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City of Westminster

Committee Agenda

Title:	**Health & Wellbeing Board**
Meeting Date:	**Thursday 1st October, 2015**
Time:	**4.00 pm**
Venue:	**Rooms 3 & 4 - 17th Floor, City Hall, 64 Victoria Street, London SW1E 6QP**

Members:

Councillor Rachael Robathan (Chairman)	Cabinet Member for Adults & Public Health
Dr Ruth O'Hare	Central London Clinical Commissioning Group
Councillor Danny Chalkley	Cabinet Member for Children and Young People
Councillor Barrie Taylor	Minority Group
Eva Hrobonova	Tri-borough Public Health
Liz Bruce	Tri-borough Adult Social Care
Andrew Christie	Tri-borough Children's Services
Dr Philip Mackney	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, Toby Howes, Senior Committee and Governance Officer.

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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 **(Pages 1 - 16)**

I) To agree the Minutes of the meeting held on 9 July 2015.

II) To note progress in actions arising.

4. CENTRAL LONDON CLINICAL COMMISSIONING GROUP - BUSINESS PLAN 2016/17 **(Pages 17 - 38)**

To consider the Central London Clinical Commissioning Group's Business Plan for 2016/17.

5. WESTMINSTER HEALTH AND WELLBEING HUBS PROGRAMME UPDATE **(Pages 39 - 44)**

To consider the Westminster Health and Wellbeing Hubs Programme.

6. DEMENTIA JOINT STRATEGIC NEEDS ASSESSMENT - COMMISSIONING INTENTIONS AND SIGN OFF **(Pages 45 - 78)**

To consider the Dementia Joint Strategic Needs Assessment commissioning intentions and sign off.

7. WESTMINSTER PRIMARY CARE PROJECT UPDATE **(Pages 79 - 84)**

To consider an update on the Westminster Primary Care Project.

8. CHILDREN AND FAMILIES ACT UPDATE (Pages 85 - 92)

To receive an update on the implementation of the Children and Families Act.

9. BETTER CARE FUND UPDATE (Pages 93 - 102)

To receive an update on delivery of the Better Care Fund Programme.

10. PRIMARY CARE CO-COMMISSIONING UPDATE (Pages 103 - 106)

To receive an update on progress in Primary Care Co-Commissioning.

11. MINUTES OF THE JOINT STRATEGIC NEEDS ASSESSMENT STEERING GROUP MEETING HELD ON 27 JULY 2015 (Pages 107 - 110)

To note the minutes of the Joint Strategic Needs Assessment Steering Group meeting held on 27 July 2015.

12. WORK PROGRAMME (Pages 111 - 112)

To consider the Work Programme for 2015/16.

13. ANY OTHER BUSINESS

Charlie Parker
Chief Executive
23rd September 2015

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CITY OF WESTMINSTER

MINUTES

WESTMINSTER HEALTH & WELLBEING BOARD
9 JULY 2015
MINUTES OF PROCEEDINGS

Minutes of a meeting of the **Westminster Health & Wellbeing Board** held on Thursday 9th July, 2015 at 4.00pm at Westminster City Hall, 64 Victoria Street, London, SW1E 6QP

Members Present:
Chairman: Councillor Rachael Robathan, Cabinet Member for Adults and Public Health
Cabinet Member for Children and Young People: Councillor Danny Chalkley
Minority Group Representative: Councillor Patricia McAllister
Director of Public Health: Dr Ike Anya (acting as Deputy)
Tri-Borough Executive Director of Children's Services: Mike Potter (acting as Deputy)
Clinical Representative from the West London Clinical Commissioning Group: Dr Philip Mackney
Representative from Healthwatch Westminster: Janice Horsman
Chair of the Westminster Community Network: Jackie Rosenberg
Representative for NHS England: Dr Belinda Coker (acting as Deputy)

Also Present: Matthew Bazeley (Managing Director, NHS Central London Clinical Commissioning Group) and Louise Proctor (Managing Director, NHS West London Clinical Commissioning Group).

1 MEMBERSHIP

1.1 Apologies for absence were received from Dr Ruth O'Hare (Central London Clinical Commissioning Group) and Liz Bruce (Tri-Borough Executive Director of Adult Social Care).

1.2 Apologies for absence were also received from Councillor Barrie Taylor, Eva Hrobonova (acting as the Deputy Tri-Borough Director of Public Health), Andrew Christie (Tri-Borough Executive Director of Children's Services), Dr Naomi Katz (West London Clinical Commissioning Group) and Dr David Finch (NHS England). Councillor Patricia McAllister, Dr Ike Anya, Mike Potter, Dr Philip Mackney and Dr Belinda Coker attended as their respective Deputies.

1.3 The Board noted that Dr Philip Mackney had replaced Dr Naomi Katz as the representative for the West London Clinical Commissioning Group.

2 DECLARATIONS OF INTEREST

2.1 No declarations were received.

3 MINUTES AND ACTIONS ARISING

3.1 **RESOLVED:** That

(1) The Minutes of the meeting held on 21 May 2015 be approved for signature by the Chairman; and

(2) Progress in implementing actions and recommendations agreed by the Westminster Health and Wellbeing Board be noted.

3.2 The Chairman sought clarification in respect of when the North West London Mental Health and Wellbeing Strategic Plan, Children and Young People's Mental Health and Child Poverty items would be considered at future Board meetings. Mike Potter agreed to follow this up with Rachael Wright-Turner (Tri-Borough Director for Children's Commissioning) to advise the Board accordingly. Holly Manktelow (Principal Policy Officer) added that the North West London Clinical Commissioning Group would want to present their 'Case for Change' in respect of the North West London Mental Health and Wellbeing Strategic Plan item.

3.3 The Chairman advised that she would take forward matters relating to Primary Care Project and in identifying a Board sponsor to oversee progress on the project in between meetings.

3.4 In reply to a query from the Board, Holly Manktelow advised that Mental Health's listing on the Work Programme for the 19 November 2015 Board meeting was provisional and that Rachael Wright-Turner was working with the Children's Trust Board to develop the vision for Children and Young People's Mental Health and Wellbeing.

4 FIVE YEAR FORWARD VIEW AND THE ROLE OF NHS ENGLAND IN THE LOCAL HEALTH AND CARE SYSTEM

4.1 Dr Belinda Coker (NHS England) gave a presentation that set out NHS England's view on the Five Year Forward View and its role in the Local Health and Care System. The Board heard that the challenges facing the health and care system nationally and for London were set out in three key strategy documents, these being the Five Year Forward View, Better Health for London and Transforming London's Health and Care Together. There was £1.8 billion funding for primary care co-commissioning for West and North West London and £1 billion over four years, yet to be allocated, for the whole of London for the Primary Care Infrastructure Fund. The Board also heard that expressions of interest were being received regarding the new models of care.

4.2 During discussion, the Board enquired whether the primary acute care budget would be increased to cover areas where there was increased demand or

would funding be moved from other areas to accommodate this. Information was sought on how NHS England's work would tie in with the local Clinical Commissioning Groups' (CCGs) intentions and the local Health and Wellbeing Boards (HWBs) and local authorities' strategies. The Board asked how the local work of Health and Wellbeing Boards could be demonstrated to connect with what NHS England was doing. Another member enquired what action NHS England would take when a serious problem had been identified locally.

4.3 In reply, Dr Belinda Coker advised that the intention was to have the ability to move funds around more freely for Primary and Acute Care, so that if an area had been identified as having a particularly high demand for a service, funds could be reallocated to the area to boost the service. However, she added that this would mean taking funding away from other areas with less demand and so funding overall was not necessarily being increased. Dr Belinda Coker stated that NHS England saw HWBs playing a key role in providing a local influence on health provision and also the role the voluntary sector could play. The Five Year Forward View was a national vision setting out a broad view. Dr Belinda Coker added that HWB's role in producing a local strategy in terms of local commissioning was key as it took into account the needs of the local area. The Board heard that NHS England would take action once evidence of a serious problem had been put together, and the action taken may involve either remediation or in more serious cases putting a 'caretaker service' in place.

4.4 Louise Proctor (Managing Director, NHS West London Clinical Commissioning Group) remarked that there were often estate consequences when individual GP practices closed, especially if they were privately managed. She emphasised that the main points to consider was whether co-commissioning provided a better local solution and did NHS England's vision fit in with the work being done across North West London. In her view, although the language used by NHS England was different to that used locally, the action being taken locally was consistent with NHS England's view. Louise Proctor added that it was very important to get the local offer right and to ensure that there was sufficient capacity. Thought also needed to be given as to whether joint co-commissioning would be able to help the Board and the CCGs have more local influence in future.

4.5 The Board sought further details about what steps would be taken by NHS England in the event of a problem of such seriousness as to be considered an emergency. Members asked whether formal notice was required when a GP practice was to close and what arrangements were in place if a closure meant there was no provision in a locality and was there a bank of GPs who could be used in such situations. It was suggested that the future should involve co-designed models of healthcare and that it would be desirable that the language of NHS England, the local CCGs and HWBs were aligned. A Member stated that patients regularly expressed concern that they did not feel they were given enough time during appointments. Another Member sought NHS England's views on HWBs role in promoting immunisations and other preventative health measures. Clarification was also sought on the opening hours of GP practices.

4.6 In reply to further issues raised, Dr Beliinda Coker advised that in emergency situations where there was no provider, a caretaker provider would be put in place immediately, whilst bidders could submit their applications within a few days to become the next permanent provider, with implementation of a new provider taking between two to four weeks. The Board was advised that GP practices were required to provide due notice within a statutory time prior to closure. Dr Belinda Coker asserted that there would always be GP providers available even when a practice closed as a result of the system of procurement. She stated that information on immunisations and preventative health was available and part of HWBs role was in feeding additional information on these services locally. The Board noted that GP practices were contracted to provide a service between 8.00am and 6.30pm.

4.7 Holly Manktelow emphasised the importance of NHS England engaging with CCGs and HWBs when developing strategies and that the HWBs could play a role in communicating NHS England's messages.

4.8 The Board noted that although the language used by NHS England was different to that used locally, the action being taken locally was consistent with NHS England's view. The Board agreed with Louise Proctor suggestion that NHS England's documents be compared to the documents produced locally by CCGs and HWBs, demonstrating how they tied in together. It was also agreed that it would be useful for the Board to receive regular updates from NHS England on what it was doing and how the Board could support its work.

5 JOINT STRATEGIC NEEDS ASSESSMENT UPDATE

5.1 Thilina Jayatilleke (Public Health Analyst) gave a presentation on the Evidence Hub that was in the process of being developed and aimed to provide a wide range of data obtained from a number of sources which would then be made available in one place. The Evidence Hub would also be used as an online tool for new Joint Strategic Needs Assessments (JSNAs), providing the latest data. Thilina Jayatilleke advised that the intention was not to replicate data and the GSI Team had provided health data, demographics and other useful information to the Evidence Hub. As well as holding raw data, the Evidence Hub intended to provide information that would be of interest and use to users. Thilina Jayaktilleke advised that the aim was to provide a health profile for Westminster and the other tri-boroughs by 2016. He then provided a demonstration of the Evidence Hub to the Board.

5.2 During discussion, a Member asked if confidential school data would be published and whether the information on voluntary and community organisations was up to date and could it be mapped. A Member welcomed progress on the Evidence Hub and in noting that JSNA data was heavily detailed by nature, enquired how this would be accessed. Another Member enquired whether immunisation data was available and would it interface with other data sets and he suggested that this data could be presented to the Board at a future meeting. It was also remarked that it would be beneficial if the Evidence Hub could be used to access urgent care data.

5.3 In reply, Thilina Jayaktilleke advised that the Evidence Hub would not publish confidential school data. He stated that at this stage, it was intended to provide JSNA data via the JSNA website, however how this data would be accessed was still under consideration. He advised that voluntary and community organisations would be mapped through postcodes, and pharmacies could also be mapped, although there will still be a need for separate documents. Thilina Jayaktilleke confirmed that immunisation data was contained in the Evidence Hub and that he expected this to interface with other data sets, although in some cases data may need to be linked manually. He advised that data by ward was also available.

5.4 The Board welcomed progress on the Evidence Hub and the potential it offered and welcomed further updates on its development at future meetings.

5.5 Colin Brodie (Public Health Knowledge Manager) then presented a report updating the Board on the progress of the JSNA products. He drew Members' attention to the progress from evidence set out in the deep dive JSNAs published in 2013-14. He informed the Board that the JSNA Steering Group had discussed alignment between the JSNA Work Programme and the HWB's priorities at a meeting on 4 June. The Steering Group had noted that the Westminster Joint Health and Wellbeing Board Strategy was due to be updated in the near future and considered that this would be an ideal opportunity to pursue closer alignment. Colin Brodie welcomed suggestions from the Board on how the JSNA could help support its priorities.

5.6 The Board emphasised the need to ensure that JSNAs helped the Board impact upon policy areas.

6 WESTMINSTER DRAFT HOUSING STRATEGY

6.1 Andrew Barrypurssell (Head of Spatial and Environmental Planning) gave a presentation on the draft Westminster Housing Strategy that was out for consultation from 3 June until 31 July 2015. He explained that the draft strategy had been developed over the past year and links to the strategy had been sent to over 400 stakeholders and colleagues. Andrew Barrypurssell stated that the strategy sought to address some key housing issues in Westminster, including the fact that the ability to provide new social housing was limited by high costs and the shortage of available land. Customers also faced long waits in respect of temporary housing.

6.2 Andrew Barrypurssell advised that the Housing Strategy was an essential element for all of the three City for All themes of 'Aspiration', 'Choice' and 'Heritage'. The strategy was based on four themes, with the first, 'Homes' focusing on delivering 1,250 new affordable homes in the next five years, developing new types of intermediate housing and changing planning policies so that for new developments with an affordable housing element, 60% would be intermediate and 40% social housing in order to help those on lower or middle incomes. In view of the shortage of available land, consideration would also be given in using resources to deliver affordable homes outside Westminster to help explore the possibility of providing more affordable homes above the 1,250 target. The strategy's second theme, 'People',

included investing in tackling cold and damp in council homes and reviewing older people's housing provision and support, particularly as the older population in Westminster was increasing, and also in working with vulnerable Council tenants. Andrew Barrypurssell advised that Westminster was amongst the top ten London boroughs to receive requests to house homeless people and that it was working with other London boroughs and the Mayor of London on how to tackle this issue.

6.3 Andrew Barrypurssell stated that the third theme, 'Places', included focusing delivery on current estate renewal schemes and consideration of providing a range of services to suit customer needs in one place. In respect of the fourth theme, 'Prosperity', he stated that social tenants often faced a range of issues to overcome, such as finding employment and mental health factors, and the Council intended to work with partners to provide tailored support to social housing tenants.

6.4 During Members' discussion, Jackie Rosenberg (Westminster Community Network) informed the Board of feedback from the Westminster Community Network (WCN) which had received a presentation on the draft housing strategy. She stated that WCN had expressed a need for the strategy to address the risk of family fragmentation, particularly in situations where older people were becoming more isolated due to younger family members having to move out of Westminster and therefore impacting upon their ability to support older relatives. This could also affect an older person's ability to access health services or to live in their own home. The draft strategy had not made any reference to 'family life' which was also at risk from fragmentation. Jackie Rosenberg added that there was now a much larger private rented sector in Westminster, however many properties were often in bad condition and this also needed to be addressed. Councillor Danny Chalkley added that local authorities were obliged to review private sector housing.

6.5 Matthew Bazeley (Managing Director, NHS Central London Clinical Commissioning Group) suggested that investment in environmental housing needed to be emphasised more, stating that the majority of referrals came from health teams, whilst environmental health teams were also informing health teams of issues they needed to be aware of. He advised that a Network of Health Providers was being developed in Central and West London and they could also provide input into the strategy. Matthew Bazeley also felt that procurement of care homes, which were fundamentally homes but with care facilities, could be drawn out more in the strategy. He welcomed the strategy's emphasis on tackling homelessness, particularly as this was one of the most vulnerable groups, and any initiatives which supported those with housing needs receiving care.

6.6 A Member commented that properties adapted for those with disabilities were often one bedroom, however there were instances where the carer was a family member and so this often dissuaded residents from moving to the adapted property. She enquired whether there were any plans to build more adapted properties with at least two bedrooms. Another Member welcomed moves to promote supported housing and emphasised the need to focus on those with mental health needs, where community networks were vital in

providing stability. She added that placing customers with mental health needs out of Westminster could have a negative effect on their recovery.

6.7 Mike Potts confirmed that Children's Services would provide a formal response to the consultation. In respect of child poverty and homelessness, he suggested that the strategy had the potential to feed into City for All in respect of 'Aspirations for Children.' The Board also enquired what the next steps were with regard to older people housing. Colin Brodie advised that Public Health had discussed the Housing JSNA with housing colleagues and that he welcomed the opportunity to ensure that the housing JSNA aligned with the Housing Strategy.

6.8 In response to the issues raised, Andrew Barrypurssell advised that out of borough housing was more intended in terms of temporary accommodation. However, where this option was sought, it was not the intention to place residents a long way from Westminster. However, he advised that there was no easy solution in providing enough temporary and social housing, although every effort would be made to secure as much accommodation as possible. Andrew Barrypurssell confirmed that enforcement in respect of private sector housing standards would be included in the strategy. The Board heard that housing for older people was a national issue and details of actions to be taken on this topic would be included in the final strategy document. Andrew Barrypurssell acknowledged that the housing JSNA had linkages to some of the aims of the strategy and that it could assist the strategy and he welcomed any further suggestions in respect of this. He informed the Board that a refreshed rough sleeper strategy was also being scoped.

6.9 The Board, in noting that a JSNA on housing was being developed that focused in particular on the needs of older and vulnerable people, emphasised the importance of ensuring that the housing JSNA fed into the Housing Strategy.

6.10 The Board felt that it was particularly important that older people felt safe and were able to live in their own homes and this needed to be aligned with the needs of residents with mental health issues in sheltered housing to ensure both groups' needs were met without adversely affecting the other. The implications of the Care Act on housing needs also needed to be taken into account and the Board requested that both these topics be taken into account when finalising the strategy. Members agreed that the Housing Strategy be bought back to a future meeting for the Board to make its recommendations.

7 UPDATE ON PREPARATIONS FOR THE TRANSFER OF PUBLIC HEALTH RESPONSIBILITIES FOR 0 - 5 YEARS

7.1 Ike Anya (Deputy Director, Public Health) presented the report and explained that responsibility for health visiting and Family Nurse Partnerships for 0 – 5 years would move from NHS England to local authorities in October 2015. These services would be commissioned from October 2015 to deliver against the standard national service specification, until a new service is re-commissioned in 2016-17. Ike Anya advised that initial analysis of performance data from quarter 4 of 2014-2015 suggested that the health

visiting service was meeting performance requirements for the mandated elements of the Healthy Child Programme.

7.2 A Member commented that a lot of ground work had been done in respect of midwifery, nursery providers and health visitors and she felt there was a lot of ground support for earliest years services. She felt that GP practices could benefit from a more joined up approach. Louise Proctor stated that the efforts to cover potential gaps and risks in services during the re-organisation of work in this area had been effective.

7.3 The Board suggested that ways in which the work of the Family Nurse Partnership could link with troubled families be considered. The Board also requested an update on this item at a future meeting in 2016.

8 BETTER CARE FUND

8.1 Matthew Bazeley provided an update on the progress in the Better Care Fund Plan. He advised the Board that the Community Independence Service was progressing well, whilst the In-Reach Service had enjoyed even greater success, although there was still a need for improvement in terms of getting patients more quickly to the appropriate health service location. Matthew Bazeley added that the next update would provide examples of success and challenges to date. Challenges continued to remain with regard to recruitment, particularly around social care providers, however a collaborative approach was being taken to address this. Proposals to increase capacity in term of New Road rehabilitation were in the process of being finalised and it was intended to commission 19 additional beds. In reply to a query from a Member, Matthew Bazeley confirmed that the Hospital Discharge Project, which had shown early signs of success, did not include mental health discharges.

9 PRIMARY CARE CO-COMMISSIONING

9.1 Matthew Bazeley updated the Board on progress in primary care co-commissioning and advised that the Terms of Reference for the Primary Care Co-Commissioning Joint Committees was in the process of being agreed. The Board heard that the first meeting of the Central London Clinical Commissioning Group (CCG) Joint Co-Commissioning Committee had taken place on 21 May and a representative from the Board was sought to serve on the Committee. The Board was also invited to appoint a representative on the Local Operational Committee, whose work Matthew Bazeley suggested may be of particular interest to the Board. Matthew Bazeley confirmed that he would provide the terms of reference for the North West London CCG Joint Commissioning Committee and the Local Operational Committee at the next Board meeting.

9.2 The Board acknowledged the need to appoint a member to the Central London CCG Joint Co-Commissioning Committee and this would be undertaken once the new Director of Public Health was in post.

10 WORK PROGRAMME

10.1 The Board noted the current Work Programme.

11 ANY OTHER BUSINESS

11.1 On behalf of the Board, the Chairman thanked Holly Manktelow for her support and advice that she had provided to the Board over the last few years and wished her every success in her new role. The Chairman also welcomed Meenara Islam (Principal Policy Officer) who would be taking on the role of supporting the Board.

The Meeting ended at 6.03 pm.

