of the GP contract in 2004.QOF awards surgeries achievement points for managing some of the most common chronic diseases e.g. asthma, diabetes; how well the practice is organised; how patients view their experience at the surgery; the amount of extra services offered such as child health and maternity service

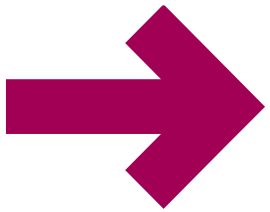
NHS England

Primary Medical Services



GPOS and GPHLI

- Area Team Breakdown
- GPOS Summary Map
- GPHLI Summary Map
- Indicator Specific Practice level charts
- CHD Trigger Practice Table

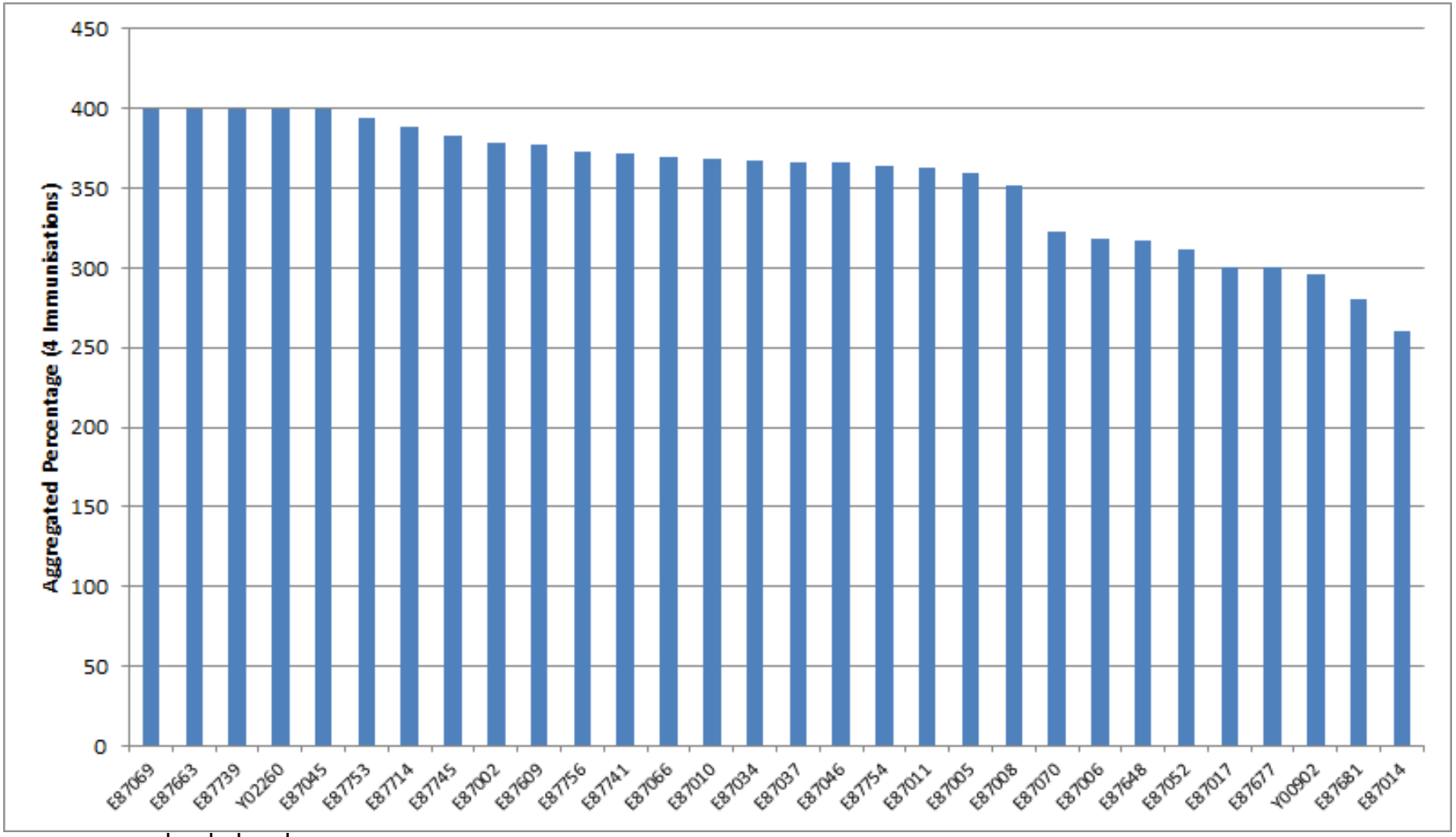


GPOS headlines for NHS Central London (Westminster) CCG: Percentage of GP practices in each achievement category

- **August 2014:**
  - 39 Practices
  - 0 practices higher achieving (0%)
  - 7 practices achieving (18%)
  - 13 practices approaching review (33%)
  - 19 practices review identified (49%)
- **December 2013:**
  - 37 Practices
  - 1 practice higher achieving (3%)
  - 5 practices achieving (14%)
  - 11 practices approaching review (30%)
  - 20 practices review identified (54%)
- **Significant changes:**
  - The number of practices has decreased by 2 since December 2013
  - The proportion of achieving practices has increased from December 2013 (14%) to August 2014 (18%)

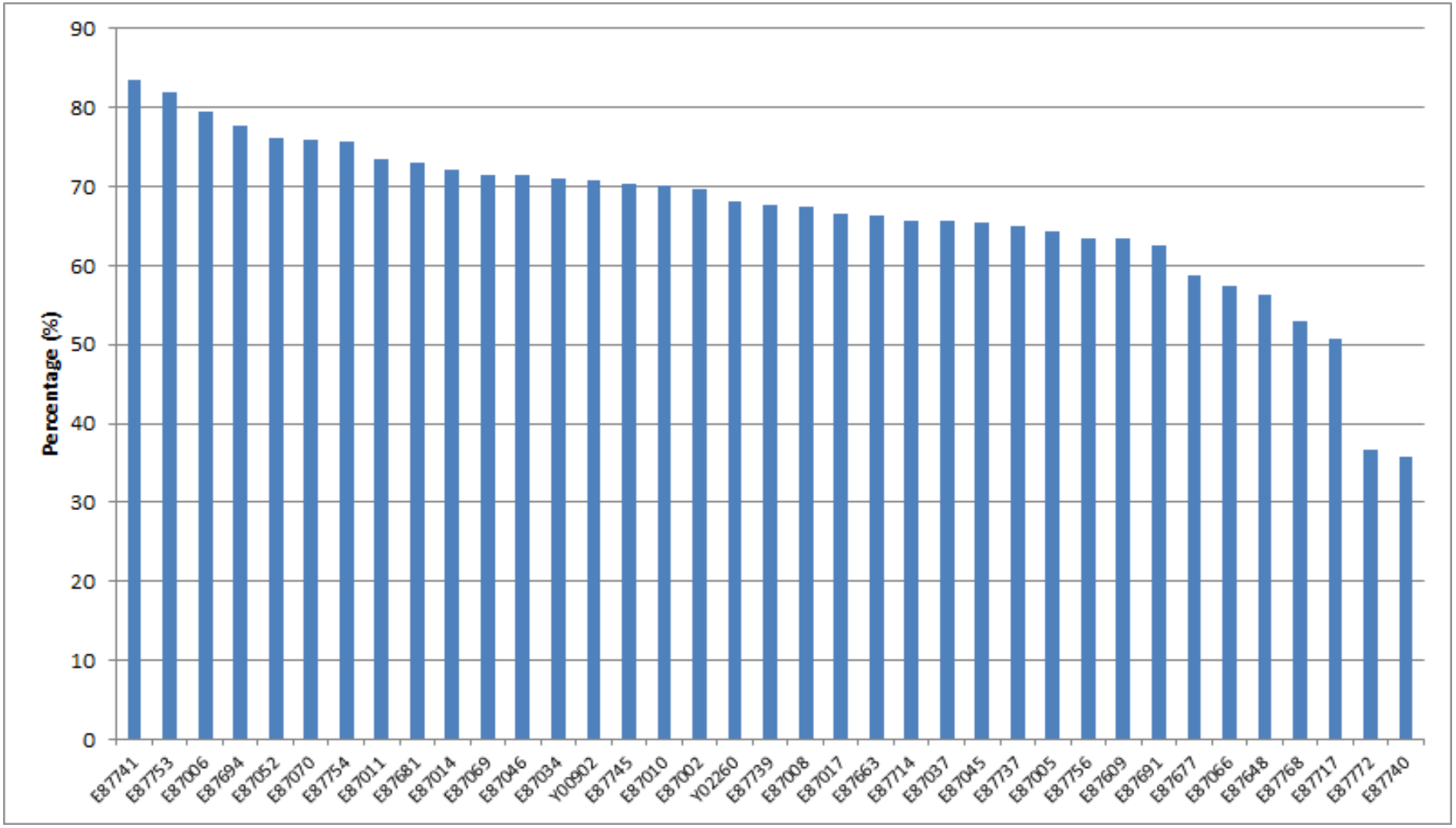
GPOS: Childhood Immunisation Practice Level, NHS Central London (Westminster) CCG Practices, Q4 2011/12

The aggregated percentages of a range of completion rates of immunisations for children by ages 1 and 2.



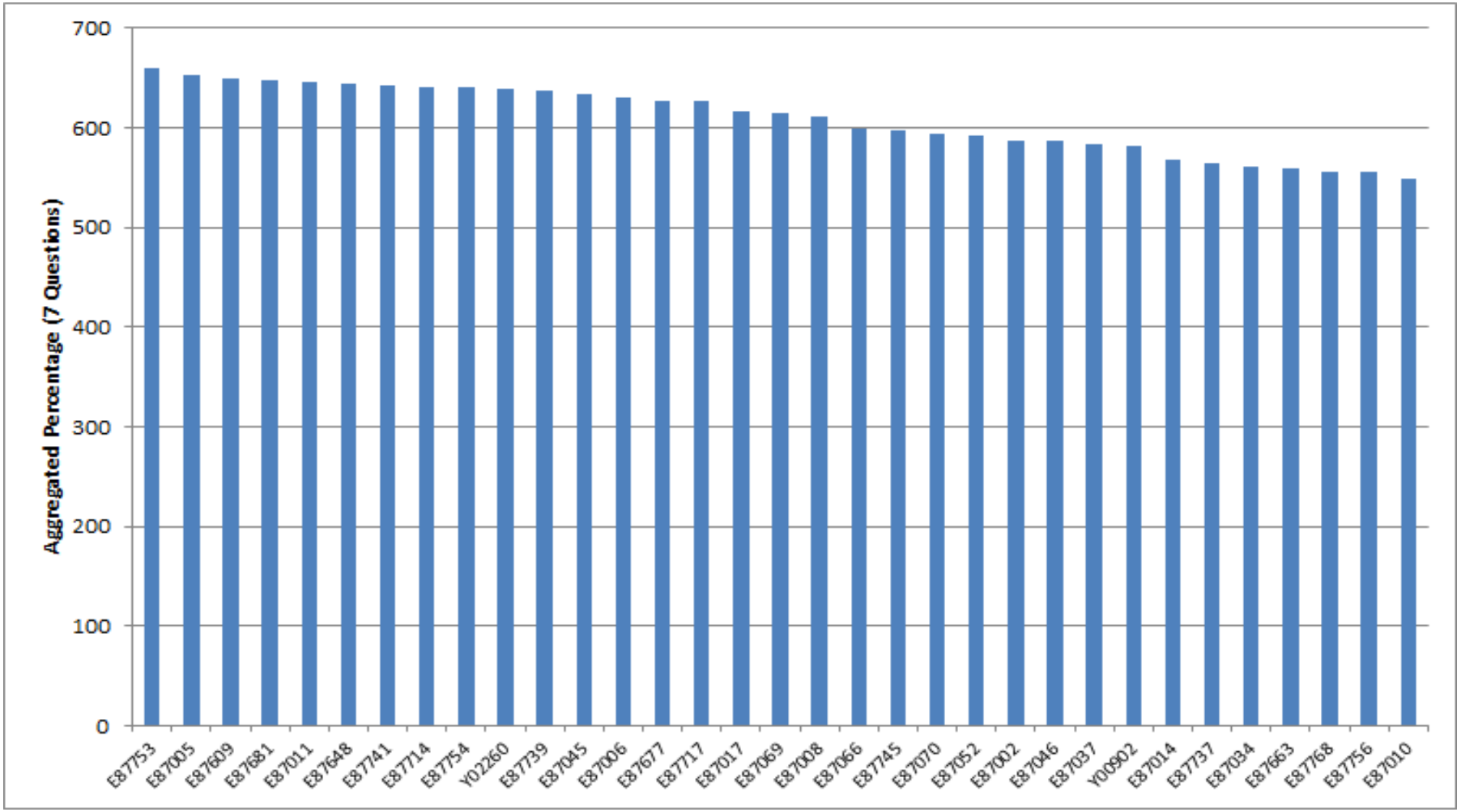
GPOS: Cervical Cytology Practice Level, NHS Central London (Westminster) CCG Practices, Q2 2013/14

The percentage of women aged from 25 to 64 whose notes record that a cervical smear has been performed in the past five years.



