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City of Westminster

Committee Agenda

Title:	**Health & Wellbeing Board**
Meeting Date:	**Thursday 2nd February, 2017**
Time:	**4.00 pm**
Venue:	**Rooms 3 & 4 - 17th Floor, Westminster City Hall, 64 Victoria Street, London, SW1E 6 QP**

Members:

Councillor Heather Acton (Chairman)	Cabinet Member for Adult Social Services and Public Health
Dr Neville Purssell	Central London Clinical Commissioning Group
Councillor Richard Holloway	Cabinet Member for Children, Families and Young People
Councillor Barrie Taylor	Minority Group
Eva Hrobonova	Tri-borough Public Health
Liz Bruce	Tri-borough Adult Social Care
Melissa Caslake	Tri-borough Children's Services
Barbara Brownlee	Housing and Regeneration
Dr Philip Mackney	West London Clinical Commissioning Group
Janice Horsman	Healthwatch Westminster
Sarah Mitchell	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 6.00pm. 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.

Tel: 7641 8470; Email: thowes@westminster.gov.uk
Corporate Website: www.westminster.gov.uk

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

AGENDA

PART 1 (IN PUBLIC)

1. MEMBERSHIP

To report any changes to the Membership of the meeting.

2. DECLARATIONS OF INTEREST

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

3. MINUTES AND ACTIONS ARISING **(Pages 1 - 24)**

a) To agree the Minutes of the meeting held on 17 November 2016.

b) To agree the Minutes of the extraordinary meeting held on 13 December 2016.

c) To note progress in actions arising.

4. HEALTH AND WELLBEING STRATEGY FOR WESTMINSTER 2017 - 2022 IMPLEMENTATION **(Pages 25 - 34)**

To consider an update on the implementation of the Health and Wellbeing Strategy for Westminster 2017 – 2022.

5. PRIMARY CARE CO-COMMISSIONING UPDATE **(Pages 35 - 54)**

To consider an update on primary care co-commissioning.

6. FAMILY HUBS - COMMISSIONING INTENTIONS FOR CHILDREN AGED 0-5 **(Pages 55 - 60)**

To consider a report on the Family Hubs commissioning intentions for children aged 0-5.

7. PHARMACEUTICAL NEEDS ASSESSMENT - INTRODUCTION **(Pages 61 - 96)**

To consider a report on the Pharmaceutical Needs Assessment.

8. JOINT STRATEGIC NEEDS ASSESSMENT UPDATE: YOUNG ADULTS, ONLINE JOINT STRATEGIC NEEDS ASSESSMENT HIGHLIGHTS AND PROGRAMME FORWARD PLAN **(Pages 97 - 190)**

To consider an update on the Joint Strategic Needs Assessment.

9. CONTRIBUTING TO HEALTH AND WELLBEING THROUGH INVESTMENT IN HOUSING **(Pages 191 - 212)**

To consider a report on contributing to health and wellbeing through investment in housing.

10. WORK PROGRAMME **(Pages 213 - 214)**

To consider the Work Programme for 2017.

11. MINUTES OF THE LAST JOINT STRATEGIC NEEDS ASSESSMENT STEERING GROUP MEETING HELD ON 15 DECEMBER 2016 **(Pages 215 - 218)**

To note the Minutes of the last Joint Strategic Needs Assessment Steering Group meeting held on 15 December 2016.

12. ANY OTHER BUSINESS

Charlie Parker
Chief Executive
26 January 2017

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CITY OF WESTMINSTER

MINUTES

Health & Wellbeing Board

MINUTES OF PROCEEDINGS

Minutes of a meeting of the **Health & Wellbeing Board** held on **Thursday 17th November, 2016**, Rooms 3 and 4, 17th Floor, City Hall, 64 Victoria Street, London, SW1E 6QP.

Members Present:
Chairman: Councillor Rachael Robathan, Cabinet Member for Adults and Public Health
Clinical Representative from the Central London Clinical Commissioning Group:
Dr Neville Purssell
Cabinet Member for Children and Young People: Councillor Karen Scarborough (acting as Deputy)
Minority Group Representative: Councillor Barbara Grahame (acting as Deputy)
Deputy Director of Public Health: Eva Hrobonova
Tri-Borough Director of Adult Services: Sarah McBride (acting as Deputy)
Tri-Borough Children's Services: Jayne Vertkin (acting as Deputy)
Director of Housing and Regeneration: Barbara Brownlee
Clinical Representative from West London Clinical Commissioning Group:
Dr Philip Mackney
Representative of Healthwatch Westminster: Carena Rogers (acting as Deputy)
Chair of Westminster Community Network: Sarah Mitchell

1 MEMBERSHIP

1.1 An apology for absence was received from David Finch (NHS England).

1.2 Apologies for absence were also received from Councillor Danny Chalkley (Cabinet Member for Children and Young People), Councillor Barrie Taylor (Minority Group Representative), Liz Bruce (Tri-borough Director of Adult Social Care), Melissa Caslake (Tri-borough Children's Services) and Janice Horsman (Healthwatch Westminster). Councillor Karen Scarborough (Deputy Cabinet Member for Children and Young People), Councillor Barbara Grahame (Minority Group Representative), Sarah McBride (Tri-Borough Director for Whole Systems Integration Health and Care), Jayne Vertkin (Head of Early Years Help) and Carena Rogers (Healthwatch Westminster) attended as their respective Deputies.

1.3 Apologies for absence were also received from Jules Martin (Managing Director, NHS Central London Clinical Commissioning Group) and Louise

Proctor (Managing Director, NHS West London Clinical Commissioning Group). Chris Neill (Interim Deputy Managing Director, NHS Central London Clinical Commissioning Group) and Kerry Doyle (Head of Corporate Services, NHS West London Clinical Commissioning Group) attended on their behalf.

2 DECLARATIONS OF INTEREST

2.1 There were no declarations of interest.

3 MINUTES AND ACTIONS ARISING

3.1 **RESOLVED:**

1. That the minutes of the meeting held on 15th September 2016 be signed by the Chairman as a correct record of proceedings, subject to the following sentence to be added to the end of paragraph 5.3, page 5:

   Councillor Karen Scarborough (Deputy Cabinet Member for Children and Young People) requested whether a GP could be based at Family Hubs. Dr Neville Purssell (NHS Central London Clinical Commissioning Group) indicated that this may be feasible.

2. That progress in implementing actions and recommendations agreed by the Westminster Health and Wellbeing Board be noted.

4 UPDATE ON THE NORTH WEST LONDON SUSTAINABILITY TRANSFORMATION PLAN AND WESTMINSTER'S JOINT HEALTH AND WELLBEING STRATEGY

4.1 The Chairman introduced the item and advised that sign-off of the North West London Sustainability Transformation Plan (STP) had been put back until the end of December. There was still considerable work to be undertaken until this point and the Council was taking leadership of the finance and property workstreams.

4.2 Chris Neill (Interim Deputy Managing Director, NHS Central London Clinical Commissioning Group) then provided an update on progress with the STP and advised that the draft STP had been published online on 21st October. He advised that the areas of work the STP was focusing on included governance, resources and reporting, finance, contracting processes and system leadership, with a whole systems approach being taken. The operational plan was due to be completed by 23rd November and contract processes by 23rd December.

4.3 Meenara Islam (Principal Policy Officer) introduced the update on the Joint Health and Wellbeing Strategy and handed over to Emma Playford (Engagement and Corporate Affairs Lead, NHS Central London Clinical Commissioning Group) who gave a presentation on progress on the strategy. Emma Playford informed Members that there had been 76 responses to the online consultation on the strategy, with around 83% from individuals and 17% from organisations. There had also been five formal submissions to the

joint health and wellbeing strategy dedicated email address, 23 written submissions to the Open Forum event and feedback received from the three events organised with stakeholders. Meenara Islam advised that the four headline priorities of the strategy were supported by most of the respondents. Respondents wished to see partners promote existing services already available to improve health and the majority were supportive of partnership working across housing, leisure and wellbeing, transport and planning and public health to realise further health benefits. Respondents also welcomed and supported a focus on ensuring people have regular opportunities to be active and on person-centred care. Emma Playford then referred to the changes to the strategy since taking on board feedback from the consultation as set out in the Appendix 1 of the report.

4.4 Phoebe Morris-Jones (Policy Officer) then advised Members that the next steps included any further amendments in response to the Board's and the NHS Central London and NHS West London Clinical Commissioning Groups' (CCG) respective Governing Bodies. The strategy would then be put before the Council's Cabinet and the NHS Central London and NHS West London CCGs' Leadership Executive Committee and Operations Group respectively, with a view to launching the strategy on 19th December. From January 2017, an implementation plan and performance monitoring mechanism would be developed by the Council, NHS Central London and NHS West London CCGs, the voluntary and community sector and Healthwatch to align with the STP's implementation plan and would be brought to the Board at the 2nd February 2017 meeting.

4.5 The Chairman added that there was also a strong desire to report back to communities on how the strategy was progressing in meeting its' objectives and this would be undertaken on an annual basis, as well as being reported back to the Adults, Health and Public Protection Policy and Scrutiny Committee. Engagement with communities had been encouraging to date and it was important to keep this dialogue going.

4.6 During Members' discussion it was commented that there had been some confusion at a consultation event at City Hall as to whether the STP as well as the strategy was being consulted on, and some people had felt that they had not had sufficient opportunity to comment on the STP. A Member stated that the strategy played a significant role in into informing the STP. Eva Hrobonova (Tri-borough Public Health) advised that the local Public Health Team was doing some work in relation to the costs associated with obesity, although it was difficult to prove that measures taken to tackle this gave a return of investment. Sarah Mitchell (Westminster Community Network) felt that there had been good engagement with the voluntary sector on the strategy. She stated that the voluntary sector played an important role in interpreting health sector language to the public and voluntary organisations could play a larger role in helping the CCGs on this.

4.7 In reply to the issues raised, Chris Neill stated that he would feedback to the CCGs comments in relation to consultation on the STP and efforts would be made to ensure that the voice of groups such as special educational needs and those with disabilities were heard. Kerry Doyle (Head of Corporate

Services, NHS West London Clinical Commissioning Group) added that developing the STP was an on-going process and there were still opportunities to provide feedback. Meenara Islam also confirmed that comments would be taken on board in respect of the strategy.

4.8 The Chairman acknowledged that consulting on both the strategy and the STP simultaneously may have been confusing for some, however efforts had been made to explain the connection. She stated that both the strategy and the STP were living plans and the comments and concerns raised had been acknowledged and there was huge determination to engage as widely as possible. The Chairman thanked all involved in the huge effort they had made in developing the strategy and the STP.

5 LOCAL SAFEGUARDING CHILDREN BOARD DRAFT ANNUAL REPORT 2015-16

5.1 Jean Daintith (Independent Chair of the Local Safeguarding Children Board) presented the report and stated that this was the fifth annual report that the Local Safeguarding Children Board (LSBC) had produced. An Ofsted inspection of all three of the tri-boroughs had taken place during 2015-16 and there had also been five serious case reviews over the same period. Jean Daintith advised that the Government was consulting on changes to LSBCs that were due to take place. This included Children's Services taking an enhanced role in safeguarding children. The draft annual report was due to go to the Children, Sports and Leisure Policy and Scrutiny Committee and there were still some changes to be made to it. Each member of LSBC had the opportunity to contribute to the report and to provide updates in key areas and it was noted that there was a health representative on the LSBC.

5.2 Jean Dainitith advised that the tri-boroughs were considering alternative arrangements for Children's Services which were going through a transitional phase and it may be 18 months before everything was finalised. The LSBC had a number of sub-groups which aimed to help frontline staff and the Health and Wellbeing Board could also play a role in measuring impact on frontline services.

5.3 During Members' discussions, the Chairman emphasised the importance of ensuring that the Board did not repeat the discussions to be heard at the Children, Sports and Leisure Policy and Scrutiny Committee and she sought views as to what the Board should focus on. Another Member stressed the importance of data sharing and asked what steps were being taken to promote this. Barbara Brownlee (Director of Housing and Regeneration) advised that Housing were working ever closer with Children's Services, with some Housing staff based at Children's Hubs and she added that having a GP located at these hubs would also be beneficial. Housing was also working closely with health services and affordable housing providers who housed a significant proportion of vulnerable people. A Member asked why there had been a reduction in the number of children in care. In respect of young carers, it was commented that there had been recent changes to the way they were supported and concerns had been expressed about how this area would be monitored and the number it may impact upon.

5.4 In reply to the issues raised, Jean Daintith emphasised the role of the STP in ensuring there was appropriate safeguarding of children and remarked that for instance, there were very few children who transferred from Child and Adolescent Mental Health Services (CAMHS) to adult mental health services and this was an area the Board could focus on. Other areas including the mental wellbeing of children and their relationships with their parents and the impact of events such as moving home and Children's Services were working closely with Housing on such matters. The overall health of children could also be looked at and the effectiveness of services such as the school nurse service, transition to adult services and services tackling female genital mutilation.

5.5 Jean Daintith advised that each CCG had a dedicated nurse who would address gaps in service identified by the LSBC. In respect of a drop in children in care, she informed Members that this was also happening elsewhere in the country and the reduction may be due to the preventative work undertaken following the earlier spike in children coming into care following the Baby P case. In addition, some children who had been taken into care following the Baby P case had since become adults and had left Children's Services. Jean Daintith acknowledged that there had not been a huge focus in respect of young carers and she would raise this as an issue to be addressed, although there was already a LSBC sub group that considered such matters. Another area that needed greater focus was with regard to children with disabilities and Jean Daintith added that there could be more communication generally on measures taken to safeguard children.

5.6 Chris Neill stated that data sharing was a very high priority for the CCGs and a Care Information Exchange platform was being developed. The STP also sought to make full use of digital applications and GPs were signing up to information sharing agreements. Dr Neville Purssell (NHS Central London Clinical Commissioning Group) added that better communication between partner organisations was vital, as well as staff being appropriately trained and every effort should be made to ensure that families did not 'slip under the net.'

5.7 Councillor Karen Scarborough (Deputy Cabinet Member for Children and Young People) advised that she would seek information on what work was being undertaken to support young carers in Westminster. The Chairman stated that it was important to reinforce that children's safeguarding was the role of all partner organisations and services and not just Children's Services. It was also essential that people knew who to contact if they thought that a child may be in danger.

6 SAFEGUARDING ADULTS EXECUTIVE BOARD ANNUAL REPORT 2015-16

6.1 Helen Banham (Strategic Lead in Professional Standards and Safeguarding) presented the report and gave an apology for absence on behalf of Mike Howard (Independent Chair of the Safeguarding Adults Executive Board). Helen Banham advised that this was the third annual report that the

Safeguarding Adults Executive Board (SAEB) had produced, and the first since Schedule 2 of the Care Act 2014 had been introduced and the report sought to focus what needed to be in place under Schedule 2. Members heard that the Chairman of SAEB welcomed a broad approach in involving a number of organisations and the safeguarding of adults was the responsibility of a wide range of partner organisations. The sub groups of SAEB were all chaired by people outside of Adult Social Care and this helped to engage a wider audience. The SAEB had identified a number of issues to be addressed and consulted with the public on what safeguarding is. There were a number of issues identified that had led to abuse and this helped inform the creation of preventative measures.

6.2 Helen Banham referred to a serious case review highlighted in the report concerning the death of a person living in a residential care home that involved another resident who had severe dementia. A number of lessons had been learnt from this incident and there had been good engagement and joined up working with Housing, the CCGs, the Police, the Coroner and Adult Social Care and a number of changes had since been made as a result of this incident. Helen Banham added that the voluntary sector had made a valuable contribution to safeguarding adults.

6.3 During Members' discussion, Barbara Brownlee emphasised the strong link between Housing and Adult Social Care in respect of adults safeguarding, including provision of new housing and refurbishing existing housing appropriately as a preventative measure. A Member sought further information on work being undertaken in respect of Deprivation of Liberty Safeguard (DoLS) assessments. Sarah McBride (Tri-borough Adult Social Care) stated that new models of care were being developed and would be influenced by changes to primary care and GPs were also involved in serious case reviews. She asked how information learned from the serious case reviews was fed back to the SAEB. Sarah McBride noted that 60% of incidents of abuse reported to have occurred in victim's homes was comparatively high, with a lower number in care homes, whilst financial abuse was also comparatively high and she sought a further explanation of this.

6.4 The Chairman advised that she had met with the Chief Executive of CityWest Homes and it had been agreed that focus be given to providing housing that was more appropriate for those that were vulnerable. She also informed the Board that a workshop was also to take place involving housing and health colleagues and Members were invited to attend to provide their feedback and to discuss the kind of accommodation specification that could make a difference.

6.5 Chris Neill asked if there were any other priorities mapped out for the future, including joint packages involving health, housing and social care and that such arrangements can be problematic to design.

6.5 In reply to issues raised by Members, Helen Banham stated that the serious case review she had referred to had meant that the adults concerned were subjected to a 'pinball' like experience with reactive pathways to the problems experienced and the lessons learnt included creating proactive pathways. She

advised that Adult Social Care processed DoL applications, however a person's preference as to where they wished to live would be prioritised. Adult Social Care was also responsible for following through on data obtained as a result of serious case reviews and the Board would have an oversight of activities. An assessment of where adults had been abused would be undertaken and Members noted that the proportion of adults remaining in their own homes was increasing. Focus was also being given on tackling financial abuse, including scamming. Helen Banham added that greater effort was also being made to improve the proportion of cases being concluded in a timely manner.

6.6 The Chairman concluded discussions on this item by welcoming a focus on recruiting more care workers in order to help address adults' safeguarding needs.

7 OPTIMISING OLDER PEOPLE HUBS

7.1 The Chairman introduced the item and advised that the Health and Wellbeing Hubs Programme sought to re-design services to support the preventative agenda. The programme included three workstreams, one of which was the Older People Hubs programme.

7.2 Sarah McBride (Tri-Borough Director for Whole Systems Integration Health and Care) presented the report to update Members on the Older People Hubs programme in light of changes taking place as a result of the North West London STP and increased partnership working. She advised that a joint strategic review of health and adult social care preventative services for older people was nearing completion which would inform the approach for new contracts being in place from 1 August 2017. Members then received a presentation on the Older People Hubs programme and Sarah McBride advised that the objectives of this work stream included identifying opportunities to reduce duplication of services, increasing integration with partners and making best use of health and wellbeing hubs for older people. A multi-agency project team was also to be established to shape and agree the future service model for the Older People's preventative programme.

7.3 During the Board's discussions, the Chairman stressed the importance of this piece of work and taking a joined-up approach with other services and organisations and of the need to manage the estates more effectively and she welcomed any further feedback. The desirability of having GPs present at the Older People Hubs and involving the voluntary sector more was also raised by Members.

7.4 Chris Neill stated that there was a need to make local links with models of service and commissioning pathways. Some work could be focused on local pressures, such as homelessness, rough sleeping and drug taking.

7.5 Barbara Brownlee advised that a new pathway was being developed in respect of housing and rough sleepers and this was a big area of work. However, helping those who were not Westminster residents was difficult and

usually the only services available to such category of rough sleepers were the Accident and Emergency units in hospitals.

7.6 The Chairman stated that the Newman Street Pilot had achieved early successes in helping young people by providing accommodation and helping their health needs, with 100% of these residents now registered with GPs. She concurred on the need for joint pathways working with partner organisations. The Chairman added that the purpose of the hubs was not necessarily to have all services based in one building, but to ensure that services were linked up more effectively and that the estates were used more effectively. She suggested that birth registrations could also be undertaken at Children and Family Hubs.

8 DEMENTIA JOINT STRATEGIC NEEDS ASSESSMENT PROGRESS REPORT

8.1 Ben Gladstone (Head of Complex Needs Older People) presented the report and stated that a Joint Health and Social Care Dementia Programme Board (JHSCDPB) had been created to implement the recommendations of the dementia joint strategic needs assessment. He drew Members' attention to the five priorities identified and the progress made against these to date as set out in the report. In respect of the second priority concerning coordinated training and support for people across the dementia pathway, the first wave of internet training was due to be completed by February 2017. In respect of establishing a Joint Dementia Programme Board, Ben Gladstone advised that this would be linked to the work of the Safeguarding Adults Executive Board. The JHSCDPB, which met four times a year, would also continue to work closely with the Safeguarding Adults Executive Board.

8.2 Sarah McBride welcomed the priorities set out in the report and stated that there needed to be a performance management tool in place to monitor progress. She also emphasised the need for the JHSCDPB to align its work with that of the Health and Wellbeing Board's strategy and its delivery plan for dementia, which would include a set of actions to measure. The Board indicated its support for the work of the JHSCDPB.

9 CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH TRANSFORMATION PLAN UPDATE AND NEXT STEPS

9.1 At this point, Councillor Rachael Robathan (Chairman and Cabinet Member for Adults and Public Health) left the meeting and Dr Neville Purssell assumed the role of Chairman.

9.2 Angela Caulder (CAMHS Commissioner) introduced the report and advised that the Transformation Plan had been submitted to NHS England. Achievements to date included the introduction of new services, including co-production work with young people and a Young People's Mental Health Conference had been held on 29th October. She advised that the next steps involved a re-design of the CAMHS service, increasing work in schools and mapping delivery services across the tri-boroughs for those with learning

disabilities, including autism. A Partnership Alliance was also due to be launched on 17th January 2017.

9.3 Jackie Shaw (Central and North West London Service Director of Westminster CAMHS) then provided details on the new community eating and disorder service for young people, advising that it already supported 25 young people and had received positive feedback from both young people and parents.

9.4 A Member commented on the lack of uptake in transition of services from CAMHS to adult mental health services and asked what steps were being taken to address this. Another Member enquired why the number of school aged pupils with Special Educational Needs (SEN) in Westminster was the highest amongst North West London boroughs. Members also noted that the Council was considering withdrawing or re-directing funding in respect of young people's mental health services and further comments were sought on this matter.