CHAIRMAN: ______________________ **DATE** ___________________

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WESTMINSTER HEALTH & WELLBEING BOARD
Actions Arising

Meeting on Thursday 9th July 2015

Action	Lead Member(s) And Officer(s)	Comments
Five Year Forward View and the Role of NHS England in the Local Health and Care System		
That a document be prepared comparing NHS England's documents with the Clinical Commissioning Groups to demonstrate how they tie in together.	Clinical Commissioning Groups/NHS England	To be considered at a forthcoming meeting.
Board to receive regular updates on the work of NHS England and to see how the Board can support this work.	NHS England	To be considered at future meetings.
Westminster Housing Strategy		
Housing Strategy to be brought to a future meeting for the Board to feed back its recommendations.	Spatial and Environmental Planning	To be considered at a forthcoming meeting.
Update on Preparations for the Transfer of Public Health Responsibilities for 0-5 Years		
Board to receive and update in 2016.	Public Health	To be considered at a meeting in 2016.

Meeting on Thursday 21st May 2015

Action	Lead Member(s) And Officer(s)	Comments
North West London Mental Health and Wellbeing Strategic Plan		
That a briefing paper be prepared outlining how the different parts of the mental health services will work and how various partners can feed into the process.	NHS North West London	To be considered at a forthcoming meeting.
Adult Social Care representative to be appointed onto the Transformation Board.	NHS North West London Adult Social Care	To be confirmed.
Children and Young People's Mental Health		
A vision statement be produced and brought to a future Board meeting setting out the work to be done in considering mental health services for 16 to 25 year olds, the pathways in accessing services and the flexibility in both the setting and the type of mental health care provided, whilst embracing a multidisciplinary approach.	Children's Services	To be considered at a forthcoming meeting.

The role of pharmacies in Communities and Prevention		
Public Health Team and Healthwatch Westminster to liaise and exchange information in their respective studies on pharmacies, including liaising with the Local Pharmaceutical Committee and the Royal Pharmaceutical Society.	Public Health Healthwatch Westminster	Completed
Whole Systems Integrated Care		
That the Board be provided with updates on progress for Whole Systems Integrated Care, with the first update being provided in six months' time.	NHS North West London	First update to be considered at the 19th November 2015 Health and Wellbeing Board meeting.
Joint Strategic Needs Assessment		
Consideration be given to ensure JSNAs are more line with the Board's priorities.	Public Health	Report being considered 9th July 2015
The Board to be informed more frequently on any new JSNA requests put forward for consideration.	Public Health	On-going.
Better Care Fund		
An update including details of performance and spending be provided in six months' time.		Update to be considered at the 19th November 2015 Health and Wellbeing Board meeting.
Primary Care Co-Commissioning		
Further consideration of representation, including a local authority liaison, to be undertaken in respect of primary care co-commissioning.	Health and Wellbeing Board	In progress
Work Programme		
Report to be circulated on progress on the Primary Care Project for comments.	Holly Manktelow Health and Wellbeing Board	Circulated.
The Board to nominate a sponsor to oversee progress on the Primary Care Project in between Board meetings.	Health and Wellbeing Board	To be confirmed.
NHS England to prepare a paper describing how they see their role on the Board and to respond to Members' questions at the next Board meeting.	NHS England	To be considered at the 9th July 2015 Health and Wellbeing Board meeting.

Meeting on Thursday 19th March 2015

Action	Lead Member(s) And Officer(s)	Comments
Pharmaceutical Needs Assessment		
Terms of reference for a separate wider review of the role of pharmacies in health provision, and within integrated whole systems working and the wider health landscape in Westminster, to be referred to the Board for discussion and approval.	Adult Social Care	Completed

Meeting on Thursday 22nd January 2015

Action	Lead Member(s) And Officer(s)	Comments
Better Care Fund Plan		
Further updates on implementation of the Care Act to be a standing item on future agendas.	Adult Social Care	Completed.
Child Poverty		
Work to be commissioned to establish whether and how all Council and partner services contributed to alleviating child poverty and income deprivation locally, through their existing plans and strategies – to identify how children and families living in poverty were targeted for services in key plans and commissioning decisions, and to also enable effective identification of gaps in provision.	Children's Services	In progress.
To identify an appropriate service sponsor for allocation to each of the six priority areas, in order to consolidate existing and future actions that would contribute to achieving objectives.	Children's Services	In progress.
Local Safeguarding Children Board Protocol		
Protocol to be revised to avoid duplication and to be clear on the different and separate roles of the Health & Wellbeing Board and the Scrutiny function.	Local Safeguarding Children Board	Completed.
Primary Care Commissioning		
A further update on progress in Primary Care Co-Commissioning to be given at the meeting in March 2015.	Clinical Commissioning Groups. NHS England	Completed.

Meeting on Thursday 20th November 2014

Action	Lead Member(s) And Officer(s)	Comments
Primary Care Commissioning		
The possible scope and effectiveness of establishing a Task & Finish Group on the commissioning of Primary Care to be discussed with Westminster's CCGs and NHS England, with the outcome be reported to the Health & Wellbeing Board.	Clinical Commissioning Groups NHS England	Completed
Work Programme		
A mapping session to be arranged to look at strategic planning and identify future agenda issues.	Health & Wellbeing Board	Completed.

Meeting on Thursday 18th September 2014

Action	Lead Member(s) And Officer(s)	Comments
Better Care Fund Plan 2014-16 Revised Submission		
That the final version of the revised submission be circulated to members of the Westminster Health & Wellbeing Board, with sign-off being delegated to the Chairman and Vice-Chairman, subject to any comments that may be received.	Director of Public Health.	Completed.
Primary Care Commissioning		
The Commissioning proposals be taken forward at the next meeting of the Westminster Health & Wellbeing Board in November	NHS England	Completed.
Details be provided of the number of GPs in relation to the population across Westminster, together with the number of people registered with those GPs; those who are from out of borough; GP premises which are known to be under pressure; and where out of hours capacity is situated.	NHS England	Completed.
Measles, Mumps and Rubella (MMR) Vaccination In Westminster		
That a further report setting out a strategy for how uptake for all immunisations could be improved, and which provides Ward Level data together with details of the number of patients who have had measles, be brought to a future meeting of the Westminster Health & Wellbeing Board in January 2015.	NHS England Public Health.	To considered at the forthcoming meeting in May 2015. This has been pushed back to later in 2015

Meeting on Thursday 19th June 2014

Action	Lead	Comments

	Member(s) And Officer(s)	
Whole Systems		
Business cases for the Whole Systems proposals to be submitted to the Health & Wellbeing Board in the autumn.	Clinical Commissioning Groups.	Complete.
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.	To be considered at a forthcoming meeting
The Health & Wellbeing Strategy		
A further update on progress to be submitted to the Westminster Health & Wellbeing Board in six months.	Priority Leads.	Completed
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	Completed
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. *Note: Recommendations to be put forward in next year's programme.*	Public Health Services Senior Policy & Strategy Officer.	Completed

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.	Strategic Director of Housing	Being considered at the 9th July 2015 Health and Wellbeing Board
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.	Completed.
Tri-borough Joint Health and Social Care Dementia Strategy		
Comments made by Board Members on the review and	Matthew Bazeley	Completed

initial proposals to be taken into account when drawing up the new Dementia Strategy.	Janice Horsman Paula Arnell	
Whole Systems		
A further update on progress to be brought to the Health & Wellbeing Board in June.	Clinical Commissioning Groups	Completed.

Westminster Health & Wellbeing Board

Date:	1 October 2015
Classification:	**General Release**
Title:	Central London CCG business plan 2016/17
Report of:	Matthew Bazeley, Managing Director, Central London Clinical Commissioning Group
Wards Involved:	All
Policy Context:	Central London CCG is currently in the process of establishing its commissioning plans for 2016/17, which will be used to inform contract notices issued to NHS providers in October. This report gives an overview of the vision and priorities for the CCG, an overview of the document (including transformational projects in the appendix) and next steps. The draft plan has been endorsed at the Governing Body session for approval by chair's action.
Financial Summary:	Financial implications of the plan are still being developed as projects and transformational programmes are currently in discussion.
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1. Executive Summary

1.1 Commissioning plans help identify potential provider impacts of any transformational projects the CCG is looking to undertake in the following year, reflecting the North West London Vision (in areas such as Acute Reconfiguration; Primary Care Transformation; Whole Systems Integrated Care; and, Mental Health Transformation), as well as the local CCG priorities. Projects below include transformational initiatives for all settings of care as well as support in Public Health interventions.

1.2 Members of the Health and Wellbeing Board are asked to review and endorse the projects as described in this paper. This paper provides an overview of the CCG's strategy and vision and current plans.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board are asked to note Central London CCG's draft business plan for 2016/17 (appended to the document).

3. Background

3.1 CCGs are required to provide contract notices six months in advance of any potential changes to NHS providers. Projects included in the document relate to the North West London Vision and the CCG priorities, outlined below.

3.2 NORTH WEST LONDON VISION
All eight of NWL's Clinical Commissioning Groups and partner organisations are continuing to work together in a collective way to successfully plan and implement cutting edge of healthcare innovation, pioneering new ways of integrating care, transforming access and reconfiguring hospitals. Our vision is to deliver care which is:

- Personalised – Enabling people to manage their own care themselves and to offer the best treatment to them. This ensures care is unique.
- Localised – Localising services where possible, allowing for a wider variety of services closer to home. This ensures care is convenient.
- Integrated – Delivering care that considers all the aspects of a person's health and is coordinated across all the services involved. This ensures care is efficient.
- Centralised – Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures care is better.

Our vision is centred on the needs of the North West London (NWL) population, developed from the patient views on their requirements of healthcare. These views then formed as the ambitions of our strategy and vision for the healthcare transformation in North West London.

3.3 We are already delivering this transformation through the Shaping a Healthier Future (SaHF) portfolio. This work will continue during 2016/17 through local activity within the individual boroughs and within the following major programmes being run on a pan- NWL level:

- Acute Reconfiguration;
- Primary Care Transformation;

- Whole Systems Integrated Care; and,
- Mental Health Transformation.

3.4 CENTRAL LONDON CCG'S PRIORITIES

Central London CCG has been undertaking process of establishing its annual objectives for 2015/16. At the Public meeting of the Governing Body on 3rd June 2015, the CWHHE strategic objectives were presented and accepted as the CCG's long term goals. These objectives are outlined in below:

- Enabling people to take more control of their health and wellbeing through information and ill-health prevention.
- Securing high quality services for patients and reducing the inequality gap.
- Strengthen the organisation's infrastructure to help us deliver high quality commissioning.
- Working with stakeholders to develop strategies and plans.
- Delivering strategic change programmes in the areas of primary care, mental health, integrated care and hospital reconfiguration.
- Empowering staff to deliver our statutory and organisational duties.

3.5 PRIORITY AREAS

The CCG agreed its priority areas should focus on having clarity of purpose and outcomes to be achieved, leading to sustainable change with measurable results, supported by well-established processes. Our three transformational objectives for the year are:

1) Confirm clear, aligned models of care for key areas by establishing clear, shared models of care and supporting incentive approaches for:
   - Integrated care (link to business case)
   - Primary care (link to out of hospital and co-commissioning)
   - Unscheduled care (link to Vanguard)
   - Mental Health (link to borough redesign and current review)
   - Planned Care (offer definition)

2) Address Westminster's priority inequalities by, working with the Local Authority, developing a clear plan to address key areas of focus arising from the JSNA
3) Establish priorities for contracting by, developing a set of 'must-do' KPIs to be included in contracts that are relevant to Westminster's particular needs

4. Options / Considerations

4.1 The Health and Wellbeing Board is asked to consider and endorse the below transformational projects which will be undertaken by the CCG (including joint commissioning teams during 2016/17).

5. Legal Implications

None

6. Financial Implications

6.1 The CCG has been able to identify between 60%-70% of the financial target for the year. Additional work is being undertaken to identify North-West London-wide transformational opportunities in areas such as diagnostics, pathology, end of life, urgent care centres, orthopaedics; paediatrics, frail elderly; and sector-wide collaboration on bank and agency staffing. The CCG is also working closely with the Provider Network for Whole Systems Integrated Care to identify additional opportunities.

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

Matthew Bazeley

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APPENDICES:

- Central London CCG Draft Business plan 2016/17

BACKGROUND PAPERS:

None

NHS
Central London
Clinical Commissioning Group

Central London CCG Draft Business plan 2016/17

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Vision

North West London (NWL) is changing. We are undertaking a historic transformation of the healthcare system that will dramatically improve care for over two million people. We are on the cutting edge of healthcare innovation, pioneering new ways of integrating care, transforming access and reconfiguring hospitals.

All eight of NWL's Clinical Commissioning Groups and partner organisations are continuing to work together in a collective way to successfully plan and implement this change. Our vision is to deliver care which is:

- **Personalised** – Enabling people to manage their own care themselves and to offer the best treatment to them. This ensures care is ***unique***.
- **Localised** – Localising services where possible, allowing for a wider variety of services closer to home. This ensures care is ***convenient***.
- **Integrated** – Delivering care that considers all the aspects of a person's health and is coordinated across all the services involved. This ensures care is ***efficient***.
- **Centralised** – Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures care is ***better***.

Our vision is centred on the needs of the NWL population, developed from the patient views on their requirements of healthcare. These views then formed as the ambitions of our strategy and vision for the healthcare transformation in North West London.

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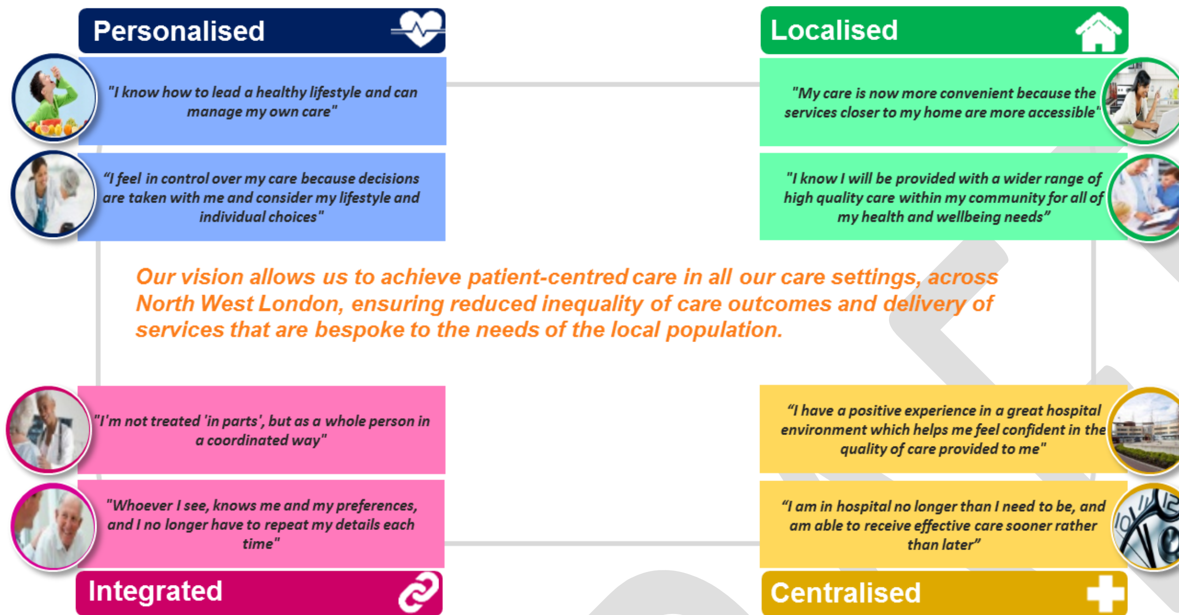

We are already delivering this transformation through the Shaping a Healthier Future (SaHF) portfolio. This work will continue during 2016/17 through local activity within the individual boroughs and within the following major programmes being run on a pan- NWL level:

- Acute Reconfiguration;
- Primary Care Transformation;
- Whole Systems Integrated Care;
- Mental Health Transformation.

Acute Reconfiguration: *Improved hospitals delivering better care 7 days a week, and ensuring there are more services available closer to home.*

In NWL, we have recognised the changes in population demographics and lifestyles, and, as such, are changing the way we organise our hospitals and community health services. By making these changes, we can ensure that the highest standards of care are met; that our hospitals have the specialist doctors and facilities in place to deal with

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your specialist needs round-the-clock, and out-of-hospital services are on hand to treat your everyday health needs as quickly and conveniently as possible, either closer to or within your own home. Acute Reconfiguration aim to deliver:

- A major shift in care from within a hospital setting to an out-of-hospital setting so more people are treated closer to their homes;
- The concentration of acute hospital services in order to develop centres of excellence which are able to achieve higher clinical standards and provide a more economic approach to the delivery of care.

In 16/17 the focus will be to:

- Deliver a revised Implementation Business Case for approval by the NHS and HM Government, allowing for capital investments to be made to transform NHS estates in NWL;
- The delivery of the transition of paediatric services from Ealing Hospital by June 30, as agreed by Ealing CCG Governing Body (on behalf of all other Governing Bodies in NWL) earlier this year;
- Planning for the transition of other services from Ealing and Charing Cross Hospitals as we continue to transform these sites to their future state.

Primary Care Transformation: *Placing Primary Care at the heart of whole system working, and improving access to GP services*

Primary Care, and in particular General Practice, is at the centre of the NWL vision. However, the model of general practice that has served Londoners well in the past is now under unprecedented strain. There are significant challenges that must be addressed, including increasing demand and projected shortages in workforce. Patients' needs are changing and the systems that are currently in place need to evolve to ensure that they are still fit for purpose in light of this change.

The implementation of Shaping a Healthier Future (SaHF) will deliver a vision where patients can benefit from:

- Improved health outcomes, equity of access, reduced inequalities and better patient experience;
- Services that are joined up, coordinated and easy to use;
- More services available, closer to homes;
- High quality out-of-hospital care;
- More local patient and public involvement in developing services, with a greater focus on prevention, staying healthy and patient empowerment.

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This will then enables us to provide accessible, coordinated and proactive care, as set out in the London-wide Strategic Commissioning Framework.

To ensure the vision is successfully realised and these benefits become tangible and sustainable, the model of Primary Care needs to be transformed so that it can become the strong and sustainable for Whole Systems Integrated Care (WSIC).

As we move through this year, our priority areas in 16 / 17 are as follows:

- Approving the new model of primary care through the joint co-commissioning committees in common and implementing this across NWL and ensuring that this is a fundamental part of an integrated care offer for patients;
- Working to ensure that all necessary enablers are in place to support the new model of care rollout (including workforce, technology and contracts);
- Putting the right support in place to nurture and grow GP federations so they are able to deliver sustainability in the long term as part of Accountable Care Partnerships (ACPs);
- Progressing with the primary care estates strategy that takes into account the development of out of hospital hubs across NWL. Currently, 19 sites are in the pipeline. Once delivered these will provide significant additional space to deliver primary and integrated care.

Whole Systems Integrated Care: *Coordinating care across commissioning bodies and provider, centred around the patient.*

Across NWL we are approaching year three of a five year journey towards delivering the Whole Systems Integrated Care (WSIC) vision. The characteristics of WSIC (outcome-based models of care, accountable care partnerships, capitated payments and system-wide risk and reward sharing) have been reinforced through national policy as articulated by the "Five Year Forward View".

Full implementation of WSIC will require a multi-year transition towards:

- Jointly commissioned population level outcomes that span health and wellbeing;
- Accountable care partnerships (ACPs) delivering co-produced models of care and managing the clinical and financial risk for their registered populations;
- During 16/17 Early Adopters will begin the transition to WSIC through the roll out of new care models, the development of shadow ACP boards and the roll out of key enablers such as shared analytics, joint governance (commissioner-commissioner, commissioner-provider, provider-provider) and the testing of new approaches to payment and risk/reward sharing.

Therefore the focus for WSIC in 16/17 is to:

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- Roll out, review and refine new models of care that reflect the WSIC vision of person-centred care, supporting people to direct the care they need in their homes and local communities;
- Embed new ways of working, culture and behaviours to underpin the system changes required;
- Support and engage with shadow ACP boards as they develop;
- Shape an approach to assurance that will ensure WSIC provides the best quality and best value care for the population of NWL;
- Monitor the new models of care against a shadow population-level capitated budget;
- Introduce a ring-fenced element of real risk share where appropriate;
- Continue to embed co-production throughout ways of working;
- Share learning and best practice across and beyond NWL.

Mental Health Transformation: *Improving mental and physical health through integrated services.*

NWL is committed to collaborating with key partners to co-produce a mental health and wellbeing strategy which will improve outcomes and value.

Across the system we have agreed to ensure that there is:

- Support for people who have experienced mental health problems to live well in the community;
- Promotion of recovery, resilience and deliver excellent health and social care outcomes including employment, housing and education;
- Development of new high quality services in the community, focusing on community based support rather than inpatient care so that people can stay closer to home;
- Services that provide urgent help and care which are available 24 hours a day 7 days a week for people who experience or are close to experiencing crisis.

As part of our commissioning intentions we would want providers to be proactively involved in transformation work and in implementing the outputs of transformation work. Specifically in 2016/17 we want to focus on:

- Implementation of new urgent care pathways and compliance with national target waiting times;

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- Implementation of Future in Mind, the national strategy for children and young people to respond to local needs;
- Work with local specialist Mental Health and Learning Disabilities providers to implement local pathways to enable people to be cared for within NWL;
- Work collaboratively to implement the emerging outputs of the Like Minded strategy.

Further details are provided in Appendix 1.

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Strategic objectives

Central London CCG has been undertaking process of establishing its annual objectives for 2015/16. At the Public meeting of the Governing Body on 3rd June 2015, the CWHHE strategic objectives were presented and accepted as the CCG's long term goals. These objectives are outlined in below.
These are:

1. Enabling people to take more control of their health and wellbeing through information and ill-health prevention.
2. Securing high quality services for patients and reducing the inequality gap.
3. Strengthen the organisation's infrastructure to help us deliver high quality commissioning.
4. Working with stakeholders to develop strategies and plans.
5. Delivering strategic change programmes in the areas of primary care, mental health, integrated care, and hospital reconfiguration.
6. Empowering staff to deliver our statutory and organisational duties.