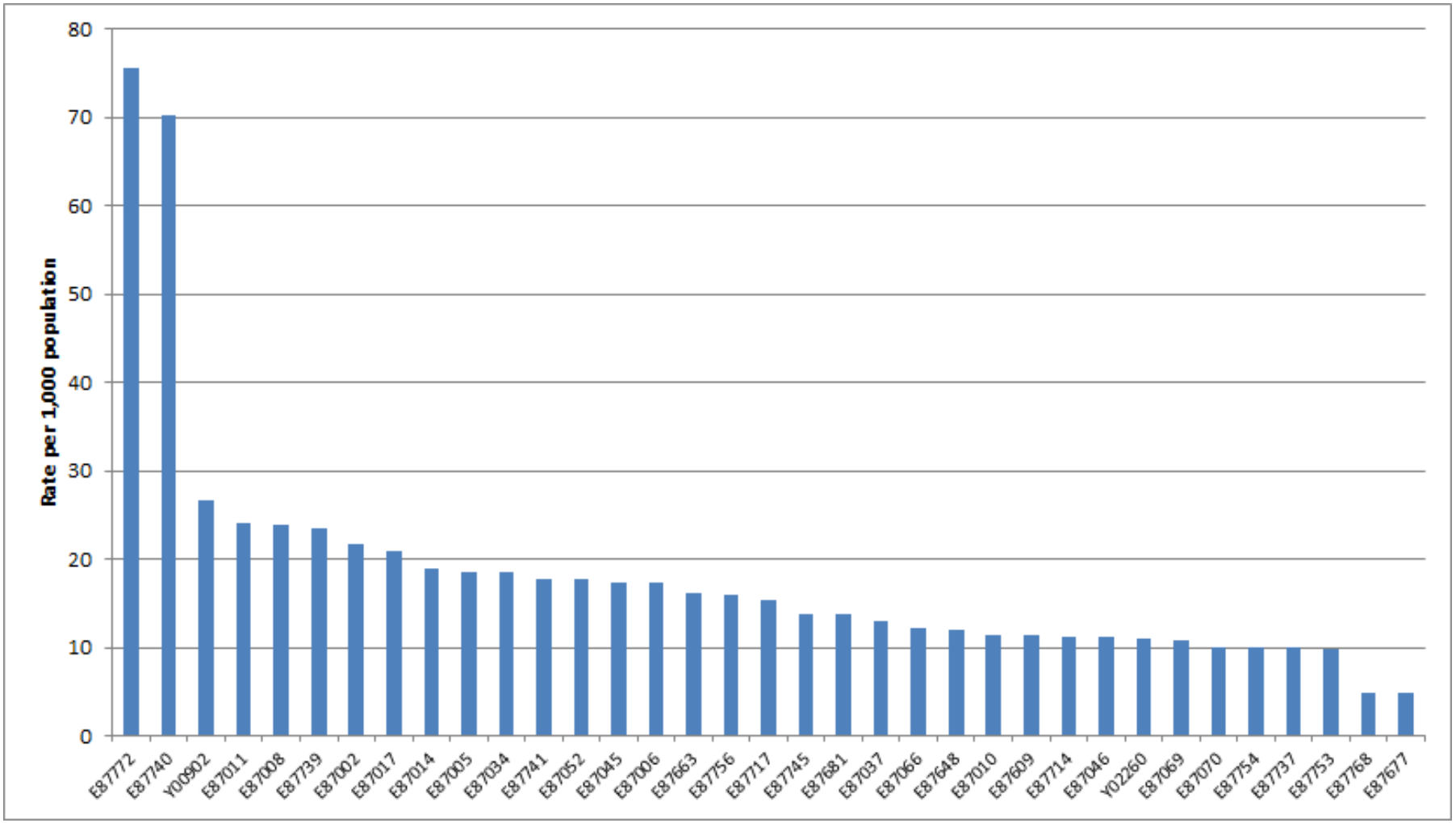
GPOS: Patient Satisfaction (Quality) Practice Level, NHS Central London (Westminster) CCG Practices, Q4 2013/14

The aggregated percentage of patients gave positive answers to selected questions in the GP survey about their satisfaction with overall care received.



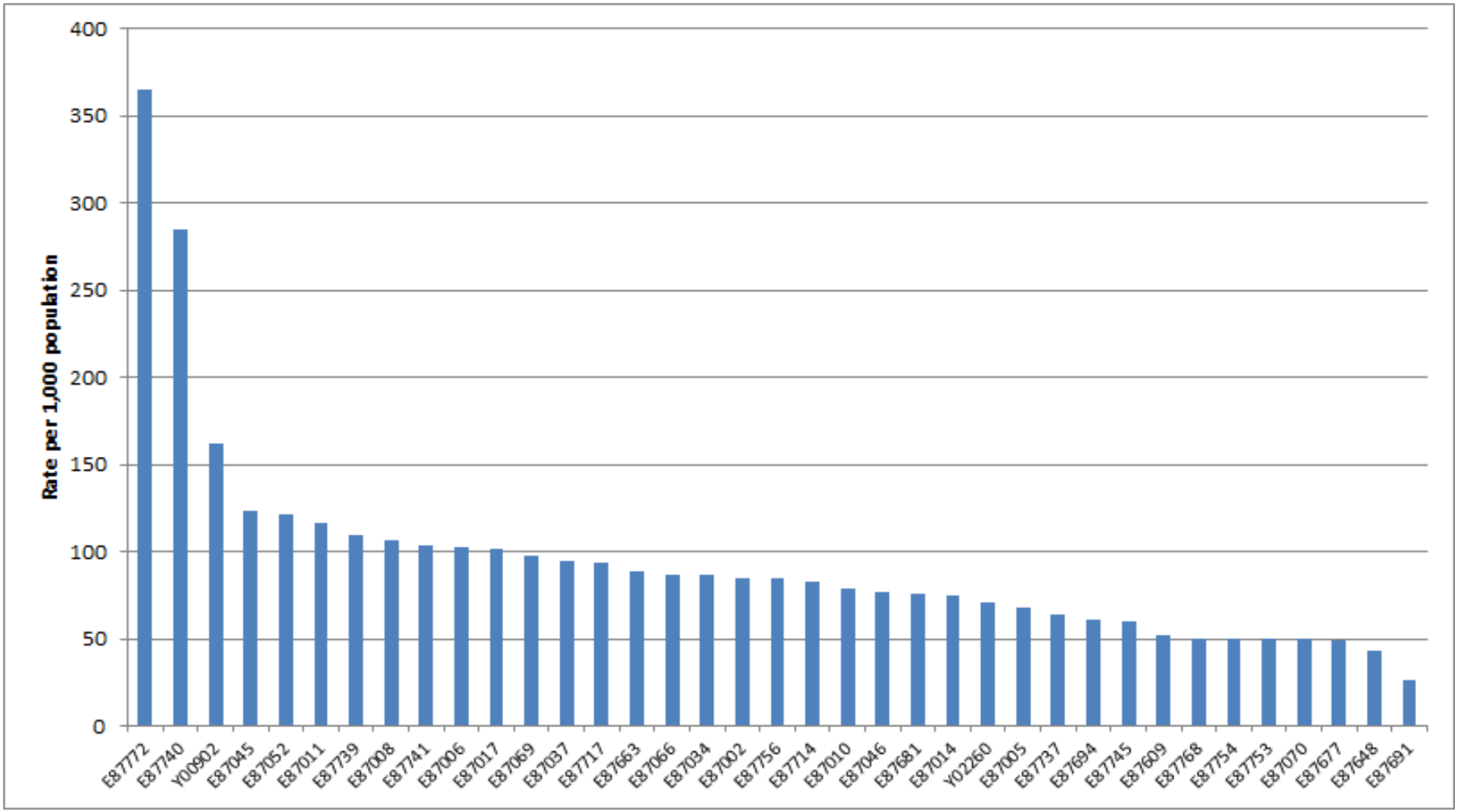
GPOS: Emergency Admissions Practice Level, NHS Central London (Westminster) CCG Practices, Q3 2013/14

Rate of emergency hospital admissions for selected long term conditions as a proportion of total number of patients per GP practice.



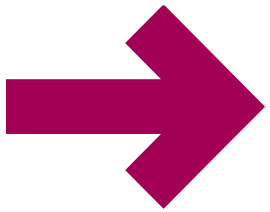
GPOS: A&E Attendances Practice Level, NHS Central London (Westminster) CCG Practices, Q3 2013/14

The rate of A&E attendances per 1000 patients on GP practice register

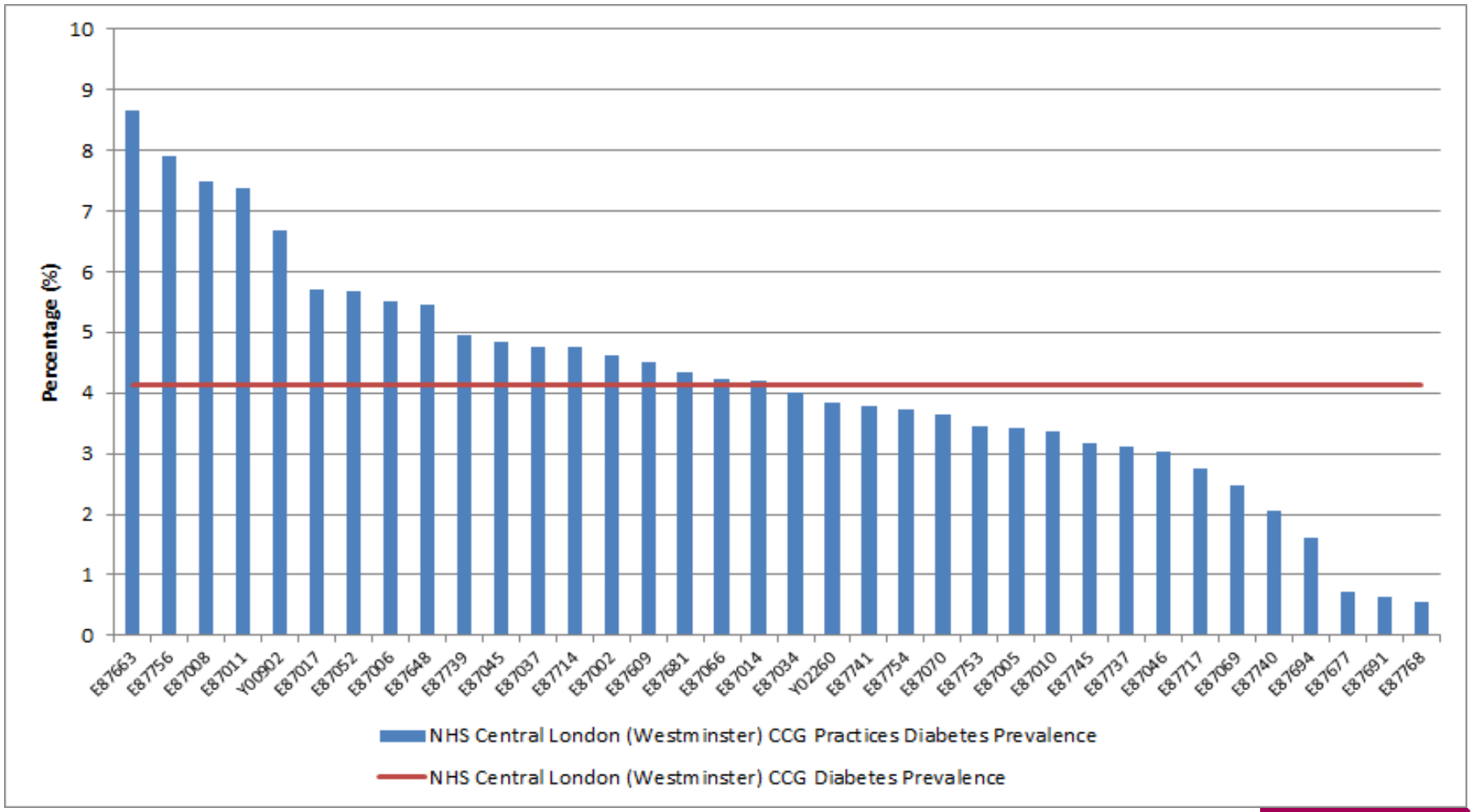


Diabetes in NHS Central London (Westminster) CCG

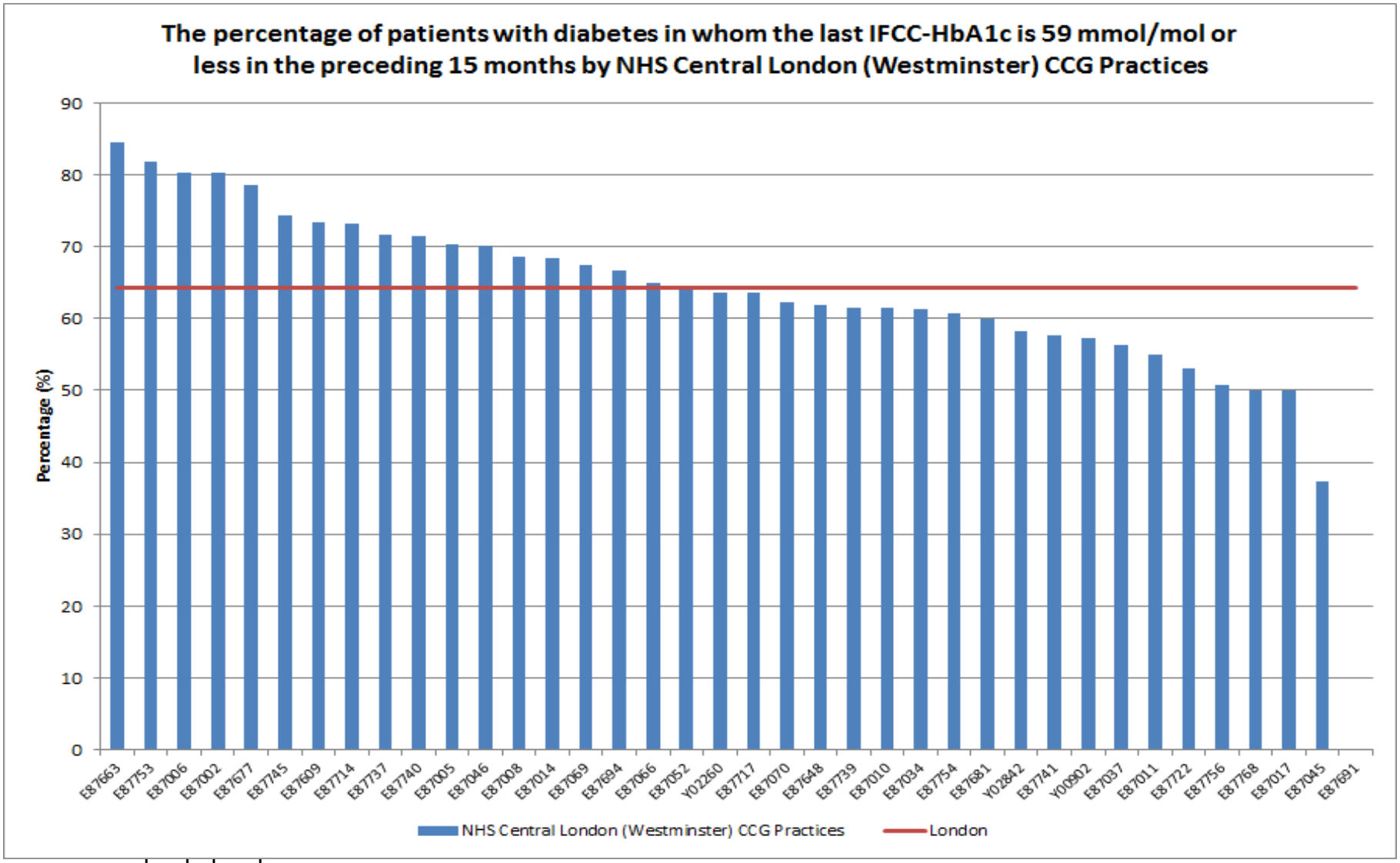
- Prevalence of Diabetes
- Diabetes Care Processes