9.5 In reply, Angela Caulder advised that there were difficulties in transition of services from CAMHS to adult mental health services nationally, with the issue complicated by the fact that local authorities arrangements varied. In particular, there was a gap in services for young people between 16 to 25 years old with less serious mental health conditions. Angela Caulder stated that this was one of the reasons for running a pilot scheme for high functioning young people with autism in which it was hoped enough evidence could be compiled to re-design services. She acknowledged that the possibility of the Council withdrawing or re-directing funding for young people's mental health services was a concern and alternatives would need to be identified if this happened. Eva Hrobonova (Tri-borough Public Health) added that the Council's financial capacity overall needed to be considered in the context of this issue.

9.6 In noting the financial situation, the Board indicated its support for the work undertaken in transforming mental health services for young people whilst it currently received some funding from the Council.

10 WORK PROGRAMME

10.1 Meenara Islam advised that the next Pharmaceutical Needs Assessment was due to commence shortly and the first report would be presented to the Board at the next meeting on 2 February 2017.

10.2 Chris Neill suggested that an item on regeneration schemes and their impact on adult social care be added to the work programme.

11 ANY OTHER BUSINESS

11.1 There was no other business.

The Meeting ended at 5.59 pm.

CHAIRMAN: _____ **DATE** _____

CITY OF WESTMINSTER

MINUTES

Health & Wellbeing Board

MINUTES OF PROCEEDINGS

Minutes of an extraordinary meeting of the **Health & Wellbeing Board** held on **Tuesday 13th December, 2016**, Lord Mayor's Parlour, 18th Floor, City Hall, 64 Victoria Street, London SW1E 6QP.

Members Present:
Chairman: Councillor Rachael Robathan, Cabinet Member for Adults and Public Health
Clinical Representative from the Central London Clinical Commissioning Group: Dr Neville Purssell
Cabinet Member for Children and Young People: Councillor Karen Scarborough (acting as Deputy)
Minority Group Representative: Councillor Guthrie McKie (acting as Deputy)
Tri-Borough Director of Adult Services: Sarah McBride (acting as Deputy)
Director of Housing and Regeneration: Barbara Brownlee
Clinical Representative from West London Clinical Commissioning Group: Dr Philip Mackney
Representative of Healthwatch Westminster: Janice Horsman
Chair of Westminster Community Network: Sarah Mitchell

1 MEMBERSHIP

1.1 Apologies for absence were received from Eva Hrobonova (Deputy Director of Public Health), Melissa Caslake (Director of Family Services) and Dr David Finch (NHS England).

1.2 Apologies for absence were also received from Councillor Danny Chalkley (Cabinet Member for Children and Young People), Councillor Barrie Taylor (Minority Group Representative) and Liz Bruce (Tri-borough Director of Adult Social Care). Councillor Karen Scarborough (Deputy Cabinet Member for Children and Young People), Councillor Guthrie McKie (Minority Group Representative) and Sarah McBride (Tri-borough Director for Whole Systems Integration Health and Care) attended as their respective Deputies.

1.3 Apologies for absence were also received from Jules Martin (Managing Director, NHS Central London Clinical Commissioning Group) and Louise Proctor (Managing Director, NHS West London Clinical Commissioning Group). Chris Neill (Interim Deputy Managing Director, NHS Central London

Clinical Commissioning Group) and Mona Hayat (Associate Director of Transformation, NHS West London Clinical Commissioning Group) attended on their behalf.

2 DECLARATIONS OF INTEREST

2.1 There were no declarations of interest.

3 NHS CENTRAL LONDON AND NHS WEST LONDON CLINICAL COMMISSIONING GROUPS' COMMISSIONING PLANS

3.1 The Chairman introduced the item and stated that the purpose of the meeting was for the NHS Central London and NHS West London Clinical Commissioning Groups (CCGs) to inform the Board of their commissioning plans for Westminster in respect of delivering the North West London Sustainability Transformation Plan (STP).

3.2 Chris Neill (Interim Deputy Managing Director, NHS Central London CCG) then presented the report. He advised that because of the introduction of the STP, contracts for service delivery needed to be agreed by 23 December. The contracts would be of two years' duration and the report sought to explain how the STP was aligned to the Joint Health and Wellbeing Strategy (JHWBS) and how the STP would be delivered. Chris Neill advised that both NHS Central London and West London CCGs would then put together business plans in January and February 2017 to provide further details on implementing the STP. Members noted the delivery areas setting out the STP's priorities, the Board's priorities and the local priorities identified within Westminster as set out in the report.

3.3 During Members' discussion, the Chairman emphasised that it was important to explain to Westminster residents what changes would be made to services during implementation of the STP, including changes to financial allocations for specific services. In addition, the STP should demonstrate how the commissioning plans aligned to the JHWBS. Members concurred that more details on the financial spend for services in Westminster from NHS Central London and NHS West London CCGs would be desirable in order to demonstrate how the commissioning plans aligned with delivering the STP locally. It was noted that the CCGs would be able to provide details of the value of the contracts to be agreed.

3.4 In reply to issues raised by Members, Chris Neill advised that the work on financial planning across North West London was not yet broken down into individual boroughs, however Westminster was taking the lead on the finance stream. He acknowledged that the way the information was presented within the individual CCGs in the North West London STP had presented varied and NHS Central London CCG had focused on explaining how the STP would be delivered.

3.5 Dr Neville Purssell (NHS Central London Clinical Commissioning Group) added that the STP was designed for North West London overall and in the case of Westminster, a lot of work was based around the JHWBS refresh and

the STP's delivery areas were in congruence with the strategy. He stated that the STP was addressing the areas identified in the JHWBS and there was more work to be done in providing information such as financial details.

3.6 Members acknowledged that there had been effective joint working between the Council, the CCGs and other partner organisations in putting together the JHWBS. In order for the Board to support NHS Central London and NHS West London CCGs' commissioning plans, Members requested that the CCGs provide details of the value of the current contracts, including the spend from the last year, and how the value of these contracts would change as the STP was being implemented. The Board also requested that more information be provided in respect of the delivery plans, including providing information to residents on the changes they will see to services. Members concurred that an explanation of some of the more complicated terms in order that residents could understand and the language used would be beneficial in making the document accessible to residents. The Chairman welcomed any further comments from Members on the commissioning plans to be fed back to NHS Central London and NHS West London CCGs by no later than 20th December.

The Meeting ended at 11.54 am.

CHAIRMAN: _____ **DATE** _____

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WESTMINSTER HEALTH & WELLBEING BOARD
Actions Arising

Extraordinary Meeting on Tuesday 13th December 2016

Action	Lead Member(s) And Officer(s)	Comments
NHS Central London and NHS West London Clinical Commissioning Groups' Commissioning Plans		
Members to provide any further comments on the Commissioning Plans by 20 December.	All Board Members	To be provided by 20 December.

Meeting on Thursday 17th November 2016

Action	Lead Member(s) And Officer(s)	Comments
Update on the North West London Sustainability Transformation Plan and Westminster's Joint Health and Wellbeing Strategy		
Board's comments in respect of the North West London Sustainability Transformation Plan to be fed back to the NHS Central and NHS North West London Clinical Commissioning Groups.	Chris Neill (NHS Central London Clinical Commissioning Group)	To be considered at the 17 November meeting.
Work Programme		
Board to receive first report on the next Pharmaceutical Needs Assessment at next meeting.	Mike Robinson / Colin Brodie	To be considered at the 2 February 2017 meeting.

Meeting on Thursday 15th September 2016

Action	Lead Member(s) And Officer(s)	Comments
Draft Westminster Health and Wellbeing Strategy Refresh		
Final strategy to be put to the Board at the next meeting.	Meenara Islam	To be considered at the 17 November meeting.
Housing Support and Care Joint Strategic Needs Assessment		
Board to look at the Housing Support and Care Joint Strategic Needs Assessment in more detail and to support the recommendations, subject to any concerns raised by Members in the next two	All Board Members / Anna Waterman	Comments to be made by 29 September.

weeks.		

Meeting on Thursday 14th July 2016

Action	Lead Member(s) And Officer(s)	Comments
Draft Westminster Health and Wellbeing Strategy Refresh		
Meenara Islam to circulate the dates that the consultation events and meetings are taking place to Members.	Meenara Islam	Members to provide comments by 30 June.
Tackling Childhood Obesity Together		
Progress on the programme to be reported back to the Board in a year's time.	Eva Hrobonova	
Health and Wellbeing Hubs		
Details of the children's workstream to be reported to the Board at the next meeting.	Melissa Caslake	To be considered at the 15 September meeting.

Meeting on Thursday 26th May 2016

Action	Lead Member(s) And Officer(s)	Comments
Draft Westminster Health and Wellbeing Strategy Refresh		
Members to provide any further input on the strategy before it goes to consultation at the beginning of July.	All Board Members	Members to provide comments by 30 June.

Meeting on Thursday 17th March 2016

Action	Lead Member(s) And Officer(s)	Comments
Westminster Health and Wellbeing Strategy Refresh Update		
Members requested to attend Health and Wellbeing Board workshop on 5 April.	All Board Members	Workshop to take place on 5 April.
Meenara Islam to circulate details of proposals discussed at an engagement plan meeting between Council and Clinical Commissioning Group colleagues.	Meenara Islam	

NHS Central and NHS West London Clinical Commissioning Group Intentions		
Clinical Commissioning Groups to consider how future reports are to be presented with a view to producing reports more similar in format and more user friendly.	Clinical Commissioning Groups	On-going.

Meeting on Thursday 21st January 2016

Action	Lead Member(s) And Officer(s)	Comments
Commissioning Intentions: (A) NHS Central London Clinical Commissioning Group; (B) NHS West London Clinical Commissioning Group		
Update on the Clinical Commissioning Groups' intentions to be reported at the next Board meeting.	Clinical Commissioning Groups	To be considered at the 17 March 2016 meeting.
Westminster Health and Wellbeing Strategy Refresh		
Draft proposals for the strategy refresh to be considered at the next Board meeting	Adult Social Care, Clinical Commissioning Groups and Policy, Performance and Communication	To be considered at the 17 March 2016 meeting.

Meeting on Thursday 19th November 2015

Action	Lead Member(s) And Officer(s)	Comments
Westminster Health and Wellbeing Hubs Programme Update		
Update on the Programme to be reported at the next Board meeting.	Adult Social Care	To be considered at the 21 January 2016 meeting.
Like Minded – North West London Mental Health and Wellbeing Strategy – Case for Change		
Board to receive report on Future In Mind programme to include details of how it will impact upon Westminster and how the Board can feed into the programme to provide more effective delivery of mental health services.	Children's Services	To be considered at earliest opportunity.
Board to receive report on young people's services, including how they all link together in the context of changes to services.	Children's Services	To be considered at earliest opportunity.

Meeting on Thursday 1st October 2015

Action	Lead Member(s) And Officer(s)	Comments
Central London Clinical Commissioning Group – Business Plan 2016/17		
West London Clinical Commissioning Group to circulate their Business Plan 2016/17 to the Board.	West London Clinical Commissioning Group	
Westminster Health and Wellbeing Hubs Programme Update		
Board to nominate volunteers to be involved in the Programme and to be on the Working Group.	Meenara Islam	
Update on the Programme to be reported at the next Board meeting.	Adult Social Care	To be considered at the 19 November 2015 meeting.
Dementia Joint Strategic Needs Assessment – Commissioning Intentions and Sign Off		
Board to receive and update at the first Board meeting in 2016.	Public Health	To be considered at the 21 January 2016 meeting.

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 an 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	Children's Services	In progress.

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.		
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	Director of Public Health.	Completed.

comments that may be received.		
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 Member(s) And Officer(s)	Comments
Whole Systems		
Business cases for the Whole Systems proposals to be submitted to the Health & Wellbeing Board in the autumn.	Clinical Commissioning Groups.	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	Public Health	Completed

successful health outcomes to be considered as a further JSNA application. *Note: Recommendations to be put forward in next year's programme.*	Services Senior Policy & Strategy Officer.	

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

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City of Westminster

Westminster Health & Wellbeing Board

Date:	2 February 2017
Classification:	General Release
Title:	Health and wellbeing strategy for Westminster 2017-2022 implementation
Report of:	Chairman of the Health and Wellbeing Board
Wards Involved:	All
Policy Context:	Health and Wellbeing
Financial Summary:	N/A
Report Author and Contact Details:	Meenara Islam (mislam@westminster.gov.uk) or 020 7641 8532

1. Executive Summary

1.1 The Health and Wellbeing Board formally adopted the Health and Wellbeing Strategy for Westminster 2017-22 on 17 November 2016. The strategy has also been formally adopted by Westminster City Council's cabinet and both Central and West London CCG governing bodies.

1.2 The Health and Wellbeing Board agreed, in consultation with the chairs of both CLCCG and WLCCG and Westminster Council's Cabinet, that the Health and Wellbeing Strategy would articulate the local priorities for Westminster within the sub-regional priorities of the Sustainability & Transformation Plan (STP) for North West London (as detailed in Appendix B).

1.3 To support the delivery of our Health and Wellbeing Strategy at a city-wide level and the STP at a North West London level, the board agreed in January 2016 to jointly develop an implementation plan which would explain the actions that the council, CCGs and voluntary sector would be taking over the next five years to deliver our shared priorities.

1.4 This paper proposes an approach to develop this plan and sets out the Council's draft plans for 2017/18. Please note that the Council's Budget and Council Tax

Report will be voted on by the Full Council on 1 March and the associated high level strategy and business plans.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board is asked to:

A. Consider how board members and their organisations can contribute to the delivery of the strategy noting the initial mapping exercise; and

B. Comment on and approve proposed governance performance management approach.

3. Background

3.1 The Health and Wellbeing Strategy for Westminster 2017 – 2022 was published on 15 December 2016, following a year-long development process which included extensive data analysis and engagement with residents to determine local needs.

3.2 The strategy commits the Health and Wellbeing Board to driving four priorities, which are closely linked to the 'Delivery Areas' of the North West London Sustainability and Transformation Plan (STP) (see page 5) over the next five years. To keep the delivery of the commitments focused and driven by the needs and experiences of Westminster's people where possible, each priority is underpinned by "I" statement outcomes.

3.3 This paper sets out proposals for the Health and Wellbeing Board to consider on implementation, performance management and invites Board members to contribute to the proposed implementation plan.

4. Developing our joint implementation plan

4.1 Board members and the majority of people who participated in the engagement process for the Health and Wellbeing Strategy in 2016 agreed that the strategy must be underpinned by a delivery plan that:

- Involves Westminster's people and partners in designing and delivering the strategy's commitments and outcomes
- Can evolve over the next five years to respond to emerging challenges and the city's changing context
- Draws on the 'wider determinants' of health and wellbeing – which means that everyone – all council and CCG departments, the voluntary and community sector, businesses and people – has a role in delivering the strategy's ambitions

- Is regularly monitored and progress is reported back to the public and partners regularly.

4.2 Members of the Health and Wellbeing Board and broader partners have a considerable amount of work either underway or planned that will be contributing to the delivery of the strategy and STP priorities. Please see appendix A for examples.

A. How can board members and their organisations contribute to the delivery of the strategy?

Developing our approach to governance and monitoring

4.3 This joint implementation plan will assist the Health and Wellbeing Board to deliver the commitments of the strategy and the STP priorities. An officer level implementation group leading on delivery is proposed. The following are suggested members:

- Officer from Central London CCG
- Officer from West London CCG
- Health and Wellbeing Board manager for Tri-borough
- Officer from Policy and Strategy, Westminster City Council
- Officer from Public Health Intelligence
- Representative from Healthwatch
- Representative from VCS

4.4 This group will provide regular informal feedback to senior responsible officers – Executive Director of Adult Social Care, and the Managing Directors of Central and West London CCGs – and the Chair and Vice Chair of the Board. Officers will bring thematic updates to Board meetings focusing on one of the four priorities. Information on the progress of actions, issues and future plans on the selected theme will be provided.

4.5 The implementation group will meet once a month, starting in February and will be responsible for:

- Regularly gathering information from departments and partner organisations against the commitments
- Using this information to provide updates to the Chair and Vice Chair, the Health and Wellbeing Board and senior officers with a view to report progress and bring to the attention risks and issues that require the Board's help with resolving

- Involving the public and wider partners to design and deliver ways to deliver commitments in the strategy.

4.6 To measure performance, officers will be taking two approaches:

- To measure progress of **commitments** officers will gather updates directly from service areas and departments using key performance indicators which will be developed during February. The Board will receive updates at every meeting. The Board may wish to consider publishing a progress report on the strategy commitments for the public and partners to view progress and provide an opportunity for them to feedback and make suggestions.

- To measure **outcomes** ("I" statements), the Board may wish to consider commissioning officers to carry out an annual 'temperature check' through a survey and some focus groups to measure progress on outcomes and provide an opportunity for people to influence the delivery of the strategy for the following year. If the Board agrees, officers can undertake a first year temperature check to establish a baseline.

B. Do board members agree with the proposed approach to governance performance management?

5 Timeline for implementation plan

HWB members to email Ezra Wallace (ewallace@westminster.gov.uk) with suggestions for the implementation plan	**By 17 February**
Finalise implementation plan with the information received – including identifying 'gaps' potential projects and work streams, and timing.	**February**
Develop and finalise a common performance framework	**February**
Survey/focus groups on the strategy's "I" statements (outcomes) to establish a baseline to measure progress against annually	**March**
HWB approval and publication of implementation plan	**23 March meeting**
HWB to identify 'gaps' potential work streams/projects	**25 May meeting**

APPENDIX A: INITIAL AREAS OF ACTIVITY IDENTIFIED THROUGH MAPPING

Health & Wellbeing Strategy Priority 1: Improving outcomes for children and young people

(Contributes to the STP priorities Delivery Area 1 - Radically upgrading prevention; and Delivery Area 2 - Eliminating unwarranted variation and improving long-term care management)

- Implementing Future in Mind locally and working with you Youth Council to design local awareness campaigns of services available to children and young people.
  Lead organisations: Westminster City Council , CLCCG and WLCCG Joint Commissioning

- Strengthening and delivering the Tackling Childhood Obesity programme, which will be delivered in partnership between Public Health, Sports and Leisure, and Libraries teams.
  Lead organisations: Westminster City Council

- Supporting, encouraging and rewarding children and young people who volunteer and engage in civic activities through programmes such as Spice Time Credits and Libraries Volunteering Initiative.
  Lead organisation: Westminster City Council

- Implementing Family Hubs for 0-19 year olds, including the co-location of midwives and health visitors into the hubs, enabling all staff to refer families for employability support and launching a new Early help Information Service as a communication tool between all staff as a way of supporting families.
  Lead organisation: Westminster City Council

- Providing access to good quality youth club provision for 300 young people a week on Westminster's residential estates as well as supporting primary schools to offer homework and breakfast clubs.
  Lead organisation: Westminster Community Homes

Health & Wellbeing Strategy Priority 2: Reducing the risk factors for, and improving the management of, long term conditions, such as dementia

(Contributes to the STP Delivery Area 2 - Eliminating unwarranted variation; and improving long-term care management and Delivery Area 3 - Achieving better outcomes and experiences for older people)

- Implementing the 2016 Dementia JSNA recommendations.
  Lead organisation: Westminster City Council

- Supporting the development of the Spice Time Credits Scheme to encourage voluntary activity in local communities.

Lead organisation: Westminster City Council

- Investing in support for carers and self-advocacy services.
  Lead organisation: Westminster City Council

- Implementing the Work and Health programme in Central London in partnership to improve pathways to, uptake of and outcomes from employment support.
  Lead organisation: Westminster City Council

- Designing and delivering a 'Front door' and demand management programme including improving the functionality of the People First website to enable digital self-assessment.
  Lead organisation: Westminster City Council

- Improving the provision of property for older people to assist older people to remain fit and active, living in their own homes for longer.
  Lead organisation: City West Homes

- Tackling poor living conditions and to provide adaptations enable independent living for older or vulnerable adults through Disabled Facility Grants for adaptations as well as using Safe and Secure grants for older people to provide security measures in the home.
  Lead organisation: Westminster City Council

- Investing in extra care schemes in Westminster, including securing 60 residential care units at Chelsea Barracks. Planning is also underway for a modern residential care facility containing 84 units. This facility will include suitable adaptations for people with long term conditions such as dementia. It will also support end of life care for residents which means residents do not have to be transferred to a specialist facility when nearing the end of life.
  Lead organisation: Westminster City Council

Health & Wellbeing Strategy Priority 3: Improving mental health outcomes through prevention and self-management

(Contributes to the STP Delivery Area 4 -Improving outcomes for children and adults with mental health needs)

- Investing in services that prevent/reduce homelessness, including implementing Westminster City Council's forthcoming Rough Sleeping Strategy, which has a priority around addressing mental health needs of people.
  Lead organisation: Westminster City Council

- Locally implementing the Like Minded strategy which aims to transform mental health services.
  Lead organisations: Westminster City Council, CLCCG and WLCCG Joint Commissioning

- Delivering the Work Place Charter to provide mental health training to employees in the workplace.
  Lead organisation: Westminster City Council

- Increasing control through personalisation and continued promotion of recovery approaches, including access to mainstream community services (Implementation of Westminster Day Services Redesign) working with local voluntary, Clinical Commissioning Groups and Secondary Mental Health Care Services to build an integrated pathway.
  Lead organisation: Westminster City Council

- Investing in and designing befriending services for vulnerable people including those with mental health conditions.
  Lead organisation: Westminster City Council

Health & Wellbeing Strategy Priority 4: Creating and leading a sustainable and effective local health and care system for Westminster

(Contributes to the North West London STP including the Finance work stream and all STP Delivery Areas)

- Undertaking financial modelling of system demand, pressures and redesign underway through the NWL STP
  Lead organisation: Westminster City Council and Central and West London CCGs

- Undertaking analysis and modelling of joint commissioning and pooling budget opportunities through the Better Care Fund
  Lead organisation: Westminster City Council and Central and West London CCGs

- Developing our workforce through developing the skills our social care system will need for the future through the North West London STP
  Lead organisation: Westminster City Council and Central and West London CCGs

APPENDIX B: OVERLAPPING PRIORITIES BETWEEN THE HEALTH & WELLBEING (HWB) STRATEGY AND SUSTAINABILITY & TRANSFORMATION PLAN (STP)

HWB PRIORITY 1 – Improving outcomes for children and young people

PRIORITY VISION: All children and young people live healthy active lives and are supported into healthy active adults who contribute to society and share their positive learning and experiences with their families, friends and neighborhoods.