Priority areas

The CCG agreed its priority areas should focus on having clarity of purpose and outcomes to be achieved, leading to sustainable change with measurable results, supported by well-established processes.
Our three transformational objectives for the year are:

1) Confirm clear, aligned models of care for key areas by Establishing clear, shared models of care and supporting incentive approaches for:
   - Integrated care (link to BC)
   - Primary care (link to OOH and co-comm)
   - Unscheduled care (link to Vanguard)
   - Mental Health (link to borough redesign and current review)
   - Planned Care (offer definition)

2) Address Westminster's priority inequalities by, working with the LA, developing a clear plan to address key areas of focus arising from the JSNA
3) Establish priorities for contracting by, developing a set of 'must-do' KPIs to be included in contracts that are relevant to Westminster's particular needs

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Figure 1– Central London CCG's objectives

Central London CCG buys services for Westminster's patients which are…

BASED ON A DETAILED UNDERSTANDING OF NEEDS
homelessness, childhood obesity, mental health prevalence, falls, HIV, TB, liver disease, suicide, vaccinations coverage

PART OF A COHERENT STATED APPROACH BY DELIVERY PROGRAMME

Working with GP Practices
Supporting the GP federation
OOH Services, LIS
Co-commissioning
EPP, Patient information
PRIMARY CARE

In emergencies
Community Independence Service
UCC/A&E sustainability
NHS 111 and GP Out of Hours
Intermediate Care beds
UNSCHEDULED CARE

To join up care
Test villages
IC Business Case
Children's services
Homeless service redesign
INTEGRATED CARE

For good mental health
Community services review,
IAPT, CNWL Urgent SPA,
Perinatal, Dementia,
Suicide training
MENTAL HEALTH

To improve health
Embed redesigned services
Cardio/Resp; Dermatology;
MSK; Ophthalmology
Gynaecology/Urology
PLANNED CARE

ALIGNED TO STRATEGIC PRINCIPLES
Personalised
Localised
Integrated
Centralised

BUILT ON SOLID FOUNDATIONS
Patient and public involvement, GP member engagement,
honest contracting, robust financial control, clear governance

UNDERPINNED BY
Clear, visible leadership
Local system focus and collaboration
Quality and safety culture

CCG transformational objectives 2015/16

CCG annual objective:
Address Westminster's priority inequalities by developing a clear plan to address key areas of focus arising from the Joint Strategic Needs Assessment

CCG annual objective:
Confirm models of care for key areas by establishing clear, shared delivery models and supporting incentive approaches

CCG annual objective:
Establish priorities for contracting by developing a set of 'must-do' KPIs to be included in contracts that are relevant to Westminster's particular needs,

Smart Priorities

To deliver the strategic objectives, in 2016/17 we will do a number of projects, as outlined below.

[to be updated when final projects and numbering are in place]

Project Name	Programme area	QIPP /BAU/ Enablers	Personalised	Localised	Integrated	Centralised
Project 1	Primary Care	QIPP	✓			
Project 2	Integrated Care	BAU		✓		
Project 3	Mental Health	Enabler		✓	✓	

The full list of projects in included Appendix 2 below.

Provider impacts of QIPP related initiatives are included in Appendix 3 below.

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Appendix 1 Strategic programmes shared across North West London

Programme	Project	Outputs/Outcomes	Expected Completion
Acute reconfiguration	Paediatrics	Paediatrics transition from Ealing Hospital completed	Jun-16
	Business Case Development	Development of Implementation Business Case Development of business case for: ChelWest, Middlesex, NWP, Hillingdon, St Mary's, Ealing, Charing Cross, CMH	Feb -16 to Dec -18
	Capital Works Programmes	Build programme complete for: ChelWest, Middlesex, NWP, Hillingdon, St Mary's, Ealing, Charing Cross, CMH	Sep -18 to Dec – 25
	Out of Hospital	Out of Hospital delivery rebased Establish tracking of out of hospital delivery	Nov – 15
	Ealing Transitions	Transition of Ealing Hospital in line with the proposed local hospital model of care	Sep -18 to Sep -20
	Charing Cross Transitions	Transition of Charing Cross hospital in line with the proposed local hospital model of care	Sep -18 to Sep -20
	CMH Transformation	CMH developed in line with the proposed local hospital model of care	TBC
Primary Care Transformation	New Model of Primary Care	New model of primary care providing improved outcomes for patients while ensuring the sustainability of general practice and focused on a proactive and preventative approach, including non-medical services, to be implemented	Dec-16
	GP Network Readiness	Providing greater flexibility for patients in scheduling appointments, e.g. advance booking am-8pm GP appointments available Monday – Friday, and Saturday and Sunday services.	Apr-15
	Primary Care Estates	Clear strategy for investing in primary care and community/OOH estates, making them fit-for-purpose	Jun-16
	Primary Care Co-Commissioning	Providers working to deliver shared outcomes, jointly commissioned for a whole population segment	Sep -15
Whole Systems Integrated Care	Informatics	Population level information available and used for resource planning and patients records available online that are clear and concise	Dec-15
	Outcomes & Metrics	Developing and syndicating a single set of Outcomes & Metrics for the Whole Systems programme	Jan-16
	Change Academy	Developing New team-based ways of working support integration and continuity	Jun-16
	Early Adopters	Transitioning out of hospital managed consistently 7 days a week Pharmacy making greater contributions to care, providing advice and support Care Plans provided to patients to manage their care Diagnostics available in community settings	Apr-17
	Early Adopters Mental Health	Working across West London CCG the WSIC Early Adopter for Long Term Mental Health Needs (LTMHN) aims to develop a new model of care - based on co-production to date this will be on the basis of a 'Community Living Well' Model.	Apr-17
Mental Health and Wellbeing	MH & Wellbeing Strategy	Bring together local commissioners, providers, users and carers and other local stakeholders to identify, test and refine the optimal approach to delivering mental health and wellbeing services across NWL and to transition to implementation of this solution.	Apr-17
	Urgent Care Redesign	Improving the entire acute mental health pathway, including access to support, advice and assessment services, through prevention and self-help, to the role of primary and secondary care in providing a high quality, timely and effective crisis service	Apr-16
	Learning Disabilities	Learning Disabilities and Mental Health teams working jointly to ensure patients receive the care and treatment they need locally	Apr-16
	Long Term Mental Health Needs	Ensure the 8 borough based Early Adopters looking at over 65s/75s/LTCs include the requirement for the right mental health involvement in their development and their models of care	Aug-15
	Perinatal	Models of care and best practice examples researched to inform pathway development and generic NWL Perinatal service specification developed	Apr-16
	System Resilience Programme	Ensuring services users are empowered in-line with recovery principles and drive change with paid professionals and Focusing on Crisis Care and Early Intervention in Primary Care, preventing unnecessary referrals and improving access to services	Apr-16

Appendix 2 List of projects/programmes

QIPP/ BAU /ENABLER	Scheme / project name	Scheme / project description	Theme	Objectives and key aims	Expected Benefits	Responsibilities of the providers	Clinical lead (name)
Service Redesign	Integrated gynaecology and urology service	Introduction of community dermatology service	Planned care	Service aims: Delivery of the right care at the right time; Integrated care, removing fragmentation across specialties and providers; Co-ordinated care with effective care planning across the pathway; Early diagnosis of conditions and a focus on prevention and self-care; Improved clinical management of continence conditions Appropriate transfer of outpatient care from hospital to a community setting, in line with local priorities, Training and education for primary care clinicians; and Sustainable, value for money services.	More coordinated care for patients through integrated approach (Better patient self-care through care plans and education. More care in primary care through GP education and training. More effective use of NHS resources through single point of access. Reduced reliance on acute care when it's not needed. Sustainable and Value for Money services.	The new provider will have responsibility for safe and effective mobilisation and operation of service.	Dr Sheila Neogi Dr David Spiro
Service Redesign	Integrated Cardio Respiratory Service	Introduction of integrated cardiology and respiratory service covering diagnosis, treatment and rehabilitation services.	Planned care	Service aims: Delivery of the right cardiology and respiratory care at the right time; Integrated care, removing fragmentation across specialties and providers; Co-ordinated care with effective care planning across the pathway; Early diagnosis of conditions and a focus on prevention; Appropriate transfer of outpatient care from hospital to a community setting, in line with local priorities, Training and education for primary care clinicians; and Sustainable, value for money services.	More coordinated care for patients through integrated approach (especially diagnostics/rehabilitation)/ MDT approach. Better patient self-care through care plans and education. More care in primary care through GP education and training. More effective use of NHS resources through single point of access Reduced reliance on acute care when it's not needed. Sustainable and Value for Money services.	ICHT, subcontracting part of the service to Chelsea and Westminster hospital identified as the providers and responsibility for safe and effective mobilisation and operation of service.	Dr Maroof Harghindawal and Dr Neville Pursell
Service Redesign	Community Dermatology service	Introduction of community dermatology service	Planned care	Service aims: Delivery of the right care at the right time; Integrated care, removing fragmentation across specialties and providers; Co-ordinated care with effective care planning across the pathway; Early diagnosis of conditions and a focus on prevention and self care; Appropriate transfer of outpatient care from hospital to a community setting, in line with local priorities; Training and education for primary care clinicians; and Sustainable, value for money services.	More coordinated care for patients through integrated approach (Better patient self-care through care plans and education. More care in primary care through GP education and training. More effective use of NHS resources through single point of access Reduced reliance on acute care when it's not needed. Sustainable and Value for Money services.	ICHT, identified as the provider and responsibility for safe and effective mobilisation and operation of service.	Dr Kasheef
QIPP	Community Independence Service (ex BCF08)	Continue implementation and further development of the Community Independence Service, forging stronger integration between health and social care.	Urgent Care / Intermediate Care	Following on from the design and implementation of the new Community Independence Service last year, we will further develop this service, strengthening the links to intermediate bedded care, neuro-rehab, mental health support and whole systems integrated care. We will also work with the providers to consolidate benefits achieved to date and evolve the service to improve its efficiency and effectiveness	We expect to achieve better value for money from this service by improving the links and pathways between this service and other health and care services, including intermediate bedded care, NHS 111 and Out of Ours GP services and Neuro-Rehabilitation to further reduce the need for non-elective admission to hospital, A&E attendances, and residential care and also Length of Stay (LoS) reductions in acute settings,	Lead providers for the service will need to review their pathways with a wider range of services and improve linkages. They will also need to continue to improve coordination with social care and ensure that staff levels are built up and maintained at a level necessary to deliver desired activity	Dr Afsana Safa
Enabler	IAPT	Review of talking therapy services for patients with common mental illness, aiming to increase compliance with national standards for increasing access to psychological therapies (IAPT) key activities include working closely with all providers to promote the service and increase access; to review case complexity and fidelity to the NICE model to improve recovery rates to consider contracting options to increase the diversity of service provision. Mental health services with the purpose of strengthening access to psychological therapies, in line with national IAPT model.	Mental Health	To achieve nationally set KPI's for access (15% of CMI prevalence), recovery (50% of those entering treatment should move to recovery) and waiting times (75% of patients entering treatment should be seen within 6 weeks and 95% within 19 weeks.	Ensuring patients with anxiety and/or depression receive talking therapies this is a preventative measure that reduced the likelihood of developing a long term mental health conditions, helping people to return to work and supporting people to manage their issues when required.	To promote the service and engage with under-served groups such as those with long term conditions, BME communities and older adults. All providers to maintain compliance with the NICE model to be managed through IAPT working group and LES counsellors forum.	Paul O'Reilly
Enabler	Community and Primary Care Mental Health Service Review	To review all community and primary care mental health services.	Mental Health	To highlight any gaps and issues in the provision of mental health service currently provided across CL CCG including dementia and perinatal services.	To ensure commissioned services for mental health offer the right care in the right place at the right time for patients across CLCCG.	To support the review, by providing relevant data and information to enable a transparent and representative outcome.	-
Enabler	Suicide Intervention and Prevention Training	To provide suicide intervention and prevention training to GP Practice staff, secondary care staff and the voluntary sector.	Mental Health	To provide training for a range of organisational staff that may come in to contact with suicidal people.	To increase awareness and create possible interventions for those people who are suicidal across Westminster, Kensington and Chelsea and Hammersmith and Fulham	To engage with relevant organisations, provide all organisational aspects of training including administration, and to provide regular reports on the topic.	-

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QIPP/ BAU /ENABLER	Scheme / project name	Scheme / project description	Theme	Objectives and key aims	Expected Benefits	Responsibilities of the providers	Clinical lead (name)
QIPP/BAU	Medicines Management	To provide our patients with adequate medicines and medicine management services that contribute to improving their health outcomes.	Prescribing	The programme has a number of aims, including: Improve cost effective prescribing; Reduce incidences of unintended harm from prescribed medicine; Reduce incidences of errors with prescribed medicines following discharge from hospital; Address problematic poly-pharmacy to improve health outcomes and quality of life.	Achieve better value and improve health outcomes from the monies spent on prescribed medicines. Reduce unplanned hospital admissions resulting from adverse effects of medicines.	GPs need to engage with programme to improve cost effective prescribing and implement agreed action plans. GPs to agree to dedicate sufficient time to implement actions resulting from delivery of projects aimed at reducing medicines related harm.	Dr Sheila Neogi
QIPP	Improving children and young peoples' services in villages	Joint Primary Care/Paediatrician hubs	Integrated Care	1) o move paediatric first and follow up appointments from the hospital setting into GP practice, clinically appropriate 2) to up-skill primary care clinicians. 3) to build parent/carer confidence in accessing the most appropriate and timely care for their children	More convenient access for patients, with shorter waits for an appointment. Skills and knowledge of primary care clinicians will be improved. Communication between all professionals who care for children will be enhanced resulting in better overall outcomes for children. Patient confidence in accessing high quality care will be increased	GP Providers will need to: 1) Ensure that all paediatric referrals are directed into the GP/Village clinic, unless requiring other specialist paediatric input 2) Ensure that referrals into the GP practice clinic are appropriate (and would otherwise have been referred into secondary care). 3) Bring cases for 4/Disseminate learning. Acute providers will need to:1) Ensure consistent availability of a paediatrician 2) Ensure that paediatric referral waiting list in acutes do not increase 3) Consider any referrals with view to re-directing these into the GP practice clinic where appropriate.	Niamh McLaughlin
QIPP	Homelessness	Intermediate Care	Integrated Care	Improve care of homeless patients by having a better co-ordinated community offering and beds in hostels for homeless patients to be discharged to where they can recuperate / be stepped up to when they need additional input to keep them out of hospital. MH and Physical health beds	Better overall, co-ordinated management of homeless patients with better long-term outcomes for patients and reduced time in hospital. Provide better support to mainstream GPs and acutes through education and training.	To work closely together, under the homeless GP management, to deliver a more co-ordinated service from patient identification to timely delivery of care and development of a move-on plan.	Paul O'Reilly
QIPP	Hepatitis C	Hep C clinics at 2 locations aimed at high risk, homeless population	Integrated Care		Increased completion of successful treatment / increased life expectancy of population /reduced public health risk	Report on referral/treatment as per specification document. Provide clinic space & consultant and 2 nurses to run the service/ use the clinical systems required	Paul O'Reilly
Enabler	Groundswell	Advocacy and Targeted Advocacy for Homeless patients	Integrated Care		Peer advocates provide support to homeless, working with them to get them to engage with health issues, help them get to appointments and understand the implications/options open to them	Practices to refer patients and include Groundswell in MDTs Groundswell to target patients for assistance as directed by the Practices	Paul O'Reilly
QIPP	Integrated NHS 111 / GP Out of Hours	Commissioning a new integrated NHS 111 / GP Out of Hours service.	Urgent Care	To work with partners across North West London to develop an integrated NHS 111 / GP OOHs service which aligns to a national framework and provides people with urgent but not life threatening needs a highly responsive, effective and personalised services outside of hospital.	We expect to achieve better value for money from this service by helping people access the right care at the right time and improving the pathway and linkages between the urgent care, intermediate care, primary care and social care systems which will help to reduce A&E attendances and non-elective admissions, increase self-care.	To be confirmed	To be confirmed
QIPP	St Mary's UCC	Either: Operating St Mary's UCC from at a new tariff; or Reviewing and re-procuring St Mary's UCC	Urgent Care	If new tariff: To develop and negotiate a new tariff for the St Mary's UCC with the new provider that increases the value for money of the service. If reprocuring the service: To procure an improved primary care-led Urgent Care Centre at St Mary's Hospital that optimises the throughput of the UCC and maximises its effectiveness as a service through well-developed pathways, improved streaming with the ED, closer alignment with the rest of the urgent care system and improved partnership working with the acute hospital provide.	We expect to achieve better value for money both by securing a better price for the CCG for this service and improving the service so that it sees a higher percentage of urgent care system activity, reducing A&E attendances and non-elective admission.	Develop partnership arrangements and joint clinical governance to ensure the UCC and ED work well together and that streaming into the UCC and ED maximise the opportunities to ensure the correct acuity is dealt with at the appropriate location	Dr Afsana Safa
QIPP	Neuro-Rehab	The procurement of Neuro-Rehab care provision	Intermediate Care	To procure a neuro-rehab service, building on the NHSE Service Specification and national definition that provides rehabilitation for patients with complex needs in order to assist them to achieve their maximum potential for physical, cognitive, social and psychological function, enhance their participation in society and improve their quality of life.	Effective specialist neuro-rehabilitation for people with traumatic brain, spinal injury and stroke will reduce: Length of stay in hospital; Longer-term dependency Longer-term (continuing care) costs.	To work in an integrated and partnership-centred way with acute. Intermediate and community care providers.	Dr Alan Haikin

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QIPP/ BAU /ENABLER	Scheme / project name	Scheme / project description	Theme	Objectives and key aims	Expected Benefits	Responsibilities of the providers	Clinical lead (name)
Transformational	Urgent Care System development	To develop a system-wide collaborative approach to urgent care that further aligns and integrates urgent care provision to ensure that no matter where a patient accesses the system, they have the same easy access to the appropriate care pathways. To support and enable this, the project will also aims to develop a strong governance framework within which urgent care will operate that encourages effective system leadership of plans to develop, integrate and deliver sustainability within the urgent care system.	Urgent Care	To develop an integrated vision and a five year plan for the development of the urgent care system in central London. To improve the effectiveness of the Tri-borough SRG and ensure it provides leadership over the development of the urgent care system in central London and beyond. To develop with partners the NWL Urgent and Emergency Care Network, ensuring that its roles and responsibilities are clearly defined and that the local governance structure surrounding the urgent care system is clear	We expect this to deliver improved leadership, held by providers, commissioners and clinicians, over the urgent care system. This should enable to system, over the longer term, to develop in a way which delivers improved sustainability (including in times of pressure) and improved outcomes for patients	To play an active role in system development and to work in partnerships with other providers, commissioners and clinicians to take a systems approach	Dr Alan Haikin
Transformatioal	CAMHS services	Local implementation of Future in Mind – transformation of CAMHS services. These include: Establishing a community Eating Disorder Service; Improving CAMHS Learning Disabilities ('LD') services.Improved access to consultation and advice service and efficient access to CAMHS. Improved 24/7 crisis response service Out of Hours Co-ordinated training and public education programme with Public Health.Improve NHS England ('NHSE') pathway in and out of CAMHS Tier 4. Explore home treatment options. CAMHS Improving Access to Psychological Therapies ('IAPT'): training on outcomes to be concluded	Children's Services	Submit a NW London Transformation Plan to access additional funding: approx. 3/400K per CCG, to provide the above services.	The aim of the programme is far-reaching and includes: Development of a cost-effective community Eating Disorder Service created. Promoting resilience, prevention and early intervention. Improving access to effective support. Care for the most vulnerable. Accountability and transparency. Development and modernisation of workforce.	Service redesign and modernisation expectations: flexible hours, improved crisis response, transparency and outcomes focus [pending to link with specific deadlines and risk mitigation in previous section]	Niamh McLaughlin for CL CCG
BAU	Children's and Families Act 2014 (including personal health budgets)	Implement changes required as a consequence of the Act.	Children's Services	Co-ordinated assessment: 0-25 Education, Health and Care for children and young people with Special Educational Needs and Disabilities Signposting families to the LA/CCG 'local offer' - website which includes summaries of Health services available for young people with SEN and disabilties. Continue to commissioning local child development services to provide timely health assessments for EHC Plans. Focus on preparing for adulthood – young people can have a plan beyond 19 years if required to support access to employment or independence. LAs and health expected to jointly commission services based on JSNAs. Involvement and co-production of children, young people and families Collaborating with our LA partners to deliver 'personal budgets' and 'personal health budgets'.	Reform the system of support across Education, Health and Social Care to ensure that services are organised with the needs and preferences of the child and their family firmly at the centre, from birth to the transition to adulthood.	Providing advice for EHC needs assessments and transfers from Statements within statutory timescales. Attending multi agency meetings and tribunals.Working with LA colleagues.Supporting and working with families and children and young people in the process.	Niamh McLaughlin
BAU	Children's Continuing Care	Ensuring efficient, up to date and value for money packages of care for children meeting the criteria for continuing care.	Children's Services	Adhering to the National Framework for Children and Young People's Continuing Care. The Framework sets out a children and young people's continuing care process that should: adhere to a set of core values, key principles and timetables; make the child or young person and their family the focus of the continuing care process and facilitate the provision of personalised packages of care; be developed and owned locally by a multi-agency team; cross organisational and inter-agency boundaries, thus reducing the possibility of fragmented care; and include measurement of outcomes and promote continuous quality improvement.	Children, young people and their families are actively engaged in the continuing care process; The continuing care process is co-ordinated and consistent between organisations; Health and social care practitioners, including those working in the independent and third sectors, and the public understand the continuing care process.	Delivering care packages as commissioned within contractual arrangements and local safeguarding guidelines.	Niamh McLaughlin
Transformational	Speech and Language Therapy (SALT) re-commissioning and re-procurement	Jointly Commissioning and Tendering the Paediatric Speech and Language Therapy (SALT) Service	Children's Services	Jointly commissioned across the three LAs and the three Clinical Commissioning Groups (CCGs) in Central London, Hammersmith and Fulham and West London. Review of current delivery model and re-specification of the service – opportunity to change the delivery model Undertake an open market tender exercise in line with procurement requirements, with a view to awarding the new contract by October 2016.	New more integrated jointly commissioned service. Maximised value for money. Flexible response to nee EHC plans. Capability to meet the18 to 25 challenge.	Engagement of current provider in the process. Potential providers engage in the commissioning opportunity.	Niamh McLaughlin