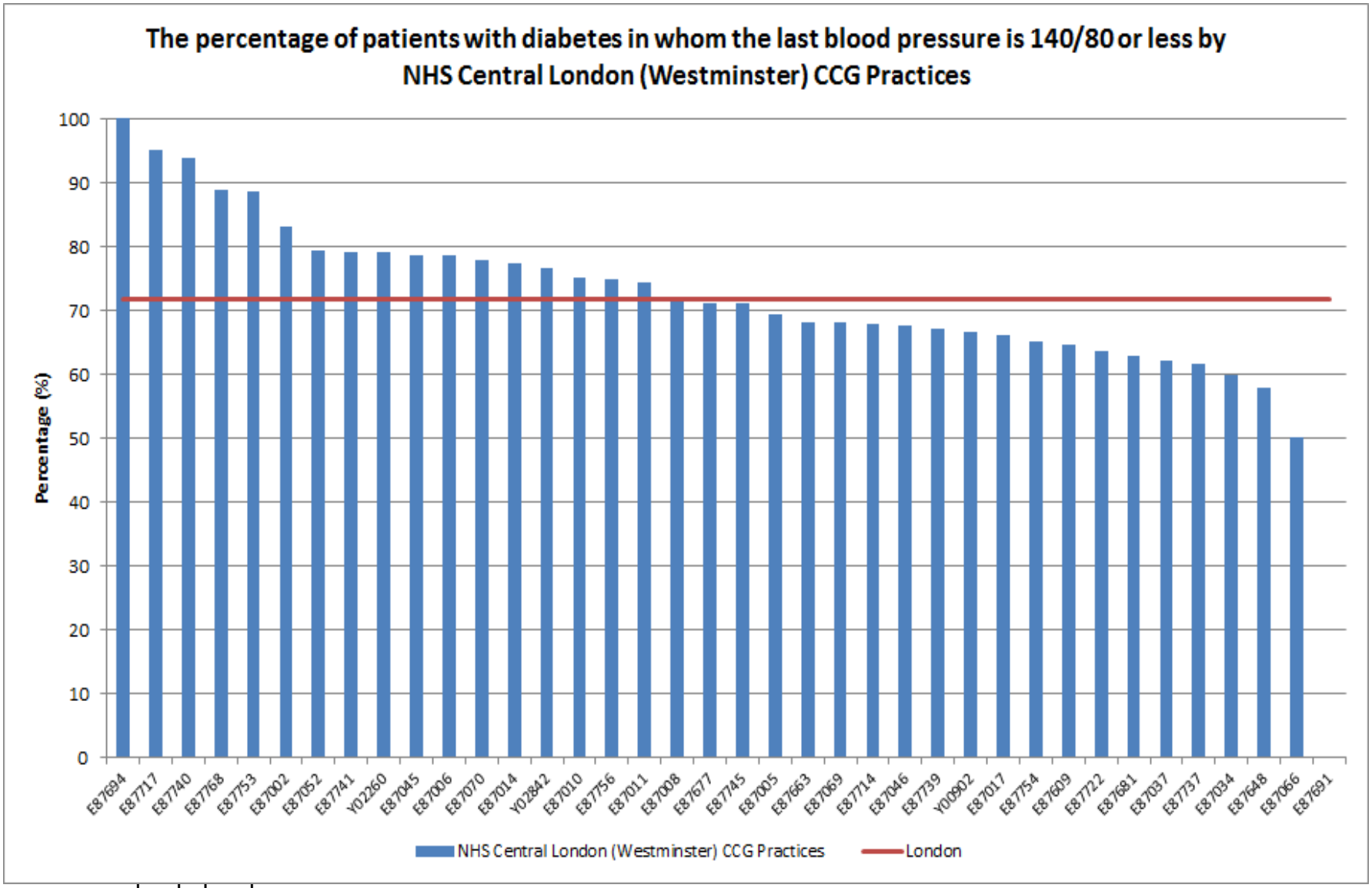
Diabetes Prevalence (17+) Practice level, NHS Central London (Westminster) CCG Practices, QOF 2012/13



Diabetes Care Processes – Cholesterol Measurement

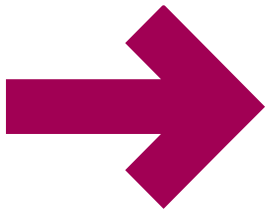


Diabetes Care Processes – Blood Pressure Measurement



GP Patient Survey

- Summary
- NHS Central London (Westminster) CCG Comparison with London & England
- Survey question breakdown by NHS Central London (Westminster) CCG practices



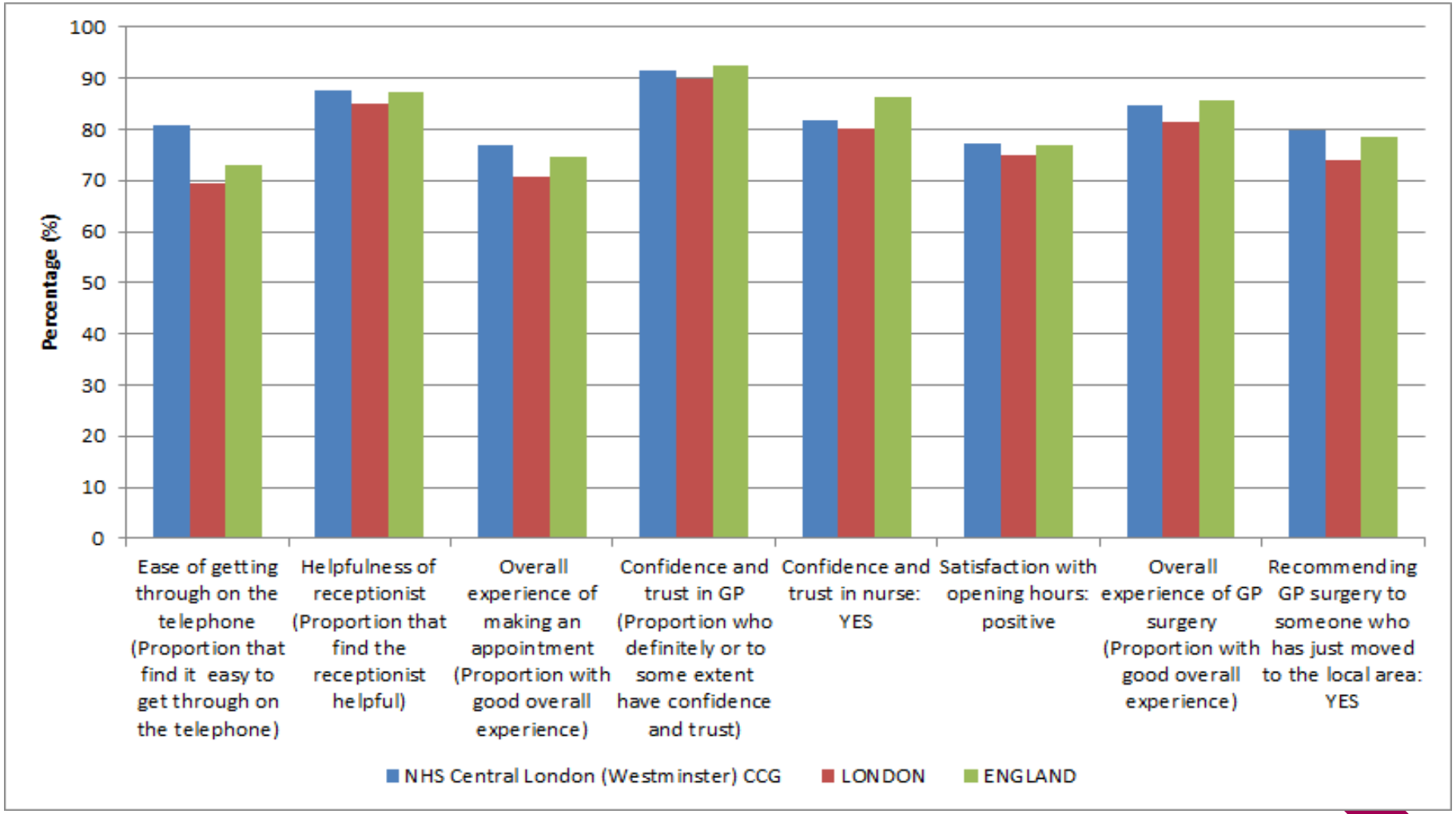
GP Patient Survey July 2013-March 2014: Headlines for NHS Central London (Westminster) CCG

- Across 8 selected questions which were analysed, the question which had the **lowest** number of practices who had significantly worse scores than the CCG average was the proportion of patients who found the receptionist helpful. The score for NHS Central London (Westminster) CCG in relation to this question was 87.5%, compared with 85.1% for London and 87.3% for England.

- The largest variation between NHS Central London (Westminster) CCG and London occurred for the % of patients who found it easy to get through on the telephone (80.7% in NHS Central London (Westminster) CCG compared with 69.3 % in London)

- The % of patients who had trust in their nurse varied from 41.1% to 93.4% in NHS Central London (Westminster) CCG.

GP Patient Survey Confidence and Trust in GP, NHS Central London (Westminster) CCG Practices, July 2013-March 2014



- The % of patients in NHS Central London (Westminster) CCG (80.7%) who found it easy to get through on the telephone was higher than in London (69.3%) and England (72.9%)
- The % of patients in NHS Central London (Westminster) CCG (77.2%) who were satisfied with their surgery opening hours was higher than in London (74.9%) and England (76.9%).

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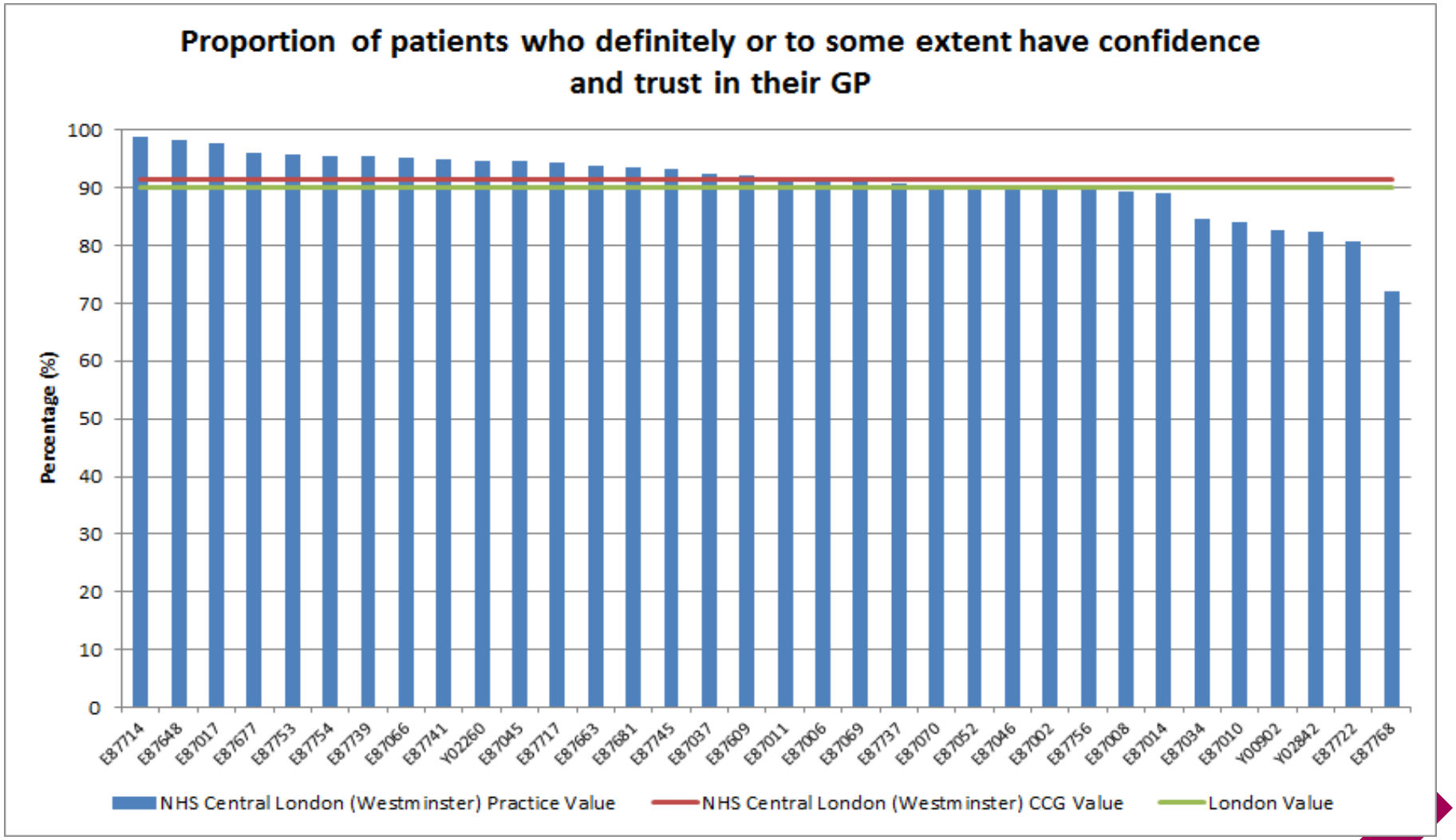
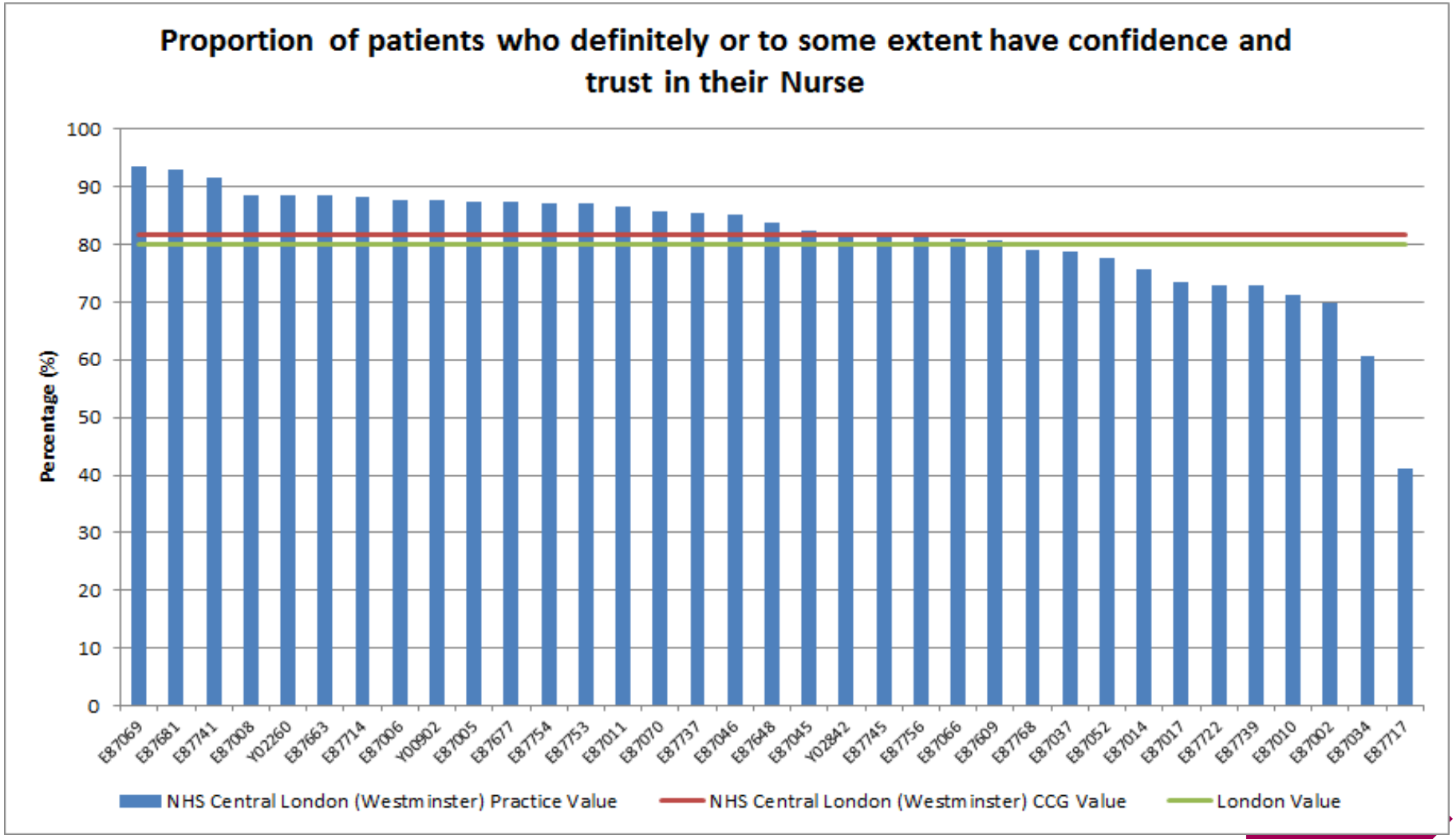
GP Patient Survey Confidence and Trust in GP, NHS Central London (Westminster) CCG Practices, July 2013-March 2014