HWB PRIORITY 2 – Reducing the risk factors for, and improving the management of, long term conditions, such as dementia

PRIORITY VISION: People remain healthy, well and independent for as long as possible. The likelihood of developing long term conditions is reduced, through the management of risk factors such as poor diet and insufficient physical activity. People, carers, families, communities and professionals work together to ensure people living with long term conditions (and their families and carers) receive high quality and timely health and care, and other public services to improve their quality of life. When nearing the end of life, people, their families and carers are supported to plan for care which is dignified and honours their personal preferences.

HWB PRIORITY 3: Improving mental health outcomes through prevention and self-management

PRIORITY VISION: People are able to maintain mental good health and wellbeing. Those with short or long term mental health conditions receive timely and effective support to manage and reduce the impact of their condition, and they are treated with dignity and respect.

HWB PRIORITY 4: Creating and leading a sustainable and effective local health and care system for Westminster

PRIORITY VISION: We will be an integrated and collaborative health and care system using our collective resources (such as data, technology, estates and workforce) to deliver person centred information and care in the right place at the right time.

STP DA1 - Radically upgrading prevention

a) Enabling and supporting healthier living for the whole population
b) Keeping people mentally well and avoiding social isolation
c) Helping children get the best start in life

STP DA2 - Eliminating unwarranted variation and improving LTC management

a) Delivering the Strategic Commissioning Framework and FYFV for Primary Care
b) Improve cancer screening to increase early diagnoses
c) Better outcomes and support for people
d) Reducing variation by focusing on Right Care
e) Improve self-management and 'patient activation'

STP DA3 - Achieving better outcomes and experiences for older people

a) Improve market management and take a whole systems approach to commissioning
b) Implement accountable care partnerships
c) Upgrade rapid response and intermediate care services
d) Create an integrated and consistent transfer of care approach
e) Improve care in the last phase of life

STP DA4 -Improving outcomes for children and adults with mental health needs

a) Implement new models of care for people with serious and long-term mental health needs to improve physical and mental health and increase life expectancy
b) Focused interventions for target populations
c) Crisis support services
d) Implementing Future in Mind

STP DA5 - Ensuring we have a safe, high quality sustainable acute services

a) Specialised commissioning to improve pathways from primary care and support consolidation of specialised services
b) Deliver 7 day service standards
c) Reconfigure acute services
d) NW London Productivity Programme

Enablers

a) Estates
b) Digital
c) Workforce

6 Legal Implications

6.3 *NA*

7 Financial Implications

7.3 NA

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

Ezra Wallace

Email: ewallace@westminster.gov.uk

Telephone: 020 7641 3056

APPENDICES:
Draft implementation plan template

BACKGROUND PAPERS:
Health and wellbeing strategy for Westminster 2017-2022 (separate hard copy to be provided to Board)

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City of Westminster

Westminster Health & Wellbeing Board

Date:	2nd February 2017
Classification:	Public
Title:	Delegated Commissioning – General update
Report of:	Central London CCG
Wards Involved:	All
Policy Context:	Central London CCG is currently commissioning primary care medical services jointly with NHS England. Therefore all decisions have to be jointly agreed with NHS England. NHS England has asked CCGs to take on fully delegated commissioning – in other words, to be responsible for most decisions on local primary care from April 2017.
Financial Summary:	An in-depth financial due diligence is currently underway across all North West London CCGs
Report Author and Contact Details:	Samar Pankanti, Holly Manktelow, Chris Neill Primary Care, Central London CCG samar.pankanti@nhs.net

1. Executive Summary

1.1 This report updates the board on Central London CCG's application, engagement, due diligence and council of members voting process on delegated commissioning of primary care services in Westminster. This includes:

- Current position on delegated commissioning process
- CL CCG's engagement so far with its membership and service users.

2. Key Matters for the Board

2.1 The board is asked to:

a) note Central London CCG's current position with regards to moving from Joint Commissioning (Level 2) to Delegated Commissioning (Level 3) of primary medical services in Westminster.

b) note due diligence underway in relation to the identification and management of legal and financial risk which may arise from delegation (see sections 5 and 6)

c) note the timetable and process for the delegation vote within Central London CCG (see paragraphs 4.6 – 4.8)

3. Background

3.1 From 1 April 2017, CL CCG along with seven North West London CCGs is exploring a move to full responsibility for commissioning General Practice services in response to the needs and circumstances of their registered populations. If members vote in favour of delegation in February 2017, CCGs will adopt a common borough based (and where appropriate shared) model of decision making and delivery that will allow for more locally focussed primary care commissioning with the ability to adopt an NW London approach where it:

- Supports delivery of the NW London's Sustainability and Transformation Plans (STP);
- Allows the CCGs to drive efficiency, best value, and consistency in our locally-driven commissioning approach and processes, and in the outcomes derived across the NW London; and
- Secures the most efficient and effective governance processes for primary care commissioning.

In 2016/17, 114 CCGs (out of 209) have delegated arrangements and approximately one third of CCGs have a joint arrangements. In London out of 32 CCGs, 11 are already delegated. A further 11 have regional approval for delegated commissioning. This is referenced by the map on page 3 of the appendix.

3.2 The policy objectives of delegated commissioning are as follows:

- To strengthen local Primary Care through an ability to channel dedicated resources to local needs.
- To bring the expertise of local CCG member practices to addressing the parts of the health service they know best – General Practice.
- To respond more fully to the views and opinions of local patients – whose use of Primary Care makes up 90% of NHS contacts.
- To target increases in primary care allocations, as part of the 'GP Forward View' Plans, informed by local knowledge of our local communities and their needs.

- To enable GPs and other clinical commissioners to take a whole-systems view of local patients' journeys along a care pathway, and give them the resources to effect real change.
- To play a full role in delivering local sustainability and transformation objectives by managing the spectrum of primary, community and hospital budgets.
- To work alongside Local Authority, NHS England and third sector stakeholders to achieve patients' expectations of fully integrated care, between organisations and across boundaries.

3.3 CL CCG along with seven other NW London CCGs submitted an application to NHS England on 05 December, with agreed caveats that include withdrawing the application if each CCG's membership votes against delegated commissioning.

4. Options / Considerations

4.1 In undertaking full delegation of commissioning functions, NHS England will retain liability for the performance of primary medical care commissioning and all statutory requirements of that body in relation to primary care.

4.2 Moving to delegated commissioning arrangements brings both opportunities and risks which our members will be carefully reviewing before they vote on delegation. The presentation attached at Appendix A provides more information on the delegation process, key benefits and key risks.

4.3 The CCG's process to identify and manage any legal and financial risk associated with delegated commissioning is explained in more detail in sections 5 and 6.

Engagement

4.4 A wide range of engagement with GPs and wider professionals, patients and wider stakeholders has taken place across CL CCG, beginning on 28 September 2016 and continuing through to mid-February. The CCG is committed to ensuring that all discussions around delegated commissioning are open, balanced and informed.

4.5 Our engagement has included:

- Regular communications to members and to CCG staff
- Regular updates at membership forums, including the Practice Nurses, GP and locality meetings
- CCG visits to practices to discuss delegated commissioning in the context of practice sustainability and planning – with a focus on estates issues An Open

Forum with our membership to discuss the opportunities and risks around delegated commissioning with key partners (NHS England, London-Wide LMC and our GP Federation).

- Forums in which GP members have been able to hear directly from clinical commissioners and GPs from other areas that have already moved to full delegation
- An open discussion with the CCG's User Panel to discuss what affect this decision would have on patients within Central London.

Governance from here – and the voting process

4.6 The CLCCG membership vote will open at the council of members meeting on 31st January 2017. The process for undertaking this vote is explicitly laid out within the CCG's constitution.

4.7 The vote can be undertaken within the Council of Members meeting, by a show of hands, as long as the meeting is quorate. However, any member may request a polled vote either before or during this meeting. It is likely that a polled vote will be requested. In this case, the CCG will open the vote on the 31st January 2017 and the vote would close on 14th February 2017. The vote would be undertaken online.

4.8 The CCG will be in a position to make a formal announcement on 28 February 2017 regarding the decision taken by our membership.

5. Legal Implications

5.1 The CCG is undertaking legal due diligence to ensure that all potential liabilities are fully understood and managed. This due diligence includes the following areas:

- Obtain a legacy list for the CCG from NHS England outlining any contractual issues and legal risks;
- Practice level information is in place outlining contractual status – ensuring signatures, performance indicators, partnership changes etc., are up to date;
- Ensure that the CCG is aware of any breach notices and what actions are in place to ensure resolution;
- Ensure that the CCG is aware of all Care Quality Commission (CQC) issues, including practice status, agreed action plans, outstanding visits and legal position of those practices currently under special measures; and

- Ensure that a plan is in place for engaging constituent member practices with the delegated process – ensuring the ballot aligns with national and local constitutional requirements.

5.2 To ensure sufficient protection for the CCG from liability, it is expected that a Memorandum of Understanding will be agreed between NHS England and the CCG before delegated commissioning commences which includes:

- Clauses to indemnify the CCG against legacy related issues; and

- Confirmation that NHS England remains both accountable and responsible for counter-fraud (or an explanation if the CCG is to be held responsible for local delivery, as to how this will be resourced and managed between the CCGs' Audit Committee and NHS England's own Audit Committee).

6. Financial Implications

6.1 Full delegation of Primary Care commissioning provides CCGs with greater flexibility over the management of the Primary Care budget previously managed by NHS England. However this flexibility comes with increased responsibility and associated risk.

6.2 Central London CCG's primary care budget is £29m, which is ten per cent of the overall CCG annual budget.

6.3 On the basis of a successful application, from 01 April 2017 CL CCG would:

- Be given full delegated authority for allocated Primary Care budget by NHS England
- Assume financial risks associated with commissioning and managing Primary Care services within allocated budget
- Assume responsibility for monitoring and incentivising performance of General Practice.

6.4 NWL London CCGs have procured RSM to undertake financial due diligence on their behalf to ensure that the financial impacts of delegation, both positive and negative, are fully understood and managed by CCGs. The RSM work will include:

- Assessment of budgetary information from NHS England (last 3 years and any forecast work for 17/18) – RSM have already requested detailed information for all NW London practices;

- Detailed practice ‘issues’ information – NHS England hold logs of any outstanding issues, problems, correspondence with practices and have agreed to share this with RSM;
- Information regarding properties and Primary Care estate issues; and
- GP practice survey - if required, building upon the work already carried out in terms of LMC surveys and property surveys.

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

Samar Pankanti, Central London CCG – samar.pankanti@nhs.net

APPENDICES:

1. Appendix 1: Presentation on the delegation process including the benefits and risks of delegation

North West London Collaboration of Clinical Commissioning Groups

Primary Care Commissioning

Delegation

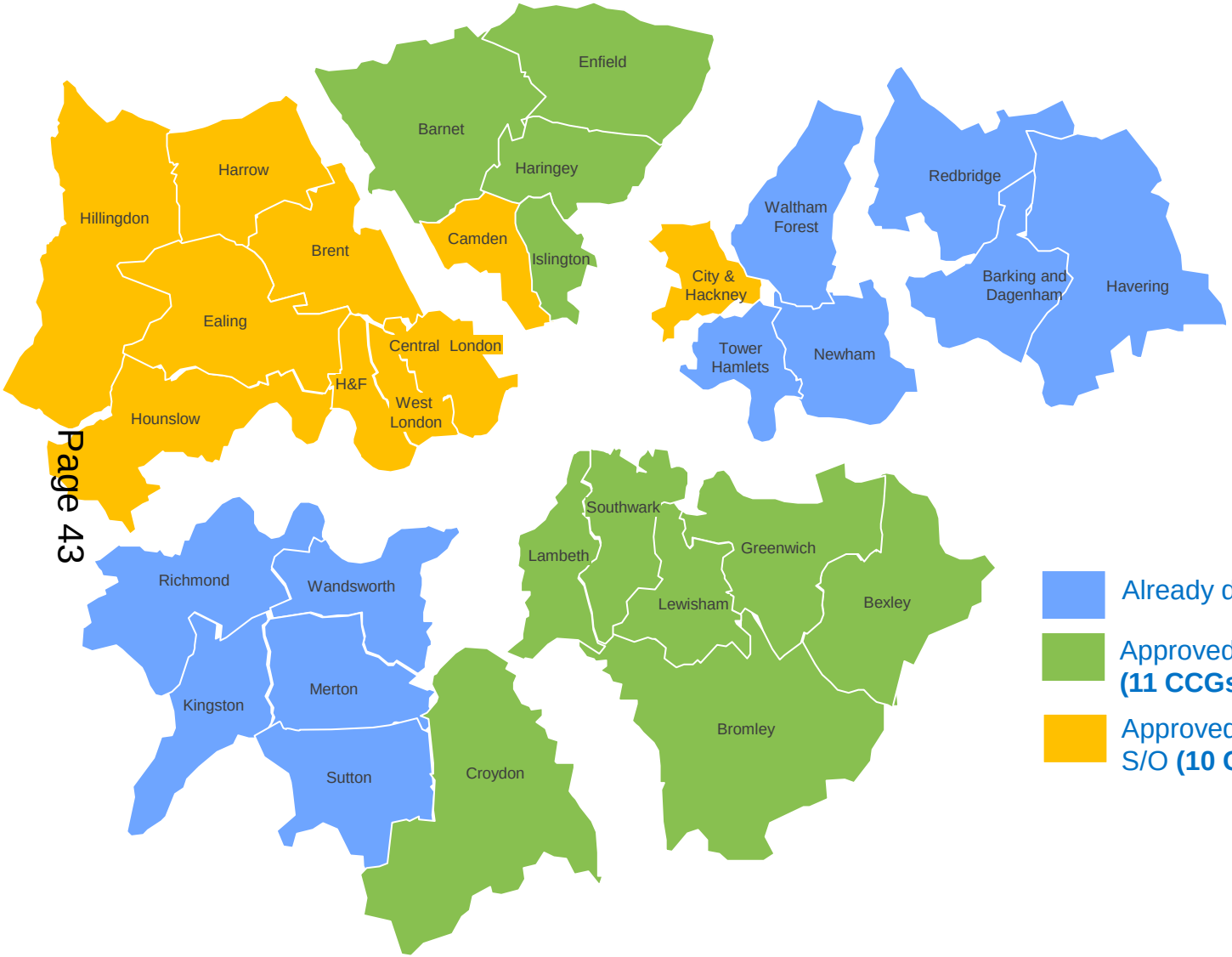
11 January 2017

Where we are now

- CCGs across North West London need to determine whether to move to delegated commissioning
- **The CCG** Governing Body needs to hear **from all Member Practices** before taking a final decision
- NWL CCGs were asked to submit a completed application checklist on the 5th December with the membership vote pending. All voting must be completed and evidence provided by the end of February (28th)

- Nationally, 63 CCGs opted for delegation in April 2015 and a further 52 did so in April 2016. **More than half of all CCGs now hold delegated responsibility and an estimated target of 91% of all CCGs will be fully delegated by April 2017.**

Expected delegation in 17/18 (as at December)



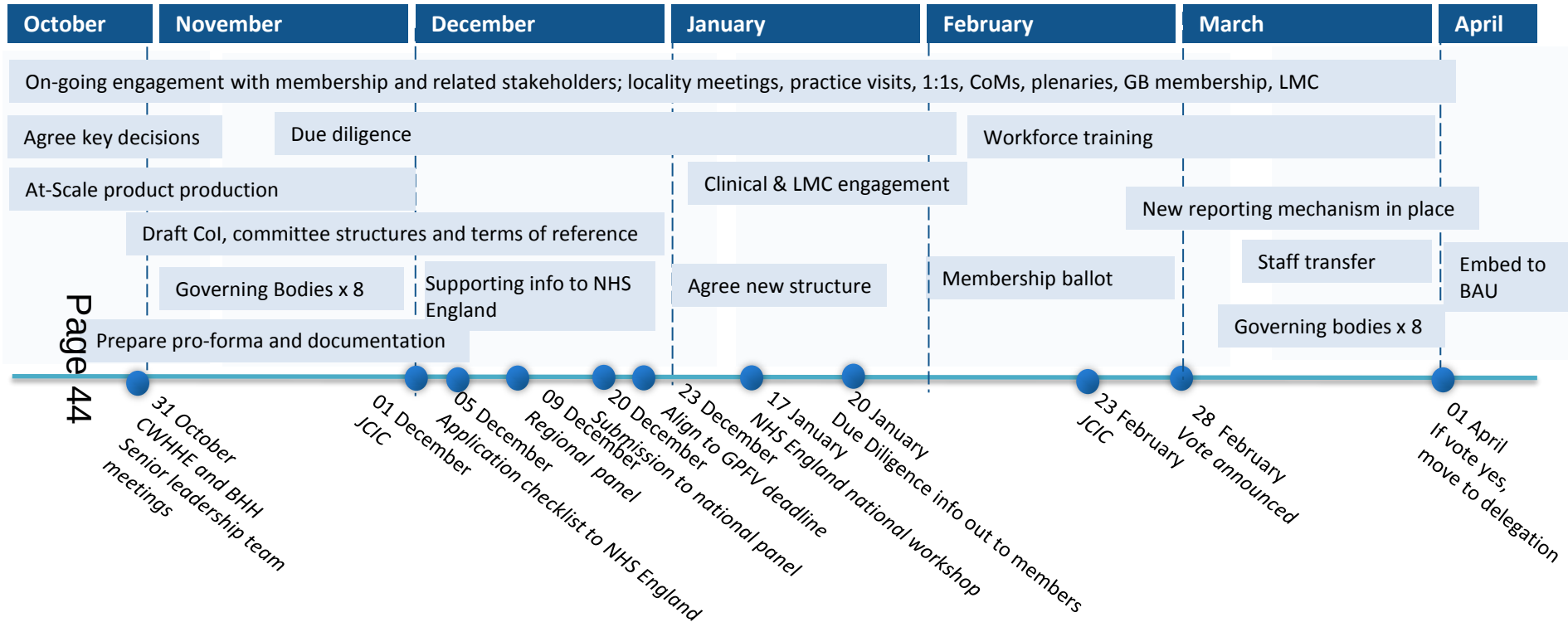
Already delegated (**11 CCGs**)

Approved (Regionally) for delegated **(11 CCGs)**

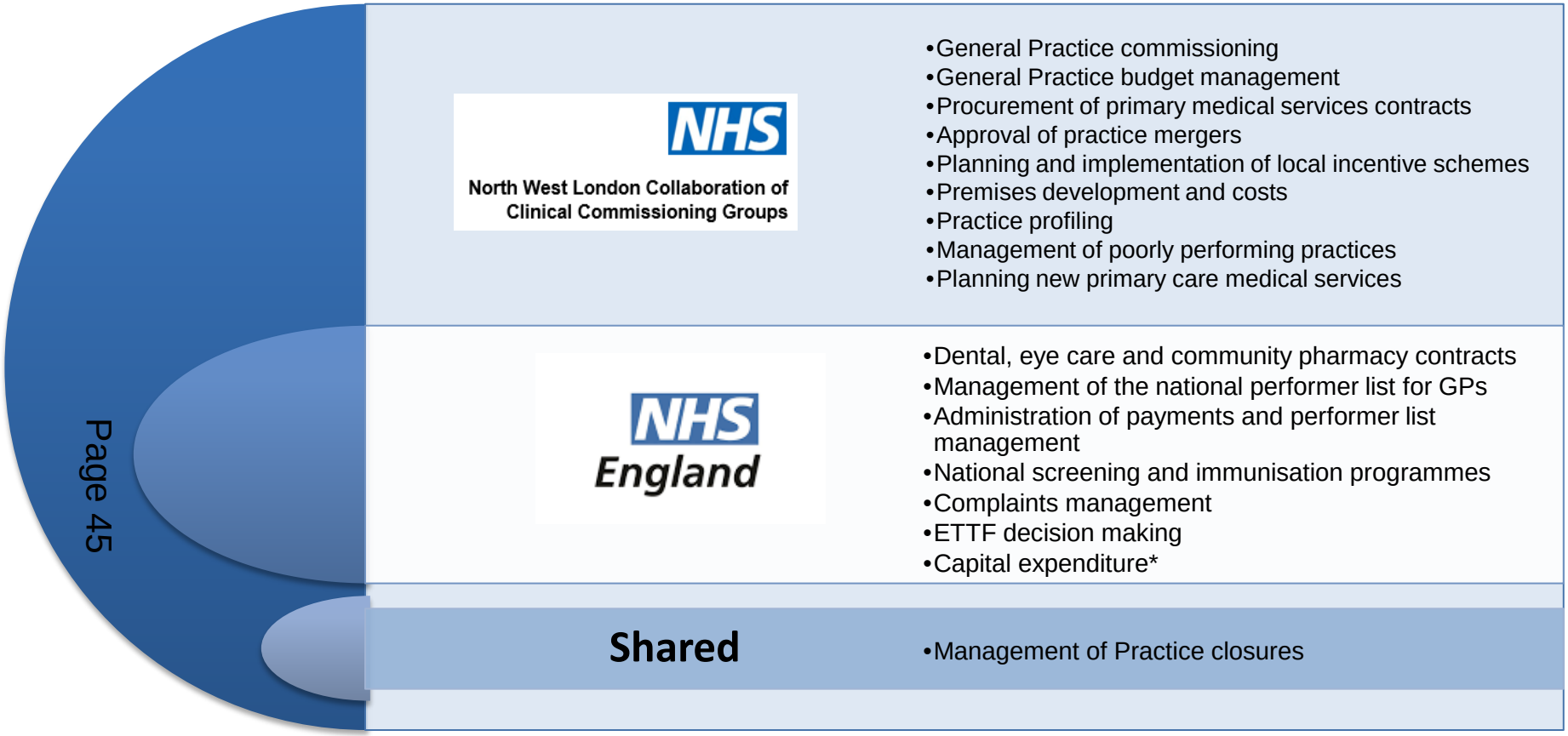
Approved regionally but awaiting CCG S/O **(10 CCGs)**