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NHS
Central London
Clinical Commissioning Group

QIPP/ BAU /ENABLER	Scheme / project name	Scheme / project description	Theme	Objectives and key aims	Expected Benefits	Responsibilities of the providers	Clinical lead (name)
Transformational	Early Support Key Working services	Early Support (Key Working) Services for children with complex needs and disabilities and their families	Children's Services	To ensure a consistent approach in working with parents to be and parents with children 0 – 5 years, the Government expects all services to work from a shared set of key principles.	Co-ordinate, streamline and add value to existing services for children with disabilities. Involve parents, grandparents and other carers in ways that build on their existing strengths; Ensure lasting support by linking activities to services for older children; be culturally appropriate and sensitive to particular needs.	Report quarterly to commissioners on the KPIs and produce an annual report that includes 2 case studies and a summary of parent/carer feedback	Niamh McLaughlin.
Enabler	Equalities Objectives 2017-2020	The CCG will be setting new Equality objectives for 2017 that reflect the diversity of our population. This is directly related to our Statutory Public Sector Equality Duty (PSED).	Engagement	The CCG understands that drawing on the expertise of patients, carers, members of the public, service providers and voluntary or community organisations is of critical importance when shaping services. This insight enables us to ensure services are of a high quality, value for money and reflect the needs of our diverse population.	If we identify the needs of our population at an early stage in the design and development of services, it will ultimately allow us to provide effective solutions to local health challenges and ensure our services are accessible to all.	Patients and the public should not be discriminated against or have their needs impacted adversely by our commissioning. Patients, the public and staff have the right to equality of opportunity.	Paul O'Reilly
Enabler	Patient & Public Involvement Policy	This policy aims to provide a more democratic approach to involvement. It was clear that with the growing number of Patient & Public Involvement opportunities, we needed a new way forward that proactively broke down some of the barriers to involvement.	Engagement	The CCG is introducing letters of engagement that include clarity over the opportunity, expectation and the support offered by CLCCG; remuneration for this active engagement with clear outcomes attached; and 1-2-1 support for patients and staff. By ensuring the roles are remunerated fairly and that patients are offered additional support, we can enable more equity to involvement.	This will allows us to formally acknowledge the great work our patients do to ensure we effectively commission services to improve the health and wellbeing of the population in Westminster. The end of year review will allow us to measure how effective the approach has been and make an informed decision as to next steps.	Patients need to be involved across the commissioning process. This approach directly relates to statutory obligation duty for participation.	Paul O'Reilly
Enabler	Patient & Public Engagement	This includes developing or implementing the CCG PPE strategy, which sets out our approach to achieving meaningful engagement with patients, carers and the public. This directly relates to our statutory participation duties set out in the NHS Act 2006 and the Health and Social Care Act 2012.	Engagement	To shape a strategic approach to patient and public engagement, which ensures we commission effectively for the entirety of our population. The document and subsequent implementation also provides the CCG officers and public with a defined work plan for engagement, this enables the CCG to be transparent and accountable.	By actively engaging with the entirety of our population the CCG ensures it delivers services that respond to our patients' needs, offering an improved patient experience. This help the CCG to proactively reduce health inequalities and improve outcomes.	Key stakeholders should have the opportunity to collaborate with the CCG as equal partners, to ensure the successful and effective commissioning of health services.	Paul O'Reilly
Enabler	Quality strategy implementation	Implementation of the strategic overview of strategy within the CCG	Quality	Work together with patients, carers and our partners to achieve the best quality healthcare outcomes by using the best clinical evidence and patient feedback to commission care that is: Effective; Safeguards patients and prevents all avoidable harm ; consistently shows improvements in positive experience and satisfaction of all patients and carers and staff	Commission high quality services; Identify improvements to secure the quality of services commissioned; The commissioning process drives continuous quality improvement	To deliver the quality the quality of care commissioned by the CCG within resources	Lizzie Wallman
Enabler	Homelessness	Hepatitis C	Integrated Care	Hep C clinics at 2 locations aimed at high risk, homeless population.	Increased completion of successful treatment / increased life expectancy of population /reduced public health risk	Report on referral/treatment as per spec Provide clinic space & consultant and 2 nurses to run the service/ use the clinical systems required	Paul O'Reilly
Enabler	Locality Scheme	The Locality Scheme is an enabler for enhancing quality and safety, promoting financial efficiency and improving patient experience and outcomes for patients. The purpose of the Locality Scheme is to implement change in primary care for improved quality outcomes for patients and increased financial efficiency across the system. The Locality Scheme is aligned to and reinforces other programmes and areas of work, including: Shaping a Healthier Future for North West London; North West London Out of Hospital Strategy; Whole Systems Integrated Care; CL CCG Operating Plan. CL CCG QIPP.	Primary Care	The objectives of the Locality Scheme are to: Invest in and assist the development of primary care; Support the delivery of redesigned care pathways to achieve improved service quality; Recognise the value of partnership working and the sharing of best practice by facilitating collaboration between member practices, and between practices and commissioners; Implement change that leads to improved quality outcomes for patients, supporting CL CCG's strategic objectives and improving financial efficiency in line with QIPP. Specific targets and priorities are identified annually and therefore the 2016/17 scheme will be shaped by engagement expected to commence in November 2015.	Better care and experience for patients; Increased member engagement with the CCG; Increased collaboration between practices: Better achievement of QIPP schemes e.g. through encouraging engagement with new services: Better access and improved outcomes for perceived vulnerable groups: Improved data quality: Improved engagement with the rollout of IT projects e.g. Referral Wizard.	Meet deadlines for submissions outlined in the Locality Scheme: Provide updates through 1:1 meetings with Locality Support Managers: Work collaboratively, participating in locality meetings and share learning.	Primary Care Governing Body Lead
Enabler	DVT Pilot	The Deep Vein Thrombosis (DVT) pilot commenced in January 2015 at eleven GP practices in the North and South localities. The pilot will run until the end of December after which point it will be reviewed to consider future commissioning recommendations and whether the service may be a candidate for an Out of Hospital Service.	Primary Care	The pilot aims to improve the clinical pathway and experience of adult patients with a suspected DVT by providing high quality diagnostic testing as close to patients' homes as possible.	Greater patient choice; More convenient care where DVT is suspected Swifter care and less pressure on acute services	To deliver the service in line with the specification. To share learning and participate in an evaluation	Krishan Aggarwal

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QIPP/ BAU /ENABLER	Scheme / project name	Scheme / project description	Theme	Objectives and key aims	Expected Benefits	Responsibilities of the providers	Clinical lead (name)
Enabler	Beat the Street – Childhood Obesity	A high proportion of population in the area do not meet the national guidelines for physical activity. Beat the Street will encourage people to walk and cycle around their area, to school, to work or to the shops as part of a challenge. Focused at children, this will lead to reduction in childhood obesity over a period of time and will support the local physical activity goals. This is a Central London CCG led project drawing on from similar successful programmes from other parts of the country. The project aims to take a population wide approach within Westminster including areas of Queen's park and Paddington (West London CCG). Other significant stakeholder will be Westminster City Council.	Public Health	To increase physical activity levels amongst participants to get people out of their cars for short journeys and to enhance levels of well-being and community cohesion. Beat the Street is designed to 'nudge' people to try walking and cycling for a period of six weeks, at the end of which it is anticipated that a significant proportion of the population will continue with the behaviour change, incorporating regular walks and bicycle rides into their daily lives, either as part of an active commute, or as a family activity.	For the **whole** community:increase physical activity levels; decrease health inequalities; support sustainable travel; increase community cohesion.	Deliver the project as per the specification. e.g. Frequent project reports/updates. Dedicated CCG dashboard to monitor. Rollout of equipment i.e. beat boxes. Timely delivery of beat the street smart cards. End of the project evaluation report including further recommendations.	Niamh McLaughlin
Enabler	Care Leavers	Engagement within a national Department of Health funded initiative for 10 CCGs across the country. To improve the health of adults and young people who were in the care of the state as children by utilising the user voice to develop guides and resources to better inform the commissioning and delivery of services. This will result in health professionals being more aware and informed of the heath issues facing care leavers and how to combat them. This will lead to better services and better outcomes for care leavers.	Inequalities (hosted in Primary Care)		Increased awareness of the health needs of care leavers. A range of resources to support commissioners. Improved commissioning of services in relation to care leaver health. Increased user voice participation in health services for care leavers. Improved long term health outcomes for care leavers		TBC

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Westminster Health & Wellbeing Board

Date:	1 October 2015
Classification:	General Release
Title:	Westminster Health and Wellbeing Hubs
Report of:	Tri-borough Director of Adult Social Care
Wards Involved:	All
Policy Context:	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 strategic ambitions, outcomes and efficiencies required from City for All.
Financial Summary:	NA
Report Author and Contact Details:	Meenara Islam, Principal Policy Officer mislam@westminster.gov.uk

1. Executive Summary

1.1 The Health and Wellbeing Hubs programme was born out of a necessity to transform the way the City Council delivers it services to improve people's life chances and reduce reliance on costly public services. In the medium to long term the Council will deliver this programme with CCGs and other partners to improve access to existing preventive services to those who are at risk of developing complex needs.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board is asked to note this programme of work and consider the outcome and objectives of the programme. The Board are also asked to consider how best this programme can support the work of partners in the local health economy.

3. Background

3.1 As local authority budgets continue to be reduced and NHS budgets contract, demand for public services by a growing and ageing population often with complex needs threatens to outstrip supply. Westminster City Council, like the rest of local government, has experienced significant budget reductions right across its services and is preparing for the future on the basis that reductions will continue. To date, it has responded by continuing to make efficiency savings, improving productivity while continuing to provide quality services that meet the needs of its population.

3.2 Now, with CCGs and other statutory and voluntary sector partners, we are continuing to adapt the way we work to meet the budgetary challenges across Public Health, Adult Social Care, Children's Services and the local health economy along with other key services where relevant. One way in which we are looking to do this is through the development and delivery of Health and Wellbeing Hubs across Council services to meet the needs of its population.

4. Health and Wellbeing Hubs ('Hubs')

4.1 The basis of the programme is to make access to existing preventative services easier for those groups of people who we know commonly do not access them despite their needs. The programme will initially focus on target groups within the wider categories of young people, older people, and single homeless people.

4.2 These population sub-groups are not necessarily high cost to the local authority and partners in terms of public services they use, or characterised by complex needs. they might be those for whom timely access to the right support can prevent or lessen their need for interventions later on. While the potential increase in uptake may demand additional resource, it will be offset in the longer term by the reduced volume of population with complex needs. The benefits will be realised not only by our clients and their families but also by the local authority, the NHS and other relevant partners such as education and police.

4.3 Ensuring timely and appropriate intervention can achieve cost avoidance downstream. Health and Wellbeing Hubs will help to achieve the aims of:

- reducing the barriers to preventative services, through improving knowledge of service availability, rationalising care pathways and helping to reduce stigma (**acceptability and availability of services**);
- through the adoption of 'person centred' service delivery, enabling residents to address their needs, reducing reliance on public services and facilitating sustainable behaviour change (**appropriateness of services**); and

- through timely intervention, preventing people’s health and wellbeing issues deteriorating and becoming more debilitating and more expensive to treat (**effectiveness of intervention**).

4.4 The programme’s approach is to establish a single point of access to a range of services in established community settings. The programme will use public service transformation principles to address the holistic needs of people by delivering person centred interventions with the aim of reducing the cost of, and reliance on, public services and will build on business opportunities that arise.

4.5 The concept of Health and Wellbeing hubs is broader than the permanent physical co-location of services in a dedicated site. It refers to a range of ways to deliver public services to our target audiences, suitable to their needs and the business opportunity in each case, which could include:

- intermittent and regular co-location of services between a range of council, community and primary care services (access to particular services at regular time and day every week);
- tacking on extra preventative services where there is an opportunity (spare physical space or capacity) to other council or partner services and premises (e.g. falls prevention classes in libraries);
- rationalising care pathways to facilitate access to a range of services (linking up and cross-referring between council and primary care services);
- up-skilling front line staff delivering council or partner services to be able to identify issues in their usual client base and provide basic advice and/or signpost to other relevant services (e.g. someone presenting as homeless can be referred by a housing officer to mental health services); every contact counts approach; and
- targeted communications, using appropriate means of communication, with known vulnerable groups or groups who show patterns of low uptake of services and are in need of early intervention to raise awareness of the preventative offer available to them.

4.6 The outcomes we seek to deliver – which are a combination of long and shorter term aims – can be summarised as follows:

- preventing people needing complex and often acute care prematurely, resulting in the reduction of costs to the council and partners (e.g. the NHS and emergency services). This can be achieved by enabling and encouraging target cohorts’ use of prevention services to reduce the medium to long term demand for costly health and care services. At the same time,

the quality of life will be improved and the number of premature and preventable deaths reduced;

- creating opportunities for realising savings resulting from reduction of costs and increase in efficiencies for the local authority and partners by sharing risk and resources, and avoiding duplication; (e.g. co-location of joint teams)
- reducing reliance on public services, and improvement in self-management and independence;
- improving physical and mental health and wellbeing of Westminster citizens through timely identification and improved pathways between services;
- supporting our preventative services offer, improving ease of access in Westminster's communities to contribute to reducing health inequalities; and
- increasing capacity for employment and meaningful occupation for citizens and supporting economic growth in the borough.

5 Work streams

5.1 Initially we will deliver three work streams targeting cohorts within the categories of: older people; youth; and single people who have made statutory homeless applications. These reconfiguration of services to establish the 'hubs' will test and evaluate the local effectiveness of co-location, integration and joint-commissioning between council service areas and between the council and partners, such as the CCG.

5.2 Newman Street, a temporary accommodation facility for single homeless people in Westminster, will form a major part of the single homeless people hub work stream. It is a good example of local authority services working with a local primary care centre to ensure residents are accessing primary care services. Newman Street accommodates some very vulnerable people with highly complex needs, many of whom are not even registered with a GP.

5.3 The Council recently deployed Floating Support (FS) workers at Newman Street who are permanently located in the building. FS workers work with vulnerable adults to assess their needs and develop with them a support plan to address those needs. Support packages include a range of services such as benefits advice and tenancy sustainment to development of life skills and accessing mental health, drug and alcohol services. The local primary care centre has invited the FS workers to weekly meetings to share information and concerns regarding residents, many of whom exhibit a need for these services yet fail to access or engage in them currently.

5.4 The Health and Wellbeing Hubs work aligns with the direction of travel of other local authorities and partners across the public services landscape and in particular with the CCGs work on *whole systems integrated care*. CLCCG's draft

business plan incorporates long term objectives for 2016/17 around enabling people to take more control of their health and wellbeing through information and ill-health prevention, as well as working with stakeholders to develop strategies and plans that align closely with the objectives of the Health and Wellbeing Hubs.

5.5 The changes at Newman Street therefore provides a useful illustration of where the council's work on Health and Wellbeing Hubs already meets with the direction of travel of the CCGs. However, achieving and taking advantage of alignment between the two approaches will be a feature across all the work streams of the Hubs programme.

5.6 Throughout development and delivery of this work, we will be linking closely with parallel work streams in partner organisations in order to share learning and ensure the changes we make are mutually supportive, timely and in answer to unmet need only. A key example of this will be our connection with the CCGs and their work to drive self-care and self-management.

5.7 We will monitor and evaluate the successes and challenges of Health and Wellbeing Hubs on current services with a structured approach to capturing learning. This will support additional work to map out further co-location and integration opportunities for the future. The effectiveness of the initial hubs will be fully evaluated taking into account impact on existing services. These results will inform the roll out of the Hubs across the local area planned for Spring 2016.

6 Legal Implications

Not applicable

7 Financial Implications

7.1 Staff time excluded, there are no direct costs associated with this programme at present.

7.2 Over the medium term, this programme of work will aim to produce a robust business case that will assess the quantum of savings that could be delivered to the Council and to partners by adopting more efficient and effective ways of working. The business case will be underpinned by a cost benefit analysis of the pilot projects that will analyse in detail: the current service costs - upstream and down-stream; future anticipated funding changes; projections of potential savings; analysis of where costs/savings fall (WCC and partners); savings profile over time and any costs to implement.

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

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Westminster Health & Wellbeing Board

Date:	1 October 2015
Classification:	**General Release**
Title:	Dementia Joint Strategic Needs Assessment and Commissioning intentions
Report of:	Tri-borough Directors of Adult Social Care and Public Health
Wards Involved:	All
Policy Context:	To support the Health and Wellbeing Board statutory duty to deliver a Joint Strategic Needs Assessment
Financial Summary:	**n/a**
Report Author and Contact Details:	Lisa Cavanagh 020 7641 2631 lcavanagh1@westminster.gov.uk and Colin Brodie 020 7641 4632 E-mail: cbrodie@westminster.gov.uk

1. Executive Summary

1.1 This report presents the key findings and recommendations from the Joint Strategic Needs Assessment (JSNA) on dementia. It also sets out the outputs of the ‘Like Minded’ North West London (NWL) Strategic Review of Dementia and how these will be used to inform future commissioning intentions to address the challenges presented by the expected increase in dementia in our local population.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board are requested to consider and approve the dementia JSNA for publication.

The Health and Wellbeing Board are requested to note how the dementia JSNA and the NWL dementia strategy will be used to inform the future commissioning intentions.

2.2 The reason for requesting approval of the dementia JSNA is to ensure appropriate future configuration of health and care support services in place to support people diagnosed with dementia and their carers to live well and to meet the increasing forecasted demand within resources.

2.3 The North West London (NWL) Mental Health & Wellbeing Strategic Implementation and Evaluation Board approved the the strategic review report of dementia on 15 May 2015 and agreed that individual CCGs would consider the outputs and outcomes as part of their service review and development process for 2015/16.

2.4 The Health and Social Care Act 2012 placed the duty to prepare a JSNA equally and explicitly on local authorities (LAs), Clinical Commissioning Groups (CCGs) and the Health and Wellbeing Boards (HWB). Local governance arrangements require final approval from the Health and Wellbeing Board prior to publication.

3. Background

3.1 The number of people with dementia is increasing, which will have a significant impact on our population, particularly older people, their families and carers.

3.2 As referenced in the full report diagnosis rates are increasing. Figures for Central London CCG show a formal GP diagnosis rate of 72% of estimated prevalence at March 2015[1]. Local estimates put the number of people aged 65+ with dementia in Westminster are 1800. It is also estimated that there will be a 45% increase in the number of people with dementia in the borough over the next 15 years[2].

3.3 According to the Alzheimer's Society there are over 40,000 younger people under the age of 65 who have dementia in the UK. Often referred to as 'early-onset dementia', 'young-onset dementia' or 'working-age dementia' these younger people with dementia experience similar symptoms as older people with dementia but may have specific needs and requirements. Younger people are more likely, for example, to be in work themselves, to have a partner who works, have children, be more physically active, and have financial commitments such as mortgages. Services need to consider the specific needs and interests of younger people, which may well be different from those designed for the over 65s.Younger people tend to have a different type of dementia than over 65s. The Alzheimer's Society indicate the following breakdown of the types of dementia among younger people:

[1] Primary Care Web Tool Data Report, published April 2015, accessed at https://www.primarycare.nhs.uk/
[2] Public Health/CLCCG to discuss further analysis of prevalence data at CCG level

- Alzheimer's disease - around 33%
- Vascular- 20%
- Fronto-temporal dementia - 12%
- Alcohol-related - 10%
- Dementia with Lewy bodies- 10%
- Rarer forms of dementia (e.g. caused by Parkinsons) - 20%

3.4 This increase will inevitably impact on the local health and social care economies and will require increasing investment in services to detect, treat, and support people with dementia and their carers.

3.5 To inform the strategic approach and future commissioning arrangements required to tackle this challenge locally, two pieces of work have been undertaken:

- A deep dive JSNA on dementia for Westminster, Hammersmith and Fulham and Kensington and Chelsea,
- The North West London Strategic Review of Dementia for Brent, Harrow, Hillingdon, Ealing, Hammersmith & Fulham, Hounslow, Central London and West London Clinical Commissioning Groups.

3.6 The JSNA provides a comprehensive evidence base and information about the local population to support the development of future commissioning intentions for dementia services across the three boroughs.

3.7 Information for the JSNA has been collected from a variety of sources including audit, relevant policy, research and local data provided by stakeholders, providers and service users. This evidence has been analysed to identify gaps and solutions and forms the basis of the recommendations that are described in the JSNA report. An Executive Summary and a full report of the JSNA are included as Background Papers to this paper.