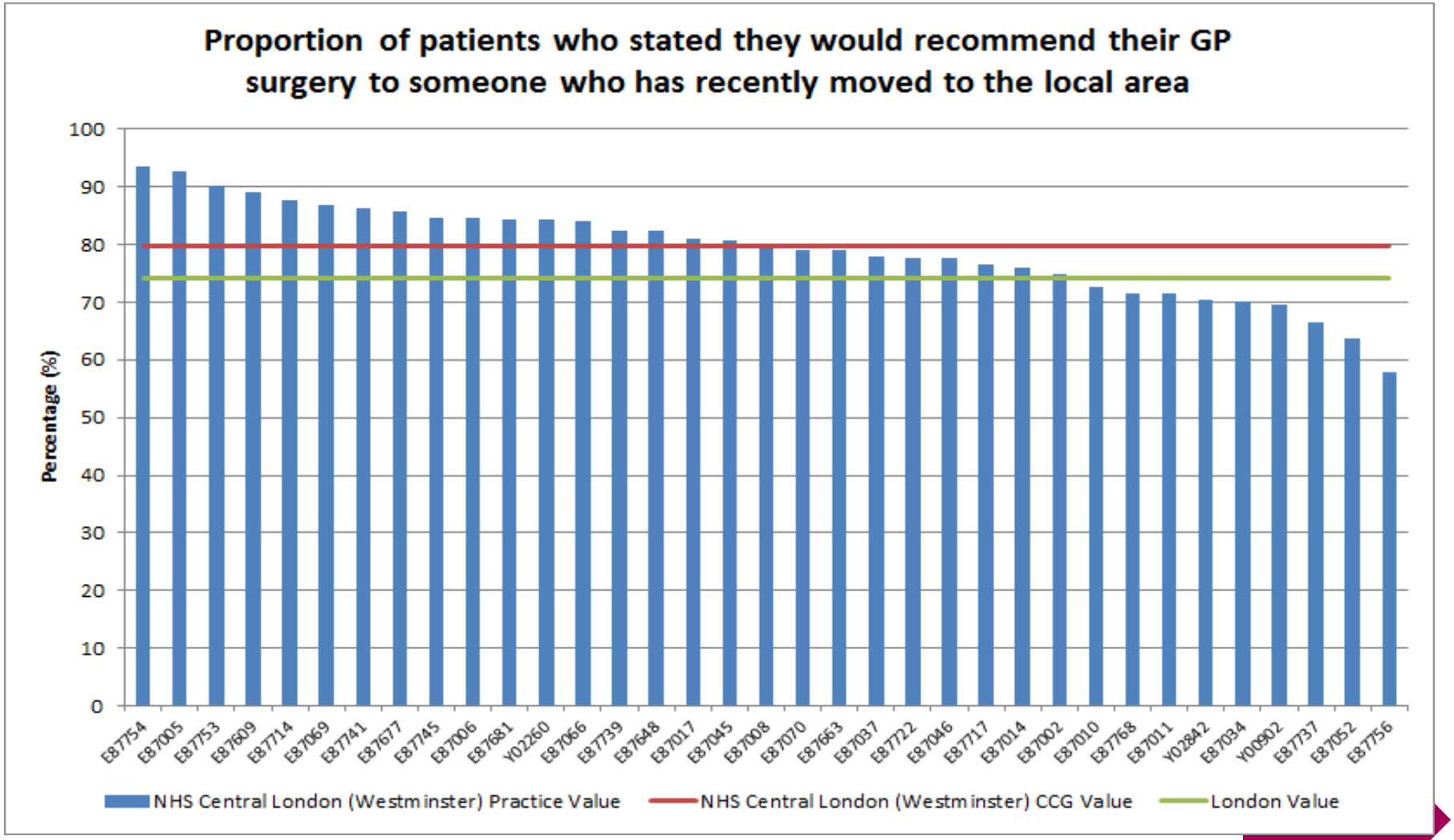
- 15 Practices had scores below the NHS Central London (Westminster) CCG average of (91.4%)

GP Patient Survey Confidence and Trust in Nurse, NHS Central London (Westminster) CCG Practices, July 2013-March 2014



- 15 Practices had scores below the NHS Central London (Westminster) CCG average of (81.8%)

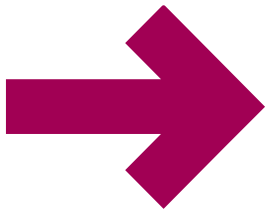
Recommending GP Surgery to someone who has just moved to the local area, NHS Central London (Westminster) CCG Practices, July 2013-March 2014



- 18 Practices had scores below the NHS Central London (Westminster) CCG average of (79.8%)

QOF

- Regional / National Summary
- London CCG Summary
- NHS Central London (Westminster) CCG Practice Summary
- Disease Prevalence Rates
- Disease Prevalence Trends



QOF – Regional Summary

Quality and Outcomes Framework 2012/13	High Level Summary						
	No. of Practices	Domain				QOF Points Total (%)	Exception Rate (%)
		Clinical (%)	Organisational (%)	Patient Experience (%)	Additional Services (%)		
National	8,020	95.4	97.3	98.7	97.0	96.1	4.1
NORTH OF ENGLAND	2,421	95.6	98.1	98.9	97.4	96.4	4.1
MIDLANDS AND EAST OF ENGLAND	2,358	95.2	97.5	99.1	97.5	96.0	4.1
LONDON	1,447	94.0	95.2	96.8	93.9	94.4	3.6
SOUTH OF ENGLAND	1,794	96.6	97.8	99.6	98.1	97.1	4.4

QOF – NHS Central London (Westminster) CCG Practice Summary

Practice Name	Practice List Size	Domain				QOF Points Total (%)	Exception Rate (%)
		Clinical (%)	Organisational (%)	Patient Experience (%)	Additional Services (%)		
National	8020	95.4	97.3	98.7	97.0	96.1	4.1
London	1447	94.0	95.2	96.8	93.9	94.4	3.6
CENTRAL LONDON (WESTMINSTER)	36	89.1	91.4	94.4	89.5	89.9	4.0
CAVENDISH HEALTH CENTRE	5519	95.9	100.0	100.0	97.2	97.4	5.4
COVENT GARDEN MEDICAL CENTRE	2573	77.2	96.9	100.0	82.6	84.6	3.4
DR ABOUZEKRY	2759	99.6	100.0	100.0	100.0	100.0	4.8
DR AHMED(G)	3029	92.6	89.8	100.0	95.5	93.7	5.4
DR EVANS(TIMOTHY)	278	70.6	49.0	100.0	100.0	74.7	2.1
DR MAHER SHAKARCHI'S PRACTICE	3483	96.2	100.0	100.0	88.0	96.9	2.6
DR VICTORIA MUIR'S PRACTICE	5797	100.0	100.0	100.0	100.0	100.0	3.0
DR WISEMAN(P)	240	24.9	23.6	0.0	40.9	35.5	0.0
DRS AMAKYE & WONG	3699	97.7	100.0	100.0	100.0	99.3	1.9
FITZROVIA MEDICAL CENTRE	6739	81.2	94.1	100.0	88.2	85.9	3.5
IMPERIAL COLLEGE HEALTH CENTRE	12509	98.0	93.7	100.0	99.2	97.3	1.4
KING'S COLLEGE HEALTH CENTRE	8284	58.3	97.2	100.0	77.9	86.6	3.0
LANARK MEDICAL CENTRE	3536	75.8	71.9	100.0	95.5	77.1	4.5
LISSON GROVE HEALTH CENTRE	7531	97.6	100.0	100.0	100.0	98.4	2.5
LITTLE VENICE MEDICAL CENTRE	4497	97.5	100.0	100.0	100.0	99.2	3.9
MARYLEBONE HEALTH CENTRE	8224	89.3	96.9	100.0	100.0	92.3	6.4
MILLBANK MEDICAL CENTRE	6119	88.2	100.0	100.0	99.0	92.3	3.8
NORTH WEST MEDICAL CENTRE	2507	85.1	80.3	100.0	88.4	86.0	7.3
PADDINGTON GREEN HEALTH CENTRE	8486	99.2	100.0	100.0	99.9	99.5	8.2
SOHO SQUARE GENERAL PRACTICE	3984	88.8	54.5	0.0	82.0	77.6	5.1
SOHO SQUARE SURGERY	2341	96.1	100.0	100.0	96.8	98.1	4.1
ST JOHN'S WOOD MEDICAL PRACTICE	10863	99.5	89.2	100.0	100.0	97.2	2.1
THE BELGRAVIA SURGERY	6076	98.2	100.0	100.0	91.8	98.4	4.6
THE CONNAUGHT SQUARE PRACTICE	5983	89.1	90.0	100.0	80.4	89.8	3.6
THE DOCTOR HICKEY SURGERY	1424	93.2	96.9	100.0	47.7	92.9	14.6
THE MAIDA VALE MEDICAL CENTRE	6614	97.3	98.0	100.0	94.9	97.7	2.2
THE MARVEN MEDICAL CENTRE	5043	83.5	100.0	100.0	86.1	88.9	4.0
THE MAYFAIR MEDICAL CENTRE	1948	80.2	85.0	100.0	71.6	83.7	4.2
THE MEDICAL CENTRE	3572	98.9	100.0	100.0	100.0	99.3	2.7
THE NEWTON MEDICAL CENTRE	7101	90.6	96.9	100.0	100.0	92.9	1.9
THE RANDOLPH SURGERY	6784	99.0	100.0	100.0	100.0	99.3	3.5
THE SURGERY	1522	86.1	94.5	100.0	43.4	88.9	2.1
THE WELLINGTON HEALTH CENTRE	6220	94.1	100.0	100.0	100.0	96.6	2.5
THE WESTBOURNE GREEN SURGERY	3860	90.8	97.2	100.0	93.8	93.1	9.1
VICTORIA MEDICAL CENTRE	12580	100.0	100.0	100.0	100.0	100.0	3.8
WESTMINSTER AND PIMLICO HEALTH CENTRE	8643	97.1	93.3	100.0	79.3	96.0	2.8

City of Westminster

Westminster Health & Wellbeing Board

Date:	18th September 2014
Classification:	Public
Title:	Measles Mumps and Rubella (MMR) vaccination in Westminster
Report of:	NHS England
Wards Involved:	All
Policy Context:	Health and Wellbeing
Financial Summary:	None
Report Author and Contact Details:	Gemma Harris, Acting Patch Lead North West London, NHS England (London Region) **E-mail:** Gemmaharris1@nhs.net

1. Executive Summary

1.1 The attached report, submitted by NHS England, provides information on the position of the measles mumps and rubella vaccination (MMR) in Westminster.

2. Key Matters for the Board's Consideration

2.1 The Westminster Health and Wellbeing Board are asked to:

a) Note the role roles and responsibilities of organisations in relation immunisation programme

b) Note the local data for the Royal Borough of Kensington and Chelsea

c) Consider the approach set out by NHSE England to improve uptake in immunisation programmes and what partner organisations should do to support this; and

d) Support the continuation of an evidence-based approach to joint working in the future to ensure that sustainable improvement in MMR (and the remaining childhood vaccinations) uptake can be realised.

3. Background

3.1 Prior to the Health and Social Care Act 2012, immunisations were commissioned by Primary Care Trusts (PCTs) and delivered by local providers to local populations. As of the 1st April 2013, the changes to the health services landscape have meant that the roles and responsibilities relating to immunisations programmes have changed.

3.2 The Department of Health is responsible for national strategic oversight, policy and finance for the national screening and immunisation programmes. This includes overall system stewardship.

3.3 Public Health England is responsible for supporting DH and NHS England with system leadership, national planning and implementation of immunisations programmes as well as providing specialist advice and information to ensure consistency across the country

3.4 NHS England is responsible for commissioning the local provision of immunisation services and the implementation of new programmes through general practice and other providers.

3.5 Locally, local Government has responsibility for taking steps to improve the public's health and has responsibilities that relate to health protection. Clinical Commissioning Groups have a duty to put and keep in place arrangements for the purposes of monitoring and improving the quality of health care.

<u>Opportunities</u>

3.9 The new configuration of the health system has created various opportunities to improve the quality of commissioning, service provision and uptake of vaccination programmes.

3.10 In London, NHS England has a single commissioning team for immunisations which has enabled the development of robust processes for contracting, commissioning and monitoring providers of immunisations. This supports a consistent approach to driving up quality and improving uptake. NHS England has also developed strong governance arrangements, such as the London Immunisations Board, that have clear lines of accountability through to the national oversight group. These governance arrangements enable timely identification of issues and concerns and support a consistent approach to address underperformance.

3.11 A number of projects and actions are also underway in London to help improve uptake which will have an impact within Westminster. This includes projects in primary care, improving data flow and the use of data to improve quality and system wide projects to ensure good oversight and the sharing of best practice.

3.12 However, there are various opportunities for NHS England, CCGs and local authorities to collaborative to ensure sustainable improvements in uptake rates.

3.13 Central and West London Clinical Commissioning groups have a role to play in:

- Endorsing systems and robust data flows such as the data linkage from primary care to the Child Health Information System (CHIS).
- Advocating commitment to Continuing Professional Development within primary care.
- Facilitating communication between NHS England and general practice
- Addressing local issues in collaboration with NHS England relating to practice delivery of immunisations

3.14 The local authority has a role to play in:

- Facilitating the development of relationships between commissioners of NHS and local authority services e.g. children's services
- Supporting information sharing about immunisations through other local authority commissioned services
- Sharing public health intelligence with NHS England and Clinical Commissioning Groups to understand how to reach underserviced population cohorts
- Signpost and raise awareness of Public Health England national immunisations resources.