It is important to note that NWL, C&H and Camden do not expect to have completed membership voting/ sign off until **February 2017**

NW London Timeline Overview



Functions of Delegated Commissioning



*__Capital expenditure__ will not be delegated to CCGs due to the capital approvals process

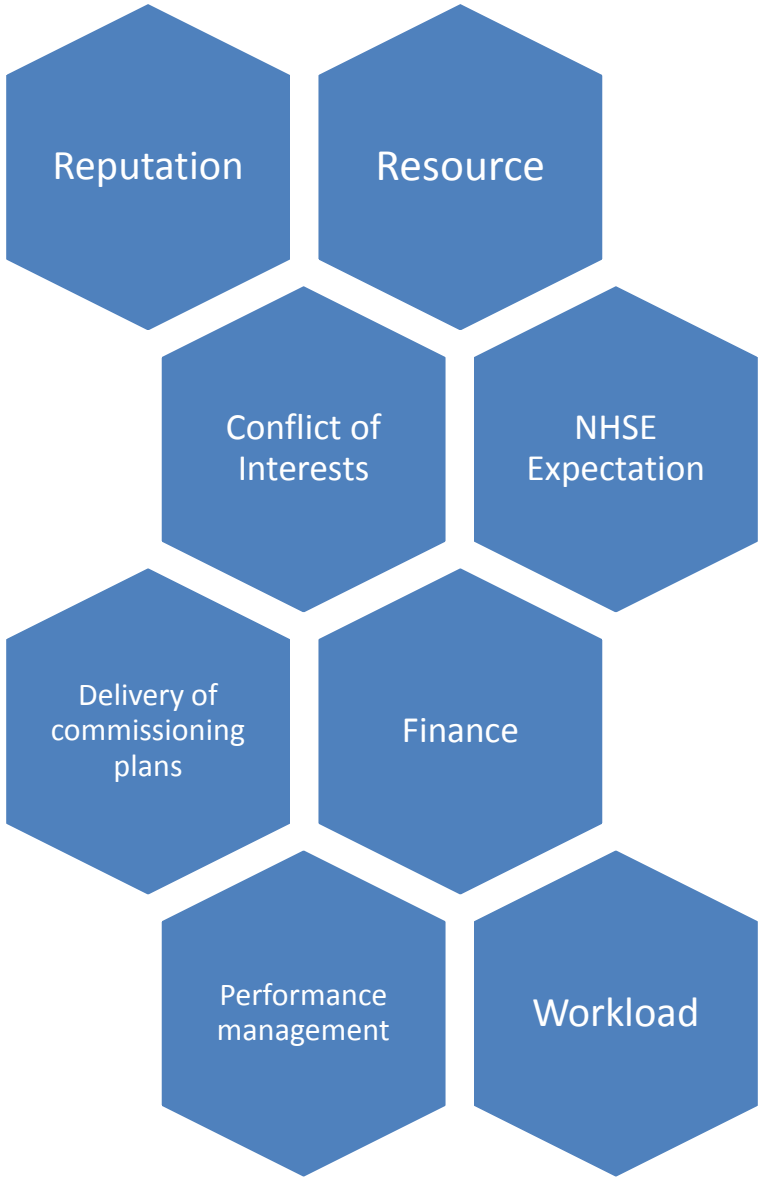
Benefits of Delegated Commissioning

What difference would this make to patients?

Positive patient impact

- Local decisions closer to patients' needs
- More local power and patient voice in the services that are commissioned in your area
- CCGs will create a 'primary care commissioning committee' to make all local decisions about patient care. These meetings will take place in public.
- Opportunity for CCGs to meaningfully engage with the local public about the totality of expectations for general practice
- Tailored services to meet the local needs of the patient population

Challenges of Delegated Commissioning



Financial Due Diligence

Legacy Issues: With regard to historic issues and for CCGs taking full delegation from 1st April 2017, NHS England will remain liable for any pre-31 March 2017 liabilities. As far as possible potential issues will be captured on NHSE's legacy list and provision will be made for these 'old-year' liabilities.

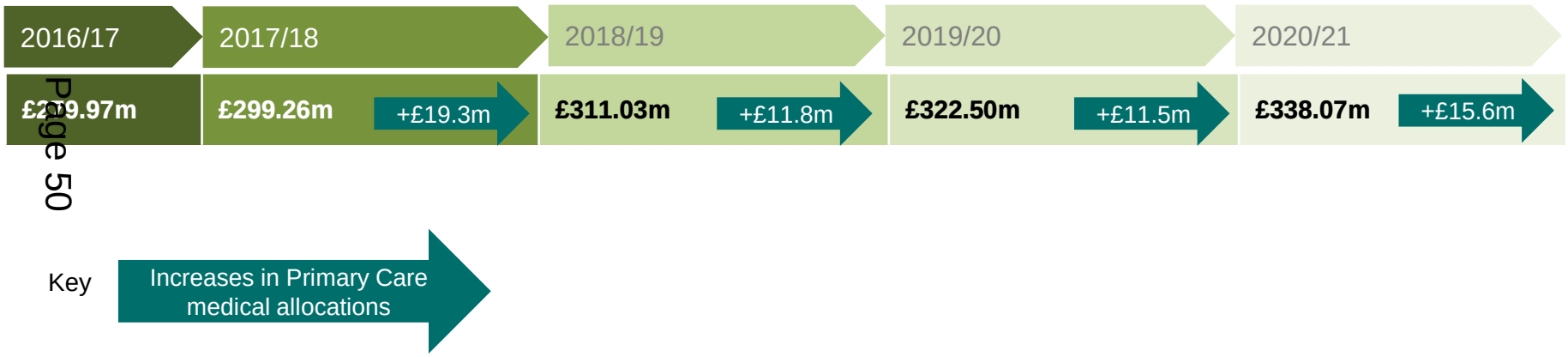
Agreement:

We are seeking agreement with NHS England, as part of our delegation agreement, that NHS England will do all it can to identify risks/disputes/ liabilities as at 31 March 2017 and make full provision in the 2016/17 annual accounts for such issues.

NHS England (London) and the CCGs will agree that if other unforeseen issues arise, both parties will use best endeavours to jointly mitigate the liability and the NHSE London region will use all the flexibility it has to fund the pre-March 2017 elements. (Where CCGs themselves take decisions that incur a new financial commitment prior to 1 April 2017, CCGs will be expected to have identified the resources required).

NW London Primary Care financials: allocations 2016/17 – 2020/21

The figures provided are based on the published Primary Medical Care allocations
source: NHS England



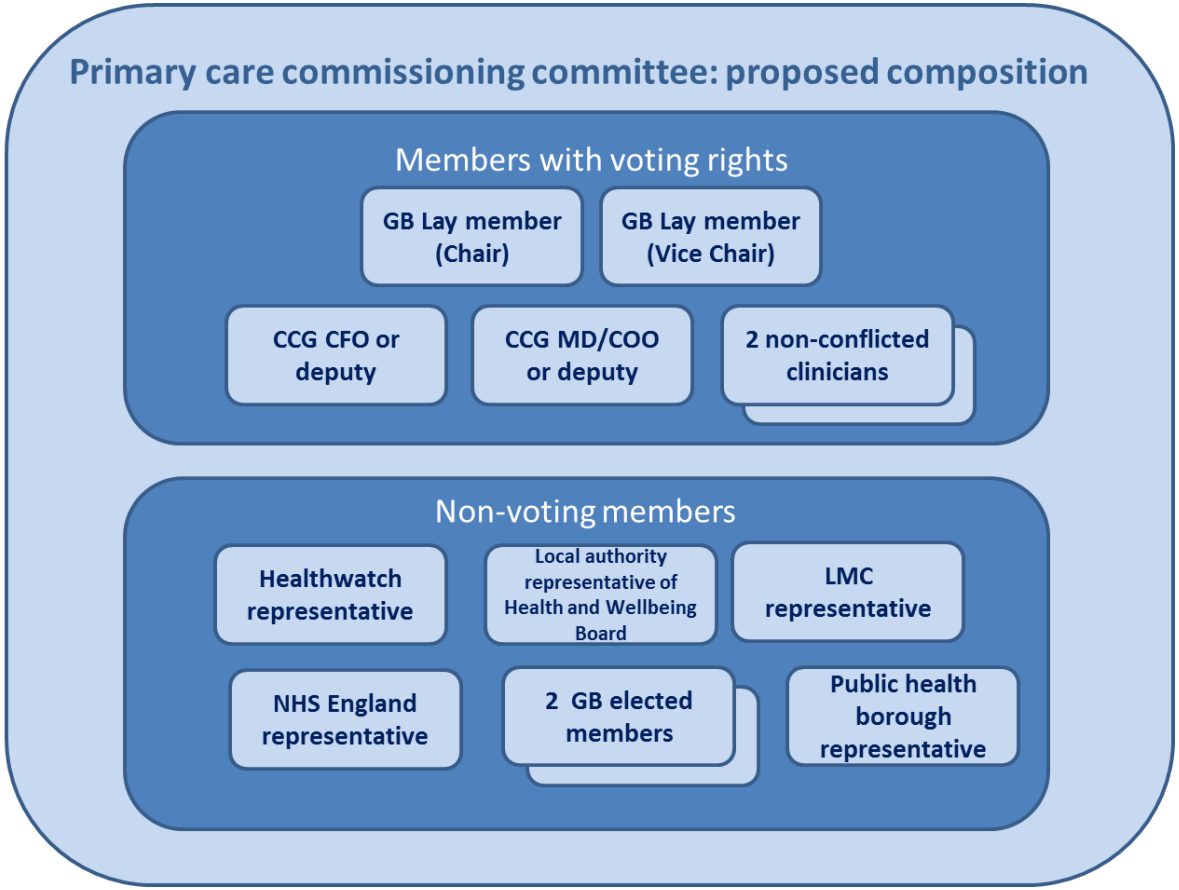
Conflicts of interest (CoI) management

Key principle:

A key principle is that our updated COI arrangements will **seek to ensure the optimal balance between achieving a strong clinical voice, whilst at the same time robustly protecting both CCGs and individual decision-makers from exposure to any real or perceived conflicts of interest**.

Proposed Primary Care Commissioning Committee

Subject to Governing Body approval



Workforce

We need to ensure that we have a Primary Care workforce that is equitably resourced; a workforce that is efficient at its core, but also retains the local knowledge and engagement required to provide a high-quality service.

NHS England are undergoing an OD review within their Primary Care teams. This means that staff currently working to support Primary Care commissioning for NW London will be assigned to our STP footprint. NHS England, working with EY, are re-baselining the provision, but we estimate that we have 16 staff assigned to Primary Care commissioning in NW London, in addition to our local CCG teams.

We are also working to ensure our local CCG workforce is adequately resourced; this offers us a great opportunity to share skills and learning across CCGs, building on our Virtual Primary Care team.

We have established a workforce task and finish group, which is responsible for overseeing the planning, analysis and implementation of the Primary Care OD review to ensure there are equitable resources to commission Primary Care across North West London, if the membership agrees to move to delegated Primary Care commissioning from 01 April 2017.

The task and finish are working with the London-wide Primary Care OD group to ensure alignment with pan-London strategy and delivery. The task and finish group is focusing on the following areas:

Phase 1

- **A review of staff capacity and training and to ensure it is fit for purpose to commission Primary Care services**
- **Submit a report of staffing options to the Delegation Executive Board**

Phase 2

- **Implement the chosen option**

Phase 3

- **Embed the staff changes and issue resolution of workforce after 01 April 2017, if members chose to delegate**

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City of Westminster

Westminster Health & Wellbeing Board

Date:	2 February 2017
Classification:	General Release
Title:	Family Hubs: commissioning intentions for children aged 0-5
Report of:	Cabinet Member for Adults and Public Health; Cabinet Member for Children and Young People
Wards Involved:	All
Financial Summary:	N/A
Report Author and Contact Details:	Melissa Caslake, Director of Family Services mcaslake@westminster.gov.uk Mike Robinson, Director of Public Health mrobinson4@westminster.gov.uk

1. Executive Summary

1.1. In September 2016, the Health and Wellbeing Board agreed a joint programme of work for developing a series of new Family Hubs that will improve access to preventative services (both universal and targeted). The services provided from these hubs will support families to understand and make effective changes that ultimately improve their health and wellbeing.

1.2. It was agreed that one of the first phases of work should be a joint approach to commissioning for children aged 0-5 with an initial focus on shaping the new Health Visiting services and Family Nurse Partnership. This paper outlines the proposed commissioning intentions for these new services with a view to achieving an ambition for greater integration and collaboration between the council, Central and West London Clinical Commissioning Groups, providers, and voluntary and community groups as set out in the North West London Sustainability & Transformation Plan, the Health & Wellbeing Strategy for Westminster 2017-22 and CCG commissioning intentions.

2. Background

2.1 On the 1 October 2015 Public Health commissioning responsibilities for children aged 0 to 5 (Health Visiting and Family Nurse Partnership – FNP) transferred from NHS England to local authorities. This marked the final part of the much larger transfer of Public Health functions to local government which took place on 1 April 2013 under the Health and Social Care Act 2012. The transfer was solely about commissioning responsibilities and not a transfer of the workforce who remained employed by provider organisations. The transfer of commissioning responsibilities for children's Public Health to local authorities is providing an opportunity to take a fresh look at delivering coherent, effective support for children locally.

2.2 Central London Community Healthcare NHS Trust (CLCH) is the current provider delivering Health Visiting and Family nurse Partnership across the borough. The current Local Authority contract runs until 30th September 2017. These services are funded through the Public Health Grant.

3. Recommendations

3.1 The Board is invited to:

- Endorse our ambition to re-shape the role of Health Visitors as the professional lead for an integrated early years pathway, taking responsibility to work with partners to identify needs within families early, to provide joined up preventative support before problems become complex and more intractable. Endorse our proposed commissioning intentions for services for 0-5 year olds
- Consider how General Practitioners and their teams can be closely involved in the development of the new services and, in particular, how the new service offer will provide a single pathway for them to identify and support at risk families

4. Key Matters for the Board

4.1 The proposed Family Hubs will be a 'virtual' network of providers working with children 0 – 19 years, who share a single approach to working with families across a given area. All providers will be working to a shared purpose and outcomes framework. It is proposed that this network of provision will bring together the Early Help (including Troubled Families) offer from Children's Services, the Health Visiting and Family Nurse Partnership offers from Public Health, the joint Child and Adolescent Mental Health Service (CAMHS) offer from Central London CCG (CLCCG) and West London CCG (WLCCG) and Public Health, and the offer from GPs.

4.2 The aim will be, through the network, to identify families with complex needs as early as possible, no matter what service they first come into contact with. This will make sure that any contact with a practitioner in the network will lead to the right intervention at the right time, with greater accountability across all agencies for identifying need earlier; leading to families understanding and making effective changes that ultimately improve their health and wellbeing.

4.3 The key outcomes, agreed by the Health and Wellbeing Board, that the Family Hubs will look to achieve will be to:

- Reduce referrals to higher level interventions, including CAMHs, social care, GP consultations, youth justice, and Housing Options, by reaching families earlier and working with families to make lasting change.

- Prevent family breakdown that results in children and young people being received into care or entering the criminal justice system.

- Promote strong and resilient parents, with support to gain employment.

- Improve outcomes for children and young people across health and well-being indicators. These will include obesity, breastfeeding rates, oral health, immunisations, and emotional wellbeing of adolescents.

Shaping joint commissioning intentions

4.4 To achieve these outcomes, the Health & Wellbeing Board agreed in September to an outline programme of work. One of the first phases of this was to work jointly on commissioning services for 0-5 year olds.

4.5 We are ambitious to take the opportunity to re-shape the role of Health Visitors so that they become the leaders of a the network of professional partners, including social workers, mid-wives and wider, to deliver an integrated early help offer to families, making sure that needs are identified early within families and preventative support is provided before problems become complex and more intractable.

4.6 To guide this joint work we propose to commission these services with the intention to:

- **Leadership, accountability and responsibility**. To commission services for 0 – 5 years olds where health visitors are accountable for bringing together the full early help offer for this age group across different partners so that there is a seamless and integrated early years pathway. This could involve them being the future children's centre leaders and taking a

lead role in a case management approach to supporting families with multiple and complex needs.

- **Evidence**. To commission services for 0 – 5 years olds based on robust evidence of where services can have significant impact on health and wellbeing outcomes for children, young people and their families and on the reduction of health inequalities, including examining alternative service models that integrate with children's centres and other early years providers.

- **Value for money**. To commission services for 0-5 year olds that uses our shared resources in the best way through greater targeting of the most vulnerable based on evidence of what works. This includes giving focused thought to the way in which we use building space for delivery of these services.

- **Integration**. To commission services for 0-5 year olds that align with, complement, and wherever possible integrate with the wider offer for 0-5 year olds, including midwifery and the clinical offer from CCGs. Furthermore, to ensure these services complement and where appropriate connect with the broader service offer to families with children across the full age range, working as an integral part of the Family Hubs model.

- **Workforce**. To commission services for 0-5 year olds that develop our shared workforces and build our capability across different professional disciplines to deliver joined-up services that effectively prevent more complex needs from developing in other parts of the family or later in life. By upskilling frontline staff and supporting them with appropriate information, training and operating frameworks, we aim to align with the principles of a ‘making every contact count’ approach.

Next steps

TASK	TIMELINE
Review of current service provision – strengths and areas for development in the context of mandated services	Mid-January 2017 ***COMPLETED***
Review of needs analysis	Mid-January 2017 ***COMPLETED***
Benchmark with other Local Authorities including KPIs and costs	End of January 2017 ***COMPLETED***
Appraise options for re-commissioning with procurement and legal teams for new contract from October 2017	Mid-January 2017 ***COMPLETED***
Develop joint commissioning strategy	End of January 2017
Submit proposals and recommendations for future delivery and agree timeline for implementation	End of February 2017

5. Legal Implications

5.1 None at this time.

6. Financial Implications

6.1 None at this time.

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

Jayne Vertkin, Head of Early Help Services

Email: jvertkin@westminster.gov.uk

Telephone: 020 7641 5745

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City of Westminster

Westminster Health & Wellbeing Board

Date:	2nd February 2017
Classification:	**General Release**
Title:	Pharmaceutical Needs Assessment (PNA)
Report of:	Director of Public Health
Wards Involved:	All Wards
Policy Context:	Health and Wellbeing Boards are required to publish and maintain a Pharmaceutical Needs Assessment by virtue of Section 128a of the National Health Service Act 2006 (Pharmaceutical Needs Assessments) and the Health and Social Care Act 2012
Financial Summary:	Costs required to produce the PNA will be identified from the 2017/18 Public Health budget. Any future financial implications that may be identified as a result of the PNA and re-commissioning projects will be presented to the appropriate board & governance channels in a separate report.
Report Author and Contact Details:	Colin Brodie, Public Health Knowledge Manager, E: cbrodie@westminster.gov.uk T: 02076414632

1. Executive Summary

1.1 This report outlines the responsibility of the Health and Wellbeing Board to publish a Pharmaceutical Needs Assessment (PNA) for Westminster, describes the purpose and requirements for the PNA and outlines the local arrangements to produce the PNA.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board are recommended to review and note the current PNA and Department of Health guidance on PNAs

2.2 The Health and Wellbeing Board are invited to consider and approve the local arrangements to producing the PNA for Westminster

2.3 The Health and Wellbeing Board are invited to consider and discuss the role of community pharmacies to deliver local strategies and priorities, particularly the Joint Health and Wellbeing Strategy and STP

2.4 The Health and Wellbeing Board member organisations are requested to agree to provide any data necessary to complete the PNA, where they are the source organisation

3. Background

3.1 Pharmacies provide a range of services to their local community. As well as dispensing medicines and appliances, they promote healthy lifestyles and public health campaigns, signpost to local sources of care and support, and provide advice to support self-care of minor ailments and common conditions. Some pharmacies are also commissioned to provide services such as medication use reviews, support with new medicines for people with long term conditions, NHS Health Checks, stop smoking services, flu vaccinations, and needle & syringe exchange programmes.

3.2 Pharmaceutical Needs Assessments (PNAs) are a statement of the needs for pharmaceutical services of the population in a defined geographical area, and are an important tool in market entry decisions.

3.3 Under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations ("the 2013 Regulations"), anyone who wishes to provide NHS pharmaceutical services must apply to NHS England to be included on a pharmaceutical list, and prove that they are able to meet a pharmaceutical need as set out in the relevant local PNA. These applications can be keenly contested by applicants and existing contractors and so can be open to legal challenge. As such, it is important that the local PNA is robust.

3.4 The responsibility for producing and managing the content and update of PNAs transferred from NHS Primary Care Trusts (PCTs) to Health and Wellbeing Boards on 1st April 2013.

3.5 The current PNA, and the first to be published by the Health and Wellbeing Board, was published in March 2015 in accordance with the "2013 Regulations". A new PNA must be developed by the Health and Wellbeing Boards every 3 years, and so a new PNA is due to be published by the end of March 2018.