3.8 In 2014, the former Mental Health Programme Board agreed to undertake a strategic review in relation to dementia for the eight CCG groups that fall within the NWL CCG collaboration. The review commenced in August 2014, it included; mapping of prevalence of dementia, mapping of progress towards achievement of 67% diagnosis rate in each area and delivery of a series of themed workshops. The outcomes and outputs of the review are included as Background Papers and summarised as follows:

- an outcome focused Framework specification that uses the Dementia 'I' statements as the basis for a suite of outcome measures. These are accompanied by a set of carers outcomes measures, developed by a carer;

- a dementia exemplar framework developed during the review, and informed by feedback and comments from people with dementia and their carers;
- a high level clinical care pathway developed and agreed by a virtual clinical leads group, which is included within the framework specification;
- a set of individual /group and organisational commitment statements which were produced in consultation workshops.

3.9 In July 2015, local authority and CCG officers met to review the JSNA recommendations with the outputs of the NWL Strategic Review of Dementia and begin planning next steps in light of the key findings of the JSNA and NWL strategy. The outputs of this session are included as Background papers.

3.10 This exercise identified that the majority of the JSNA recommendations that are RAG rated (based on identified service gaps/ opportunities) align with the proposed service aims identified through the NWL work.

4. Considerations

4.1 In the current health and social care climate there is much emphasis on sustainability through better community care, living as well as possible with dementia, keeping people out of hospital and reducing length of hospital stays. This focus is particularly salient when applied to the needs of people with dementia. In the course of writing the JSNA, several key themes were highlighted. These are described in the table below.

1. Numbers of people locally **who have dementia** will increase over the next few decades (around 55% in next 15 years across the 3 boroughs), primarily due to a greater number of older people (aged 80+)	We need **adequate resources** to deal with this challenge and we need to provide services more **efficiently** and **sustainably**
2. **Dementia diagnosis rates** have been **rising** in each of the three boroughs	This has to be followed by an equal input into **post-diagnostic care** to ensure people are **living well** with dementia
3. Most of the cost of supporting those with dementia falls on **unpaid carers** and **adult social care**. With more care provided at home, pressure on carers may increase	We need to **support, advise and empower carers** to fulfil this enhanced role without a detriment to their own quality of life
4. Whilst it is important to maintain independence for longer, there	There may be a need for **increased training** for paid and unpaid carers

needs to be **appropriate escalation of care** when needed	residential care staff, and other appropriate professionals
5. Dementia services are provided by a **range of agencies** - acute and primary care, mental health services, social care and third sector	Better **cohesion and collaboration** is needed via well-coordinated information, advice, advocacy and outreach services
6. People with dementia do not always receive fair access to services which support their **mental and physical** health needs	People with dementia need to receive **parity of access** across mental and physical health services

4.2 In the JSNA, services were RAG rated against National Strategy Objectives, NICE Guidance, views expressed by people with dementia and their carers, qualitative research with clinicians, and other supporting evidence. From this, gaps were identified and thirty two recommendations were developed. The table below highlights the recommendations from the JSNA that are a priority for multiple partners across Westminster Health, Social Care, Community and Voluntary sector organisations. A full list of the recommendations can be found in background paper no. 5

Theme	Recommendation(s)
Community Care	1. Ensure adequate provision, through third sector and health and social care services, of activities and support around living well with dementia and managing distressing behaviours. 2. Provide adequate infrastructure and training for care staff. 3. Ensure people are supported to access the care appropriate to them through the use of personal budgets. 4. Ensure adequate resource to support the work of the Dementia Action Alliance and other opportunities to raise public awareness of dementia across the three boroughs

Theme	Recommendation(s)
Residential Care	5. Address supply of local care home beds in future local authority and CCG commissioning intentions, including those specifically for dementia care. 6. Address findings from Care Quality Commission (CQC) national report on dementia care in care homes; audit to provide assurance of quality of care in care homes. 7. Ensure there are opportunities for coordinated training and support for care homes to enable recognition of patients with dementia and to improve confidence in care for complex needs and difficult behaviours.
Whole Systems Care	8. The current fragmentation in care provision would be addressed through centralised coordination and improved communication/collaboration between services.
	9. Explore joint working with police and other community safety partners to support appropriate and effective use of assistive technology/telecare for patients with dementia. 10. There should be a joint health and social care dementia programme board for the three boroughs to facilitate implementation of the North West London dementia strategy in alignment with findings and recommendations from this JSNA. 11. The increasing numbers and needs of people with dementia and their carers are taken into account in wider local authority and health strategies, especially housing and environment.
Patient and Carer's Rights	12. Provide a clear and comprehensive pathway, including respite care, for carers with equality of access across three boroughs, taking into account the unique needs of carers of people with dementia.

4.3 The key themes from the NWL Strategic Review of Dementia highlighted the importance of achieving timely diagnosis for all those who need it balanced against support being available post-diagnosis and having one named person that people with dementia and their carers can call upon.

4.4 Other recommendations to support service improvements in dementia care include:

- that voices of people with dementia and their carers continue to be heard;
- commitments should be given to utilise the dementia framework;
- the dementia commitment statements should reinforce the importance of continuing to improve dementia services across NWL;
- working in partnership to achieve implementation of local plans.

5. Consultations

5.1 In developing the JSNA a draft report was circulated to a range of stakeholders for consultation, including local authority colleagues, CCGs, Community and Voluntary Sector, and Healthwatch. Response to the consultation was good and a large number of comments were received and incorporated into the final version. The views of local people with dementia and their carers were gathered from the Adult Carers Survey and work undertaken by Healthwatch.

5.2 In the process of undertaking the strategic review of dementia services across NWL an exemplar dementia framework was developed in co-production with people with dementia and their carers. A series of themed workshops were held engaging and involving key stakeholders and this work was undertaken with input and the support of Innovations in Dementia and Age UK Kensington and Chelsea.

6. Next steps

6.1 The CCGs and local authorities have jointly committed to undertake a three borough strategic review of jointly commissioned dementia day and community services. The review will explore options to improve and develop services to include a Dementia Resource Centre service model in light of central and local strategic drivers and developments across health and social care. This review is underway and will engage with stakeholders and people with dementia and their carers. Any subsequent re-commissioning of services and procurement will be subject to formal approval by the relevant organisation(s). It is proposed, subject to agreement that a re-procurement process will take place January – September 2016 with a view to awarding a contract for service(s) to be in place October 2016.

6.2 The CCGs and local authorities will need to ensure people with dementia and their carers continue to be heard via patient/user/carer group forums to help shape dementia friendly environments and accessible health, social care and voluntary sector services. These services are vital in supporting people with dementia and their carers.

6.3 This review affords commissioners an excellent opportunity to remodel, design and align services across the dementia care pathway to meet growing demand and better meet the needs of local service users and their carers and enable them to live well with dementia.

6.4 The JSNA recommendations and NWL outputs will be key to shaping services going forward and will be used to benchmark against proposed service models.

I. The CCGs and LA to consider future work with public health within the framework of the Memorandum of Understanding (MoU), to further explore

II. dementia in the local population including alcohol related cases and homelessness

III. prevalence locally of people with younger onset dementia further analysis of prevalence data at CCG level

6.5 CCGs and LA will maximise opportunities to understand how whole systems integrated care can deliver the best possible outcomes for people with dementia and their carers and the role of the GP federation and Provider Network play in the delivery of dementia services.

7. Legal Implications

7.1 The JSNA was introduced by the Local Government and Public Involvement in Health Act 2007. Sections 192 and 196 Health and Social Care Act 2012 place the duty to prepare a JSNA equally on local authorities (LAs), Clinical Commissioning Groups (CCGs) and the Health and Wellbeing Boards (HWB).

7.2 Section 2 Care Act 2014 imposes a duty on LAs to provide or arrange for the provision of services that contribute towards preventing, delaying or reducing care needs.

7.3 Section 3 Care Act 2014 imposed a duty on LAs to exercise its Care Act functions with a view to ensuring the integration of care and support provision with health provision to promote well-being, contribute to the prevention or delay of care needs and improve the quality of care and support.

7.4 JSNAs are a key means whereby LAs work with CCGs to identify and plan to meet the care and support needs of the local population, contributing to fulfilment of LA s2 and s3 Care Act duties.

7.5 Implications verified/completed by: Kevin Beale, Principal Social Care Lawyer, 020 8753 2740.

8. Financial Implications

8.1 There are no financial implications arising directly from this report. Any future financial implications that may be identified as a result of the review and re-commissioning projects will be presented to the appropriate board & governance channels in a separate report.

8.2 Implications verified/completed by: Safia Khan, Lead Business Partner Adults, 020 7641 1060

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

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BACKGROUND PAPERS:

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	Dementia JSNA and Executive Summary	Colin Brodie	Public Health
2	Dementia Report 06.05.15	Barbara Edwards & Debbie Mayor	CLCCG
3	NWL Strategic Review of	Barbara Edwards &	CLCCG

	Dementia 15.06.15	Debbie Mayor	
4.	Dementia Framework Service Specification	Barbara Edwards & Debbie Mayor	CLCCG
5.	Dementia JSNA and NWL outputs	Lisa Cavanagh	Joint Commissioning

JSNA
Joint Strategic Needs Assessment

Dementia

A Joint Strategic Needs Assessment (JSNA) Report for
Hammersmith and Fulham   Kensington and Chelsea   Westminster

Executive Summary

[July 2015]   www.jsna.info

1 Executive Summary

1.1 Purpose of the JSNA

The purpose of this Joint Strategic Needs Assessment (JSNA) is to provide a comprehensive evidence base and information about the **local population** to inform **commissioning intentions for** Hammersmith and Fulham, Kensington and Chelsea, and Westminster, that takes account of national and local policy, the North West London strategic approach to dementia and guidance.

Specifically the report aims to:

- Draw together the strategic drivers from central and local government
- Describe the local picture of need and model future trajectories to enable forward planning
- Set out the current pathways and services for people with dementia and their carers including diagnosis, treatment and post –diagnostic support
- Identify and understand the gaps in service provision for local residents
- Review guidance and evidence to inform best practice locally
- Make recommendations to align commissioning across the three boroughs and meet likely future needs.

Information has been collected from a variety of sources including audit, relevant policy and research as well as local data provided by stakeholders, providers, service users and carers. This evidence has been analysed to identify gaps and solutions and forms the basis of the recommendations outlined in the next chapter.

Throughout this document people with dementia have been referred to as patients, service users, clients or customers. These terms have been employed in different sections depending on the context and relationships.

It is also worth noting that this JSNA overlaps with other JSNA reports that have already been published or are currently in development, such as the End of Life Care JSNA. For further information on other JSNAs please visit http://www.jsna.info

The full version of this report is available at (insert link here)

1.2 Key themes of the JSNA

In the current health and social care climate there is much emphasis on sustainability through better community care, living as well as possible with dementia, keeping people out of hospital and reducing length of hospital stays. This focus is particularly salient when applied to the needs of people with dementia. In the course of writing the report, several priority themes have been highlighted. These are described in the table below.

Table 1: Themes of Dementia JSNA

Theme	Response
1. Numbers of people locally **who have dementia** will increase over the next few decades (around 55% in next 15 years), primarily due to a greater number of older people (aged 80+)	We need **adequate resource** to deal with this challenge and we need to provide services more **efficiently** and **sustainably**
2. Dementia diagnosis rates have been **rising** in each of the three boroughs	This has to be followed by an equal input into **post-diagnostic care** to ensure people are **living well** with dementia
3. Most of the cost of supporting those with dementia falls on **unpaid carers** and **adult social care**. With more care provided at home, pressure on carers may increase	We need to **support, advise and empower carers** to fulfil this enhanced role without a detriment to their own quality of life
4. Whilst it is important to maintain independence for longer, there needs to be **appropriate escalation of care** when needed	There may be a need for **increased training** for paid and unpaid carers residential care staff, and other appropriate professionals
5. Dementia services are provided by a **range of agencies** - acute and primary care, mental health services, social care and third sector	Better **cohesion and collaboration** is needed via well-coordinated information, advice, advocacy and outreach services
6. People with dementia do not always receive fair access to services which support their **mental and physical** health needs	People with dementia need to receive **parity of access** across mental and physical health services

1.3 Recommendations

The report draws together population analysis, policy, research and clinician and user views to inform an analysis of gaps and opportunities, and to evidence our recommendations for commissioning intentions. These recommendations are arranged according to the following priority areas:

- Memory Service Care
- Community Care
- Residential Care
- General Medical Care
- Whole Systems Care
- Patients and Carer's Rights

A summary of how each recommendation has been developed from this analysis can be found in the full report (insert link) in Appendix A: RAG rating of local assets.

Table 2: Recommendations

	Gap/Opportunity	Recommendation(s)
Memory Service Care	*A. Memory service care varies between provider: in some cases the patient may not have access to timely diagnostic or adequate community support.* *B. Peer support is now being commissioned as part of Living Well service in Westminster and Kensington and Chelsea; however there appears to be a lack of resource in Hammersmith and Fulham.*	1. Develop a single point of access to diagnostic assessment and ensure all patients across all three Boroughs have equitable access 2. Introduce a peer support programme across three boroughs taking into account evaluation findings of Kensington and Chelsea/Westminster programme
	C. Diagnosis rates still do not meet estimated prevalence and can be further improved *D. Training is needed for GPs, staff in care and support roles and families to recognise the signs and symptoms of dementia and know what to do next*	3. Improve screening and diagnosis in care home and Extra Care residents 4. Consider training to increase referral from or support diagnosis in primary care, in line with NWL strategy 5. Audit completion of diagnostic assessment for those first identified in hospital and address accordingly 6. Establish a good standard of training to achieve a level of expertise across all partner agencies including social care, residential care, extra care, clinicians, GPs

	Gap/Opportunity	Recommendation(s)
Community Care	*E. It is not clearly understood whether voluntary sector resources and support available to carers is adequate to need, distributed equitably and accessible to all. There is variation between boroughs in the extent of such services available* *F. There appears to be insufficient community support for people with dementia and their carers to learn to manage distressing signs of dementia, e.g. through purposeful activity.* *G. There are Dementia Advisers and Dementia Guides but there appears to be insufficient resources to meet need. There is a lack of dementia advice/care coordination to support timely access to advice. Resources are needed across 3 boroughs to ensure care staff have support to recognise and signpost people for diagnosis and to provide the right interventions and level of support.*	7. Ensure adequate provision, through 3rd sector and health and social care services, of activities and support around living well with dementia and managing distressing behaviours 8. Provide adequate infrastructure and training for care staff. 9. Ensure people are supported to access the care appropriate to them through the use of personal budgets 10. Ensure that there are sufficient Dementia Advisers to coordinate access to services.
	H. There is insufficient support for work of the Dementia Action Alliances across the three boroughs (can eventually join up across 3 boroughs and the Pan-London Alliance)	11. Ensure adequate resource to support the work of the Dementia Action Alliance and other opportunities to raise public awareness of dementia across the three boroughs

	Gap/Opportunity	Recommendation(s)
Residential Care	*I. The provision of care home beds locally (particularly dementia specific beds) tends to be lower than many other areas, meaning a significant proportion of residents are placed out of borough, in some cases away from family and friends.*	12. Address supply of local care home beds in future local authority and CCG commissioning intentions, including those specifically for dementia care.
	J. Little is known about the quality of dementia care in care homes locally	13. Address findings from Care Quality Commission (CQC) national report on dementia care in care homes; audit to provide assurance of quality of care in care homes. 14. Ensure there are opportunities for coordinated training and support for care homes to enable recognition of patients with dementia and to improve confidence in care for complex needs and difficult behaviours. 15. Ensure either all staff in intermediate care have appropriate training for looking after people with dementia or a specialist service is provided.
General Medical Care	*K. Little is known about adequate use of antipsychotics – an audit is due to take place in Chelsea and Westminster Hospital.*	16. Audit and address accordingly use of antipsychotics in hospitals and community prescriptions
	L. A need has been speculated for increased liaison psychiatry provision in Hammersmith and Fulham, dementia specialist nursing in the community and in hospital, and care navigators. *M. Opportunities for reducing escalation of problems and care need have been identified through early targeted hospital care.*	17. Ensure adequate monitoring, assessment and provision of care for other physical and mental health needs for people with dementia. 18.Ensure timely identification and targeted care of those with dementia in hospital 19. Provide dementia friendly environment within hospitals 20. Ensure adequate provision of liaison psychiatry and dementia nurses, consider expanding remit

	Gap/Opportunity	Recommendation(s)
Whole Systems Care	*N. There are few easy channels of communication between different providers of dementia care*	21. All patients, carers and clinicians should have consistent and comprehensive information with clear signposting of care pathways 22. The current fragmentation in care provision would be addressed through centralised coordination and improved communication/collaboration between services
	O. Numbers of people with dementia are likely to increase by 55% in the next 15 years, all relevant providers and services must be equipped with adequate resource to meet this need.	23. Ensure adequate training and support across all services for staff and carers looking after people with dementia 24. Current practice and resources must be scaled to meet increasing need or consider adapting models of care with innovation across health and social care to reduce the scale of care required. Ensure that any changes to services are evidence based. 25. Explore joint working with police and other community safety partners to support appropriate and effective use of assistive technology/telecare for patients with dementia.
	P. The Dementia Strategy in Kensington and Chelsea will end in 2016. The Westminster and Hammersmith and Fulham strategies have both expired. The North West London Mental Health Programme Board has recently produced a dementia strategy for diagnosis and treatment support	26. There should be a joint health and social care dementia programme board for the three boroughs to facilitate implementation of the North West London dementia strategy in alignment with findings and recommendations from this JSNA. 27.Local services are active stakeholders with wider initiatives to ensure strategy is sensitive to local needs
	Q. Housing, environment and planning strategies do not specifically mention dementia or carers of people with dementia	28. The increasing numbers and needs of people with dementia and their carers are taken into account in wider local authority and health strategies, especially housing and

	Gap/Opportunity	Recommendation(s)
		environment
Patient and Carer's Rights	*R. Lack of sufficient resource to support with end of life care across the three boroughs.* *S. Lack of defined carer support pathway.* *T. Support is needed for advocating peoples' best interests and awareness of the Mental Capacity Act 2005* *U. There is little supporting infrastructure available to provide help to self-funders to "micro-commission" care as mandated by the Care Act 2014.* *V.*	29. Ensure that there is a clear end of life care pathway for people with dementia with appropriate advanced care planning and powers of attorney and clinicians are responsive to these wishes. 30. Provide a clear and comprehensive pathway, including respite care, for carers with equality of access across three boroughs, taking into account the unique needs of carers of people with dementia. 31. Patients and carers should be aware of advance directives and power of attorney and how to initiate them. 32. Ensure there is adequate infrastructure to support self-funders to access care

1.4 About dementia

Dementia is a condition that affects about 800,000 people in the UK[1]. Dementia is an umbrella term that is used to describe a group of progressive symptoms such as memory loss, changes in personality, and difficulties in day-to-day living. There are several different causes of dementia, the most common being Alzheimer's (62% of cases) and vascular dementia (17% of cases).

Dementia has a significant impact on an individual's health and quality of life. It can result in a range of health and social problems which can be challenging for the person with dementia, their carers, and health and social care professionals.

People with dementia are likely to have significant physical and mental comorbidities, such as depression, hypertension and diabetes. Average life expectancy ranges from 6.5 years for those diagnosed between the ages of 60-69; to 1.8 years for those diagnosed at age 90 and older.

The main risk factor for dementia is growing older and ageing. While the evidence base on the prevention of dementia is not yet fully developed (and will be informed by a number of current studies), research has indicated that most success lies with modifying cardiovascular risk factors.

> *'Looking after someone with dementia is the most difficult job in the world'* **Local Carer, 2014/15 Survey of Adult Carers**

[1] Alzheimer's Society http://www.alzheimers.org.uk/statistics

Carers play a vital role in supporting people with dementia. Unpaid care contributes more in financial terms than contributions from any other agency (45% of the total, with social care providing 40%). Carers are often old themselves, more likely to be women, and are likely to be providing a substantial number of hours of support.

Carers for people with dementia often experience poorer physical and mental health, social isolation, fewer opportunities to employment or education, or having time to themselves or with friends. For young carers, it can often mean life chances are severely limited.

At any one time, a quarter of acute hospital beds are in use by people with dementia (Royal College of Psychiatrists, 2013). The recent introduction of dementia CQUIN payments (Commissioning for Quality and Innovation) has led to increased provision of dementia specialist nursing and better identification of dementia.

Nationally, 1/3rd of people identified as having dementia are resident in a care home[2], and local audits have identified at least two thirds of older people newly admitted to care homes had dementia. Care home provision is therefore an important factor in dementia.

The average costs of caring for people with dementia in England are approximately £37k per year for people in residential care and £29k per year for people in the community. For the most complex cases, annual costs of c. £70k have been reported[3].

If the national figures are apportioned locally using the number aged 75+, then the estimated total cost of dementia care in the three boroughs is expected to be £161 million of which £70 million is for unpaid care.

Table 3: Estimated local cost of dementia care in the three Boroughs

Cost Type	Amount (£)
Unpaid Care	70,000,000
Social Care	64,000,000
Healthcare	25,000,000
Other Costs	700,000
Total	**161,000,000**

[2] Alzheimer's Society Statistics http://www.alzheimers.org.uk/statistics

[3] London Dementia Needs Assessment 2011, NHS London

1.5 Dementia in our population

Current estimates of the number of people with dementia in the local population are approximately 1200 in Hammersmith and Fulham (LBHF); 1500 in Kensington and Chelsea (RBKC) and 1800 in Westminster (WCC). About half of these people are aged 85+. The total across the three boroughs is estimated to rise from 4,500 in 2015 to 7,000 in 2030 for those aged 65+, if the current prevalence rates in the population remain the same. Prevalence rates do fluctuate and recent estimates may indicate a reduction in prevalence due to an improvement in general health in recent years.