4. Legal Implications

4.1 None

5. Financial Implications

5.1 N/A

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:
Gemma Harris, Acting Patch Lead North West London
NHS England (London Region)
E-mail: Gemmaharris1@nhs.net

APPENDICES:

Appendix A: NHS England Report, ""Measles Mumps and Rubella Vaccination in Westminster "

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Appendix 1

Measles Mumps and Rubella Vaccination in Westminster

1.0 SUMMARY

This paper was requested by the health and wellbeing board to provide an update on the position of measles mumps and rubella vaccination (MMR) in Westminster. The paper provides a background to the childhood immunisations programmes, with a focus on MMR; outlines roles and responsibilities of organisations in relation to the section 7a immunisations programmes; provides the local context and data for Westminster; sets out NHS England's work streams and what partner organisations should be doing in order to support an improvement in uptake of immunisations programmes. Whilst this paper remains focussed on MMR it should be noted that the NHS England approach and commitment required from other organisations remains relevant to the wider childhood immunisations programmes.

Risks and mitigations to immunisations:

1. COMMISSIONING FOR WESTMINSTER POPULATION	
RISKS	**MITIGATION**
Lack of information flow across the newly formed organisations	A variety of meetings (with robust governance structures) have been organised to ensure that the different sectors of the health economy are engaged in the immunisation programme. These meetings include the NWL Quality Board Immunisation meeting and the London Immunisation Improvement Board. At these meetings immunisation assurance is provided to Directors of Public Health. There is also the local Tri –borough (Westminster and K&C and H&F) meeting which take place between NHS England, Tri-borough LA and the local CCGs.
2. UPTAKE & COVERAGE	
RISKS	**MITIGATION**
Immunisation uptake rates remain static	**Trajectory setting:** NHS England, the Local Authority and local CCG are working together to ensure that reasoned and upward trajectories are set for the COVER indicators.
Increasing unregistered cohort	There has been a steady increase in the unregistered cohort (community data) which has negatively impacted on COVER uptake. NHS England & the local CCG are working together to understand the root causes for this increase. An action plan

	will be developed that will include what primary care and the provider need to undertake.
3. DATA / DATA FLOWS	
RISKS	**MITIGATION**
Community Provider Clinical System change	The community provider is changing from Rio to System One. Though this would ensure there is greater compatibility between the GP practices & the community provider- there is still potential for data error whilst the changeover is taking place. Currently implementation of this is on hold until assurance has been provided to NHS England that information data flows will not be adversely affected.
COVER not submitted accurately as a new role for the CHIS.	NHS England has commissioned a Data Linkage project to ensure that data continues to flow from GP practices to the local CHIS. The CHIS will then send this data onto PHE for COVER submission.
Potential interrupted data flows due to Westminster GP Clinical system change	As practices in Westminster change to System One, work between NHS England, CCG and community provider is being undertaken to ensure that there is no impact of data quality. For example this includes, developing and implementing a standard template that will limit data quality errors.

2.0 INTRODUCTION

2.1 Immunisation is described by the World Health Organisation as one of the most effective things we can do to protect individuals and the community from serious diseases.

Immunisation against infectious disease (known as 'The Green Book'), a UK document, issued by Public Health England, provides guidance and the main evidence base for all immunisation programmes (link in appendix 1).
The aim of vaccination programmes is to provide immunity for individuals and the population from a disease, interrupt the spread of the diseases and reduce the associated morbidity and mortality.

As uptake of an immunisation increases there are fewer individuals left susceptible and once a critical proportion is reached the reduction in onward transmission is greatly reduced as is the potential for outbreaks. This is referred to as community resilience against vaccine preventable diseases. The proportion of the population to be immunised to reach community resilience varies by disease but in the childhood vaccinations schedule usually sits around 95%.

The aim of vaccination programmes in England is to achieve community resilience. The effectiveness of our national childhood routine immunisation programme is carefully monitored by the Department of Health (DH) through COVER (Cover of Vaccination Evaluated Rapidly) information e.g. the percentage of the population who has received vaccination by age 1, age 2 and age 5 within specific timeframes (i.e. quarter and annual). COVER also includes the proportion of 12-13 year old girls who receive the 3 doses of HPV by year.

2.2 MMR Vaccine

Measles, mumps and rubella vaccine is a combined live attenuated vaccine that protects against measles, mumps and rubella, all highly infectious viral infections. MMR vaccine was introduced as a single dose schedule in 1988 and a two-dose schedule in 1996 with the aim of eliminating measles and rubella (and congenital rubella) from the UK population. Between 5 and 10% of children are not fully immune after the first dose. The second dose provides a further opportunity to protect children who did not respond to the first dose of MMR, with less than 1% of children remaining susceptible after receiving the two recommended dose. Further information about the diseases is provided in in Appendix 2.

3.0 ROLES AND RESPONSIBILITIES IN THE NEW SYSTEM

Prior to transition and the new structure of the health system, immunisations were commissioned by Primary Care Trusts (PCTs) and delivered by local providers to local populations. PCTs often had a role in their structure known as an immunisation coordinator. This role usually had oversight of the locally commissioned vaccinations services. In addition, these post holders were often public health professionals whose skill set enabled them to understand the factors affecting uptake in the local population, and ensure service provision or projects were commissioned to improve uptake.

As of the 1st April 2013 and the introduction of the new health service landscape, roles and responsibilities related to immunisations programmes changed. This has not only changed the way services are commissioned and monitored but has also created various new opportunities. These opportunities will be discussed in further detail later in the report.

The service specification document “NHS public health functions agreement 2014-15: Public health functions to be exercised by NHS England” (see Appendix 3 for link) is the service specification for the public health programmes that forms part of the agreement made under the section 7a of the National Health Service Act 2008. It sets out requirements for evidence underpinning a service to be commissioned by NHS England. The document describes the shared vision between Department of Health (DH), NHS England and Public Health England (PHE) of working in partnership to achieve the benefits of this agreement for the people of England. In line with the Government’s strategies for the NHS and the public health system, the aim is to:

- improve public health outcomes and reduce health inequalities, and
- contribute to a more sustainable public health, health and care system

The roles and responsibilities of the different organisations associated with the section 7a immunisations programs are summarised in table 1 below.

Table 1: Roles & Responsibilities of organisations in the New Health Economy

Organisation	**Responsibility in relation immunisations programmes**
Department of Health (DH)	DH is responsible for national strategic oversight, policy and finance for the national screening and immunisation programmes which includes overall system stewardship, based in part on information provided by PHE, and for holding NHS England and PHE to account through their respective framework agreements, the Mandate and the Section 7A agreement.
Public Health England (PHE)	An executive agency of the DH. PHE is responsible for supporting both DH and NHS England, with system leadership, national planning and implementation of immunisation programmes (including the procurement of vaccines and immunoglobulins) and specialist advice and information to ensure consistency in efficacy and safety across the country. PHE undertakes the purchase, storage and distribution of vaccines at a national level. It holds the coverage and surveillance data and has the public health expertise for analysing the coverage of, and other aspects of, immunisation services. PHE will also support the Directors of Public Health in local authorities in their role as leaders of health locally provides clinical advice and works with NHS England at national and regional levels in outbreak management.
NHS England (London region)	NHS England is responsible for commissioning the local provision of immunisation services and the implementation of new programmes though general practice and all other providers. It is accountable to the Secretary of State for Health for delivery of those services. Other bodies in the new comprehensive health system also have key roles to play and are vital to ensuring strong working relationships.
Directors of Public Health (DsPH) - Local Authority	Local government has responsibility for taking steps to improve the public's health, supported by the independent expertise of PHE. DsPH based in local authorities play a key role in providing independent scrutiny and challenge and will publish reports on the health of the population in their areas, which could include information on local immunisation services and views on how immunisation services might be improved. In addition, provide local leadership and liaise with local councillors and children & young people's services to ensure

	support to improve uptake. DsPH and their local authorities will support community and schools engagement with the programme, providing advice to the CCGs and encouraging primary care participation.
Clinical commissioning groups (CCGs)	Clinical Commissioning Groups are groups of General Practices that work together to plan and design local health services in England. Clinical Commissioning Groups work with patients and health and social care partners (e.g. local hospitals, local authorities, local community groups etc.) to commission services that meet local needs. CCGs have a duty to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care provided by and for that body.
Commissioning Support Units (CSUs)	CSUs provide a variety of support functions to CCGs. NWL CSU provide a range of high quality IT services to general practice that cost effectively address their core needs for clinical and management IT systems.

Within NHS England, the commissioning of immunisations programmes sits in the Public Health, Health in the Justice System and Military Health team. The structure of the team incorporates roles that have a pan London remit and those located within patch teams that have a locally facing remit. Within the patch teams there are commissioning managers who are aligned to specific boroughs.

4.0 THE LOCAL PICTURE IN WESTMINSTER

4.1 Local population profile

Children and young people under the age of 20 years make up 19.2% of the population of Westminster. Of great significance is the population churn, that is the number of people moving in and out of the borough each year: whilst it is some 10% in London overall, it is as high as 30% in Westminster. And whilst all London boroughs have a mixture of people living in deprived areas and others in affluent areas (which influences attitudes to childhood immunisation), Westminster, has some of the most affluent areas in the country. A further influence on attitudes to immunisation is ethnicity and thus culture, values and beliefs. Again, Westminster is different, with about half of the population being born abroad, with between a quarter and a third of the population not having English as a first language; this also influences the impact of promotion of, and information about, immunisation.

4.2 Uptake rates in Westminster

In Westminster uptake of childhood vaccinations is lower than the London average. Rates are roughly comparable with other inner north west London boroughs, but, do not reach levels required for community resilience. The picture has remained relatively static during the transition from PCTs to the new commissioning arrangements. Details of immunisations programmes service provision can be found in Appendix 4.

Table 2 below provides a breakdown of uptake rates of MMR in Westminster by quarter during 2013/14, with a comparison to 2012/13 annual data. Data is provided for the same period for the other routine childhood vaccinations in Appendix 5.

Table 2. Westminster MMR1 & MMR2 Uptake – 2013/14

Indicator	Quarter 1 2013/14*	Quarter 2 2013/14	Quarter 3 2013/14	Quarter 4 2013/14	Annual 2013/14	Annual 2012/13
2 yr – 1st dose MMR	-	76.7%	77.4%	78.3%	***Available end September 2014***	75.1%
5 yr- 2nd dose MMR	-	59.3%	58.2%	61.9%		75.4%

* Quarter 1 data not published due to data quality issues

4.3 Data trends- MMR 1 (dose 1, age 12-13months)
Quarter 1 data for 2013/14 was not published due to data quality issues. Quarter 2, Quarter 3 & Quarter 4 figures show similar uptake and are slightly higher than the previous annual uptake of 2012/13.

4.4 Data trends- MM2 (dose 2, age 3 years four months or soon after)
Quarter 1 data for 2013/14 was not published due to data quality issues. Quarter 2 and Quarter 3 figures (2013/14) show similar uptake as quarter on quarter trend.

4.5 Population characteristics that impact on immunisation uptake
The following factors contribute to the apparent gap between reported uptake and that required to reach community resilience in the MMR programme (95% uptake).

Certain populations' characteristics are known to be associated with variation in uptake of vaccinations. The following factors are known to impact on the level of uptake of vaccinations in the borough of Westminster:

- International and local migration - there are high levels of families moving in and out of the borough from international countries (see table 3 below). These issues make it more challenging to keep an accurate record of the true eligible population (denominator), and to hold correct contact information to able successful invitation and therefore immunisation of these children.

Table 3. Internal and international migration comparison in North West London

	Rate per 1,000	
Migration Indicator	**INWL (Hammersmith & Fulham, Kensington & Chelsea, Westminster)**	**Outer NWL (Ealing, Hillingdon, Hounslow)**
Internal Migration - In	82	65
Internal Migration - Out	86	69
International Migration - In	38	24
International Migration - Out	38	14

- European schedule – children who spend a proportion of the year in another country or families that have strong links with their country of origin may follow the immunisation schedule of that country. Schedules (timings of immunisations) often differ from country to country, thus creating challenges for providers to monitor vaccination status or timeliness of vaccinations to provide community resilience.

- Private vaccinations – a proportion of parents in this borough opt to vaccinate their children privately. This information is not always shared with the GP to enable accurate measurement of the vaccinated population (coverage).

- Data quality – ensuring vaccination histories are accurate and consistency of reporting and recording by providers has been challenging in Westminster. Clinical system change in Westminster GP practices has also had an impact on how data has been reported to COVER.

- Local population variations – as referred to above in the population profile, particular populations characteristics are associated with variation in uptake of vaccinations. In addition, media coverage has impacted the MMR uptake in the Wakefield cohort (MMR catch up campaign described in further detail below).

- Unregistered Cohort- the unregistered cohort in Westminster that is reported to COVER data has been steadily increasing. This has an impact on uptake rates.

- Child Health Information Systems (CHIS) – as of 1st April 2013, CHIS's gained a statutory responsibility to submit COVER data to PHE. This is a new role for many of the London CHIS's including the CHIS covering Westminster. Though this has required changes to the way the CHIS team has worked NHS England is reassured that that this responsibility is being enacted.