3.6 In 2013 the Department of Health produced an Information Pack on PNAs for Health and Wellbeing Boards.

3.7 **It is recommended that the Board review and familiarise themselves with the current PNA and the Information Pack**

4. Purpose and requirements of the PNA

4.1 The objectives of the PNA are:

- to provide a clear picture of the current services provided by community pharmacies and identify gaps in service provision in relation to NHS pharmaceutical services;
- to be able to plan for future services to be delivered by community pharmacies and ensure any important gaps in services are addressed;
- to provide robust and relevant information on which to base decisions about applications for market entry in accordance with The National Health Service (Pharmaceutical Services) Regulations 2012

4.2 The detailed requirements for the PNA are set out in Regulations 3-9 and Schedule 1 of the "2013 Regulations"

4.3 The PNA project deliverable are:

- A PNA report for Westminster, in accordance with the "2013 Regulations"
- A map of local pharmacy service provision for Westminster

4.4 Health and Wellbeing Boards are required by law to consult a specified list of bodies at least once for a minimum of 60 days during the process of developing the PNA. These bodies include the Local Pharmaceutical Committee; Local Medical Committee; any persons on pharmaceutical lists and any dispensing doctors; any local Healthwatch or any other patient, consumer and community group which (in the opinion of the Health and Wellbeing Board) has an interest; NHS England; and neighbouring Health and Wellbeing Boards.

5. Local arrangements of delivering the PNA

5.1 While overall responsibility and accountability for the PNA rests with individual Health and Wellbeing Boards, on 27 Feb 2014 the Westminster Health and Wellbeing Board agreed that the PNA would be incorporated into the JSNA work programme. Individual PNAs for each of Westminster, Hammersmith and Fulham, and Kensington and Chelsea are produced using a jointly-agreed and combined approach.

5.2 To provide assurance to the three Health and Wellbeing Boards:

- As part of the JSNA work programme, the Public Health Knowledge Manager and JSNA Manager are responsible for the day to day management of the production of the PNA
- The JSNA Steering Group retains overall accountability to the three Health and Wellbeing Boards for the production of the PNAs and should provide assurance to the Boards on progress and quality.
- A smaller PNA Task and Finish Group will be established to steer the work. This group will be responsible for ensuring that all the legislative and regulatory requirements are fully met by the revised PNAs

5.3 Key milestones for producing the PNA are outlined below:

Milestone	**Date completed**
Establish PNA Task and Finish Group	Mar 2017
Complete analysis of health needs and priorities	May 2017
Complete analysis of current pharmaceutical services provision	August 2017
Prepare draft PNA for consultation and sign-off at HWB	Sept 2017
Consultation	Dec 2017
Prepare final report for HWB sign-off	Jan 2018
Final sign-off by HWB and publication	Mar 2018

5.4 The PNA Task and Finish Group is currently drafting the project plan and scoping an options appraisal on whether the PNA will be delivered in-house or through contracting PNA specialist support.

6. Issues for consideration by the Health and Wellbeing Board

Pharmacies supporting local strategy and priorities

6.1 The Health and Wellbeing Board will wish to consider the role of community pharmacies in delivering on local priorities and strategies, such as the Joint Health and Wellbeing Strategy (JHWS) and Sustainability and Transformation Plan (STP). Although the PNA is largely a technical document and its primary use is for market entry decision making, the PNA also provides an opportunity to add to the local evidence base to inform strategic and commissioning decision-making.

6.2 Community pharmacies offer accessibility for those who cannot or do not wish to access conventional services, long opening hours and convenience, a health resource on the high street and in supermarkets, anonymity, a flexible and informal environment, a local business well connected to their local community,

and staff who tend to reflect the social and ethnic backgrounds of the population they serve.

6.3 Delivering services through pharmacies has the potential to relieve pressure on GPs and Accident and Emergency Departments, ensure optimal use of medicines, provide better value and better patient outcomes, and contribute to delivering 7 day health and care services.

6.4 A 2013 review by PHE found the following evidence on the pharmacy contribution to public health:

PHE Evidence[1] on the pharmacy contribution to public health

Service	Evidence of success
Stop Smoking Services	**Very positive** *55% quit rate (49% UK average and 42% GP av.)*
Emergency hormonal contraception (EHC)	**Positive** Evidence to suggest highly rated services
Healthy eating	**Promise, but positive** Insufficient evidence
Drug and alcohol misuse	**Promise, but positive** Insufficient evidence
Infection control and prevention	**Promise, but positive** Insufficient evidence
Chronic disease management & prevention	**Very positive** Good empirical evidence to suggest improved prevention in patients.

[1] *Public Health England (2013) Consolidating and developing the evidence base and research for community pharmacy's contribution to public health: a progress report from Task Group 3 of the Pharmacy and Public Health Forum*

6.5 The **Health and Wellbeing Board are invited to consider the role of community pharmacies to deliver local strategies and priorities, particularly the Joint Health and Wellbeing Strategy and STP**

Funding for community pharmacies

6.6 This PNA will be undertaken at a time when community pharmacies are facing financial challenges. The majority of NHS income for community pharmacies comes from NHS England through the NHS pharmaceutical services contract. As part of wider efficiency savings across the NHS, the Government announced in October 2016 that funding for NHS contractors providing services under the contract would be reduced in 2016/17 and 2017/18 (equivalent to a 4% reduction in 2016/17 and a further 3.4% reduction in 2017/18). These changes came into effect from 1 December 2016

6.7 There has been criticism and opposition to these funding cuts with industry groups asserting that the cuts will lead to the closure of community pharmacies. At the current time the impact of these funding cuts locally is uncertain.

Access to data

6.8 Another challenge for the PNA is ensuring timely access to data. The data required to produce the PNA is held by a number of organisations, including Public Health, other local authority departments, Clinical Commissioning Groups, NHS England, and local pharmacies.

6.9 **The Health and Wellbeing Board member organisations are asked to agree to provide any data where they are the source organisation.**

7. Legal Implications

7.1 Health and Wellbeing Boards are legally required to publish and maintain a PNA for their local area by virtue of Section 128a of the National Health Service Act 2006 (Pharmaceutical Needs Assessments) and the Health and Social Care Act 2012.

7.2 All Health and Wellbeing Boards were required to publish a PNA by 1 April 2015. After it has published its first PNA, each HWB must publish a statement of its revised assessment within 3 years of its previous publication of a PNA.

7.3 PNAs must be developed in line with the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013

7.4 Verified by Kevin Beale, Senior Corporate Lawyer, Shared Legal Services

8. Financial Implications

8.1 Costs required to produce the PNA will be identified from the 2017/18 Public Health budget.

8.2 Verified by Richard Simpson, Public Health Finance Manager

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

Colin Brodie, Public Health Knowledge Manager

Email: cbrodie@westminster.gov.uk

Telephone: 02076414632

BACKGROUND PAPERS:

1. Westminster Pharmaceutical Needs Assessment 2015

2. Department of Health (2013) Pharmaceutical needs assessments: information pack for local authority Health and Wellbeing Boards

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Department of Health

Pharmaceutical needs assessments

Information Pack for local authority Health and Wellbeing Boards

May 2013

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Pharmaceutical Needs Assessment

Information Pack for local authority Health and Wellbeing Boards

Prepared by Medicines, Pharmacy and Industry – Pharmacy Team with the assistance of the Local Government Association and members of the National Learning Network for HWBs

Contents

Preface

This information pack has no statutory standing, nor does it constitute non-statutory guidance, but it aims to support local authorities to interpret and implement their duty with regard to pharmaceutical needs assessments (PNAs)

Summary

- The Health and Social Care Act 2012 transfers responsibility for the developing and updating of PNAs to health and wellbeing boards (HWBs). Under the Act, the Department of Health has powers to make Regulations.

- The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs and can be found at: http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/.

- This information pack is intended to support local authority HWBs in a practical way in understanding and implementing these requirements. The pack is set out as follows:

  - chapter 1 gives an introduction and legislative background;

  - chapter 2 outlines what the term “pharmaceutical services” includes in relation to PNAs;

  - chapter 3 outlines the minimum information that must be in PNAs;

  - chapter 4 expands on what the legislation says about the publication and updating of PNAs;

  - chapter 5 explains the consultation requirements; and

  - chapter 6 outlines matters to consider when making assessments.

- There are two appendices:

  - appendix 1 contains a glossary of terms and phrases used in regulation 2 of the 2013 Regulations; and

  - appendix 2 sets out some frequently asked questions and answers.

Chapter 1 – introduction and legislative background

Introduction

1. If a person (a pharmacist, a dispenser of appliances, or in some circumstances and normally in rural areas, GPs) wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list. Pharmaceutical lists are compiled and held by the NHS Commissioning Board, now known as NHS England. This is commonly known as the NHS "market entry" system.

2. Under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations ("the 2013 Regulations"), a person who wishes to provide NHS pharmaceutical services must generally apply to NHS England to be included on a relevant list by proving they are able to meet a pharmaceutical need as set out in the relevant PNA. There are exceptions to this, such as applications for needs not foreseen in the PNA or to provide pharmaceutical services on a distance-selling (internet or mail order only) basis. The first PNAs were published by NHS primary care trusts (PCTs) and were required to be published by 1 February 2011.

3. From April 2013, Health and Well-being Boards (HWBs) will be developing PNAs for the first time. We therefore have limited examples of practice involving HWBs. However, we have included some examples of the ways in which PCTs developed their first PNAs. The examples are illustrative and provide HWBs with an indication of how they may wish to approach their work.

Legislative background

4. The Health and Social Care Act 2012 established HWBs. The Act also transferred responsibility to develop and update PNAs from PCTs to HWBs. Responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from PCTs to NHS England from 1 April 2013.

5. The NHS Act (the "2006" Act), amended by the Health and Social Care Act 2012, sets out the requirements for HWBs to develop and update PNAs and gives the Department of Health (DH) powers to make Regulations.

128A Pharmaceutical needs assessments

(1) Each Health and Well-being Board must in accordance with regulations--

(a) assess needs for pharmaceutical services in its area, and

(b) publish a statement of its first assessment and of any revised assessment.

(2) The regulations must make provision--

(a) as to information which must be contained in a statement;

(b) as to the extent to which an assessment must take account of likely future needs;

(c) specifying the date by which a Health and Well-being Board must publish the statement of its first assessment;

(d) as to the circumstances in which a Health and Well-being Board must make a new assessment.

(3) The regulations may in particular make provision--

(a) as to the pharmaceutical services to which an assessment must relate;

(b) requiring a Health and Well-being Board to consult specified persons about

specified matters when making an assessment;

(c) as to the manner in which an assessment is to be made;

(d) as to matters to which a Health and Well-being Board must have regard when making an assessment.

Wider context

6. The Health and Social Care Act 2012 also amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for HWBs in relation to Joint Strategic Health Assessments (JSNAs). The aim of JSNAs is to improve the health and wellbeing of the local community and reduce inequalities for all ages. They are not an end in themselves, but a continuous process of strategic assessment for the health and wellbeing needs of the local population. They will be used to determine what actions local authorities, the NHS and other partners need to take to meet health and social care needs and to improve health outcomes and address health inequalities.

7. The preparation and consultation on the PNA should take account of the JSNA and other relevant strategies, such as children and young people's plan, the local housing plan and the crime and disorder strategy in order to prevent duplication of work and multiple consultations with health groups, patients and the public. The development of PNAs is a separate duty to that of developing JSNAs as PNAs will inform commissioning decisions by local authorities (public health services from community pharmacies) and by NHS England and clinical commissioning groups (CCGs). HWBs may therefore wish to note that PNAs, as a separate statutory requirement, cannot be subsumed as part of these other documents but can be annexed to them.

Chapter 2: Pharmaceutical needs assessments

What the legislation says

1. Regulations 3-9 and Schedule 1 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the requirements for PNAs.

Pharmaceutical services

2. Section 126 of the 2006 Act places an obligation on NHS England to put arrangements in place so that drugs, medicines and listed appliances ordered via NHS prescriptions can be supplied to persons. This section also makes provision for the types of healthcare professional who are authorised to order drugs, medicines and listed appliances on an NHS prescription.

3. "Pharmaceutical services" in relation to PNAs include:

- *"essential services"* which every community pharmacy providing NHS pharmaceutical services must provide and is set out in their terms of service[1] – the dispensing of medicines, promotion of healthy lifestyles and support for self-care;
- *"advanced services"* - services community pharmacy contractors and dispensing appliance contractors can provide subject to accreditation as necessary – these are Medicines Use Reviews and the New Medicines Service for community pharmacists and Appliance Use Reviews and the Stoma Customisation Service for dispensing appliance contractors; and
- *locally commissioned services* (known as enhanced services) commissioned by NHS England.

4. The following are included in a pharmaceutical list. They are:

- *pharmacy contractors* (healthcare professionals working for themselves or as employees who practice in pharmacy, the field of health sciences focusing on safe and effective medicines use); and
- *dispensing appliance contractors* (appliance suppliers are a specific sub-set of NHS pharmaceutical contractors who supply, on prescription, appliances such as stoma and incontinence aids, dressings, bandages etc). They cannot supply medicines.

[1] The precise contractual requirements for providing NHS pharmaceutical services are set out in Schedules 4-6 of the Regulations.

5. In addition, there are two other types of pharmaceutical contractor - d*ispensing doctors,* who are medical practitioners authorised to provide drugs and appliances in designated rural areas known as “controlled localities” (see Appendix 1) and *local pharmaceutical services (LPS) contractors* who provide a level of pharmaceutical services in some HWB areas.

6. A Local Pharmaceutical Service (LPS) contract allows NHS England to commission community pharmaceutical services tailored to specific local requirements. It provides flexibility to include within a single locally negotiated contract a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under national pharmacy arrangements set out in the 2013 Regulations. All LPS contracts must, however, include an element of dispensing.

7. The definition of “pharmaceutical services” in relation to PNAs is set out in the following table:

Regulation	Explanation
Regulation 3(2) *– the pharmaceutical services to which each pharmaceutical needs assessment must relate are all the pharmaceutical services that may be provided under arrangements made by the NHS CB for:* *(a) the provision of pharmaceutical services (including directed services) by a person on a pharmaceutical list.*	There are three types of pharmaceutical service provided by pharmacy and dispensing appliance contractors as outlined in paragraph (3) above. Directed services are those services set out in Secretary of State Directions to NHS England, for example, medicines use reviews and NHS England commissioned enhanced pharmaceutical services, such as services to care homes, language access and patient group directions.
(b) the provision of local pharmaceutical services under an LPS scheme (but not LP services which are not local pharmaceutical services).	A Local Pharmaceutical Service (LPS) contract allows NHS England to commission community pharmaceutical services tailored to specific local requirements. “LP services” is a legal term. NHS England has powers to include in LPS contracts other NHS services or other wider services, such as services relating to the provision of education and training. However, including those other services in an LPS contract turns those services into “LP services” but it does not turn them into “local pharmaceutical services”.
(c) the dispensing of drugs and appliances by a person on a dispensing doctors list (but not other NHS services that may be provided under arrangements made by the NHS CB with a dispensing doctor).	For dispensing doctors, only the provision of those services set out in their pharmaceutical services terms of service (set out in the Schedules to the 2013 Regulations) is included within the definition of pharmaceutical services. Services such as GP enhanced services – either directed, such as childhood immunisation programmes or local, such as phlebotomy are not “pharmaceutical services”.

3: Information to be contained in PNAs

What the legislation says

1. Regulation 4 and Schedule 1 of the 2013 Regulations outline the minimum requirements for PNAs.

Pharmaceutical needs

2. When assessing local need for pharmaceutical services, HWBs may wish to note that general health need is not the same as the need for pharmaceutical services. There will be differences within HWB areas between:

- those health needs that may be met using pharmaceutical services commissioned by NHS England. For example, NHS England wishes to commission pharmaceutical services that help reduce the number of people in the HWB area who are being unnecessarily readmitted to hospital due to non-compliance with their medication. NHS England might therefore commission local community pharmacies to carry out medication use review services;
- public health services commissioned by local authorities; and
- those that cannot be met by pharmaceutical contractors, for example, minor surgery clinics.

3. Schedule 1 sets out the minimum information to be contained in pharmaceutical needs assessments. The following table provides the text of the Schedule as well as an explanation:

Regulation	Explanation
Schedule 1, paragraph 1 – necessary services: current provision *1. A statement of the pharmaceutical services that the HWB has identified as services that are provided:* *(a) in the area of the HWB and which are necessary to meet the need for pharmaceutical services in its area; and* *(b) outside the area of the HWB but which nevertheless contribute towards meeting the need for pharmaceutical services in its area (if the HWB has identified such services).*	In order to assess the adequacy of provision of pharmaceutical services, current provision by all providers of such services needs to be mapped. This can be done, for example, by using NHS England's list of pharmaceutical services providers for the relevant area. This will need to include providers and premises within the HWB area, and also those that may lie outside in a neighbouring HWB area but who provide the services to the population within the HWB area. Examples of this type of service provider are pharmacies, distance-selling pharmacies (those who provide pharmaceutical services but not face to face on the premises, dispensing appliance contractors and dispensing doctors). Data from the Information Services Portal at the NHS Business Services Authority (NHS BSA)[2] can be used to assess the use of distance-selling pharmacies and dispensing appliance contractors by people residing within the HWB's area. The PNA includes a statement outlining this provision.

[2] The Information Services Portal provides access to a variety of information reports on key prescribing areas. It is anticipated that all NHS Prescription Services reporting will be accessed via the Portal in the future. For more information, see: http://www.nhsbsa.nhs.uk/PrescriptionServices/3607.aspx.

Schedule 1, paragraph 2 – necessary services: gaps in provision *2. A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied-* *(a) need to be provided (whether or not they are located in the area of the HWB) in order to meet a current need for pharmaceutical services, or pharmaceutical services of a specified type, in its area;* *(b) will, in specified future circumstances, need to be provided (whether or not they are located in the area of the HWB) in order to meet a future need for pharmaceutical services, or pharmaceutical services of a specified type, in its area.*	Having assessed local needs and the current provision of services, the PNA needs to identify any gaps that need to be filled. Such needs might comprise a pharmacy providing a minimum of "essential services" in a deprived area, or pharmaceutical services of a specified type. The PNA may also identify a gap in provision that will need to be provided in future circumstances, for example, a new housing development is being planned in the HWB area. Gaps in provision are not just gaps in pharmaceutical health needs but also gaps by service type. For example, a locality may have adequate provision of essential services to meet the needs of the population, but have a need for more specialist services, such as the management of a long-term condition. Examples of gaps that HWB's may identify, include: • inadequate provision of essential services at certain times of day or week leading to patients attending the GP-led health centres being unable to have their prescription dispensed; • opening hours that do not reflect the needs of the local population; • areas with little or no access to pharmaceutical services; and • adequate provision of dispensing services (by those GPs who dispense), but patients unable to access the wider range of essential services. The PNA includes a statement outlining any gaps.

Schedule 1, paragraph 3 – other relevant services: current provision *3. A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are provided-* *(a) in the area of the HWB and which, although they are not necessary to meet the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access to pharmaceutical services in its area;* *(b) outside the area of the HWB and which, although they do not contribute towards meeting the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area;* *(c) in or outside the area of the HWB and, whilst not being services of the types described in sub-paragraph (a) or (b), or paragraph 1, they nevertheless affect the assessment by the HWB of the need for pharmaceutical services in its area.*	This is related to the types of application that persons can make to be included on a pharmaceutical list or provide directed services. There are five types of market entry application (known as routine applications): • current need; • future need; • improvements or better access; • future improvements or better access; and • unforeseen benefits (where the applicant provides evidence of a need that was not foreseen when the PNA was published). The HWB will have identified those services that are necessary for the provision of adequate pharmaceutical services (See the section on Schedule 1, paragraph 1 above). There may, however, be pharmaceutical services that provide improvements to the provision or better access for the public whether at the current time or in the future.

Schedule 1, paragraph 4 – improvements and better access: gaps in provision *4. A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied-* *(a) would, if they were provided (whether or not they were located in the area of the HWB), secure improvements, or better access to pharmaceutical services, or pharmaceutical services of a specific type, in its area,* *(b) would, if in specified future circumstances they were provided (whether or not they were located in the area of the HWB), secure future improvements, or better access, to pharmaceutical services, or pharmaceutical services or a specified type, in its area.*	It is important that PNAs identify services that are not currently being provided but which will be needed to secure future improvements to pharmaceutical services – common examples of this are major industrial, communications or housing developments, service redesign as set out in, for example, the Joint Health and Wellbeing Strategy, or re-provision. Provision may also change where significant economic downturn is expected, i.e. a large employer moves their operations to Europe or Asia. HWBs can also identify those services, which are currently not being commissioned by NHS England, local authorities or CCGs but may be services that could be commissioned in the future. It should be noted that if a HWB identifies a need or improvement and better access, NHS England does not have to meet the need – this is because NHS England may have other factors to take into account, i.e. other commissioning decisions. The PNA includes a statement outlining this provision.
Schedule 1, paragraph 5 – other services *5. A statement of any NHS services provided or arranged by the HWB, NHS CB, a CCG, an NHS trust or an NHS foundation trust to which the HWB has had regard in its assessment, which affect-* *(a) the need for pharmaceutical services, or pharmaceutical services of a specified type, in its*	There may be services provided or arranged by the HWB, NHS England, a CCG, an NHS trust (including foundation trusts) which could, if they were included in a PNA, be provided by pharmaceutical services contractors. For example, a large health centre providing a stop smoking service or immunisation service at a community hospital. Only those NHS services which affect the need for pharmaceutical services or potential pharmaceutical services need to be included.

area; or *(b) whether further provision of pharmaceutical services in its area would secure improvements, or better access to pharmaceutical services, or pharmaceutical services of a specific type in its area.*	The PNA includes a statement outlining the services identified in the assessment which affect pharmaceutical needs.
Schedule 1, paragraph 6 – how the assessment was carried out *6. An explanation of how the assessment has been carried out, in particular –* *(a) how it has determined what are the localities in its area;* *(b) how it has taken into account (where applicable)-* *(i) the different needs of different localities in its area, and* *(ii) the different needs of people in its area who share a protected characteristic; and* *(c) a report on the consultation that it has undertaken.*	HWBs may wish to divide up their area to reflect different needs in different localities – for example, to identify needs for different segments of their populations. If so, HWBs may wish to designate any PNA localities to mirror JSNA localities. The PNA includes a statement setting out how the HWB has determined the localities; the different needs of different localities in its area including the needs of those people in the area sharing a protected characteristic, for example, a large travellers' site; and a report on the consultation undertaken on the PNA.