Current published diagnosis rates – the numbers known by GPs to have dementia - are 63% of the estimated prevalence rates in Hammersmith and Fulham Clinical Commissioning Group (LBHF), 65% in West London CCG (RBKC plus Queens Park and Paddington) and 65% in Central London CCG (WCC minus QPP,) based on old prevalence rates[4]. This compares to 60% across London. There are unpublished results that are included in section **Error! Reference source not found.**

> *'A significant proportion of people [with] dementia don't want to know, they won't bring it up of their own accord'*
>
> **Local Clinician, 2014**

Through the aging of the population alone, we can estimate a 55% increase in the number of people across the three boroughs with dementia over the next 15 years: 50% for Hammersmith & Fulham; 70% for Kensington & Chelsea; and 45% for Westminster. Diagnostic, treatment and care service provision may need to expand proportionately to meet this increasing need.

Across the three Boroughs there are approximately 39,000 residents who identify themselves as providing unpaid care. According to the Survey of Adult Carers in 2014/15 in the three boroughs, around a quarter of carers responding to the survey in WCC and RBKC care for someone with dementia, rising to a third in LBHF. Of the survey responders, over 50% were providing more than 50 hours a week of unpaid care, with many living with the person they care for. Around 50% had been caring for the person for 5 years or more

> *'My mother is unaware she has dementia and is very depressed and anxious and depends entirely on me. She refuses to pay for a carer insisting that I am there and care for her. She is scared of being left alone and I am afraid of leaving her for any length of time'* Local Carer.
>
> **2014/15 Survey of Adult Carers**

[4] Prevalence rates are discussed in more detail in the full report in section 3.5

1.6 Dementia services and asset mapping

Basic pathways of care involve diagnosis in a Memory Service; either led by mental health or by general medical services. Patients are referred to this service via their GP, although some will be identified through hospital admission or adult social care. The voluntary sector is also often well placed to notice early signs of dementia in their service users. On-going care is provided initially by the Memory Service then via GP, social care and the voluntary sector.

Memory Services are shared between RBKC and WCC. A Living Well service for on-going care is also being developed jointly between RBKC and WCC. LBHF has Memory Services provided by West London Mental Health NHS Trust and Imperial College Healthcare NHS Trust. A detailed map of service provision has been created and is available in Chapter 5.

> *'Having the same referral strategy across whole trust is important'*
>
> **Local Clinician, 2014**

Local authority Adult Social Care departments are responsible for supporting people with dementia to live safely and independently within their own homes, and local community, for as long as possible. Staff will assess an individual's social care needs and work with that person to devise and coordinate a tailored, person centred support plan detailing what the person wishes to achieve, what is needed to make this possible and who will provide it. Core services provided are home care, memory cafés, and day services.

People who need adult social care services will be allocated a personal budget which can be used to fund a range of support including information and advice, home adaptations, assistive technology, rehabilitation or reablement, or moves to extra care sheltered housing or residential care where necessary. Adult Social Care also commission services to support carers, such as respite care, to prevent carers from developing their own needs for care and support.

Published rates of care home bed provision have identified a national rate of 114.1 beds per 1,000 aged 75+. Provision across the three boroughs is less than half of this at 45.5 per 1000; 59.3 in LBHF, 46.6 in RBKC and 35.7 in WCC (the lowest in England). Surrounding boroughs also have lower provision of beds than the national average. A local audit of those identified as having dementia indicates 60% are placed outside of their original borough of residence.

There is a strong local emphasis on caring for people at home for longer and delaying entry to care homes when that person can be supported in the community. It is important to ensure that patients are receiving adequate support whether at home or via residential care regardless of capacity and availability of care, and that external placement where possible do not go against the wishes of patients.

> *'Voluntary services are huge and play a massive role'*
>
> **Local Clinician, 2014**

The voluntary sector plays a key role for people living with dementia in the community, including providing day services, activities and befriending schemes.

Our needs assessment has collated feedback from local clinicians and service users. Through this we have identified several areas for improvement regarding quality, supply and cohesion of services. These are addressed in the gaps and recommendations.

1.7 Views of people with dementia and their carers

Research shows that a large proportion of people with dementia feel unsupported, do not feel part of their community, often experience anxiety or depression, and do not feel society is geared to deal with dementia (Alzheimer's Society, 2012). While a survey undertaken by the Alzheimer's Society (Alzheimer's Society, 2013) suggests that progress is being made, with almost two-thirds (61%) of respondents reporting that they were living well with the condition, the report also found that quality of life is still varied for a significant number of people with dementia. Environment, presence of depression, social isolation and loneliness are key drivers for quality of life for people with dementia.

Patient and carer's choices over type of support and care they receive may be influenced by cultural background, beliefs and their relationship and communication with professionals. Some may find it difficult to engage with advance care planning.

This is reflected locally where users and carers have identified that they particularly value respite care, practical (financial and legal) advice, memory cafes and day centres. Areas for improvement include staff training, access to and cohesion of services, consistency of support and personal control when choosing services

> *'…(x) is great; she organises a book clubs… reads books out loud,*
> *…royal academy workshop discusses paintings - once a month'*
>
> **Service User**

1.8 Review of evidence and models of care

Management of dementia centres around medication for symptoms of cognitive impairment and distressing behaviour, and care that includes stable staffing, calm environments and appropriate stimulation (NICE, 2006). The Prime Minister's Challenge has prioritized research into finding a cure for dementia or solutions to delay the progress of symptoms, and sharing best practice for service delivery.

There is increasing emphasis on the creation of 'dementia friendly communities' and dementia friendly environments, supported by the Dementia Action Alliance and Prime Minister's Challenge[5].

Technologies such as remote tracking, alarms and telecare may aid in diagnosis of dementia and management of problems such as wandering, however need to be supported by surrounding infrastructure.

'Caring communities are difficult in an urban inner city'

Local Clinician, 2014

The Blackfriars Consensus[6] recognises the overlap between risk factors for vascular disease and dementia, and the potential for effective approaches to prevent non-communicable diseases, such as cardiovascular disease, to be effective in the prevention of dementia.

Key routes to reducing the risk of dementia are:

- modifying cardiovascular risk
- maintaining mental stimulation
- social engagement
- physical activity
- treating depression.

Three large research studies are currently taking place in Europe and the results will inform the case for preventive intervention. NICE is currently developing guidelines referring to midlife prevention of dementia.

New models of care may enable provision of better quality and more streamlined, cost effective services. The North West London dementia strategy highlights a primary-care based diagnostic approach. Scotland's national Dementia Strategy outlines the '8 Pillars' model with care centred around a 'dementia practice coordinator'. Watford's Dual Frailty ward and Delirium Recovery Programme may reduce incidence of escalation to residential care.

[5] Prime Minister's challenge on dementia 2020 https://www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020 (accessed 1 July 2015)

[6] Public Health England/UK Health Forum. *Blackfriars Consensus* http://nhfshare.heartforum.org.uk/RMAssets/Dementia/Blackfriars%20consensus%20%20_V19b.pdf

1.9 Conclusion

The North West London Strategic approach to dementia was finalized in the course of writing this report. The strategy includes a co-produced 'exemplar framework,' outlining the ideal client and carer-centred dementia service. A high level clinical pathway and service specification has also been produced to accompany this with an outcomes framework set against achieving the 'I statements' for both people with dementia and their carers based upon the national quality outcomes framework.

This JSNA provides a comprehensive evidence base and information about the local population to inform the development of commissioning intentions and support the strategic approach taken across North West London.

It provides an opportunity to understand the whole landscape and customer journey for people with dementia and their families and carers, and to highlight areas for improvement.

North West London Mental Health & Wellbeing Strategic Implementation and Evaluation Board

Excellent, integrated mental health services to improve mental and physical health, secured through collaboration and determination to do the best for the population of North West London

Item 3: Strategic Review of Dementia
15th May 2015

Date: 6 May 2015	**Presenter: Dr Serena Foo**
Author(s): Barbara Edwards & Debbie Mayor	
Appendices: 1 Strategic Review; 2: Framework Service Specification 3: Exemplar Framework & Statements	

Purpose	**Action Required**
The purpose of this paper is to provide an update of the outcome of the strategic review of dementia services across NWL.	Discussion, comment, noting and implementation

Executive Summary/Key Issues

This executive summary and more detailed report (see appendix 1) reflects:
- background to the strategic review of dementia
- processes undertaken
- co-production and collaboration
- outputs and outcomes from the review
- recommendations for taking the review forward

Background

The former Mental Health Programme Board agreed to undertake a strategic review of dementia in 2014. This process commenced in August 2014. Dementia continues to remain a high national and local priority.

Process

The process undertaken has included

- Mapping of local levels of current and projected need and dementia prevalence across NWL.
- Mapping of progress towards achievement of dementia diagnosis rate of 67% for prevalent local population.
- Delivery of a series of three stakeholder workshops, which have fully informed the outputs of the process including a framework service specification, set of dementia commitment statements and dementia exemplar framework.

Co-production and Collaboration

- People with dementia and their carers were involved and engaged in the workshops, and in different individual and group meetings over the autumn/winter.
- Innovations in Dementia, working alongside Age UK, facilitated a separate session with a group of people with dementia about the review. The group presented their views and findings at the final workshop in February.

Outputs and outcomes

- Framework specification is outcomes focussed, and uses the Dementia 'I' statements, as the basis for a suite of outcome measures.
- These are accompanied by set of carers outcomes measures, developed by a carer.
- A dementia exemplar framework was developed over the course of the review, and informed in particular by feedback and comments from people with dementia and their carers. Two CCGs are intending to use this, against which to benchmark their current dementia service pathways and provision.
- A high level clinical care pathway was developed and agreed by a virtual clinical leads group, and is included within the framework specification.
- A set of individual/we/group and organisational commitment statements have been produced via the workshops.

Taking the Review Forward

- Seeking 'sign off' from the Board.
- Ensuring key stakeholders are fully aware of the output documents, and their purpose . Key documents including the framework service specification and commitment statements have been circulated to all former workshop attendees.
- Ensuring that these are utilised to support on-going service improvement and development in dementia care and services within NWL.
- Individual CCGs to consider as part of their service review and development process for 15/16.

Decisions/Actions Required
The Board is asked to consider, discuss the contents of the report and to support CCGs and Local Authorities to utilise the outputs of the process in future commissioning of dementia services.

Identification of Risks (& any Mitigation) **in the next period.**
None identified

North West London Mental Health & Wellbeing Strategic Implementation and Evaluation Board

Excellent, integrated mental health services to improve mental and physical health, secured through collaboration and determination to do the best for the population of North West London

Like Minded
WORKING TOGETHER FOR MENTAL HEALTH AND WELLBEING IN NW LONDON

Item 3: Strategic Review of Dementia
15th May 2015

Date: 6 May 2015	**Presenter: Dr Serena Foo**
Author(s): Barbara Edwards & Debbie Mayor	
Appendices: 1 Strategic Review; 2: Framework Service Specification 3: Exemplar Framework & Statements	

Purpose	**Action Required**
The purpose of this paper is to provide an update of the outcome of the strategic review of dementia services across NWL.	Discussion, comment, noting and implementation

Executive Summary/Key Issues

This executive summary and more detailed report (see appendix 1) reflects:

- background to the strategic review of dementia
- processes undertaken
- co-production and collaboration
- outputs and outcomes from the review
- recommendations for taking the review forward

Background

The former Mental Health Programme Board agreed to undertake a strategic review of dementia in 2014. This process commenced in August 2014. Dementia continues to remain a high national and local priority.

Process

The process undertaken has included

- Mapping of local levels of current and projected need and dementia prevalence across NWL.
- Mapping of progress towards achievement of dementia diagnosis rate of 67% for prevalent local population.
- Delivery of a series of three stakeholder workshops, which have fully informed the outputs of the process including a framework service specification, set of dementia commitment statements and dementia exemplar framework.

Co-production and Collaboration

- People with dementia and their carers were involved and engaged in the workshops, and in different individual and group meetings over the autumn/winter.
- Innovations in Dementia, working alongside Age UK, facilitated a separate session with a group of people with dementia about the review. The group presented their views and findings at the final workshop in February.

Outputs and outcomes

- Framework specification is outcomes focussed, and uses the Dementia 'I' statements, as the basis for a suite of outcome measures.
- These are accompanied by set of carers outcomes measures, developed by a carer.
- A dementia exemplar framework was developed over the course of the review, and informed in particular by feedback and comments from people with dementia and their carers. Two CCGs are intending to use this, against which to benchmark their current dementia service pathways and provision.
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Taking the Review Forward

- Seeking 'sign off' from the Board.
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- Ensuring that these are utilised to support on-going service improvement and development in dementia care and services within NWL.
- Individual CCGs to consider as part of their service review and development process for 15/16.

Decisions/Actions Required
The Board is asked to consider, discuss the contents of the report and to support CCGs and Local Authorities to utilise the outputs of the process in future commissioning of dementia services.

Identification of Risks (& any Mitigation) **in the next period.**
None identified

Background Paper – Outputs Dementia JSNA and NWL Strategic Review

In the JSNA, services were RAG rated against National Strategy Objectives, NICE Guidance, views expressed by people with dementia and their carers, qualitative research with clinicians, and supporting evidence. From this RAG rating, gaps were identified and recommendations developed. The table below highlights the recommendations which were developed from the areas highlighted as Red or Amber in the JSNA and those that align with the service aims from the North West London Service Framework Specification (NWL Strategic Review of Dementia May 2015)

	Gap/Opportunity	Recommendation(s)	Links to NWL Strategic Review
Memory Service Care	*A. Memory service care varies between provider: in some cases the patient may not have access to timely diagnostic or adequate community support.* *B. Peer support is now being commissioned as part of Living Well service in Westminster and Kensington and Chelsea, however there appears to be a lack of resource in Hammersmith and Fulham.*	1. Develop a single point of access to diagnostic assessment and ensure all patients across all three Boroughs have equitable access 2. Introduce a peer support programme across three boroughs taking into account evaluation findings of Kensington and Chelsea/Westminster programme	Aim 6: To promote a positive experience of services to people with dementia and family/carers
	C. Diagnosis rates still do not meet estimated prevalence and can be further improved *D. Training is needed for GPs, staff in care and support roles and families to recognise the signs and symptoms of dementia and know what to do next*	3. Improve screening and diagnosis in care home and Extra Care residents 4. Consider training to increase referral from or support diagnosis in primary care, in line with NWL strategy 5. Audit completion of diagnostic assessment for those first identified in hospital and address accordingly 6. Establish a good standard of training to achieve a level of expertise across all partner agencies including social care, residential care, extra care, clinicians, GPs	Aim 2: To provide high quality advice and support for other Providers, especially Primary Care, on assessment and management interventions for dementia Aim 5: To support the development of the workforce and volunteers providing the Service with the right attitudes and skill mix

	Gap/Opportunity	Recommendation(s)	Links to NWL Strategic Review
Community Care	*E. It is not clearly understood whether voluntary sector resources and support available to carers is adequate to need, distributed equitably and accessible to all. There is variation between boroughs in the extent of such services available* *F. There appears to be insufficient community support for people with dementia and their carers to learn to manage distressing signs of dementia, e.g. through purposeful activity.* *G. There are Dementia Advisers and Dementia Guides but there appears to be insufficient resources to meet need. There is a lack of dementia advice/care coordination to support timely access to advice. Resources are needed across 3 boroughs to ensure care staff have support to recognise and signpost people for diagnosis and to provide the right interventions and level of support.*	7. Ensure adequate provision, through 3rd sector and health and social care services, of activities and support around living well with dementia and managing distressing behaviours 8. Provide adequate infrastructure and training for care staff. 9. Ensure people are supported to access the care appropriate to them through the use of personal budgets 10. Ensure that there are sufficient Dementia Advisers to coordinate access to services.	Aim 4: To promote support and inclusion for people with dementia and family/carers using the Service Aim 5: To support the development of the workforce and volunteers providing the Service with the right attitudes and skill mix Aim 6: To promote a positive experience of services to people with dementia and family/carers
	H. There is insufficient support for work of the Dementia Action Alliances across the three boroughs (can eventually join up across 3 boroughs and the Pan-London Alliance)	11. Ensure adequate resource to support the work of the Dementia Action Alliance and other opportunities to raise public awareness of dementia across the three boroughs	Aim 4: To promote support and inclusion for people with dementia and family/carers using the Service

	Gap/Opportunity	Recommendation(s)	Links to NWL Strategic Review
Residential Care	*I. The provision of care home beds locally (particularly dementia specific beds) tends to be lower than many other areas, meaning a significant proportion of residents are placed out of borough, in some cases away from family and friends.*	12. Address supply of local care home beds in future local authority and CCG commissioning intentions, including those specifically for dementia care.	
	J. Little is known about the quality of dementia care in care homes locally	13. Address findings from Care Quality Commission (CQC) national report on dementia care in care homes; audit to provide assurance of quality of care in care homes. 14. Ensure there are opportunities for coordinated training and support for care homes to enable recognition of patients with dementia and to improve confidence in care for complex needs and difficult behaviours. 15. Ensure either all staff in intermediate care have appropriate training for looking after people with dementia or a specialist service is provided.	Aim 5: To support the development of the workforce and volunteers providing the Service with the right attitudes and skill mix Also links to Aim 3
Medica l	*K. Little is known about adequate use of antipsychotics – an audit is due to take place in Chelsea and Westminster Hospital.*	*16.* Audit and address accordingly use of antipsychotics in hospitals and community prescriptions	Aim 3: To prevent or minimise the inappropriate use of anti-psychotic medication, including advice on alternative strategies for people with dementia living at home, in care homes or in other

	Gap/Opportunity	Recommendation(s)	Links to NWL Strategic Review
			residential settings
	L. A need has been speculated for increased liaison psychiatry provision in Hammersmith and Fulham, dementia specialist nursing in the community and in hospital, and care navigators. *M. Opportunities for reducing escalation of problems and care need have been identified through early targeted hospital care.*	17. Ensure adequate monitoring, assessment and provision of care for other physical and mental health needs for people with dementia. 18. Ensure timely identification and targeted care of those with dementia in hospital 19. Provide dementia friendly environment within hospitals 20. Ensure adequate provision of liaison psychiatry and dementia nurses, consider expanding remit	Aim 1: To provide commissioners with confidence that service specifications and operational standards are consistently met Aim 2: To provide high quality advice and support for other Providers, especially Primary Care, on assessment and management interventions for dementia Aim 6: To promote a positive experience of services to people with dementia and family/carers

	Gap/Opportunity	Recommendation(s)	Links to NWL Strategic Review
Whole Systems Care	*N. There are few easy channels of communication between different providers of dementia care*	21. All patients, carers and clinicians should have consistent and comprehensive information with clear signposting of care pathways 22. The current fragmentation in care provision would be addressed through centralised coordination and improved communication/collaboration between services	Aim 2: To provide high quality advice and support for other Providers, especially Primary Care, on assessment and management interventions for dementia Aim 6: To promote a positive experience of services to people with dementia and family/carers
	O. Numbers of people with dementia are likely to increase by 55% in the next 15 years, all relevant providers and services must be equipped with adequate resource to meet this need.	23. Ensure adequate training and support across all services for staff and carers looking after people with dementia 24. Current practice and resources must be scaled to meet increasing need or consider adapting models of care with innovation across health and social care to reduce the scale of care required. Ensure that any changes to services are evidence based. 25. Explore joint working with police and other community safety partners to support appropriate and effective use of assistive technology/telecare for patients with dementia.	Aim 1: To provide commissioners with confidence that service specifications and operational standards are consistently met Aim 5: To support the development of the workforce and volunteers providing the Service with the right attitudes and skill mix
	P. The Dementia Strategy in Kensington and Chelsea will end in 2016. The Westminster and Hammersmith and Fulham strategies have both expired. The North West London Mental Health Programme Board has recently produced a dementia strategy for diagnosis and	26. There should be a joint health and social care dementia programme board for the three boroughs to facilitate implementation of the North West London dementia strategy in alignment with findings and recommendations from this JSNA. 27. Local services are active stakeholders with	Aim 1: To provide commissioners with confidence that service specifications and operational standards are consistently met

	Gap/Opportunity	Recommendation(s)	Links to NWL Strategic Review
	treatment support	wider initiatives to ensure strategy is sensitive to local needs	
	Q. Housing, environment and planning strategies do not specifically mention dementia or carers of people with dementia	28. The increasing numbers and needs of people with dementia and their carers are taken into account in wider local authority and health strategies, especially housing and environment	Aim 2: To provide high quality advice and support for other Providers, especially Primary Care, on assessment and management interventions for dementia
Patient and Carer's Rights	*R. Lack of sufficient resource to support with end of life care across the three boroughs.* *S. Lack of defined carer support pathway.* *T. Support is needed for advocating peoples' best interests and awareness of the Mental Capacity Act 2005* *U. There is little supporting infrastructure available to provide help to self-funders to "micro-commission" care as mandated by the Care Act 2014.* *V.*	29. Ensure that there is a clear end of life care pathway for people with dementia with appropriate advanced care planning and powers of attorney and clinicians are responsive to these wishes. 30. Provide a clear and comprehensive pathway, including respite care, for carers with equality of access across three boroughs, taking into account the unique needs of carers of people with dementia. 31. Patients and carers should be aware of advance directives and power of attorney and how to initiate them. 32. Ensure there is adequate infrastructure to support self-funders to access care	Aim 1: To provide commissioners with confidence that service specifications and operational standards are consistently met Aim 6: To promote a positive experience of services to people with dementia and family/carers

Agenda Item 7

Westminster Health & Wellbeing Board

Date:	**1 October 2015**
Classification:	**General**
Title:	**Westminster Primary Care Project**
Report of:	**Councillor Rachael Robathan, Chairman of the Health & Wellbeing Board**
Wards Involved:	**All**
Policy Context:	**Health and Wellbeing**
Financial Summary:	**N/A**
Report Author and Contact Details:	**Stuart Lines, Deputy Director of Public Health slines@westminster.gov.uk 020 7641 4690**

1. Executive Summary

1.1 This report sets out the progress made by Westminster City Council, Central London Clinical Commissioning Group and West London Clinical Commissioning Group with progression of the Westminster Primary Care Project.