5.0 WHAT IS CURRENTLY BEING DONE TO ADDRESS ISSUES IN MMR UPTAKE IN WESTMINSTER?

As mentioned above, the new configuration of the health system has created various opportunities to improve the quality of commissioning, service provision and the uptake of vaccination programmes. Opportunities fall into two broad categories:

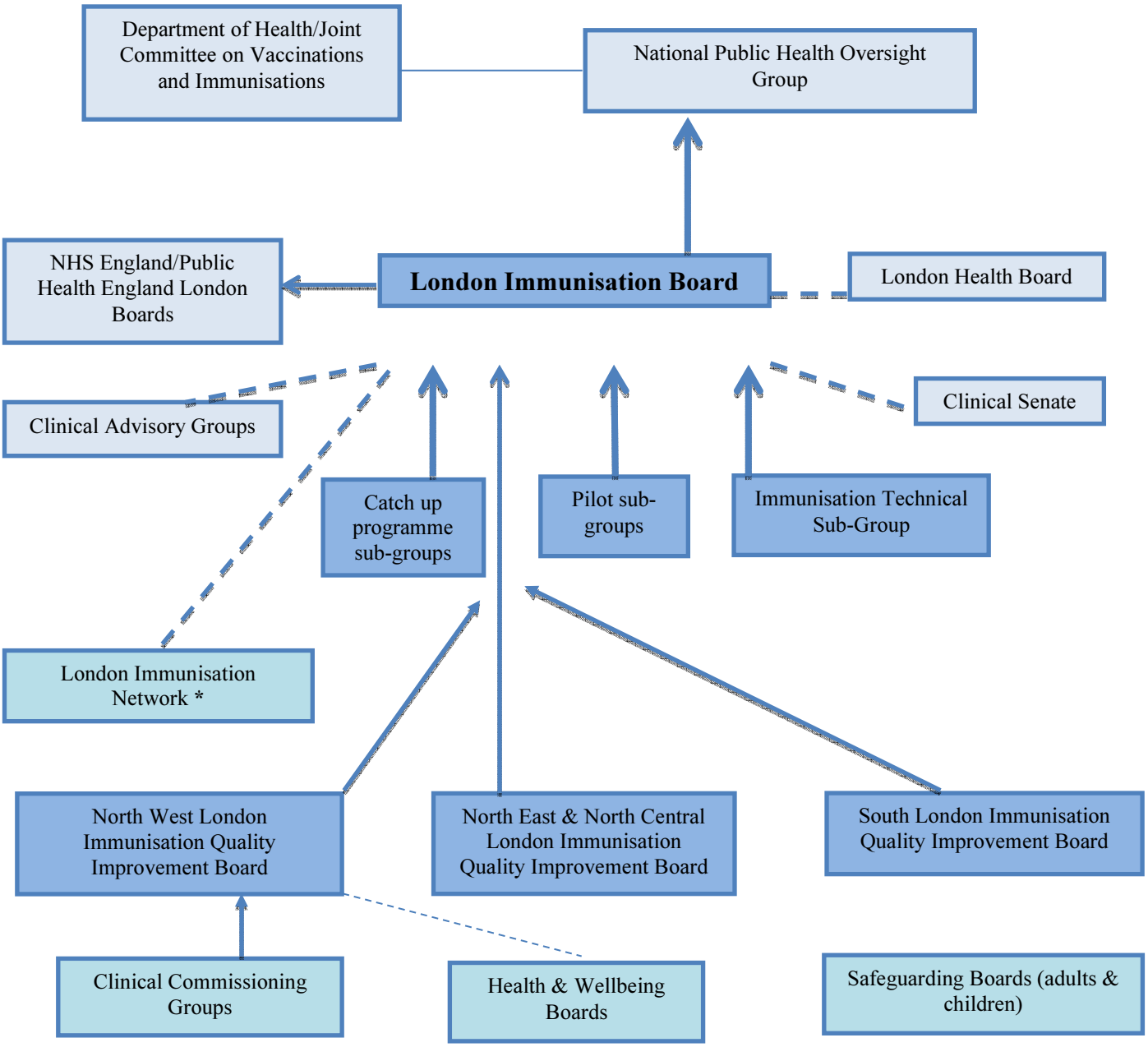
- Systems & levers
- interventions & projects

5.1 Systems & levers

In London, NHS England has a single commissioning team for immunisations. This has enabled the development of robust processes for contracting, commissioning and monitoring providers of immunisations. This in turn supports a consistent approach to driving up the quality of immunisation provision and improve uptake. By utilising a consistent approach to contracting it allows NHS England to identify and hold providers to account where the performance and quality is sub-optimal. Contract levers can then be utilised to support improvement in performance and quality and ultimately increase uptake.

In addition to robust contracting, NHS England has developed strong governance arrangements that have clear lines of accountability through to the national oversight group (see diagram 1).

Diagram 1: Local & National Immunisation Governance Structure.
The boxes in dark blue represent NHS England groups, the remaining boxes represent external groups or boards. Some have direct reporting mechanisms for accountability, depicted by arrows. Dotted lines indicate information exchange/stakeholder input.



*Professional networks are an important mechanism for disease management through sharing of good practice and links between existing networks and proposed governance structures have been included.

The London Immunisation Board is the key mechanism by which NHS England (London region) will provide assurance on delivery of the immunisation programmes in the section 7a mandate.

The table in Appendix 6 describes the various NHS England boards/groups and their functions.
Through strong governance structures and consistent application of the NHS standard contract with all providers the system in London is set up to have robust oversight and management of the services provided across London. It enables timely identification of issues/concerns/outliers. It supports a consistent contract management approach to address underperformance and utilises an evidence based approach to identifying and commissioning interventions.

NHS England's vision for immunisations programmes is illustrated using a single slide (Appendix 7). This incorporates both the system mechanisms and provides an indication of some of the work streams that will be taken forward.

5.2 Interventions & projects
NHS England has a number of projects/actions in place across London that contributes to realising the vision. These are and will have an impact within Westminster:

- Primary care – Project to map & review all GMS / PMS and APMS contracts including the key performance indicators (KPI's) across London identifying problems with consistency / accuracy and the impact of new immunisation programmes.
- CHIS –
    - Data linkage between GPs and CHIS. This project aims to improve the data flows between primary care and the CHIS to ensure high quality data reporting for the COVER reports. Progress is reported to the NWL Immunisations Quality Improvement Board.
    - A protocol has been put into place across London for earlier scrutiny of immunisation rates prior to submission to COVER by the patch and central immunisation commissioning teams in NHSE. This is helped by the new minimum child health dataset (implemented 1st September 2013) which enables monthly reports on immunisations to the NHSE immunisation teams.
    - Regular meetings with CHIS providers to address data quality issues.
    - NHS England CHIS community of practice created to drive service development and ensure services are fit for purpose, now and in the future.
- System wide –
    - Ambition plans are being developed by NHS England via the technical subgroup. These plans will provide indicative trajectories that will be influenced by interventions. Once signed off, these will be monitored via the NWL Quality Improvement Board.
    - An incident protocol is currently being developed and tested before formal roll out. Once embedded this will assist in ensuring stakeholders understand their roles and responsibilities in relation to immunisations incidents. This will enable good oversight and sharing of learning from incidents therefore reducing the likelihood of repetition.

The work programmes/projects etc. listed above have a specific impact on MMR vaccination uptake. It should be noted that there are other work programmes/projects

not listed that impact on the other immunisations programmes. Information on these is available on request.
It is also important to recognise that since the establishment of NHS England on 1st April 2013, there is evidence of various success stories:

- Successful response to the national outbreak of MMR
    - Based on evidence gathered by auditing 10 years' worth of child records. Partner organisations including NHS England, PHE, CCGs and LA's worked together to provide a response to a national outbreak. The response enabled assurance to be provided that the onward spread and continued outbreak was brought under control.
- Successful introduction of rotavirus vaccination
    - NHS England commissioned a new national programme in its first year, which has already brought about a measurable reduction in A&E admissions in infants across London.

5.3 What this means for Westminster

NHS England has a solid work programme aimed at commissioning high quality immunisation services. Where these services are of sub-optimal quality and/performance, mechanisms are being put in place to address these issues.

The programmes/projects and structures described above describe how NHS England is working to drive up performance and quality of immunisations services in Westminster.

However, it is widely acknowledged that partnership working across multiple agencies is the only way in which sustainable improvements can be achieved.

6.0 HOW DO PARTNER AGENCIES WORK TOGETHER TO MAKE SUSTAINABLE IMPROVEMENTS IN UPTAKE RATES?

There are various opportunities for NHS England, CCGs and Local Authority Public Health (plus other departments) to collaborate to ensure sustainable improvements in uptake rates.

Below is a description of what NHS England will be doing, followed by a description of what CCGs and Public health in the Local Authority are doing and suggestions of further opportunities to work together.

6.1 NHS England

- Use appropriate commissioning arrangements to ensure immunisation services that are accessible and of high quality
- Recognise the potential impact of interventions including system interventions e.g. data linkage from primary care to CHIS via the technical subgroup of the London immunisations board
- Where possible co-commission or use other appropriate mechanisms to introduce evidence based interventions – such as data linkage project,
- contract manage providers and hold them to account where sub optimal performance/variation is evidenced

6.2 Central London CCG

As part of the section 7a agreement CCGs are required to drive up quality of primary care. This should be done by using best practice evidence to change behaviour.

Partnership working between NHS England and Central London CCG should be based on best practice evidence (NICE 2009). Roles that the CCG should enact fall under the following themes:

- IT - Endorsing systems and robust data flows such as the data linkage from primary care to CHIS, and systematic coding
- CPD - Advocating commitment to CPD within primary care
- Communication - Facilitate communication between NHS England and general practice particularly around profiling policy and schedule amendments
- Addressing local issues - Collaborate with NHS England to understand/address specific issues with practice delivery of immunisations

Good relationships have been developed between NHS England and Central London CCG. Listed below are various projects underway as part of a partnership between NHS England and Central London CCG during 2013/14 and 2014/15.

- Central London CCG meet regularly with their CHIS provider
- Central London CCG has a commitment to CPD – via Health Education England & Nursing Forums
- A 'Good practice guidance' on immunisations was developed and sent out to Member practices last year
- Regular vaccine updates and newsletters are circulated to practices via GP Bulletins and updated on the CCG extranet
- Central London CCG provides representation at NWL Immunisation Quality Board meetings.
- As well as attending the technical sub-group to set up immunisation
- Improvement ambition plans and trajectories for the next 5 years and at performance boards.
- The CCG has been part of 'Celebrate and Protect' immunisations birthday cards initiative for the last 2 years and continue to use this initiative (CCG funded from April 2014 for 12 months).

NHS England is also working with the CCG and CHIS provider to seek assurance on development of robust data flows for immunisation programmes.

6.3 Local Authority Public Health Team

The DPH has a local health system leadership role. In relation to immunisations this can be enacted by:

- Facilitating development of relationships between commissioners of NHS and local authority services e.g. children's services to support engagement of underserved population cohorts
- Supporting information sharing about immunisations through other local authority commissioned services. One example may be leaflets in libraries or housing offices.
- Sharing public health intelligence with NHS England and CCGs to understand how to reach underserviced population cohorts.
- Signpost/raise awareness using PHE national immunisations resources

NHS England has developed good relationships with the local authority public health team. This has resulted in partnership working in the following areas:

- DPH (or deputy) attendance at NWL Immunisations Quality Improvement Board – for assurance of immunisations programmes
- Triborough CCGs public health steering group – operational group to facilitate delivery of local actions from NWL quality improvement board

7.0 CONCLUSION

On 1st April 2013 roles and responsibilities for commissioning and oversight of immunisations programmes changed considerably. Various organisations are required to work in partnership to ensure sustainable improvements in the quality and performance of immunisations programmes.

In the lead up to and post transition, the position in Westminster has remained relatively static. Uptake for MMR remains lower than the London and national average. However structures, processes have been developed to enable partners to work together. Noting the population's characteristics that provide challenges to the achievement of community resilience in Westminster, NHS England would like to assure the board that plans are in place and being enacted that will see a measurable improvement in the position for Westminster.

The board is asked to note the partnership working between the three organisations to date. In addition, the board is asked to support the continuation of an evidenced based approach to joint working in the future to ensure sustainable improvements in MMR (and the remaining childhood vaccinations) uptake can be realised for Westminster.

Appendices

APPENDIX 1 – The green book

The green book - https://www.gov.uk/government/organisations/public-health-england/series/immunisation-against-infectious-disease-the-green-book

APPENDIX 2 – Information about measles, mumps and rubella

Measles - A highly infectious viral illness that is characterised by coryza, cough, conjunctivitis and fever. Koplik spots (small bluish white spots on the buccal mucosa) are present about one to three days before the onset of the rash and although characteristic of measles are not found in all cases. After a few days a maculo-papular (red-brown spotty) rash will appear. Measles can be extremely unpleasant and can lead to complications such as meningitis and pneumonia, in rare cases people can die from measles. Statutory reporting of measles began in England and Wales in 1940. Before the introduction of a measles vaccine in 1968, annual notifications varied between 160,000 and 800,000, with peaks every two years, and around 100 deaths from acute measles occurred each yea

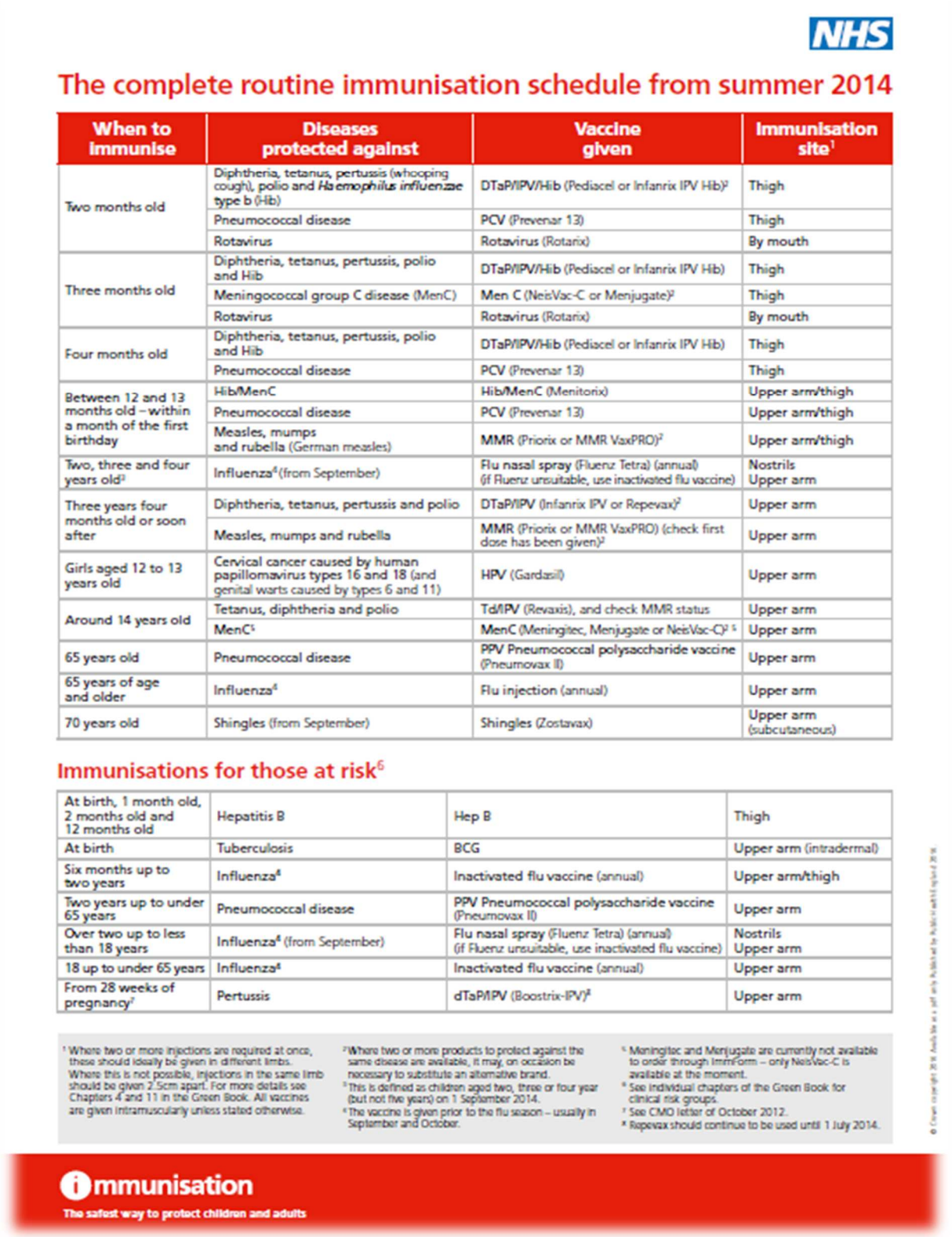
Mumps - Mumps is a viral infection that causes an acute illness with swelling of the parotid glands. Mumps is spread in the same way as colds and flu, by infected drops of saliva that can be inhaled or picked up from surfaces and passed into the mouth or nose. Serious complications are rare but it can lead to viral meningitis, orchitis and pancreatitis.