Maps

4. Paragraph 7 of Schedule 1 of the 2013 Regulations specifies that HWBs are required to include a map in their PNA identifying the premises at which pharmaceutical services are provided in the area of the HWB.

5. Regulation 4(2) requires HWBs to keep the above map up to date, in so far as is practicable (without the need to republish the whole of the assessment or publish a supplementary statement) – see Chapter 4 below.

Case study

Several PCTs worked with other agencies and organisations to produce pertinent maps. When Greater Manchester PCT wanted to determine the accessibility of their pharmacies by determining the hours they were open, they asked the Greater Manchester Passenger Transport Executive for their help in calculating this using a specific software package.

4: Publication and updating of PNAs

What the legislation says

1. Regulations 5 and 6 cover the date by which the HWB's first PNA must be published and the arrangements for revising the PNA.

Publication of first PNA

2. Regulation 5 states that the HWB's first PNA must be published by 1 April 2015. However, this does not preclude HWBs from publishing their first PNA earlier.

Updating and revising PNAs

Timelines for publication of first and revised assessments

- The National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 come into force on 1 April 2013;
- HWBs will be required to produce **the first** assessment **by 1 April 2015**;
- HWBs will be required to publish a revised assessment within **three years** of publication of their first assessment; and
- HWBs will be required to publish a revised assessment as soon as is reasonably practical after identifying significant changes to the availability of pharmaceutical services since the publication of its PNA unless it is satisfied that making a revised assessment would be a disproportionate response to those changes.

6. The following box gives some examples of possible changes which may mean a revised assessment or supplementary statement is needed and the factors HWBs may want to consider:

Revised PNA or supplementary statement?

Example: in its first PNA, the HWB identifies that a housing development is anticipated to commence in the second year of its PNA and that there would be a need for the provision of pharmaceutical services to the development at the point of occupation of the hundredth house. Subsequently, they are advised that the development has been delayed for two years.

In this instance, the HWB may need to consider whether it is disproportionate to revise the assessment in year 2. The HWB may consider not issuing a Supplementary Statement as there have been no changes to the availability of pharmaceutical services.

Example: a contractor with several outlets in the HWB area gives notice that it intends to close all or some of these outlets.

The HWB may consider whether the making of a revised assessment is a proportionate response. Will the provision of services be continued for its population, i.e. are there alternative providers of services? Would closure of all or some of the outlets warrant a full-scale revision of the PNA or would that be disproportionate, taking into account all relevant circumstances? If the change in the availability of pharmaceutical services is likely to have an impact on the need for additional pharmaceutical services, the HWB may consider issuing a supplementary statement.

Example: within its PNA, the HWB has identified that a locality has over-provision of essential and advanced services. Subsequently, one pharmacy within that locality gives notice to NHS England that it intends to close.

Following that closure, the HWB may consider issuing a Supplementary Statement that stated pharmacy X had closed. The HWB may also consider issuing a Supplementary Statement if the change is relevant to whether or not there is a gap in the provision of pharmaceutical services.

5: Consultation

What the legislation says

1. Regulation 8 sets out the requirements for consultation on PNAs. The local authority duty to involve was first introduced in the Local Government and Public Involvement in Health Act 2007 and was updated and extended in the Local Democracy, Economic Development and Construction Act 2008.

Those to be consulted

2. The Regulations set out that:

- HWBs must consult the bodies set out in Regulation 8 at least once during the process of developing the PNA. Any neighbouring HWBs who are consulted should ensure any LRC in the area which is different from the LRC for the original HWB's area is consulted;
- there is a minimum period of 60 days for consultation responses; and
- those being consulted can be directed to a website address containing the draft PNA but can, if they request, be sent an electronic or hard copy version.

6: Matters for consideration when making assessments

What the legislation says

1. Regulation 9 sets out the matters HWBs must have regard to when developing their PNAs as far as is practicable to do so.

Matters for consideration

2. The following are the matters for consideration by HWBs:

- the demography of its area;
- whether there is sufficient choice with regard to obtaining pharmaceutical services; (see box below);

Possible factors to be considered in terms of the benefits of sufficient "choice"

- What is the current level of access within the locality to NHS pharmaceutical services?
- What is the extent to which services in the locality already offer people a choice, which may be improved by the provision of additional facilities?
- What is the extent to which there is sufficient choice of providers in the locality, which may be improved, by additional providers?
- What is the extent to which current service provision in the locality is adequately responding to the changing needs of the community it serves?
- Is there a need for specialist or other services, which would improve the provision of, or access to, services such as for specific populations or vulnerable groups?
- What is the HWB's assessment of the overall impact on the locality in the longer-term?

- any different needs of different localities in its area;
- the pharmaceutical services provided in the area of any neighbouring HWB which affect the need for pharmaceutical services in its area, or whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area;
- any other NHS services provided in or outside the area (not covered above) which affect the need for pharmaceutical services in its area, or whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area; and
- likely future needs (see box below).

Identifying known future needs

Are there:

- known firm plans for the development/expansion of new centres of population i.e. housing estates, or for changes in the pattern of population i.e. urban regeneration, local employers closing or relocating?
- known firm plans in and arising from local joint strategic needs assessments or joint health and wellbeing strategies?
- known firm plans for changes in the number and/or sources of prescriptions i.e. changes in providers of primary medical services, or the appointment of additional providers of primary medical services in the area?
- known firm plans for developments which would change the pattern of local social traffic and therefore access to services, i.e. shopping centres or significant shopping developments whether these are in town, on the edge of town or out of town developments?
- plans for the development of NHS services?
- plans for changing the commissioning of public health services by community pharmacists, for example, weight management clinics, lifechecks?
- introduction of special services commissioned by clinical commissioning groups?
- new strategy by social care/occupational health to provide aids/equipment through pharmacies or dispensing appliance contractors?

Appendix 1 – Glossary of terms and phrases defined in regulation 2 of the 2013 Regulations

Term or phrase	Definition as per regulation 2 of the 2012 Regulations	Explanation
Controlled localities/controlled locality	Means an area that is a controlled locality by virtue of regulation 36(1) or is determined to be so in accordance with regulation 36(2).	A controlled locality is an area which has been determined, either by NHS England, a primary care trust a predecessor organisation or on appeal by the NHS Litigation Authority (whose appeal unit handles appeals for pharmaceutical market entry and performance sanctions matters), to be "rural in character". It should be noted that areas that have not been formally determined as rural in character and therefore *controlled localities*, are not *controlled localities* unless and until NHS England determines them to be. Such areas may be considered as rural because they consist open fields with few houses but they are not a *controlled locality* until they have been subject to a formal determination.

Core opening hours	Is to be construed, as the context requires, in accordance with paragraph 23(2) of Schedule 4 or paragraph 13(2) of Schedule 5, or both.	Pharmacies are required to be open for 40 hours per week, unless they were approved under Regulation 13(1)(b) of the 2005 Regulations in which case they are required to open for 100 hours per week. Dispensing appliance contractors (DACs) are required to be open for not less than 30 hours per week.
Directed services	Means additional pharmaceutical services provided in accordance with directions under section 127 of the 2006 Act.	These are advanced and enhanced services as set out in Directions.
Dispensing doctor(s)	Is to be construed in accordance with regulation 46(1).	These are providers of primary medical services who provide pharmaceutical services from medical practice premises in the area of NHS England; and general practitioners who are not providers of primary medical services but who provide pharmaceutical services from medical practice premises in the area of the HWB.
Distance selling premises	Listed chemist premises, or potential pharmacy premises, at which essential services are or are to be provided but the means of providing those services are such that all persons receiving those services do so otherwise than at those premises.	These premises could have been approved under the 2005 Regulations in which case they could be pharmacies or DACs. Under the 2012 and 2013 Regulations only pharmacy contractors may apply to provide services from distance selling premises. Distance-selling contractors are in the main internet and some mail-order, but they all cannot provide “essential services” to persons face to face at their premises and must provide a service across England to anyone who requests it.

Enhanced services	Means the additional pharmaceutical services that are referred to in direction 4 of the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013.	These are pharmaceutical services commissioned by NHS England, such as services to Care Homes, language access and patient group directions.
Essential services	Except in the context of the definition of "distance selling premises", is to be construed in accordance with paragraph 3 of Schedule 4.	These are services which every community pharmacy providing NHS pharmaceutical services must provide and is set out in their terms of service – these include the dispensing of medicines, promotion of healthy styles and support for self-care. Distance-selling pharmacy contractors cannot provide essential services face to face at their premises.
Neighbouring HWB	In relation to a HWB (HWB1), means the HWB of an area that borders any part of HWB1.	Used when, for example, an HWB is consulting on their draft PNA and needs to inform the HWBs which border their HWB area.
NHS chemist	Means an NHS appliance contractor or an NHS pharmacist.	

Appendix 2 – Frequently asked questions

Q1: What are "pharmaceutical services"?

The NHS Act 2006[3] sets out a wider definition for pharmaceutical services. Pharmaceutical services are generally provided by virtue of Part 7 of the Act. Under section 126(1) – (3), NHS England is required to secure, on the basis of Regulations made by the Secretary of State, the provision of services to people in their area of medicines and listed appliances and "such other services as may be prescribed" (*section 126(3)(e)*). Prescribed services must be set out in Regulations. Therefore, these prescribed services, and the dispensing services referred to in section 126(3)(a) to (d), constitute the core NHS pharmaceutical services. Section 127 also provides for "additional pharmaceutical services" to be set out in Directions to NHS England. This facility was originally introduced in the late 1990s to enable pharmacies to provide other types of service that did not fall within those core services as defined by Section 126(3). Directed services include advanced and enhanced services for pharmacy contractors and advanced services for dispensing appliance contractors.

Pharmaceutical services do not include any services commissioned directly from the above pharmaceutical contractors by local authorities, clinical commissioning groups etc.

Q2: Wouldn't it have been better if the Board produced and updated Pharmaceutical Needs Assessments as it is commissioning NHS pharmaceutical services?

No. Local authorities worked with PCTs (and are now working with NHS England) to produce Joint Strategic Needs Assessments. It was therefore a logical step for HWBs to take over PNAs from PCTs. These PNAs are designed to be an integral part of that wider strategic approach to commissioning. Alongside identifying strategic health needs through JSNAs, HWB PNAs will inform the commissioning of community pharmacy services by NHS England and local public health commissioning decisions.

[3] http://www.opsi.gov.uk/acts/acts2006/ukpga_20060041_en_1

Q3: Is market entry the responsibility of the local authority since they will be more familiar with local health and wellbeing issues than NHS England?

No. Commissioning and market entry are inter-related and if local authorities took on responsibility for market entry, they would also need to be the commissioners of pharmaceutical services. This would divorce pharmaceutical services from the rest of primary care and would create new burdens and costs for local authorities who would need to acquire specialist knowledge to implement legislation with which they were unfamiliar.

Added to that, if a local authority came to the conclusion that there was, for example, a gap in pharmaceutical services, it would have to bear the consequences in terms of more costs to itself of any increased capacity that the local authority had concluded in its pharmaceutical needs assessment was necessary.

Q4: Will Health and Wellbeing Boards be obliged to consult pharmacists about local PNAs?

Yes. The NHS Act 2006 already requires the Department to set out in Regulations various matters about pharmaceutical needs assessments. The 2013 Regulations stipulate minimum consultation requirements, including a need to consult local contractors.

Q5: If the PNA identifies a need for pharmaceutical services, then shouldn't NHS England be required to address that need?

NHS England will be acting under an annual mandate from Secretary of State. Beyond that, NHS England should therefore be free to decide how best to meet its responsibilities for commissioning services according to the needs of the local population. We expect NHS England to weigh all the evidence carefully – taking account of pharmaceutical needs alongside other relevant factors. Placing an obligation on NHS England to fill a gap would hamper the Board's ability to make such robust commissioning decisions.

City of Westminster

Westminster Health & Wellbeing Board

Date:	2 February 2017
Classification:	General Release
Title:	Joint Strategic Needs Assessment (JSNA) Update: Young Adults, Online JSNA and Programme Forward Plan
Report of:	Director of 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:	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.
Report Author and Contact Details:	Jessica Nyman, JSNA Manager, jnyman@westminster.gov.uk, 0208 641 8461

1. Executive Summary

1.1 This report provides an update on the current JSNA work programme and outlines proposals for future projects. The paper presents two JSNA products for consideration and approval by the Health and Wellbeing Board: the Young Adults (18-25) JSNA report and recommendations, and the JSNA Highlights Report online version.

1.2 This paper also asks for the Board's endorsement of the forward plan for a Deep Dive JSNA on Children with Complex Needs and the Pharmaceutical Needs Assessment (PNA), which will be expanded on in a separate paper.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board is requested to consider and approve the Young Adults JSNA for publication.

2.2 The Health and Wellbeing Board are invited to comment on the content and user experience of the **JSNA Highlight Report** (Online JSNA), and share it within their respective organisations after the Board meeting.

2.3 The Health and Wellbeing Board are requested to approve that data in the JSNA Highlights Report (Online JSNA) is updated by the Public Health Intelligence team on a rolling basis as and when it becomes available, and provide an annual summary of changes made to the Health and Wellbeing Board.

2.4 The Health and Wellbeing Board is requested to consider and approve proposals for the future JSNA work programme for 2017/2018, incorporating the Children with Complex Needs JSNA and the refresh of the Pharmaceutical Needs Assessment for 2018, which will be explained in detail in a separate paper.

3. Background

3.1 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 for the JSNA work programme and deep dive JSNAs prior to publication.

3.2 This report provides an update of the current JSNA work programme for 2016/17 and a look forward to the 2017/2018 work programme. Two JSNA products are presented for approval prior to publication:

- Young Adults (18-25) JSNA
- JSNA Highlights Report

4. Current JSNA Work Programme (2016/17)

Young Adults JSNA

4.1 While health and social care service provision has often focussed on children, older people and the very unwell, there is an emerging consensus that the needs of young adults are not always fully understood or being met.

4.2 This deep dive JSNA has looked at the health and wellbeing needs of young adults age 18-25. The key objectives of this JSNA are:

- To capture the unique health and wellbeing needs and issues affecting young adults age 18-25s.
- Identify the provision and gaps in provision of services for young people.
- To identify how to improve early interventions in issues which could affect people's long term outcomes.

4.3 Young adults (age 18-25) make up 10.7% of the population in Westminster and 16% of Central London CCG's patients. Historically, very little evidence has been gathered about their needs and so a JSNA has been conducted on the health and wellbeing needs of 18-25 year olds locally.

4.4 The JSNA looks at how young adults use health and care services, and looks in detail at care leavers, eating disorders, substance misuse and sexual health which were identified as being key areas to establish an evidence base to improve commissioning.

4.5 A full set of the recommendations from the Young Adults JSNA is included in Appendix 1 and Chapter 10 of the full report. The key recommendations are summarised below:

Theme	**Gap or challenge**	**Recommendation**	**Lead**
Primary care	The current model of primary care is not well suited to young adults, who are overall less satisfied with their GP than older adults and more likely to use walk-in centres and urgent care than other age groups. Young adults would benefit from GP services configured to their health needs, such as at The Well Centre in Lambeth.	Pilot an integrated primary care model at one or more GP practice in each CCG with a high number of young adult patients. Consider services which could have a presence, such as sexual health services, eating disorder services and talking therapies. Offer training for GPs in young adults' health.	Chris Neill, Deputy Managing Director
Eating disorders	A small fraction of the estimated numbers of young adults with eating disorders are receiving a service. Evidence shows better outcomes when ED is treated promptly, but waiting times locally are long. National and local strategies require the development of out of hospital services. There is currently only a	Review the eating disorder pathway as part of Like Minded *Serious and Long Term Mental Health Need* population group Business Cases. Consider ways to provide an early intervention eating disorder service in primary care offering NICE recommended rapid triage	Robert Holman, mental health lead, Central London CCG Glen Monks, Associate Director for Mental Health, West

	service in secondary care. The exemplar primary care eating disorder service in Bristol provides cost-effective help before the patient's condition deteriorates.	and assessment by a skilled practitioner in partnership with GPs for those with emerging but not life-threatening Eating Disorders.	London CCG
Care leavers	The greatest area of unmet health and wellbeing needs of care leavers is mental health needs which would not meet the threshold for Adult Mental Health Services.	Extend existing CAMHS or LAC CAMHS services to a tapered service for 16-25 year old care leavers to give continuity to those with a relationship with the service, and extend the offer to include care leavers age 18-25 not already open to LAC CAMHS who are not eligible or suitable for Adult Mental Health services.	Steve Buckerfield, Head of Children's Joint Commissioning
Substance misuse	The majority of young adults in treatment for substance misuse are addressing cannabis and alcohol issues, however adult services cater predominately to crack and opiate users.	Allow flexibility in substance misuse services to provide for young adults up to the age of 25, based on a professional assessment of their need.	Gaynor Driscoll, Head of Substance Misuse Commissioning, Public Health
General	Young adults are particularly difficult to involve in participation and engagement exercises in the typical ways that services engage patients and users.	Coproduce the redesign of services with young people.	All commissioners and service providers

4.6 A wide range of stakeholders were consulted in the development of this JSNA. This included professionals from the three boroughs who work with care leavers; professionals who work with people who misuse substances; and eating disorders professionals; Central London Clinical Commissioning Group's Transformation Redesign Group; the JSNA Steering Group; Westminster Youth Council; and a group of Westminster care leavers. In addition, a draft of the JSNA was circulated to key stakeholders for consultation in November 2016.

JSNA Highlight Report (Online JSNA)

4.7 The JSNA borough Highlight Report for Westminster has been refreshed with the latest available data and is available **through this link**. The highlight report is in a more interactive online format than previous versions, and provides the supporting evidence to the Joint Health and Wellbeing Strategy as well as an overview of the

health and wellbeing needs of local residents.

4.8 The Online JSNA Highlight Report uses national and local evidence sources in a format that links directly to the most recently available data and a variety of other publically available tools.

4.9 The key objectives of this project are:

- To describe the health and wellbeing needs of the local population in order to identify priorities and service planning.
- To enable staff and partners to easily find the rich and extensive data on the population of the Westminster that is publically available but difficult to locate.
- To enable analysts to respond quickly to common questions or requests with the most up to date data without unnecessary duplication of work.
- To increase engagement with the JSNA through a more user-friendly format.

4.10 Previous JSNA Highlight Reports (most recently published March 2014) have been a static document that the Health and Wellbeing Board has signed off, which does not change until a full refresh is completed. The Online JSNA will give a date for all statements and figures, and can be easily updated when new key data becomes available in order to be more responsive to the needs of its users. This will require a change to the governance process for the Highlight Report.

4.11 **It is recommended that the Health and Wellbeing Board agree that data in the Highlight Report can be updated by the Public Health Intelligence team on a rolling basis as and when it becomes available, and provide the Board an annual summary of changes.**

4.12 The content for this online version of the Highlights Report is now in consultation. Health and Wellbeing Board members are invited to comment on the content and user experience in the Board meeting and through the feedback survey in the Online JSNA, and share it within their respective organisations after the Board meeting.

5. Future JSNA Work Programme (2017/2018)

5.1 The JSNA review undertaken in early 2016 recommends the deep dive programme directly aligns to the new Joint Health and Wellbeing Strategies, and that the exact shape of the deep dive programme should be determined with team managers from the main commissioning functions to have the maximum impact: Adult Social Care, Children's Services, The Joint Commissioning Team and the CCGs, in consultation with the Community and Voluntary Sector, and signed off at the Health

and Wellbeing Boards.

5.2 These changes have been implemented and to date, the following topic for a deep dive JSNA has been identified:

Children and Young People with Complex Needs JSNA

5.3 The Children's Services Director of Commissioning and the Head of Children's Joint Commissioning have identified that the deep dive topic that would best support the Joint Health and Wellbeing Strategy priority '*Supporting children, young people and families to have the best possible start in life*' is on **children and young people age 0-25 with complex health and care needs** as we do not currently have a jointly agreed robust dataset to underpin planning.

5.4 Under the Children and Families Act 2014, local authorities and CCGs are obliged to gain an understanding of this population in order to inform a joint commissioning strategy. A joint Ofsted and CQC inspection could take place imminently, and Ofsted will need to see evidence of the local need and how the local authority and NHS are planning to meet it.

Pharmaceutical Needs Assessment (PNA) – 2018 refresh

5.5 In addition, each HWB is required to publish a PNA by virtue of section 128A of the National Health Service Act 2006 (pharmaceutical needs assessments). **The Westminster PNA will be delivered as part of the JSNA work programme.** More detail will be provided in a separate PNA paper.

6. Legal Implications

6.1 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).

6.2 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.

6.3 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.

6.4 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.

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

7. Financial Implications

7.1 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.