2. Key Matters for the Board's Consideration

2.1 It is recommended that the Westminster Health and Wellbeing Board:

- Reviews and agrees the proposed next two phases of work
- Reviews the current governance and resourcing of the project and agrees that it is appropriate for delivering the next two phases of work

3. Background

3.1 In September 2014, the Westminster Health and Wellbeing Board received a report from NHS England on primary care commissioning. During this discussion, the Health and Wellbeing Board raised concerns that the strategy for primary care in Westminster was not forward looking enough and did not consider how

changes to the population in Westminster, in particular the demographic profile and the disease profile, could impact on the level of need for primary care. It was also considered that it might be helpful to develop a greater understanding of how long-term housing, regeneration and infrastructure plans concerning Westminster might impact on the need for primary care services.

3.2 Following this meeting, the Chairman of the Health and Wellbeing Board and the Chair of Central London Clinical Commissioning Group discussed undertaking a joint-project to develop a better joint understanding of some of these issues. At its meeting on the 20th November 2014 it was agreed that the Westminster Health and Wellbeing Board should undertake a project relating to the level of need for General Practice primary care services in Westminster.

3.3 In the first quarter of 2015 the local authority, Central London Clinical Commissioning Group and West London Clinical Commissioning Group have been working together to further refine what this project may look to achieve and what might be needed from partners around the Health and Wellbeing Board to achieve it.

3.4 A paper was then brought back to the members of the Health & Wellbeing Board in May 2015 where the scope of, and governance and resourcing for, the project was agreed.

4. Progress to date

4.1 The aim of the project is to deliver three things:

1. An understanding of the likely population size and profile for Westminster by 2040. This includes consideration of the daytime population (particularly the working population)
2. An understanding of the likely burden of disease of this population by 2040
3. Consideration as to how the new models of care being developed within the local health economy may impact on the use of primary care by this population in 2040.

4.2 Since May a joint team of analysts (nominated by the Clinical Commissioning Groups and the Council) has completed the first phase of work to model a range of projections which estimate the demographic profile of Westminster and the subsequent disease burden. This includes estimates around the numbers of:

- Mostly healthy adults (16 – 75 years) and mostly healthy elderly people over 75;

- Adults between 16 and 75 and elderly people over 75 who have one or more long-term conditions;
- People over the age of 16 who have cancer; a severe of enduring mental illness. with advanced organic brain disorders;
- People over 16 years of age with learning disabilities;
- People over the age of 16 with a FACS eligible physical disability;
- People over the age of 16 who are “socially excluded”;
- Mostly healthy young people in Westminster;
- Children and young people with one or more long-term condition or cancer;
- Children with intensive continuing care needs; and
- Young people with intensive continuing care needs.

4.3 This first phase of modelling provides a strong foundation for two further phases of work designed to fulfil the brief originally agreed by the Health & Wellbeing Board. These are:

- Phase 2: To overlay the impacts of regeneration, housing and infrastructure plans on the estimates modelled and build a tool that enables the manipulation of these impacts according to a number of variables. This will include the mapping of the existing provision of GP services both in terms of numbers of clinicians and also physical estate.

- Phase 3: To undertake a joint analysis of how the needs of the Westminster population will impact on the demand for frontline services (including primary care) with a view to this informing the analysis that will be used by NHS England, CLCCG and NWLCCG to plan for future primary care provision. This analysis completed by the project will include the identification of local authority and voluntary sector levers (such as estates and planning policy) that could be used to support the provision of primary care to match population needs.

4.4 **The Health & Wellbeing Board is asked to agree the next two phases of work**

5. Project governance and resource

Governance

5.1 The Health and Wellbeing Board oversees the delivery of this project and will be updated on progress, risk and issues at their meetings as required.

5.2 Stuart Lines, Deputy Director of Public Health, acts as the senior responsible member this project, driving its delivery between Health and Wellbeing Board meetings and being accountable to the Health and Wellbeing Board on progress.

5.3 The Project Steering Group– made up of officers nominated by the Council and CCGs –undertakes the following roles:

- Steers the development and delivery of the project;
- Decides the methodology and framework which will be used to undertake the modelling;
- Identifies the data and expertise that will be needed to deliver the project and ensure that this is fed into the steering group; and
- Keeps a record of the approach taken to deliver the project with the aim of sharing and learning from this work with other local areas.

5.4 The membership of the steering group is:

Name	Organisation	Position
Stuart Lines (Chair)	WCC	Deputy Director of Public Health-PHI & Social Determinants
Helena Stokes (CCG Project Lead)	CLCCG	Delivery Manager for Primary Care
Jonathan Bettis	CLCCG	Performance Manager
Dr Andrew Rixom	WCC	Senior Public Health Analyst
Colin Brodie	WCC	Public Health Knowledge Manager
Gayan Perera	WCC	Senior Public Health Analyst
Thilina Jayatilleke	WCC	Public Health Analyst
Damian Highwood	WCC	Evaluation and Performance Manager
Mike Rogers	WCC	Adult Social Care, Head of Business Analysis, Planning and Workforce Development
Cecily Herdman	WCC	Principle Policy Officer (Housing Strategy)

James Hebblethwaite	WCC	Senior Public Health Analyst

5.5 In addition to the commitment of officer time to the Steering Group, Westminster City Council has also allocated 0.4 x FTE project officer from within its Policy, Performance and Communications department who will be responsible on behalf of the local authority for the day-to-day management of the project. A Principal Policy Officer from the same department will provide strategic oversight of the project.

5.6 It is recommended that the Health and Wellbeing Board consider whether this resource could be complemented by some additional Clinical Commissioning Group analyst and project management resource. This may be helpful in ensuring that the project is considered within the light of the Primary Care Transformation agenda and that the CCG Governing Bodies remain sighted on the project as it develops

5.7 General Practitioners will be a key stakeholder for this work and the Clinical Commissioning Groups' Governing Bodies should have a role in shaping delivery of the project to ensure it aligns with their new role in Primary Care Co-Commissioning. With this in mind it is recommended that a GP champion is identified by Central London Clinical Commissioning Group and West London Clinical Commissioning Group. The GP champions would have a role on the project steering group and would also provide a crucial link back to the Clinical Commissioning Groups' Government Bodies.

5.8 The Health and Wellbeing Board is asked to review the current governance and resourcing of the project and agree that it is appropriate for delivering the next two phases of work.

6. Legal Implications

None at this time

7. Financial Implications

None at this time.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact: Toby Howes, telephone 020 7641 8470, email thowes@westminster.gov.uk

City of Westminster

Westminster Health & Wellbeing Board

Date:	1 October 2015
Classification:	**General Release**
Title:	Children and Families Act
Report of:	Children's Services
Wards Involved:	All
Policy Context:	The requirements of the Children and Families Act, which came into effect from 1 September 2014, represent some of the most significant changes to the way that services are delivered for young people with special educational needs (SEN) in 30 years. This paper outlines the key issues identified during the first year of implementation.
Financial Summary:	Financial risk arising from the Act is linked to the potential for increased numbers of young people being eligible for an Education, Health and Care Plan, particularly in the early years, post-16 and post-19 levels.
Report Author and Contact Details:	Steve Comber, Policy Officer, 020 8753 2188

1. Executive Summary

1.1 The requirements of the Children and Families Act, which came into effect from 1 September 2014, represent some of the most significant changes to the way services are delivered for young people with special educational needs (SEN) in 30 years. The changes aim to improve cooperation between all the services that support children and their families. 'Statements' of SEN have been replaced with a new jointly assessed 'Education, Health and Care plan', which is available for an extended age range (from birth to 25 years). Local authorities are required to publish a 'Local Offer' outlining the provision available to young people with SEN and disabilities. They are also required to offer families the option of a personal budget with which to purchase services.

1.2 The implementation of the Act has been overseen by a cross sector Children and Families Act Executive Board, which is chaired by the Director for Children's Services. During the first year, the following key issues have been identified:

- The challenging nature of the statutory timescales for the new joint assessment process, which is being delivered by a restructured SEN Team under the leadership of a new Tri-borough Management Team;
- The need to be able to provide an up-to-date Local Offer, detailing all education, health and social care services that are available for children and young people aged 0-25;
- The financial risk arising from the potential increased eligibility for statutory support at post-16 and post-19 level; and
- The need to deliver an offer of personal budgets across education, health and social care

2. Key Matters for the Board

2.1 This paper provides an update on the key issues identified during the first year of the Children and Families Act for the Health and Wellbeing Board to consider and note.

3. Background

The statutory assessment process

3.1 Education Health and Care Assessments (including assessments for those young people who are transferring from a Statement of SEN to an Education Health and Care Plan) should be undertaken jointly, with input from Education, Health and Social Care professionals. These assessments have to be completed within a statutory timeframe of 20 weeks and the responsibility for the coordination and writing of the plan sits within the SEN Service, undertaken by a SEN Keyworker.

3.2 We have established new Education, Health and Social Care 'Statutory Assessment and Resource Allocation Panels'. We have also established a new Tri-borough Complex Needs Panel, which considers those cases from Education, Health and Social Care where provision costing in excess of £50,000 per year is requested.

3.3 During the first year of implementation all local authorities have commented on the challenging nature of meeting the new 20 week statutory timescale for completing these new, more complex assessments (compared with, for example, the 26 week timeline for Statements of SEN) and the 14 week statutory timescale

for undertaking a transfer to an EHC Plan from a Statement of SEN. These concerns have been recognised by central government – reflected in the announcement in July 2015 that the timescale of transfer reviews was extended from 14 weeks to 20 weeks.

The local offer

3.4 It is a statutory requirement for all local authorities to publish a 'local offer' that outlines the services that are available to children with Education, Health and Social Care needs.

3.5 The local offer for Westminster is set out on the local authority's website. It outlines the current service offer from Education, Health and Social Care as well as providing information for parents and young people on the processes that are undertaken within the new legislative framework and updates on progress towards addressing the reforms via a regular newsletter. We are currently working on the development of a new and improved local offer website, which will provide local young people and families with improved accessibility to information about what is available locally.

Post-16 / Post-19

3.6 The extension of some Education Health and Care Plans to the age of 25 provides two specific challenges for local authorities. Firstly, the offer of high quality specialist provision for post 16 and post 19 education is currently underdeveloped. Local authorities need to quantify the number of young people who are approaching transition at 16 and at 19 years of age and will qualify for an Education Health and Care Plan and, on the basis of this demand, will need to develop their local offer to support the transition to adulthood, including planning for young people's employment and independence in or near their local community. The second issue is that there is no extra funding in the system to deliver this specialist provision; therefore this extension of the age range represents a financial risk to the High Needs Block within the Dedicated Schools Grant if it is not closely managed and delivered economically in partnership with Adult Social Care and Adult Health Services.

Personal Budgets

3.7 The legislation introduces new duties for local authorities and Clinical Commissioning Groups including the provision of Personal Budgets for children and young people, which will take some time to develop.

3.8 In line with Department for Education advice, we have started by offering personal budgets in areas where we have previous experience of delivering them across Education, Health and Social Care:

- Home to School Travel Assistance
- Personal Care
- Short Breaks
- Equipment and disposables

3.9 The Provisional Personal Budgets Policy & Guidance is available on Westminster's local offer website. In section 18 of the policy, we have indicated that we will be working with local parents and young people, the Council and Inner London CCGs to expand the needs and services covered by personal budgets.

Inspection of Local Areas

3.10 In order to review the effectiveness of local areas in delivering the vision of the reforms, the government are introducing a new SEN Ofsted and CQC Inspection Framework for Local Areas. The new Framework is expected to be announced in December 2015, with the first inspections taking place in May 2016.

3.11 The inspections will focus on two key points:

- How effectively does the local area identify children and young people who are disabled and/or have special educational needs?
- How effectively does the local area meet the needs and improve the outcomes of children and young people who are disabled and/or have special educational needs?

3.12 The inspection is not an inspection of the local authority – it is an inspection of the 'local area', incorporating judgements on education, health and social care services as well as key partners and stakeholders such as schools, early years settings, colleges and third sector organisations. Furthermore, it is not just an inspection of the provision for young people with EHC Plans, but will encompass the offer for young people with broader needs for SEN support – including the impact of Early Intervention Provision in the local area. With this in mind, a whole area approach will need to be taken in the preparation for any local inspection, which could take place at any time between May 2016 and December 2021.

Strategic involvement of Clinical Commissioning Groups

3.13 Lead Commissioners from the North West London Collaboration of Clinical Commissioning Groups have been involved with the preparation for and implementation of the requirements of the Children and Families Act.

3.14 Representatives from the CCG have sat on the Children and Families Act Executive Board, which is chaired by the Director of Children's Services and have also contributed to specific workstreams focussing on the following areas:

- Single Assessment Process for Education Health and Care Planning
- Presentation of the Local Offer
- Development of Personal Budgets
- Preparing for Adulthood (developing the Local Offer for young people aged 14-25).

3.15 Furthermore, as the CCG has also been instrumental in recruiting and supporting a Designated Clinical Officer who has worked with Education, Social Care and voluntary sector organisations to ensure that high quality joint working is achieved with Health Services, resulting in a holistic approach to planning for young people with Education, Health and Social Care Needs.

3.16 Developments in these areas are on-going and the CCG will continue to be a key partner in delivering the reforms throughout the three year period of implementation and beyond.

Feedback received during 2014/15

3.17 A key theme of the Children and Families Act is 'co-production' and it is the responsibility of the local authority to ensure that the views of parents and young people are included in any strategic planning and decision making.

3.18 To enable this process a Parent Reference Group was set up in April 2014. The group contains representatives from local support groups for parents of children with disabilities along with employees from the Information Advice and Support Service and Independent Supporters from KIDS. This group has been instrumental in allowing parents' voices to be heard in the development of new systems for the delivery of the Children and Families Act, and for receiving their feedback following the implementation of the Act in September 2014.

3.19 Members of the group have also recently provided feedback from the first cohort of parents and young people to have gone through the new joint education, health and care assessment process. This feedback has highlighted the following emerging issues:

- There is lack of confidence in the ability of staff to meet the challenging timescales and requirements of the legislation either due to a lack of skills and training or due to significantly increased workloads that are inefficiently managed
- Communication with parents is inconsistent resulting in confusion and, in some cases, conflict with the local authority
- Information regarding statutory timelines for assessment is not clear and initial information request forms are difficult to complete
- The post 16 and post 19 offer of education within local colleges is limited and lacks sufficient wrap-around care to support young people who require specific therapies in addition to educational provision

SEN Service Improvement Plan

3.20 There are a number of challenges facing the SEN Service that can broadly be summarised as follows:

- Legislative changes to policy and practice
- The resultant need to deliver a seamless service in partnership with varied stakeholders across different sectors
- Operational challenges linked to recent service development, including the implementation of new systems and processes and the difficulty to recruit and retain staff, which is a common challenge across a number of local authorities in London.

3.21 In response to these, the SEN Service has produced a Service improvement plan, which is being implemented throughout the next 12 months and will focus on the following areas:

- Customer-focused communication with parents and schools which is responsive and respectful
- Education, Health and Care (EHC) assessments, including transfers, are completed within 20 weeks
- All transfers into primary (Reception) and secondary (Year 7) school for children with a statement of SEN or EHC Plan are completed by 15 February
- Improve the SEN local offer for 16-19 year olds

- Improve the post 19 EHC Offer
- Recruitment and retention of a confident, competent, customer-focused SEN Service
- Effective SEN management information systems in place, enabling timely management reporting
- Preparation for SEN Ofsted inspection

4. Legal Implications

4.1 As this report is intended to provide an update on recent developments, there are no immediate legal implications. However any legal issues will be highlighted in any subsequent substantive reports on any of the items which are requested by the Board.

5. Financial Implications

5.1 As this report is intended to provide an update on recent developments, there are no immediate financial and resource implications. However any financial and resource issues will be highlighted in any subsequent substantive reports on any of the items which are requested by the Board.

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

[provide name of report author/contact and title]

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Westminster Health & Wellbeing Board

Date:	1 October 2015
Classification:	General Release
	Update paper for information
Title:	Better Care Fund Update
Report of:	Westminster City Council and Central and West London Clinical Commissioning Groups
Wards Involved:	All
Policy Context:	Health and Social Care Integration
Financial Summary:	As has been reported to Health and Wellbeing Board members separately, this report updates on expected benefits arising from the Better Care Fund. Based on experience of delivery since the publication of the draft and final Better Care Fund plans in April and September 2014, this paper formalises a re-profiling of expected savings arising from the Better Care Fund amounting to £2.489M in future years. The changes arise from continued work to deliver the Better Care Fund, some 18 months after the initial plan and associated financial modelling was delivered.
Report Author and Contact Details:	Rachel Wigley, Deputy Executive Director and Finance Director, Adult Social Care and Health Chris Neill, Director Whole Systems, Adult Social Care and Health Matthew Bazeley, MD of Central London Clinical Commissioning Group

1. Executive Summary

1.1 This paper is the regular update requested by the Health and Wellbeing Board on progress with the delivery of the Better Care Fund (BCF). Following discussions with Better Care Fund Board members and finance managers, it formalises a carry forward of updated savings expectations into 2015/16 and 2016/17 based on experience so far in delivering the plan. In summary, a small reduction in the savings/benefits due as a result of the delivery of the plan amounting to £2.489m is expected. These relate to reductions in expected benefits arising from residential and nursing placements and s.75 agreements.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board is asked to note that:

a. Work continues to take place on integrating care, using the Better Care Fund plan agreed and submitted in September 2014 as our joint plan,
b. Further work to validate savings has been undertaken in the light of our activities and experience over the past year,
c. Some re-profiling of benefits reflecting changes in officer expectations as to what can be delivered under the original BCF schemes is set out in this document and appendix 1,
d. Officers are working on a range of options to make further savings through integration and joint commissioning and the Health and Wellbeing Board will continue to be updated as this work progresses.

3. Background

3.1 The BCF is a single pooled budget for health and social care services to work more closely in local areas, based on a plan agreed between the NHS and local authorities. It is a national initiative to improve health and social care outcomes and cost-effectiveness, with an emphasis on more care at and near home.

3.2 Our July 2015 report to Health and Wellbeing Board members included an update on our progress against the six national conditions specified as a set of expectations for BCF implementation and an overview of how progress with local plans would be reported nationally.

3.3 Since July 2015, we have further developed the Community Independence Service (CIS) model and health and care organisations are working together to

achieve full rollout. Preparation for staff change is well advanced and a consultation on future working arrangements and roles will commence as soon as 2016-17 funding for the service is agreed between the parties. Commissioners are developing an approach to evaluate CIS achievements in 2015-16 and options for further developing the service, very much set in the context of the wider direction of travel for the NHS and local authorities.

4. Update on Benefits

4.1 In August 2015 the CCG and local authorities' Joint Executive Team (JET) presented an update on BCF benefits to the Better Care Fund Board. This included a summary of our current assumptions in the BCF plan for each of the four groups of schemes (labelled A-D), based on the detailed analysis and design completed in the past year since submission of the plan. This update followed a number of earlier discussions with the Board in March 2015 and July 2015.

4.2 Our detailed work over the past year has resulted in some re-profiling of benefits, reflecting changes in the level of savings that officers now expect to deliver under the original scheme headings. The overall outcome of this on savings is summarised in section 5, and a more detailed financial performance summary is included as Appendix 1 of this report.

4.3 Officers across the Clinical Commissioning Groups and the Councils are now investigating opportunities and options to take the original aspirations set out in the BCF to the next level. These include working with health service partners to develop a clearer future model of integration and what this could deliver. Options being considered include the potential for:

- co-commissioning
- more joint working with primary care
- a geographical focus (reflected in our patch based work and localities) and,
- integrated enablement.

Alongside this, officers are looking at opportunities to draw more clearly on the benefits that the North West London NHS collaboration can drive locally as well as in joint commissioning opportunities in mental health and placements. A further update on proposals as they develop will be provided to future Health and Wellbeing Board meetings.

5. Financial Implications

5.1 The BCF plan identified financial benefits in 2015-16 total £12.477M from the four groups of schemes. Following re-profiling of benefits, the Better Care Fund Board was advised of a reduction in expected benefits of £2.489M identifiable at this stage in the financial year. The reduction in benefits attributable to Westminster is £0.474M; the reduction in benefits attributable to Central London Clinical Commissioning Group is £0.270M.

5.2 The BCF update on financial benefits submitted to the Better Care Fund Board is included as Appendix 1 of this report.

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

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APPENDICES:

Appendix 1: Report to Better Care Fund Board on 27 July 2015 entitled Update on Expected Better Care Fund benefits

BACKGROUND PAPERS:

Parts 1 and 2 of the original Better Care Fund plan submissions dated April and September 2014

Hammersmith and Fulham Clinical Commissioning Group
West London Clinical Commissioning Group
Central London Clinical Commissioning Group
hammersmith & fulham
The Royal Borough of Kensington and Chelsea
City of Westminster

Appendix 1

Better Care Fund Update to Better Care Fund Board on 27 July 2015

Update on expected Better Care Fund benefits

1. Purpose of Paper

This paper provides further clarification of the financial benefits associated with the BCF plan, following discussion of a previous version of the update at the BCF Board meeting on 6th July.