Rubella - Rubella (also known as German measles) is a viral infection that was a common childhood infection prior to the introduction of routine immunisation. Rubella is generally a mild infection in children characterised by a maculo-papular rash and lymphadenopathy. Complications can occur and these include thrombocytopenia and rarely, post infectious encephalitis. In adults, rubella infection can (rarely) result in arthralgia.

APPENDIX 3 – Link to document “NHS public health functions agreement 2014-15: Public health functions to be exercised by NHS England”

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256502/nhs_public_health_functions_agreement_2014-15.pdf

APPENDIX 4 – The table below shows the complete routine immunisation schedule for England form the summer of 2014:



NHS

The complete routine immunisation schedule from summer 2014

When to immunise	Diseases protected against	Vaccine given	Immunisation site[1]
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (Hib)	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)[2]	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
	Rotavirus	Rotavirus (Rotarix)	By mouth
Three months old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)	Thigh
	Meningococcal group C disease (MenC)	Men C (NeisVac-C or Menjugate)[2]	Thigh
	Rotavirus	Rotavirus (Rotarix)	By mouth
Four months old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
Between 12 and 13 months old – within a month of the first birthday	Hib/MenC	Hib/MenC (Menitorix)	Upper arm/thigh
	Pneumococcal disease	PCV (Prevenar 13)	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR (Priorix or MMR VaxPRO)[2]	Upper arm/thigh
Two, three and four years old[3]	Influenza[4] (from September)	Flu nasal spray (Fluenz Tetra) (annual) (if Fluenz unsuitable, use inactivated flu vaccine)	Nostrils Upper arm
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	DTaP/IPV (Infanrix IPV or Repevax)[7]	Upper arm
	Measles, mumps and rubella	MMR (Priorix or MMR VaxPRO) (check first dose has been given)[2]	Upper arm
Girls aged 12 to 13 years old	Cervical cancer caused by human papillomavirus types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (Gardasil)	Upper arm
Around 14 years old	Tetanus, diphtheria and polio	Td/IPV (Revaxis), and check MMR status	Upper arm
	MenC[5]	MenC (Meningitec, Menjugate or NeisVac-C)[2,5]	Upper arm
65 years old	Pneumococcal disease	PPV Pneumococcal polysaccharide vaccine (Pneumovax II)	Upper arm
65 years of age and older	Influenza[4]	Flu injection (annual)	Upper arm
70 years old	Shingles (from September)	Shingles (Zostavax)	Upper arm (subcutaneous)

Immunisations for those at risk[6]

At birth, 1 month old, 2 months old and 12 months old	Hepatitis B	Hep B	Thigh
At birth	Tuberculosis	BCG	Upper arm (intradermal)
Six months up to two years	Influenza[4]	Inactivated flu vaccine (annual)	Upper arm/thigh
Two years up to under 65 years	Pneumococcal disease	PPV Pneumococcal polysaccharide vaccine (Pneumovax II)	Upper arm
Over two up to less than 18 years	Influenza[4] (from September)	Flu nasal spray (Fluenz Tetra) (annual) (if Fluenz unsuitable, use inactivated flu vaccine)	Nostrils Upper arm
18 up to under 65 years	Influenza[4]	Inactivated flu vaccine (annual)	Upper arm
From 28 weeks of pregnancy[7]	Pertussis	dTaP/IPV (Boostrix-IPV)[8]	Upper arm

[1] Where two or more injections are required at once, these should ideally be given in different limbs. Where this is not possible, injections in the same limb should be given 2.5cm apart. For more details see Chapters 4 and 11 in the Green Book. All vaccines are given intramuscularly unless stated otherwise.

[2] Where two or more products to protect against the same disease are available, it may, on occasion be necessary to substitute an alternative brand.

[3] This is defined as children aged two, three or four year (but not five years) on 1 September 2014.

[4] The vaccine is given prior to the flu season – usually in September and October.

[5] Meningitec and Menjugate are currently not available to order through ImmForm – only NeisVac-C is available at the moment.

[6] See individual chapters of the Green Book for clinical risk groups.

[7] See CMO letter of October 2012.

[8] Repevax should continue to be used until 1 July 2014.

immunisation

The safest way to protect children and adults

APPENDIX 5 – Westminster COVER Uptake by Quarter (2013/14):

Indicator	Quarter 1 2013/14* (01 Apr '13- 30 Jun '13)	Quarter 2 2013/14 (01 Jul '13- 30 Sep '13)	Quarter 3 2013/14 (01 Oct '13- 31 Dec '13)	Quarter 4 2013/14 (01 Jan- 31 Mar '14)	Annual 2013/14	Annual 2012/13
1 yr – 3 doses DTAP/IPV/HIB	-	77.6%	79.8%	78.1%	***Available end September 2014***	79.0%
2 yr – PCV Booster	-	76.2%	76.0%	75.7%		75.1%
2 yr – HiB/MenC Booster	-	76.7%	75.8%	76.8%		77.0.%
2 yr – 1st dose MMR	-	76.7%	77.4%	78.3%		77.4%
5 yr – DTAP/IPV Booster	-	61.2%	59.6%	63.5%		70.0%
5 yr- 2nd dose MMR	-	79.3%	58.2%	61.9%		75.4%

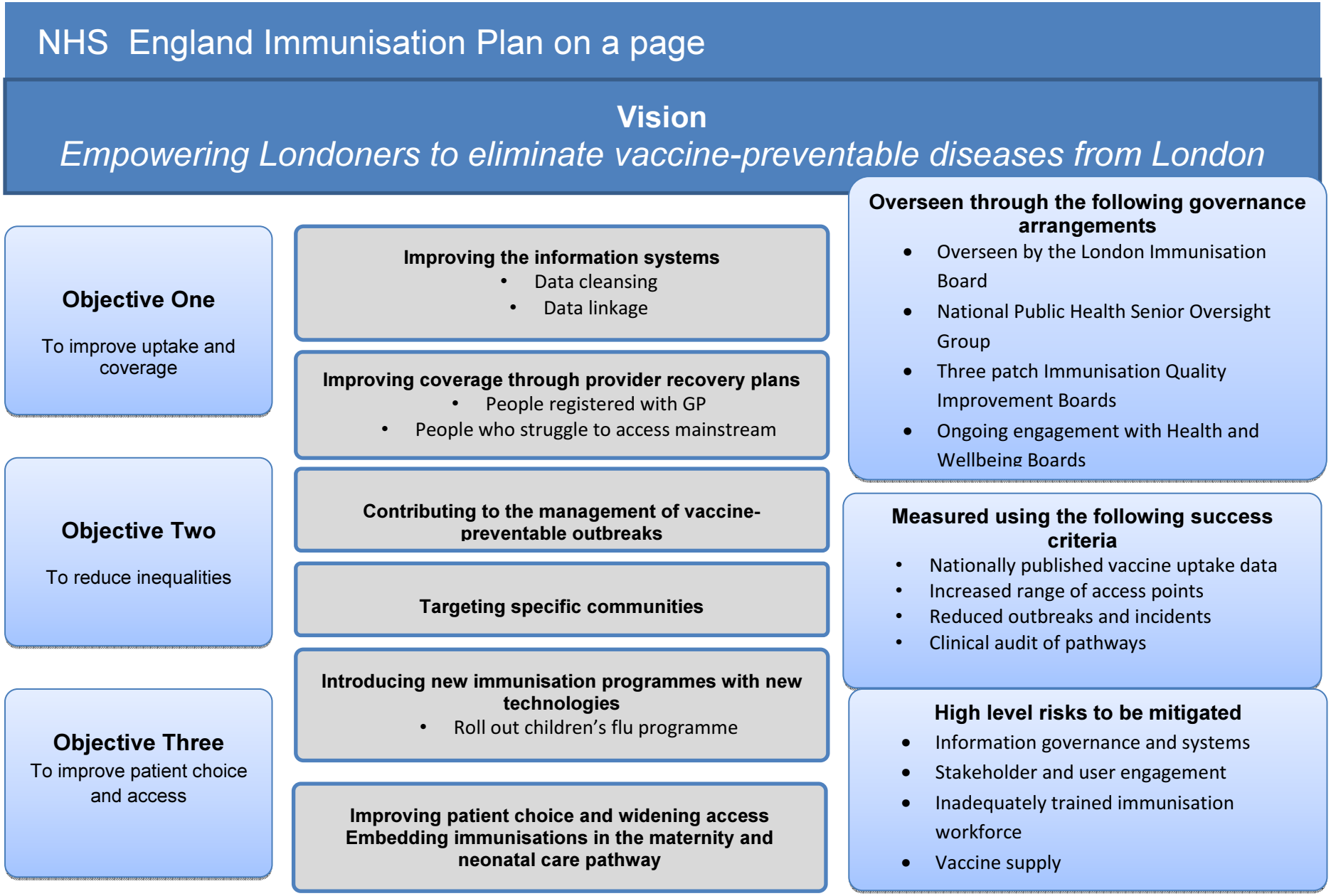
* Quarter 1 data not published due to data quality issues.

APPENDIX 6 - Local Immunisation Groups & their Functions

Meeting/group	Function	What this means for Westminster	Decision making/ advisory/ operational
London Immunisation Board	Sets the strategic direction for immunisations commissioning in London. maintains oversight for quality and performance of immunisations provision	Reviews performance, noting, underperformance and seeking assurance those robust plans are in place to address issues, seeks support from partners.	Decision making
Technical subgroup of the London Immunisation Board	establish and quality check a technical methodology that supports the development of uptake improvement plans, assesses the robustness of plans and evaluates the outcome of those plans	Supports the development of robust plans to improve uptake in Westminster, using evidence based methodology, and assists in evaluation of plans.	advisory
NWL Quality and Performance Group	Deliver measurable improvements in quality and performance for NHS commissioned immunisation	• Strengthens relationships between stakeholders and commissioning partners to understand population need • Local intelligence is shared to inform decision making relating to providers and/or programmes • Reviews local data quality and data reporting systems and makes recommendations on how these can be enhanced • Benchmark quality and performance of services in Westminster • Provides operational	• Decision making

		assurance to commissioning partners such as CCGs and Local authorities	
INWL CCG/LA (Public health) & NHS England Group	This meeting looks at a range of Public Health issues affecting INWL of which immunisation is an aspect of it. Issues requiring an operational stance are discussed here.	The group takes oversight of implementation of local operational issues that come out of the NWL Immunisations Quality Board meeting or local action plans	Operational
CHIS contract monitoring meetings	To hold providers to account for performance against their contract	NHS standard contract has been used with all CHIS providers. Providers are performance monitored against a national service specification within the contract. In addition there are London requirements that contracted such as the minimum data set that provides borough level surveillance.	Decision making

Appendix 7 – NHS England Immunisation plan on a page



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City of Westminster

Westminster Health & Wellbeing Board

Date:	18th September
Classification:	Public
Title:	Pharmaceutical Needs Assessment
Report of:	Pharmaceutical Needs Assessment Task and Finish Group
Wards Involved:	All
Policy Context:	Health and Wellbeing Boards are required to publish a new Pharmaceutical Needs Assessment for the area by 1st April 2015, following a 60 day statutory consultation on a draft Pharmaceutical Needs Assessment
Financial Summary:	N/A
Report Author and Contact Details:	Holly Manktelow, Senior Policy and Strategy Officer, hmanktelow@westminster.gov.uk Colin Brodie, Public Health Knowledge Manager, cbrodie@westminster.gov.uk

1. Executive Summary

1.1 This report sets out the progress being made by the Pharmaceutical Needs Assessment Task and Finish Group (TFG) to prepare a new Pharmaceutical Needs Assessment for the Westminster Health and Wellbeing Board by 1st April 2015.

2. Key Matters for the Board's Consideration

2.1 The Westminster Health and Wellbeing Board are asked to:

a.) Note the progress in preparing the draft Pharmaceutical Needs Assessment for publication (as outlined in Appendix A); and

b.) Agree that the Pharmaceutical Needs Assessment TFG should commence with the 60 day statutory consultation once the draft Pharmaceutical Needs Assessment is ready. A statutory consultation plan is attached at Appendix B.

3. Background

3.1 Pharmaceutical Needs Assessments are a statement of the need for pharmaceutical services of the population in a defined geographical area.

3.2 Pharmaceutical Needs Assessments are used primarily by NHS England to inform market entry decisions, in response to applications from businesses, including independent owners and large pharmacy companies. A Pharmaceutical Needs Assessment may also be used by commissioners to make decisions on which funded services need to be provided by local community pharmacies.

3.3 The responsibility for producing and managing the content and update of Pharmaceutical Needs Assessments transferred from Primary Care Trusts to Health and Wellbeing Boards on 1st April 2013. All Health and Wellbeing Boards are required to publish a fully revised Pharmaceutical Needs Assessment by 1st April 2015.

3.4 Health and Wellbeing Boards are required by law to consult a specified list of bodies at least once during the process of developing the Pharmaceutical Needs Assessment. These bodies are:

- The Local Pharmaceutical Committee;
- The Local Medical Committee;
- Any persons on pharmaceutical lists and any dispensing doctors;
- Any Local Pharmaceutical Services chemist in the area with whom the NHS Commissioning Boards has made arrangements from the provision of any local pharmaceutical services;
- Any local Healthwatch or any other patient, consumer and community group which (in the opinion of the Health and Wellbeing Board) has an interest;
- Any NHS Trust of Foundation Trust
- The NHS Commissioning Board (NHS England); and
- Any neighbouring Health and Wellbeing Boards

3.5 There is a minimum period of 60 days for consultation.

3.6 The Pharmaceutical Needs Assessment TFG have nearly completed a draft Pharmaceutical Needs Assessment for Westminster. This has required the collection and analysis of data from a variety of sources including local pharmacies.

4. Considerations

Pharmacy response rate

4.1 In Westminster, the response rate from local pharmacies was around 75%. All efforts were made to maximise this response rate, including through joint work with the Local Pharmaceutical Committee. However, the response rate was lower than expected. This most likely reflects the change of responsibilities for Pharmaceutical Needs Assessments from primary care trusts to Health and Wellbeing Boards which have less of a profile and relationship with the local pharmaceutical sector. The Task and Finish Group have contacted NHS England to request advice from them as to whether this response rate is adequate.

Slippage

5.3 The Task and Finish Group will be ready to begin the consultation on the draft Pharmaceutical Needs Assessment in October. This is a slight delay to the original timescales agreed by the Westminster Health and Wellbeing Board in March 2014 which expected the assessment to be ready for consultation in September.

5.4 This delay has been caused by difficulty in obtaining all the relevant data needed to complete the Pharmaceutical Needs Assessment to the timescales set out by the Task and Finish Group. The Task and Finish Group are still awaiting one set of data from partners. This data is comparison data on prescribing and dispensing trends to London and England. This data has been requested from North West London Commissioning Support Unit.