7.2 Implications verified/completed by: Richard Simpson, Finance Manager – Public Health, telephone 020 7641 4073.

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 – Young Adults JSNA Recommendations

BACKGROUND PAPERS: Young Adults JSNA

Appendix 1: Young Adults JSNA Recommendations

Topic	Gap or challenge	Potential solution/recommendation
Primary Care	The current model of primary care is not well suited to young adults, who are overall less satisfied with their GP than older adults. YA would benefit from GP services configured to their health needs, such as at The Well Centre in Lambeth. Co-location has come up across chapters as an effective way of increasing young adults' uptake of appropriate services, particular in hard to engage cohorts such as care leavers. Small changes that all GP practices can facilitate would make a positive difference.	1. Pilot an integrated primary care model at one or more GP practice in each CCG with a high number of young adult patients. Consider services which could have a presence, such as sexual health services, eating disorder services and talking therapies. Offer training for GPs in young adults' health. a. Consider opportunities for this approach in other contexts with target populations, such as co-location of health services at care leaver peer support groups. 2. Train local GPs and GP practice staff in the GP Champions for Youth Health Project's Toolkit for General Practice. CCGs should make use of the GP Champions for Youth Health Project's Commissioning Effective Primary Care Services for Young People.
	A small fraction of the estimated numbers of young adults with eating disorders are receiving a service. Additionally,	3. Review the eating disorder pathway as part of Like Minded Serious and Long Term Mental Health Need population group Business Cases. Consider ways to provide an early intervention eating disorder service in primary

Eating disorders	evidence shows better outcomes when ED is treated promptly in the first 3 years of the illness, but waiting times locally are long. National and local strategies require the development of out of hospital services and an early intervention approach to protect mental and physical health and wellbeing. There is currently only a service in secondary care. The exemplar primary care eating disorder service in Bristol provides cost-effective and well received help before the patient's condition deteriorates and requires treatment in secondary care.	care offering NICE recommended rapid triage and assessment by a skilled practitioner in partnership with GPs for those with emerging but not life-threatening Eating Disorders. a. Such a service would then be capable of providing the leadership and momentum for the following recommendations.
Eating disorders	The current NICE guidelines are from 2004, over a decade old, and are currently being updated with publication expected in 2017.	4. Review existing services against new NICE guidelines when available in 2017.
	Professionals outside of specialist ED services do not consistently understand what to do when an eating disorder is identified, and how to manage an eating disorder patient.	5. Map pathways and create a tool for professionals to use to enable appropriate and timely referrals. 6. Offer guidance to GPs and other health professionals to identify and then work constructively and appropriately with people with an eating disorder. a. Identify GPs with high numbers of young adults and low referral rates to eating disorder services as a target group for training.

Care Leavers	Looked after children have higher rates of mental illness than the general population; nearly half have a mental disorder. In consultation with care leavers, there was a lack of awareness and coping strategies. However, some may not want help in a clinical setting. National evidence suggests good outcomes for mentoring, which may be more appropriate where psychological therapies are not wanted.	7. Actively promote resilience, prevention and early intervention for good mental health for all in generic services for care leavers. a. Review current and past mentoring and peer mentoring schemes in the three boroughs for care leavers and / or young adults.
Care Leavers	The greatest area of unmet health and wellbeing needs of care leavers is mental health and emotional wellbeing that would not meet the threshold for Adult Mental Health Services. Nationally, 'Future in Mind' and locally, The Anna Freud Centre needs assessment for CAMHS recommend a tapered transition from age 16-25. LAC CAMHS see children over long time periods and specialise in trauma, which is most appropriate to this cohort. Some care leavers have existing relationships with LAC CAMHS staff which they would benefit from continuing; other are not ready to engage with counselling services until they are age 18 or above.	8. Extend existing CAMHS or LAC CAMHS services to a tapered service for 16-25 year old care leavers to give continuity to those with a relationship with the service, and extend the offer to include care leavers age 18-25 not already open to LAC CAMHS who are not eligible or suitable for Adult Mental Health services. a. The offer to care leavers should include flexibility if appointments are missed or service users don't want to be seen in a clinical setting.

	A significant proportion of local care leavers are former UASCs, and have specific health and care needs.	9. Professionals including Leaving Care teams to be fully trained on national guidance for unaccompanied asylum seeking and trafficked care leavers
	Consultation with care leavers identified that many sought advice from non-health professionals who they had a trusting relationship with e.g. their social worker. Although almost all are registered with a GP, most prefer to use walk in centres, A&E and urgent care. The needs and preferences of care leavers vary significantly from person to person, meaning a specific service may not be appropriate.	10. Non-health professionals working with care leavers e.g. personal advisors and key workers should routinely take an active role in the health of care leavers, such as taking them to the GP and encourage seeking help in the appropriate setting. a. Pilot a personal budget for care leavers, where an assessed physical or mental health need is established, to allow them to choose a relationship with the professional that best meets their needs
Care leavers	A small number of care leavers have significant multiple complicated physical, mental and social care needs, and a large number of professionals become involved in their case.	11. Pilot a transitions panel similar to the disabled children's panel for cases of care leavers with multiple or complicated needs.
Substance misuse	The majority of young adults in treatment for substance misuse are addressing cannabis and alcohol issues, however adult services cater predominately to crack and opiate users.	12. Review adult and young people's service offer to ensure a flexible, responsive and coordinated service is available to meet the needs of young people who use a range of substances. Allow flexibility in the young people's substance misuse services to provide for young adults up to the age of 25, based on a professional appraisal of where their need can best be met.

	Vulnerable groups are more susceptible to harmful substance misuse.	13. Develop a local strategy to reduce substance misuse among vulnerable and disadvantaged under 25s as recommended by NICE (2007).
	Although numbers in services are relatively small, substance misuse is widespread amongst young adults. There is significant variation between the boroughs in their referral rates into substance misuse services from key partners.	14. Continue to develop awareness and training for a broad range of professionals in contact with young adults to enable conversations to be started earlier, rather than when a problem has taken hold. Training should include building resilience in young people to resist pressures in their social groups, schools and universities. a. Work with young people's services, GPs and hospitals to embed effective pathways and interventions which target those most at risk of substance misuse.
Sexual Health	Sexual health is a key health issue for the vast majority of young adults.	15. Ensure all commissioned sexual health services adhere to the You're Welcome standards.
	There is a strong link between substance misuse and risky sexual behavior.	16. Consider integration of substance misuse and sexual health services for young people.
	There are clear inequalities in sexual health, particularly in socio-economic status. Care leavers have significantly higher rates of pregnancy than the general young adult population.	17. Work with young people's services to embed effective pathways and interventions which target high risk groups including care leavers.
	Young people consulted reported that adults and professionals over-medicalise what to them is a social issue.	18. Develop sexual health services to proactively address the psychosocial aspects of sexual health.
	The Framework for Sexual Health Improvement in England recommends the	19. Collaborate with other London boroughs to prioritise prevention and provide consistent health messages to enable young people to make informed and responsible decisions**.**

	prioritisation of prevention and that all young people are informed to make responsible decisions, and are aware of the risks of unsafe sex.	20. Improve local prescription of Long Acting Reversible Contraception (LARCs).
General	There is existing good practice guidance for services working with young adults on transitions and service design.	21. Health and care services should self-assess against the NICE guidance on transition from children's to adults' services for young people using health or social care services, and services that young people access should adopt the Government's 'You're Welcome' quality criteria to be more suited to young adults.
	Young adults are particularly difficult to involve in participation and engagement exercises in the typical ways that services engage patients and users.	22. Coproduce the redesign of services with young people.

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Health and Wellbeing Needs of Young Adults age 18-25

Joint Strategic Needs Assessment (JSNA) Report

The London Borough of Hammersmith & Fulham

The Royal Borough of Kensington and Chelsea

The City of Westminster

DRAFT

Pending sign-off at Health and Wellbeing Boards

January 2017

www.jsna.info

This report

This needs assessment on young adults supports the development of strategy and Local Authority (LA) and Clinical Commissioning Group (CCG) commissioning intentions to improve services for young adults.

It covers the health and wellbeing needs of young adults, focussing on 18-25 year olds but considering wider age groups where appropriate, in the London Borough of Hammersmith and Fulham, The Royal Borough of Kensington and Chelsea, and the City of Westminster. The report focuses in particular on:

- Eating disorders
- Care leavers
- Substance misuse
- Sexual health
- Wider determinants of health

Data has been collected from a number of sources, including the 2011 census from the Office for National Statistics, and local data provided by stakeholders and providers. Workshops and interviews were conducted with key local stakeholders and providers.

Authors and contributors

This report was written by Jessica Nyman with support from Naomi Potter, Clare Lyons-Amos, Chrisa Tsiarigli, Dr Gayan Perera, Toby Hyde, Colin Brodie, Matthew Mead, Steve Buckerfield and Rachel Krausz.

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Joint Strategic Needs Assessments (JSNAs)

The purpose of JSNAs is to improve the health and wellbeing of the local community, and reduce inequalities for all ages, by informing all relevant parties about the health and social care needs of the local population and how these may be addressed. They are assessments of the current and future health and social care needs of the local population, with the core aim of developing local evidence-based priorities for commissioning and strategies. The needs identified may be met by the local authorities, CCGs, NHS or others.

JSNAs are a continuous process of strategic assessment and planning, and are an integral part of CCG and local authority commissioning and planning cycles. Their agreed priorities are used to help determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing. Past reports can be found at www.jsna.info.

CONTENTS

1 Executive summary

While health and social care service provision has often focussed on children, older people and the very unwell, there is an emerging consensus that the needs of young adults are not fully understood or being met (Care Quality Commission, 2014; Goddard, 2015). More information on the needs of this age group is needed to inform local commissioning and service design, but available data and evidence (and consequently the conversation) is often merged into wider age groups (e.g. 19-64 year olds). It is therefore difficult to obtain a more specific understanding of the needs of young adults.

It is important to understand the health and care needs of this population better in order to improve their immediate and long-term outcomes (not just health), particularly those with long-term conditions. This will ensure that services are configured to meet the particular needs of young adults, and to support the transition from children's to adults' services. This JSNA seeks to describe the local characteristics of this age group and address a number of their key health and care issues.

An interactive summary of the key data and findings can be found on the **Online JSNA**.

1.1 Key themes

A number of cross-cutting themes with this age cohort became apparent across the different chapters:

Age 18 cut-off and transitioning into adult services	Across service types, practitioners and evidence suggest that having a cut-off point at age 18 is arbitrary and unhelpful. The needs and 'emotional ages' of 18 years olds differ widely, and some young adults may receive more appropriate care in a young people service than an adult service. This is unlikely to be resolved via a change to a different cut-off, so services should move towards a model of being needs-led. Additionally, young people and professionals agree on the value of continuity and stability at age 18, especially given the changes happening in people's lives at this age. The interruption of having to transition before the person is ready can have a negative outcome.
Use of health services including GPs	The model of care in a traditional GP practice is not well suited to this cohort. Young adults are less likely to go to their GPs for a variety of reasons: one being a fear of their confidentiality being breached if they have a family GP, another being that they tend to seek help in a crisis, and so will use urgent care or A&E rather than waiting to see a GP. Additionally, young adults are more likely to disengage with services or be discharged for missing an appointment, particularly if they do not have a parent or carer to encourage them to seek help and attend.
Training and awareness	Professionals who do not work solely with young adults, such as GPs, may benefit from training and awareness to identify issues that particularly affect young adults, how to discuss these constructively, and work with parents, carers, family and friends where appropriate.
Transient populations	The young adult population has a higher migration rate in and out of the boroughs than the rest of the population. They are more likely to leave home during this time, such as for university. This can interrupt delivery of health or care services or treatment, and

	may require coordination between different boroughs and Clinical Commissioning Groups (CCGs). They are more likely to be registered with a GP in a borough they do not live in. This challenges the continuity and integration of care that local services can offer, and requires empowerment of this cohort to effectively manage their own health and seek advice when required.
Participation and user involvement	Young adults are particularly difficult to involve in participation and engagement exercises in the typical ways that services engage patients and users. Alternative methods should be explored such as online platforms, youth forums and community networks.
Joined-up working and co-location of services	The importance of effective communication across professional boundaries, in particular children's and adults' services but also between health, local authority and the voluntary sector, is key to person-centred care. This was highlighted as an area for improvement locally in some of the key chapters examined in this report. Co-location has been consistently identified as a way to make services more user-friendly for young people, making them more likely to engage. The Well Centre in Lambeth co-locates GPs and youth workers, with close working with other services such as sexual health and substance misuse services. This also makes it easier for professionals to discuss the needs of the person.
Service design	Common service design requirements for young adults include flexibility, evening and weekend hours. Alternative models such as telephone, text and online appointments are also recommended.
Gender	Differences in gender can be seen in young adults. Young women are three times as likely to have a common mental disorder and ten times as likely to have an eating disorder as young men. Young men are more likely to have problematic substance misuse and less likely to be seen in services in their expected numbers.

1.2 Summary of Key Recommendations

Chapter	Gap / challenge	Recommendation
Primary care	The current model of primary care is not well suited to young adults, who are overall less satisfied with their GP than older adults and more likely to use walk-in centres and urgent care than other age groups. Young adults would benefit from primary care services configured to their health needs, such as at The Well Centre in Lambeth.	Pilot an integrated primary care model at one or more GP practice in each CCG with a high number of young adult patients. Consider services which could have a presence, such as sexual health services, eating disorder services and talking therapies. Offer training for GPs in young adults' health.
Eating disorders	A small fraction of the estimated numbers of young adults with eating disorders are receiving a service. Evidence shows better outcomes when ED is treated promptly, but waiting times locally are long.	Review the eating disorder pathway as part of Like Minded *Serious and Long Term Mental Health Need* population group Business Cases. Consider ways

	National and local strategies require the development of out of hospital services. There is currently only a service in secondary care. The exemplar primary care eating disorder service in Bristol provides cost-effective help before the patient's condition deteriorates.	to provide an early intervention eating disorder service in primary care offering NICE recommended rapid triage and assessment by a skilled practitioner in partnership with GPs for those with emerging but not life-threatening Eating Disorders.
Care leavers	The greatest area of unmet health and wellbeing needs of care leavers is mental health needs which would not meet the threshold for Adult Mental Health Services.	Extend existing CAMHS or LAC CAMHS services to a tapered service for 16-25 year old care leavers to give continuity to those with a relationship with the service, and extend the offer to include care leavers age 18-25 not already open to LAC CAMHS who are not eligible or suitable for Adult Mental Health services.
Substance misuse	The majority of young adults in treatment for substance misuse are addressing cannabis and alcohol issues, however adult services cater predominately to crack and opiate users.	Allow flexibility substance misuse services to provide for young adults up to the age of 25, based on a professional assessment of their need.
General	Young adults are particularly difficult to involve in participation and engagement exercises in the typical ways that services engage patients and users.	Coproduce the redesign of services with young people.

The full recommendations are at the end of every chapter, and summarised together in Chapter 10.

2 Introduction

2.1 National picture

While health and social care service provision has often focussed on children, older people and the very unwell, there is an emerging consensus that the needs of young adults are not being met or fully understood (Care Quality Commission, 2014; Goddard, 2015). More information on the needs of this age group are needed to inform local commissioning and service design, but available data and evidence (and consequently the conversation) is often merged into wider age groups (e.g. 19-64 year olds). This makes it difficult to obtain a more specific understanding of the needs of young adults.

Consensus is emerging through legislation and guidance that the needs of children and young people do not end at age 18, and a number of recent legislative changes and likely future legislative changes use the upper age limit of 25. The Children and Families Act 2014 has made this legislation for children with Special Educational Needs and Disabilities (SEND). The government report *Future in Mind* (Department of Health & NHS England, 2015) advised the age limit of children's mental health services should extend to age 25. The *Keep on Caring* strategy (HM Government, 2016) will extend the government duty to care leavers up to age 25 (see chapter 6). A recent NSPCC report (Bazalgette, Rahilly, & Trevelyan, 2015) described the withdrawal of CAMHS at 18 as a "cliff edge", and recommended that local authorities and health services should work together to provide mental health support for care leavers up to the age of 25.

Young adulthood is a time of significant change in life. It is an important phase of development where individuals lay the foundations for their adult futures and set behaviour patterns. Both positive and negative experiences can have a long-lasting effect. It is a time of transitioning away from being a child towards independence; living away from family; moving from school to work or university. For those with health and social care needs it can involve moving from paediatric to adult health and care services, for which NICE have produced best practice guidance (NICE, 2016). Person-centred care is particularly important for this age group, given their range of needs and 'emotional ages'.

However, young adults report widespread difficulties in accessing care (Hagell, Coleman, & Brooks, 2015). Young adults are regular users of healthcare; although many are satisfied with their experiences, many are not, and the proportions saying they are not tend to be higher than in other age groups (Healthy London Partnership, 2015). Government guidance on young people friendly services – the 'You're Welcome' quality criteria (Department of Health, 2011) - is not widely known about or used consistently.

2.2 Young adults in Hammersmith and Fulham, Kensington and Chelsea and Westminster

Young adults (age 18-25) make up around a tenth of the resident population in the three Boroughs (**12.2% in Hammersmith and Fulham, 9.6% in Kensington and Chelsea, and 10.7% in Westminster**) and a slightly smaller proportion of GP registered patients in **Hammersmith and Fulham Clinical Commissioning Group (9.3%) and West London CCG (8.1%). In Central London CCG this age group constitutes 16%** of GP registered patients. Despite this, very little evidence has been gathered about their health and wellbeing needs.

Locally, there is an understanding that this age group is transient, culturally diverse, and includes a significant student population. This JSNA seeks to describe the local characteristics of this age group and address a number of their key health and care issues.

2.3 Definitions and scope of the Young Adults JSNA

This JSNA will focus on 18-25 year olds, and in some areas people about to turn 18. However, data is not being systematically collected in this exact age bracket, and so in some instances this report will cover broader age ranges. Where this occurs, it will be made explicit in the text. In addition, the diagram below shows which age groups are covered by the data sources we have used.

Table 1: Age groups covered by data sources

	15	16	17	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**
GLA 2014 Round (population estimates) **18-25**				■	■	■	■	■	■	■	■
ONS (various population estimates) **18-25**				■	■	■	■	■	■	■	■
HSCIC (CCG data) **18-25**				■	■	■	■	■	■	■	■
Primary Care Mortality Database **18-25**				■	■	■	■	■	■	■	■
NICE (LAC and Care Leavers data) **15-17** and **18+**	■	■	■	■							
Frameworki (regarding UASC) **16-18**		■	■								
Public Health England (Drug use trends) **18-24**				■	■	■	■	■	■	■	
ONS Opinions & Lifestyle Survey 2013 **16-24**		■	■	■	■	■	■	■	■	■	
National Drug Treatment Database **15-24**	■	■	■	■	■	■	■	■	■	■	
LAPE (PHE) **16-24** and **18-25** (varies)		■	■	■	■	■	■	■	■	■	
GUMCAD (sexual health) **15-24**	■	■	■	■	■	■	■	■	■	■	
LASERS (sexual health) **16-24**		■	■	■	■	■	■	■	■	■	
NOMIS (employment data) **18-24**				■	■	■	■	■	■	■	

In agreement with key stakeholders, this report will seek to explore some particular issues which affect this age group where we are currently lacking a strong evidence base for commissioning:

- Eating disorders
- Care leavers
- Substance misuse
- Sexual health
- Wider determinants of health

This report will complement and build on other local projects, such as the needs assessment on Children and Young People's Mental Health undertaken by the Anna Freud Centre on behalf of the North West London Like Minded work programme.

The needs of young people with complex needs transitioning from Children's Services to Adult Social Care (such as children with a learning disability or autism spectrum disorder) are different to the needs described in this document. They are therefore out of scope and will be looked at in a further deep-dive JSNA on people age 0-25 with complex needs and disabilities. Additionally, the review of the wider determinants of health for this cohort – including crime and safety, housing, and employment – in chapter 9 will not go into as much detail as other chapters, as work in this area is covered in greater detail in other departments.

2.4 Relation to commissioning

This JSNA will highlight unmet need, which can inform CCG commissioning intentions, as well as the local authorities, providers of services and the community and voluntary sector.

The findings and recommendations in this report should be considered in relation to the opportunities arising in each borough.

Cross-borough/CCG programmes

- North West London Sustainability and Transformation Plan
- North West London Like Minded Strategy and Programme – mental health transformation (see Chapter 5 recommendations)
- Children and Adolescent Mental Health Services transformation (see Chapter 6 Recommendations)
- Development of policy and guidance for the issue of a personal budget for children and young people with an Education, Health and Care Plan with a focus on outcomes, which could be adapted into a consistent approach for care leavers (see Chapter 6 Recommendations).

Hammersmith and Fulham

- Old Oak redevelopment
- GP Practice Redesign at urgent care practices (see Chapter 4 Recommendations)
- Redesign of Urgent Care Centres (see Chapter 4 Recommendations)

Kensington and Chelsea

- West London CCG's new Living Well Service for mental wellbeing
- Adult IAPT accepting new patients from age 16
- Development of hubs model of delivery of health and care services including children's hubs, Whole Systems Integrated Care hubs and Care Leaver hubs currently in development (see Chapter 6).

Westminster

- Harrow Road redevelopment
- Church Street redevelopment
- Two specialist young adults GP practices at Imperial and King's College (see Chapter 4)
- Development of hubs model of delivery of health and care services (see Chapter 4)

2.5 Objectives

The key objectives of this document are:

- To capture the unique health and wellbeing needs and issues affecting young adults aged 18-25 years
- Identify the provision and gaps in provision of services for young people
- To identify how to improve early interventions in issues which could affect people's long term outcomes.

3 Population profile

This chapter will describe the young adult population in Hammersmith and Fulham, Kensington and Chelsea, and Westminster.

The majority of the data available in the report is for 18-25 year olds; however, some data is not routinely collected for this age group. Whenever a different population age group is used, it is explicitly stated. The data used in the report is the latest available at the time of writing.