2. Background

The BCF plan identified financial benefits in 2015/16 totalling £12.477m from four of its constituent schemes. At its March meeting, the BCF Board was updated on changes to benefits expectations as a consequence of additional analysis since plan submission. This paper provides a further update and flags a current savings gap of £2.489m, summarised in Table 1 below.

Further details of benefits assumptions by scheme are provided in Section 3, and by scheme and organisation in Appendix A.

Table 1: Changes in BCF Savings Expectations by Scheme and in Total

		£000s	Sum	Commentary
	Original BCF Savings Expectations			
a	A1 Community Independence Service	8,020		Adjustments to financial model have resulted in £83k benefits reduction against BCF plan total. Benefits tracking by lead providers is in progress and will inform review of assumptions later in
b	A2 Community Neuro Rehabilitation	1,417		The service will not be operational until 2016/17 so original plan savings (health only) of £1,417k will not be realised, *but as this is offset by later spend it is not a gap in 15/16 savings*
c	C1 Review of Nursing and Care Home Contracting	1,200		Genuine efficiencies still being sought but scale of opportunities in 15/16 less than anticipated and, where savings have been identified, there is overlap with the Contract Efficiencies Programme
d	C2 Jointly Commissioned Services	1,840		Savings have been identified but there remains a shortfall, and there is overlap with Contract Efficiencies. Community services savings will not be achieved in year
e	**Total of Savings in BCF Plan**	**12,477**	a+b+c+d	Health/ASC split: CCGs £7,235k; LAs £5,242k
f	**BCF Plan Savings Without Neuro Rehab**	**11,060**	e-b	Neuro rehab is a net reduction of £1,417k as later costs offset 15/16 benefits expectations
	Current BCF Savings Expecations			
g	A1 Community Independence Service	7,937		Orginal expectation of £8,020k less £83k
h	C1 Review of Nursing and Care Home Contracting	0		Savings atributed to Contract Efficiencies not BCF
i	C2 Jointly Commissioned Services	634		Orginal expectation of £1,840k less £1,206k
j	**Total of Current Savings Expectations**	**8,571**	g+h+i	Health/ASC split: CCGs £5,001k; LAs £3,570k
	Savings Gap	**2,489**	f-j	Health/ASC split: CCGs £817k; LAs £1,672k

3. Current Financial Benefits Assumptions by Scheme

Community Independence Service (CIS)

A significant component of the benefits assumptions in the BCF plan is associated with the integrated CIS. Benefits expectations are underpinned by detailed modelling, based on a range of data inputs from existing services as well as future assumptions. Verification of the model was still being undertaken when the BCF plan was completed, and some improvements were made subsequently to address inconsistencies across the boroughs. The consequence of these changes is a reduction in anticipated benefits of £83k, to a revised total of £7.937m.

There will be further adjustments as actual data becomes available to compare with modelling outputs. A process for monthly progress tracking has been developed, with data collection and reporting by the CIS lead providers for health and social care. It is still too early to confirm or revise savings assumptions based on actual performance, but this will develop as the year progresses. At present, therefore, the savings assumptions associated with the CIS scheme remain at the level of the revised model outputs, £7.937m.

Neuro Rehabilitation

Access to improved data led to significant re-scoping of this CCG-led scheme, which is now predicated on the benefits for patients and future reductions in Delayed Transfers of Care, rather than the additional value of savings in 2015/16. Procurement timescales mean that the new service is not now expected to be operational until the start of 2016/17, so costs and benefits associated with the scheme will not accrue in 2015/16.

At present, therefore, there are no savings assumptions associated with the neuro rehab scheme in 2015/16. However, as this was a cost pressure, absence of benefits is offset by absence of costs.

Review of Nursing and Residential Care Home Contracting

The financial benefits expected from review of nursing and residential care home contracting were based on bringing 25% of higher cost placements into line with lower cost placements. It was also expected that working towards an integrated team across health and social care would generate economies of scale, help to

shape market costs, remove duplication of activity, and generate process and resource efficiencies.

The March update paper noted that there may be detrimental quality and safety consequences if providers are too challenged financially by price reduction; and also that subsequent review of integrated commissioning arrangements elsewhere had not indicated significant cost reduction.

In addition, some savings anticipated from more integrated commissioning of nursing and care home placements overlap with the scheme looking at joint commissioning, as placement costs are included in Section 75 arrangements. There is overlap, too, with the Contract Efficiencies Programme in the Medium-Term Financial Strategies of the three local authorities, which also targets reduction in nursing and care home placement costs.

It is expected that where there is duplication (for which the current expectation is £0.825m), the savings identified will be attributed to the Contract Efficiencies Programme rather than the BCF. Work is continuing to review what is possible, but where there is a shortfall in savings identified and/or duplication there is a need to determine whether any further savings can be achieved through the original BCF schemes; or through different schemes that can create efficiencies from greater integration between health and social care; or via other means across the LAs and CCGs (recognising that shortfall in savings potential varies across the six organisations).

At present, therefore, no savings are assumed from the review of nursing and residential care home contracting in 2015/16, and the basis for the £1.200m savings included in LA and CCG plans is being re-assessed.

Review of Joint Commissioning and Pooled Budgets

Benefits from efficiencies in joint commissioning and existing pooled budget arrangements were expected via savings from client group contracts of £1.385m (based on 1.25% of current spend) and efficiencies from existing community services of £0.455m (based on a 2% saving in the CLCH contract). This gave a total savings expectation for this scheme of £1.840m. Existing pooled budget arrangements have been reviewed in client groups by finance and commissioning

teams from both health and social care. Against the overall savings target from client group contracts of £1.385m, savings opportunities of £1.102m have been identified. However, £0.468m of this is expected to be a further double count against the Contract Efficiencies Programme. An open book review is being progressed with CLCH to assess community services savings opportunities, but in year savings against the contract are not now expected.

At present, therefore, the savings assumptions associated with review of joint commissioning and pooled budgets in 2015/16 is £0.634m. Opportunities to realise the remaining £1.205m in LA and CCG plans will be reviewed.

4. Summary of Savings Gap

The savings gap identified comprises the elements set out in Table 2 below. It is important to note that the gap excludes neuro rehab because the costs of new capacity will not be incurred in 2015/16, offsetting the benefits loss.

Table 2: Savings Gap Elements

	£000s
CIS modelling adjustment	83
Savings identified but double counted with Contract Efficiencies Programme	1,292
Unidentified nursing and residential savings	376
Unidentified client group savings	283
Unidentified savings in CLCH contract	455
Total	**2,489**

5. Recommendation

The BCF Board is asked to note the changes identified to date in financial benefits assumptions and the currently expected gap against plan of £2.489m; to note work in progress to review ongoing CIS performance; to note the need to review other potential opportunities to bridge the savings gap envisaged in Group C schemes; and to expect a further update in the autumn.

If you have any queries about this report please contact:
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Helen Troalen, Deputy Chief Finance Officer, CWHHE CCG Collaborative (helen.troalen@nw.london.nhs.uk)

APPENDIX A – SUMMARY OF BENEFITS BY ORGANISATION

		Benefits by Organisation (£k)						
		All	H&F CCG	WL CCG	CL CCG	LBHF	RBKC	WCC
Benefits in BCF Plan								
A1: Community Independence Service		8,020	1,442	1,258	1,844	815	918	1,743
A2: Neuro Rehabilitation		1,417	418	442	557	0	0	0
C1: Transforming Nursing & Care Home Contracting		1,200	149	79	148	247	203	374
C2: Review of Jointly Commissioned Services		1,840	301	254	343	568	238	136
BCF Plan Total		**12,477**	**2,310**	**2,033**	**2,892**	1,630	1,359	2,253
Current Expectations								
A1: Community Independence Service		7,937	1,442	1,258	1,844	815	918	1,660
A2: Neuro Rehabilitation		0	0	0	0	0	0	0
C1: Transforming Nursing & Care Home Contracting		0	0	0	0	0	0	0
C2: Review of Jointly Commissioned Services		634	89	147	221	0	48	129
Total of Current Expectations		**8,571**	**1,531**	**1,405**	**2,065**	**815**	**966**	**1,789**
Group A Update								
A1: CIS	Savings Target in BCF Plan	8,020	1,442	1,258	1,844	815	918	1,743
	Revised Modelling	7,937	1,442	1,258	1,844	815	918	1,660
	Current Gap	83	0	0	0	0	0	83
	A1 Savings Total	**7,937**	**1,442**	**1,258**	**1,844**	**815**	**918**	**1,660**
A2: Neuro Rehab*	Savings Target in BCF Plan	1,417	418	442	557	0	0	0
	Target Offset by Later Cost	1,417	418	442	557	0	0	0
	Current Gap	0	0	0	0	0	0	0
	A2 Savings Total	**0**	0	0	0	0	0	0
Group C Update								
C1: Transforming Nursing & Care Home Contracting	Savings Target in BCF Plan	1,200	149	79	148	247	203	374
	Progress Against Target	824	0	0	0	247	203	374
	Double Count	824	0	0	0	247	203	374
	Current Gap	1,200	149	79	148	247	203	374
	C1 Savings Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**
C2: Review of Jointly Commissioned Services	Savings Target in BCF Plan	1,840	301	254	343	568	238	136
	Client Group Savings	*1,385*	*145*	*105*	*193*	*568*	*238*	*136*
	CLCH Savings	*455*	*156*	*150*	*149*	*0*	*0*	*0*
	Progress Against Target	1,102	175	147	295	68	214	203
	Client Group Savings	*1,102*	*175*	*147*	*295*	*68*	*214*	*203*
	CLCH Savings	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Double Count	468	86	0	74	68	166	74
	Current Gap	1,206	212	107	122	568	190	7
	C2 Savings Total	**634**	**89**	**147**	**221**	**0**	**48**	**129**
BCF Savings Gap by Organisation (Group A + Group C)		**2,489**	**361**	**186**	**270**	**815**	**393**	**464**

* Note: cost of additional neuro rehab capacity will not be incurred in 2015/16 which offsets benefits loss, so neuro rehab is not included in the savings gap

City of Westminster

Westminster Health & Wellbeing Board

Date:	1 October 2015
Classification:	**General Release**
Title:	Primary Care Co-commissioning
Report of:	Matthew Bazeley and Louise Proctor
Wards Involved:	All
Policy Context:	Central London CCG and West London CCG began co-commissioning primary care medical services with NHS England in April 2015. Co-commissioning is designed to increase CCGs' influence on this commissioning process – which until April 2015 was done by NHS England, with limited local input – and to enable them to align the development of primary care with the wider transformation of local health and care services.
Financial Summary:	NA
Report Author and Contact Details:	Christopher Cotton Chris.Cotton@nw.london.nhs.uk

1. Executive Summary

1.1 This report updates the Board on the work done over the summer to finalise the local co-commissioning infrastructure. It also includes an overview of the agenda of the co-commissioning joint committees' September meeting. A verbal update will also be provided.

2. Key Matters for the Board

2.1 Board members are asked to note the progress made over the summer and to continue their debate, began earlier this year, about how they can best participate in primary care co-commissioning in Westminster, to ensure that it benefits from the full range of local expertise and aligns with strategies being implemented across the borough's health and care economy.

3. Background

3.1 Over the last quarter the CCG has continued to work with NHS England and the other North West London CCGs to finalise the governance framework under which co-commissioning will operate, both within Westminster and across North West London (NWL). This has included:

- ongoing input into NHS England's London-wide operating model, which sets out the functions, responsibilities, and processes within co-commissioning; and
- the design of the local, CCG-specific structure that will support the work of the NWL-wide meetings of the eight CCGs' co-commissioning joint committees.

4. Options / Considerations

4.1 It is this local structure that will be the focus of the CCG's engagement on primary care. Discussions on its development have covered primarily its remit and membership.

4.2 All documentation relating to governance, at both CCG- and NWL-level, will be presented for sign-off at the September NWL-wide meeting of the co-commissioning joint committees, which will also continue its discussions about a range of commissioning issues.

4.3 Due to annual leave being taken by a majority of committee members, joint committee meetings did not take place in July and August. The next meeting is on 17 September and the agenda has now been confirmed. Items include:

- the development of primary care within NWL's whole systems programme;
- NHS England's review of PMS contracts across NWL;
- NHS England's regular financial report on primary care medical services in NWL; and
- co-commissioning governance endorsements and approvals.

4.4 A verbal update on the outcomes of these discussions will be provided to the Health and Wellbeing Board's September meeting.

5. Legal Implications

NA

6. Financial Implications

6.1 NA

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

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Joint Strategic Needs Assessment (JSNA) Steering Group

27th July 2015

Rm 5.4, 15 Marylebone Road

Minutes

In attendance	
Daniela Valdés (DV) (chair)	Head of Planning and Governance, CLCCG
Stuart Lines (SL)	Deputy Director of Public Health
Meenara Islam (MI)	Principal Policy Officer, Westminster City Council
Jessica Nyman (JN)	JSNA Manager, Public Health
Steve Bywater (SB)	Interim Policy Manager, Children's Services
Mark Jarvis (MJ)	Company Secretary, Hammersmith & Fulham CCG
Shelley Gittens (SG)	Public Health Performance Manager
Angela Spence (ASp)	Kensington and Chelsea Social Council
Angela McCall (AM) (minutes)	Business Support Officer, Public Health
Apologies: Angeleca Silversides, Mike Rogers, Bridgitte Moess, Lisa Cavanagh, Colin Brodie	

Item	Action
1. Welcome and introductions	
2. Minutes of last meeting and matters arising	
SL met with Samar Pankanti (3 CCGs Public Health lead) last week and Samar is now invited to JSNA Steering Group meetings to strengthen the CCG links.	
Current attendance list to be reviewed to ensure that the meeting is pitched at the right level – DV.	DV to check quorum.
SL informed that the 3 Cabinet Members are concerned that the join up needs strengthening for the group and Health and Wellbeing Boards and CCGs.	AMc to let the H&WBB chairs have these minutes.
JN is going to the Hammersmith & Fulham CCG and West London CCG Governing Body Seminar and the Central London CCG Transformational Redesign Group to present on the JSNA and current work programme, and it	JN

is hoped to be a regular feature.	
3. Overview of JSNA Project Plan • **Dementia JSNA sign-off** This is about to be published after the next round of HWB meetings in September and will be presented by Lisa Cavanagh and Colin Brodie. This will be presented in parallel to the NWL Dementia Strategy for agreement of publication in September/early October. A local strategy for dementia is being created. LBHF have decommissioned a memory clinic service and are recommissioning. MJ queried how this joined up with this JSNA. This prompted discussion around how the JSNAs informed commissioning decisions. MJ and DV advised that CCGs are pulling together their prospectus (commissioning intentions) for the following year. These will need to 'fit' with the work of this steering group. • **Childhood Obesity JSNA** This report is being redrafted, and a second draft will be circulated to wider stakeholders. It will go to the November H&WBB. SL advised that H&F CCG Governing Body had expressed an interest in understanding referral pathways into the PH commissioned services better. • **End of Life Care JSNA** The data analysis has been shared with the End of Life Care Steering Group for comments. Interviews are currently taking place with stakeholders such as clinical leads and providers of End of Life Care services. • **Housing: health and disability related housing needs** This is finally underway after a prolonged scoping stage. The Task & Finish Group is being put together. Lead is Selina Douglas (ASC). • **Evidence Hub** SL is looking into back fill for TJ's position so he can focus on building the Evidence Hub. A prototype will be delivered on the JSNA portal including a supplement to the Childhood Obesity JSNA, and the JSNA Highlight Reports for each borough. • **Westminster Needs Modelling project** This project aims to develop a range of projections of need of the population in Westminster over the medium and long term. The projections will be informed by data relating to the demographic profile and disease profile of	PH childhood obesity programme manager to be advised

Westminster, including changes caused by long-term housing, regeneration and infrastructure plans. The final product is due to be presented to the Health and Wellbeing Board in March 2016. This is being led by SL, AR and MI. **Risks and issues** • Capacity of public health intelligence team • Governance of processes across the 3 boroughs	
4. Engagement and alignment with Health and Wellbeing Boards/CCGs Discussion around the communication of knowledge and the findings of JSNAs that have been produced, and whether they are actually reaching the right people and informing commissioning decisions. MJ commented that CCG priorities are shaped by the 5 Year Forward View, which could be included in prioritising and informing future JSNAs. This group has been given delegated authority to make decisions on behalf of the H&WBB. As the JSNA Steering Group is a sub-committee of the Health and Wellbeing Board, they should be regularly reviewed at the HWB. Additionally, minutes need to reflect and escalate issues up to the HWBs. SL advised that minutes will now routinely be sent to HWBB chairs. CCGs to present at the next JSNA Steering Group meeting and discuss the commissioning process and what are the key stumbling blocks that are faced at the moment. This will enable greater understanding about the systems and processes that take place within the CCG, therefore council teams will have a better understanding. It was agreed that the decision to rotate the chair between CCG and council helps to share ownership, so DV will continue for the time being.	DV / MJ to organise JN to add to the next agenda.
5. JSNA Impact and Review (2013/14 programme – for information) ASp raised the importance of monitoring the impact of JSNAs and commissioning / strategy decisions and them being reported on a regular basis. SL advised that the HWBB Chairs were keen to understand this and that a summary was being prepared. However, the review of the whole commissioning cycle is outside the capacity of the Public Health team so other options would need to be considered. On this note, MJ remarked it was unclear how the TB JSNA had been taken forward in terms of commissioning services. Lesson learnt process to be reviewed for one of the areas within the impact paper.	JN - Invite a past project lead to discuss lessons learned at next meeting JN to put MJ in contact with JSNA writer

6. AOB Date of next meeting Public Health and CCGs Memorandum of Understanding – Samar and Matthew Bazeley are discussing this with SL. Angelica Silversides sent her apologies though registered her interest in contributing to the housing project. Public health / Local Authority colleagues are invited to hot desk at the CCG offices when coming for meetings, SL advised that the MoU discussions will help with this arrangement, colleagues are invited to contact DV for this to be arranged on a regular basis. **Date of next meeting will be Wednesday 30th September at 2pm at 15 Marylebone Road.**	Copy of minutes to Samar DV to arrange for seating for the PH team to work at Marylebone Road on the date of the next meeting or an ad hoc basis. DV to continue chairmanship

Westminster Health & Wellbeing Board
Work Programme
2015 / 2016

KEY
FOR DECISION
FOR DISCUSSION
FOR INFORMATION
PLANNING

Agenda Item	Summary	Lead	Item
Meeting Date 19th November 2015: SYSTEM IMPROVEMENT			
MENTAL HEALTH	Case for change - NWL Mental Health and Wellbeing Strategic Plan (If ready) Update on the developing vision for Children and Young People's Mental Health and Wellbeing	NWL CCGs	For discussion
BETTER CARE FUND 2016/17	Discussion around developing a local plan for the Better Care Fund 2016/17	Exec Director of FCS	For discussion
SAFEGUARDING	System change required as a result of the LSCB Annual Report and the ASB Annual Report	Chairs of Safeguarding Boards	For discussion
WHOLE SYSTEMS AND BETTER CARE FUND PERFORMANCE	First report on metrics and performance data relating to delivery of the Better Care Fund Plan and Whole Systems Integration	Exec Director of ASC CCGs	For discussion
WORKING IN PARTNERSHIP ACROSS SUB-REGIONAL LEVEL	Discussion to identify how the Health and Wellbeing Board can take responsibility for developing sub-regional partnerships	Chairman	For discussion
TRANSFORMATION INCLUDING WHOLE SYSTEMS INTEGRATED CARE	TBC	CLCCG TBC	For discussion
BETTER CARE FUND	Update on implementation Better Care Fund	Exec Director of ASC	For information
PRIMARY CARE CO-COMMISSIONING	Update on development of Primary Care Co-Commissioning	Chairs of CCGs	For information
PRIMARY CARE PROJECT	Update on the Westminster HWB Primary Care Modelling Project	TBC	For information

Meeting Date: 21st January 2016: MISCELLANEOUS			
HEALTH AND WELLBEING STRATEGY	Discussion on the refreshed Westminster Joint Health and Wellbeing Strategy following engagement with CCG/LA and others	Chairman of the HWB	For decision
HEALTH AND WELLBEING HUBS	Discussion on the Outline Business Case for the development of Health and Wellbeing Hubs in Westminster	Chairman of the Health and Wellbeing Board	For discussion
CHILD POVERTY	Discussion on progress being made to reduce child poverty in Westminster	Exec Director of FCS Housing	For discussion
AVAILABLE SLOT			
AVAILABLE SLOT			
BETTER CARE FUND	Update on implementation Better Care Fund	Exec Director of ASC	For information
PRIMARY CARE CO-COMMISSIONING	Update on development of Primary Care Co-Commissioning	Chairs of CCGs	For information
Meeting Date: 17th March 2016: END OF YEAR STRATEGIC PLANNING MEETING			
STRATEGIC PLANNING	Review delivery and plan for the year ahead	Exec Director of ASC	Planning
PRIMARY CARE PROJECT	Presentation on the findings of the Westminster Health and Wellbeing Board Primary Care Project	TBC	For discussion
BETTER CARE FUND	Update on delivery of the Better Care Fund outcomes in 2015/16 and sign-off of Better Care Fund plan for 2016/17	Exec Director of ASC	For decision
AVAILABLE SLOT			
AVAILABLE SLOT			
AVAILABLE SLOT			
BETTER CARE FUND	Update on implementation Better Care Fund	Exec Director of ASC	For information
PRIMARY CARE CO-COMMISSIONING	Update on development of Primary Care Co-Commissioning	Chairs of CCGs	For information