5.5 If this data is received in the next fortnight, this will not represent a significant deviation from the original timetable.

Consultation

3.8 As set out above, a 60 day statutory consultation must be undertaken with a list of statutory consulted. Appendix B provides an overview of the consultation plan for the Pharmaceutical Needs Assessment for the Westminster Health and Wellbeing Board to review.

3.9 The Pharmaceutical Needs Assessment is a technical and factual document, which provides a statement of pharmaceutical need in the area (following strict regulatory guidelines) for use by NHS England. It is not a description of policy or intent, or a document which sets out any changes to pharmaceutical services in the area.

3.10 The Pharmaceutical Needs Assessment is unlikely to be of interest to the wider public and the cost of a public consultation would be disproportionate to the response. Therefore, the Task and Finish Group do not recommend undertaking a full consultation with members of the public. However, consultation will be undertaken with patient and consumer groups to ensure that the user's perspective is referenced where appropriate within the Pharmaceutical Needs

Assessment. The draft Pharmaceutical Needs Assessment will also be available on-line (with a hard copy on request) for members of the public who may have a particular interest. This approach is in-line with the regulations and guidance.

4. Legal Implications

4.1 Health and Wellbeing Boards are required to publish and maintain a Pharmaceutical Needs Assessment by virtue of section 128A of the National Health Service Act 2006 (pharmaceutical needs assessments) and the Health and Social Care Act 2012.

5. Financial Implications

5.1 The statutory consultation plan attached at Appendix B can be implemented within current resource levels.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

Holly Manktelow, Senior Policy and Strategy Officer,
hmanktelow@westminster.gov.uk

Colin Brodie, Public Health Knowledge Manager,
cbrodie@westminster.gov.uk

APPENDICES:

A: Draft Pharmaceutical Needs Assessment outline
B: Draft Pharmaceutical Needs Assessment statutory consultation plan

BACKGROUND PAPERS:

City of Westminster's Pharmaceutical Needs Assessment
http://www.jsna.info/document/pharmaceutical-needs-assessment-0

Appendix A

Westminster Pharmaceutical Needs Assessment outline and progress update

Chapter	Description	Current state	Any further data required?	If yes, source
1 - Background	PNA definition and purpose, policy background, methodology (defining localities, demographic sources, needs), consultation process	Almost complete – compilation of previous PNA and DH PNA guidelines		
2 - Demographic & Health Needs	Mostly data and content based on the JSNA, including maps	Almost complete – Public Health Analysts completing data		
3 - Location of current health services	Maps with data from the pharmacy survey	Base map created. Awaiting list of neighbouring pharmacies to complete	List of pharmacies from neighbouring boroughs.	Requested from NHS England
4 - Prescribing and dispensing trends	Maps and graphs of prescribing within the borough	Data received from NWL CSU (ePACT) – ready for mapping	Comparison data to London/England	Requested from NWL CSU
5 - Access to pharmaceutical services	Pharmacy choice within each ward, opening hours, languages spoken	Ready for mapping	List of pharmacies from neighbouring boroughs.	Requested from NHS England
6 - Premises characteristics	Features such as private consultation rooms, handwashing, wheelchair access etc	Ready for mapping		
7 - Relationships, opportunities and skills	Relationships with GPs, LA, NHS – from survey	Ready for mapping and graphs		

8 - Services provided by pharmacies	Categorisation of services: necessary services: current provision, necessary services: gaps in provision, Other relevant services: current provision, Improvements or better access: gaps in provision	Text to be updated	Categorisation of services – currently assuming this has not changed since previous PNA	
Appendix A - Needs mapping: existing enhanced services	Table with list of pharmacies which provide enhanced services Maps and tables comparing need and current supply of services deemed necessary	Ready for mapping		
Appendix B - Needs mapping: potential new services	Maps and tables of services considered to secure improvement or better access	Ready for mapping		

Appendix B

Westminster Health and Wellbeing Board Pharmaceutical Need Assessment Statutory Consultation Plan

Holly Manktelow
Senior Policy and Strategy Officer
20th August 2014

Revision History

Date of this revision: 30th August 2014
Date of next revision: 22nd September2014

Revision Date	Previous revision date	Summary of Changes	Changes marked
20th August 2014	First version	First versions	First Version
30th August 2014	20th August 2014	Reflect comments from Chair HWB and the PNA TFG	No

1. Objectives of the consultation

The high-level objective of the Westminster Pharmaceutical Needs Assessment (PNA) statutory consultation is to ensure that statutory consultees are provided with a 60 day period between October 2014 and January 2014 in which to consider the draft PNA for Westminster and provide their views to the PNA Task and Finish Group. The list of statutory consultees are:

- The Local Pharmaceutical Committee;
- The Local Medical Committee;
- Any persons on pharmaceutical lists and any dispensing doctors;
- Any Local Pharmaceutical Services chemist in the area with whom the NHSE has made arrangements for the provision of any local pharmaceutical services;
- Any local Healthwatch or any other patient, consumer and community group which (in the opinion of the Health and Wellbeing Board) has an interest;
- Any NHS Trust of Foundation Trust
- The NHS Commissioning Board (NHS England); and
- Any neighbouring Health and Wellbeing Boards

2. Key Audiences

Audience	Approach	Responsibility
Local Pharmaceutical Committee	§ Letter and Email (on behalf of the Health and Wellbeing Board) § LPC are represented on the PNA Task and Finish Group	HWB Chair PNA Task and Finish Group
Local Medical Committee	§ Letter and Email (on behalf of the Health and Wellbeing Board) § Offer of a meeting if required	HWB Chair PNA Task and Finish Group
Individual Pharmacies	§ Email and link to the online PNA § Support from the Local Pharmaceutical Committee if required (through their membership on the PNA Task and Finish Group)	PNA Task and Finish Group
Dispensing GPs (None)	§ Email and link to the online PNA § Work with WLCCG to put out information through their channels of communication with GPs	PNA Task and Finish Group CLCCG/WLCCG
Healthwatch	§ Letter and Email sent to the Chair and support team § Offer to attend meetings or public events if required	HWB Chair PNA Task and Finish Group
WLCCG and CLCCG user panels	§ Information provided to the user panel through WLCCG channels § Offer to attend meetings if required	PNA Task and Finish Group
Other patient or consumer group	§ Healthwatch to support the provision of information	Healthwatch

	to their organisation or institutional members	
Westminster Community Network	§ Letter and Email sent to the Chair § Offer to attend meetings or public events if required	HWB Chair PNA Task and Finish Group
One Westminster	§ Letter and Email sent to the Chief Executive and Chair § Offer to attend meetings or public events if required	HWB Chair PNA Task and Finish Group
Chelsea and Westminster NHS Trust	§ Letter and Email sent to the Chief Executive and Chair, and communications team § Offer to attend meetings if required § Request that the information is shared with the trusts patient user groups	HWB Chair PNA Task and Finish Group
Imperial NHS Trust	§ Letter and Email sent to the Chief Executive and Chair, and communications team § Offer to attend meetings if required § Request that the information is shared with the trusts patient user groups	HWB Chair PNA Task and Finish Group
University College London Hospitals	§ Letter and Email sent to the Chief Executive and Chair, and communications team § Offer to attend meetings if required § Request that the information is shared with the trusts patient user groups	HWB Chair PNA Task and Finish Group
Guy's and St Thomas' NHS Foundation Trust	§ Letter and Email sent to the Chief Executive and Chair, and communications team § Offer to attend meetings if required § Request that the information is shared with the trusts patient user groups	HWB Chair PNA Task and Finish Group
Royal Free Hospital	§ Letter and Email sent to the Chief Executive and Chair, and communications team § Offer to attend meetings if required § Request that the information is shared with the trusts patient user groups	HWB Chair PNA Task and Finish Group
Central London Community Healthcare	§ Letter and Email sent to the Chief Executive and Chair, and communications team § Offer to attend meetings if required § Request that the information is shared with the trusts patient user groups	HWB Chair PNA Task and Finish Group

Central North West London NHS Trust	§ Letter and Email sent to the Chief Executive and Chair, and communications team § Offer to attend meetings if required § Request that the information is shared with the trusts patient user groups	HWB Chair PNA Task and Finish Group
City of London Health and Wellbeing Board	§ Letter and Email sent to the Chair and support team	Chair of the Health and Wellbeing Board
Southwark Health and Wellbeing Board	§ Letter and Email sent to the Chair and support team	Chair of the Health and Wellbeing Board
Lambeth Health and Wellbeing Board	§ Letter and Email sent to the Chair and support team	Chair of the Health and Wellbeing Board
Wandsworth Health and Wellbeing Board	§ Letter and Email sent to the Chair and support team	Chair of the Health and Wellbeing Board
Camden Health and Wellbeing Board	§ Letter and Email sent to the Chair and support team	Chair of the Health and Wellbeing Board
Brent Health and Wellbeing Board	§ Letter and Email sent to the Chair and support team	Chair of the Health and Wellbeing Board
RBKC Health and Wellbeing Boards	§ Email sent to the Chair and support team (Shared support team RBKC, LBHF and Westminster HWBs)	Chair of the Health and Wellbeing Board
NHS England	§ Letter and Email sent to NHS England London Region	Chair of the Health and Wellbeing Board
Relevant Scrutiny Committee (not required by legislation but good practice)	§ Letter and Email sent to the Chair and support team	Chair of the Health and Wellbeing Board

4. Communicators	
Communicator	**Responsibilities**
Westminster Health and Wellbeing Board	All communications to statutory consultees will be delivered in the name of the RBKC Health and Wellbeing Board
Healthwatch	Support communication with wider patient and consumer groups
NHS Trusts	Support communication with their patient and consumer groups
West London CCG	Support communication with individual dispensing GPs Support communication with their patient and consumer groups
Local Pharmaceutical Committee	Support communications with individual pharmacies
Westminster Community Network	Support communications with relevant community groups
One Westminster	Support communications with relevant community groups

6. Methods of Communication	
Email and Letters	Emails and letters will be the primary form of communication to statutory consultees
Presentation	May be used occasionally to support communications with patient and consumer groups (if required)
Website	The draft PNA, details on the scope of the consultation and how to provide feedback will be place on the RBKC council website, and the www.jsna.info website
Reports	Available on request (for example by NHS Trusts, Healthwatch and CCG governing body) A report will be presented to neighbouring Health and Wellbeing Boards for information
Stakeholder Group Meetings	Available on request.
Other meetings	Available on request
One-to-One meetings	Available if required due to concerns

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City of Westminster

Westminster Health & Wellbeing Board

Date:	**18th September 2014**
Classification:	**Public**
Title:	**WORK PROGRAMME**
Report of:	**Head of Legal & Democratic Services**
Wards Involved:	**All**
Policy Context:	**Health & Wellbeing**
Financial Summary:	**None**
Report Author and Contact Details:	**Andrew Palmer, Committee & Governance Services: telephone 020 7641 2802 email apalmer@westminster.gov.uk**

1. Executive Summary

1.1 The Westminster Health & Wellbeing Board is invited to review its Work Programme for 2014-15.

2. Key Matters for the Board's Consideration

2.1 That the Westminster Health & Wellbeing Board considers whether any changes need to be made to the Work Programme for 2014-15.

3. Background

3.1 At its first meeting of the 2014-15 cycle on19 June, the Westminster Health & Wellbeing Board considered and agreed issues for future consideration for including in its Work Programme (attached as Appendix A). The Board has the opportunity to review its work programme at each meeting

3.2 The Board also considered dates for future meetings, which would take place 6 times per year. Dates for future meetings are:

- Thursday 20 November 2014
- Thursday 22 January 2015
- Thursday 19 March 2015
- Thursday 21 May 2015

3.4 The 2014/15 work programme will be co-ordinated as much as is appropriate alongside the Health & Wellbeing Boards in the London Borough of Hammersmith & Fulham and the Royal Borough of Kensington & Chelsea. The work programme for the first half of 2014/15 is attached as Annex A.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact: Andrew Palmer, telephone 020 7641 2802, email apalmer@westminster.gov.uk

APPENDICES

A: Work Programme

Appendix A

Westminster Health & Wellbeing Board
Work Programme 2014/15

Agenda Item	Issue and/or decision	Reason	Lead
Meeting Date 18th September 2014			
Better Care Fund	Agree the revised Better Care Fund Plan responding to changes made to the national programe by central government over the Summer	Health and Wellbeing Board sign-off to the plan is required before submission on 19th September	Cath Attlee (ASC)
Primary Care Commissioning	To review the approach taken by NHS England to Primary Care Commissioning and consider how the Health and Wellbeing Board can ensure that commissioning reflects local need	Primary Care is central to our system change programmes underway – particularly BCF, Out of Hospital and SaHF	Karen Clinton (NHSE)
MMR immunisation	To understand the roles and responsibilities or organisations in relation to MMR and to consider how the system can work better together to improve uptake	Links to Priority 1 and key public health issue	Meradin Peachey (PH) Gemma Harris (NHSE)
CCG contracting intentions	To provide early steer on the development of CLCCG and WLCCG contracting intentions for 2015/16	Legislative requirement	Matthew Bazeley (CLCCG) Louise Proctor (WLCCG)
Pharmaceutical Needs Assessment	Endorse the PNA Consultation draft and plan	Legislative Requirement	Director of Public Health JSNA Programme Manager

Meeting Date 20th November 2014			
Children and Young People Mental Health Task and Finish Group	Discussion and endorsement of Final Report and recommendations from the Task and Finish Group	Health and Wellbeing Strategy –Priority 2	Dr Ruth O'Hare (Board Lead) Steve Buckerfield (Task and Finish Group Lead)
Commissioning intentions and Business Planning	Discussion of DRAFT commissioning intentions and business plans	Legislative requirement	TBC
Tackling Child Poverty	Development of the Child Poverty Strategy	Item of interest	Executive Director of Children's Services Strategic Director of Housing and Regeneration
Local Safeguarding Children's Board Annual Report	To consider the annual report from the Local Safeguarding Childrens Board and reflect on areas for joint-working and partnership to improve outcomes for Children at risk	Request from LSCB Chair	Jean Daintith (LSCB Chair) Andrew Christie Tim Deacon (LSCB Manager)
Health Visiting Transition	To understand the chidlrens public health (0 - 5) due to transfer to LAs in October 2015 and consider links to HWB Strategy priorities around early years such as School Nursing, MMR etc	Links to P1	Meradin Peachey
School Nursing	To consider the results of the review of school nursing services and consider options relating to service design and future commissioning intentions	Links to P1 and P2	Meradin Peachey

Meeting Date 22nd January 2015			
Commissioning intentions and Business Planning	*Discussion of DRAFT commissioning intentions and business plans*	*Legislative requirement*	*TBC*
Housing Strategy	*Update on development of Westminster Housing Strategy and opportunity to provide further steer*	*Item of Interest*	*TBC*
Report on access to services	*Report on commissioned research into access to services*	*Item of Interest*	*TBC*
Care Act Implementation	*Report on the implementation of the Care Act – focus on new responsibilities around advice and prevention*	*Item of Interest*	*TBC*

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