3.1 Summary

The young adult population of the three boroughs and CCGs is more ethnically diverse and more transient than the adult population. The areas most densely populated by young adults tend to be close to universities. Central and West London CCG's registered population are more likely than most CCG's patients to be resident in a borough other than Westminster and Kensington and Chelsea, due to the student population registering at university practices but living elsewhere.

3.2 Behaviours and characteristics

3.2.1 Risk taking

Young adults are known to have higher risk-taking behaviours such as smoking, binge drinking, substance misuse and unprotected sexual intercourse.

3.2.2 Use of technology

In 2015, 90% of 16-24 year olds owned a smartphone (Ofcom, 2015). Adolescents and young adults use technology to access information in their daily lives, but services have not yet successfully adapted to this.

NHS Go app

Through the NHS's Healthy London Partnership patient engagement activities, it has been recognised that young people often lack basic knowledge of how to access healthcare services. Engagement with young people highlighted easier access to services, particularly ways to get support out of hours and at weekends, as a priority. This gap in providing more readily accessible information needs to be filled in a way that is inclusive to young people by using forms of technology that they already utilise.

Young people co-designed an app to enable easily access information about health services, as well as healthy lifestyle advice, via a 'youth friendly portal'. The app can be downloaded through mainstream app stores.

3.2.3 Students

There are a number of large universities in central London, and many students either reside in the three boroughs, or are registered to GPs in the three boroughs – in particular Central London CCG, which has two student GP practices at King's College and Imperial.

3.3 Demography

3.3.1 Numbers or resident and registered young adults age 18-25

The population figures below are projected estimates for 2016 produced by the Greater London Authority. These projections take into account new housing developments.

Table 2: Estimated resident and GP registered population age 18-25

	Estimated Residents		CCG registered		
Local Authority / CCG	Resident	% of resident population	Registered	% of registered population	% of residents registered with CCG
LBHF / H&F CCG	22,294	**12.5%**	19,640	**9.3%**	88.1%
RBKC / WL CCG	15,582	**9.6%**	19,742	**8.1%**	126.7%
WCC / CL CCG	29,845	**10.7%**	34,338	**16%**	115.1%

Source: GLA R2014 SHLAA EGPP – capped, GP registered list size population (Jan 2016), HSCIC

The GP registered young adult population in two of the boroughs is higher than the resident population, as is the case for all ages. However, Hammersmith and Fulham has fewer young adults registered with a GP than young adults in its resident population.

Westminster and Kensington and Chelsea have an inflated registered population because patients who work or study in the two boroughs register with a GP practice near their university or work rather than in the CCG where they reside. This problem is relatively unique to inner London boroughs and CCGs, as most of England are registered and resident within the same borough and CCG boundary. In addition to this, many people die or emigrate to other areas or overseas and remain on the register, which is another cause of inflation in the GP practice population.

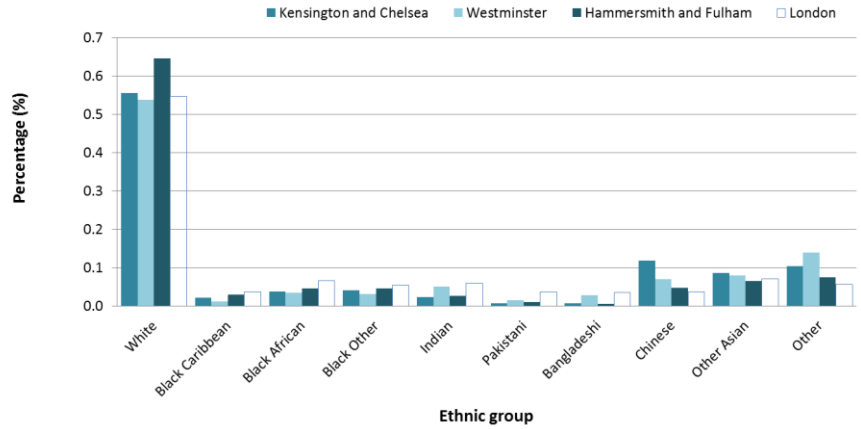
Although Westminster has higher numbers of young adults, Hammersmith & Fulham has the highest proportion (12.2%) of young adult residents of the three, while Kensington and Chelsea has the lowest proportion of young adults with 9.6%.

Central London CCG has significantly higher proportion of young adults than the other two CCGs (16% compared to 8.1% in West London CCG and 9.3% in Hammersmith and Fulham CCG). The two student GP practices inflate their numbers.

From Table 2, an estimated 26.7% of young adults in Kensington and Chelsea (4,160) and 15.1% in Westminster (4,493) are eligible to access local healthcare services as they are registered with a GP there, but not eligible for local authority-provided services as they are not resident in these boroughs. This may impact upon person-centred care and good integration of health and care services that are commissioned and provided by the local authority and the NHS.

3.3.2 Ethnicity

Figure 1: Estimated young adult population by ethnic group, 2016



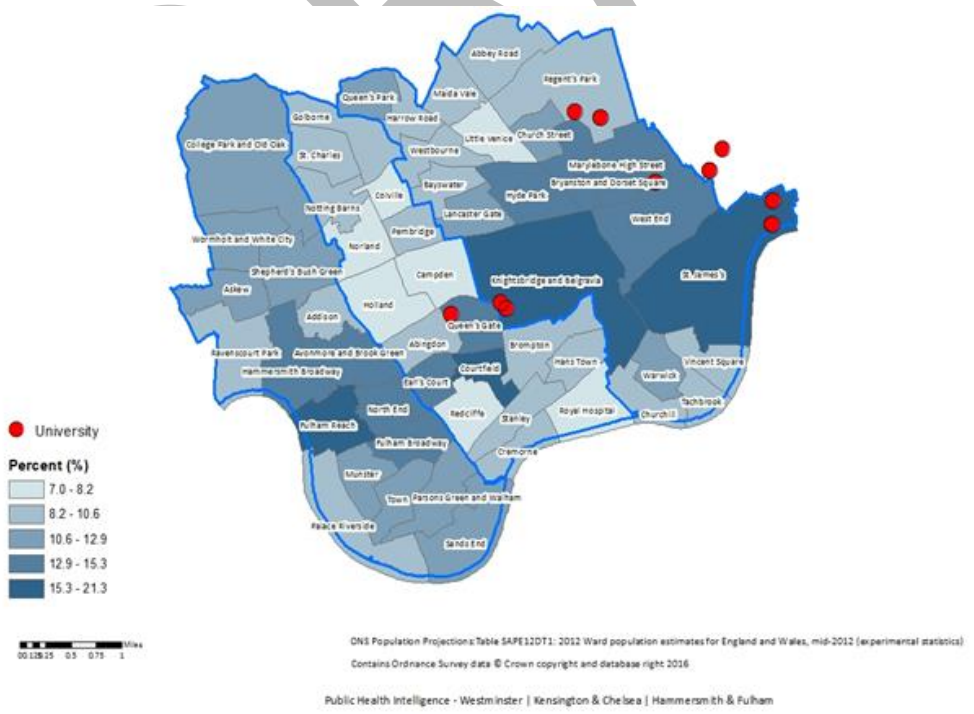
Source: GLA R2014 SHLAA EGPP – capped

The populations of each borough are predominately 'white', however there is a higher proportion of BME groups amongst 18-25s than the general population.

3.3.3 Location

The electoral wards with the highest proportion of young adults are Fulham Reach (18.3%) in Hammersmith & Fulham, Courtfield (18.7%) in Kensington & Chelsea, and Knightsbridge and Belgravia (21.3%) in Westminster. Many of the wards with the highest concentrations of young adult population are those in which a university is located.

Figure 2: Map showing percentage of young adult population by ward, 2015



Source: ONS, 2015

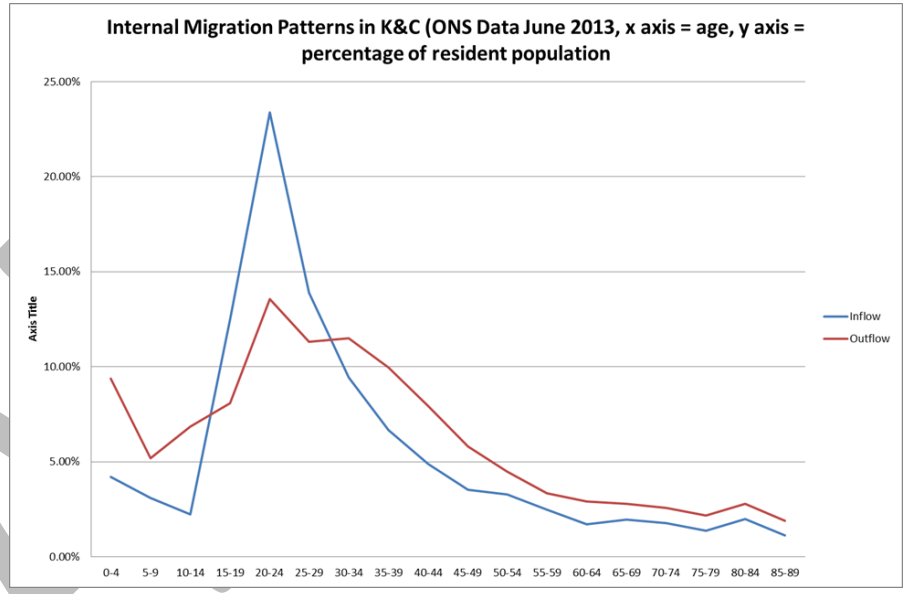
3.3.4 Migration

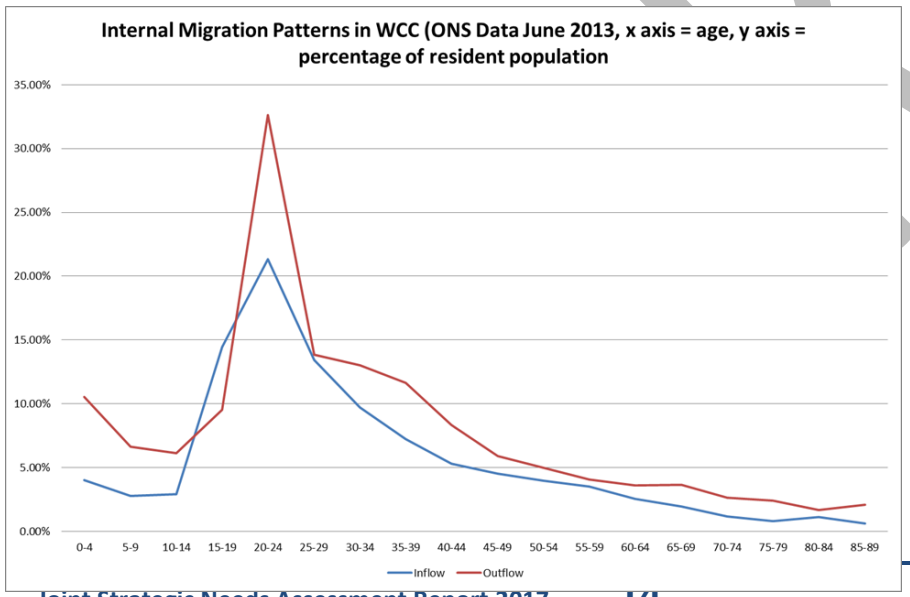
The young adult population of the three boroughs is significantly more mobile; they make up a far higher percentage of the estimated migration in and out of the borough than their percentage of the general population. Westminster has the highest net migration, and each borough has a higher rate of migration in that out.

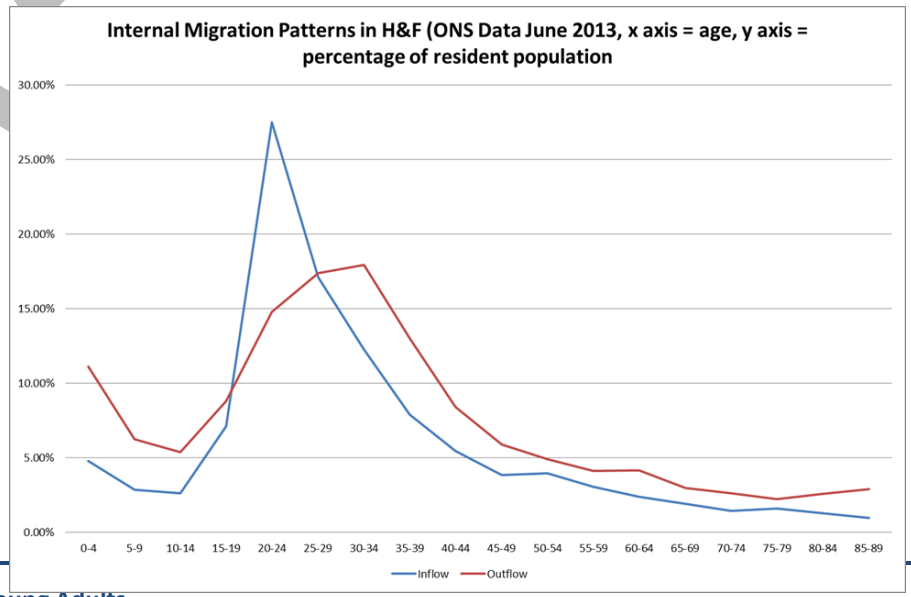
This shows that this age group is more likely to leave home during this time, such as for university. This can interrupt a health or care service they may be receiving, or require coordination between different boroughs and CCGs. They are also more likely to be registered with a GP where they no longer live. This challenges the continuity of care that local services can offer, and requires empowerment of this cohort to manage their own health and seek advice when required.

Transitions for university students, such as for mental health services, have extra complexity due to geographical relocation and transience of residence. Students may need access to mental health support at

Figure 3 Internal migration patterns





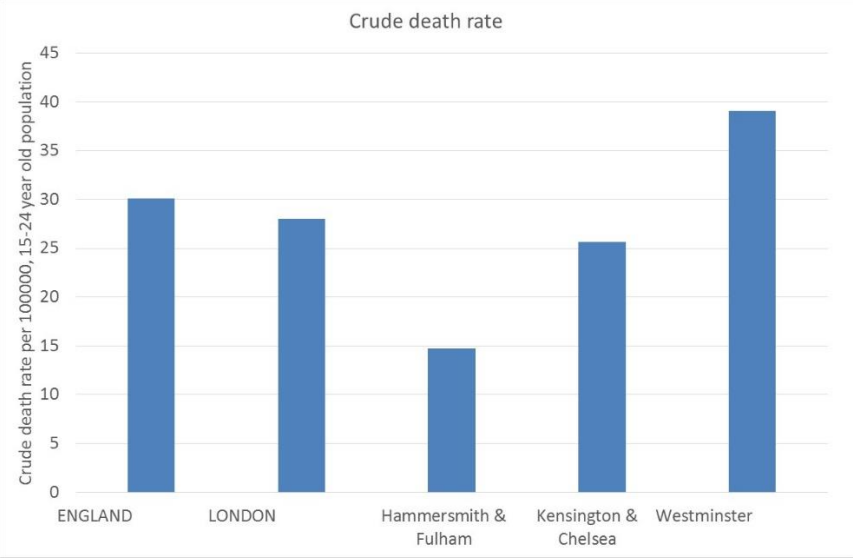


home and at university, from both primary and secondary care services. The production of best practice guidance for CCGs and GPs around student transitions, encouraging close liaison between the young person's home-based and university-based primary care teams, and promoting adherence to NHS guidelines on funding care for transient populations (Department of Health & NHS England, 2015), would be valuable to ensure seamless care.

3.3.5 Deaths

Although numbers of deaths in 15-24 year olds are low, in comparison with London and England Westminster has a significantly higher rate. **The most frequent cause of death is accidents and a significantly higher number are young men**, as is consistent nationally.

Figure 4 Crude mortality rates for young people age 15-24, 2010-14



Source: Office for National Statistics mortality data by age

4 Primary and Secondary Care health services

4.1 Primary Care

Nationally, 16–24 year-olds are less satisfied than older adults using GPs (Hagell et al., 2015). They have greater difficulty in booking GP appointments and are twice as likely to attend A&E or a walk-in centre.[1]

The Association for Young People's Health (AYPH) carried out the *GP Champions for Youth Health* project[2] from 2012-2015, funded by the Department of Health. This identified the issues adolescents and young adults experience with GPs, and through collaboration between GPs and the voluntary sector, developed new services and referral pathways for young people. The project produced the *Toolkit for General Practice*[3], a resource for all GP practices, and CCG guidance on *Commissioning Effective Primary Care Services for Young People*[4]. This includes taking sufficient time to understand underlying problems they may struggle to disclose, as well as practical elements such as drop-in appointments after college, and enabling online appointment booking.

The project explored GPs working jointly with the community and voluntary sector through the Youth Information, Advice and Counselling Services (YIACS) network to provide better health services for young people by: offering good health information through other services, supporting self-management of health needs, developing strong relationships, focussing on the holistic needs of young people, and more commonly working with people up to age 25 to support them through transition.

4.1.1 Issues with primary care

GPs provide a key universal healthcare service to people across the life course, and are a key referral point for specialist services. However, primary care was consistently highlighted as an area for improvement for young adults' health locally, in workshops relating to other chapters in this report such as substance misuse, eating disorders and care leavers, and in consultation with young people.

Confidentiality: An issue which has been raised consistently by young adults and professionals is a lack of trust in the confidentiality between GPs and young adults, particularly with a family GP.

[1] GP Champions for Youth Health Project. *Toolkit for General Practice (online)* http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/GPToolkit_ONLINE.pdf (accessed 14.12.16)

[2] AYPH. *GP Champions (online)* http://www.youngpeopleshealth.org.uk/our-work/young-peoples-participation/gp-champions (accessed 14.12.16)

[3] GP Champions for Youth Health Project. *Toolkit for General Practice (online)* http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/GPToolkit_ONLINE.pdf (accessed 14.12.16)

[4] GP Champions for Youth Health Project. (online). *Commissioning Effective Primary Care Services for Young People* http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/Commissioners_ONLINE.pdf (accessed 14.12.16)

Help seeking behaviour: In focus groups with local young people, they tend to seek help in a crisis, and so will use urgent care or A&E rather than waiting to see a GP.

Experiences at the GP: several young people reported negative experiences of GP practices from GPs and reception staff, particularly when they went without parents.

Care leavers: consultation with local care leavers raised the issue of continuity being important for care leavers, but them being unable to see the same GP and build a relationship. The group reported that they tend to use A&E, even for a check-up of a long term condition in one case. (See chapter 6 – Care Leavers).

Good practice case study: The Well Centre, Lambeth, provided by Redthread

The Well Centre in Lambeth is an example of the community and voluntary sector supporting good primary care for young people. It is a 'one-stop shop' providing GP services, youth work and nurse-led mental health services from one location attached to an existing youth centre. By providing healthcare in a youth-oriented environment, the Well Centre's founders – the Redthread youth work charity and the Herne Hill Group Practice – aim to address the common concerns of young people regarding primary care. This group frequently reports dissatisfaction with accessing healthcare, and often finds it difficult to speak to GPs over fears of breached confidentiality or being misunderstood. However, early intervention is vital: half of all lifetime cases of psychiatric disorders start by age 14 and three quarters by age 24.

Young people can either attend on a drop-in basis or by booking an appointment in advance, and as of December 2015 over 1400 had signed up. Well Centre staff also run workshops, lessons, and youth work outreach activities – including school assemblies, PHSE and regular counselling sessions in schools. Approximately 30% of the Well Centre's patients are aged 18 or over, and 43% visited from beyond the Lambeth CCG area, suggesting a wider demand for the service in terms of both age and geography.

A 2015 study (Hagell & Lamb, 2016) of the Well Centre suggested that it was accomplishing its goal of providing services to more vulnerable and socially excluded residents. Although outcome measures are still in development, 59% of young people have reported an improvement in their life satisfaction since first starting to attend. One-third of those studied in 2014 reported having no other doctor, while the proportion of those living in single-parent households was over double that of the general population. A disproportionately high number were not in education, employment or training. In terms of cost-effectiveness, a preliminary cost benefit analysis undertaken in May 2014 calculated that the Well Centre cost £450 per client; every case seen potentially saved the NHS £713 through avoided A&E visits and other long-term costs.

4.1.2 Local primary care use: General Practitioners (GPs) Practices

A few GP practices were identified as having a higher number of young adults on their patient list, particularly the practices attached to universities such as Imperial and Kings College Practices.

Table 3: List of GP practices with highest numbers of young adults by CCG

CCG	Practice name	18- 25: Male	18- 25: Female	18- 25 all persons
Hammersmith and Fulham CCG	**NORTH END MEDICAL CENTRE**	644	917	**1561**
	THE MEDICAL CENTRE, DR JEFFERIES & PARTN	565	716	**1281**
	THE BUSH DOCTORS	443	610	**1053**
West London CCG	**KINGS ROAD MEDICAL CENTRE**	**400**	**640**	**1040**
	KNIGHTSBRIDGE MEDICAL CENTRE	416	553	**969**
	FLUXMAN HARROW ROAD HEALTH CENTRE	375	441	**816**
Central London CCG	**IMPERIAL COLLEGE HEALTH CENTRE**	5269	3526	**8795**
	KINGS COLLEGE HEALTH CENTRE	2476	5314	**7790**
	MARVEN MEDICAL PRACTICE	474	590	1064
	VICTORIA MEDICAL CENTRE	451	611	1062

4.1.3 Common mental disorders (CMD)

CMD includes depression, anxiety and sleep disorders, and are usually treated in primary care. Prevalence of mental health issues has not been measured at a local level. However, the national Adult Psychiatric Morbidity Survey (APMS) last conducted 2014 measures prevalence. Using these validated surveys, the estimated prevalence of CMD among 18- 24 year olds in our local population suggests that **1 in 5 18-24s (21.07%) suffered from CMD in 2014, compared to 17.1% amongst adults age 16-64 generally, showing that CMD is more of an issue for young adults.**

The APMS 2014 results showed that CMD symptoms were about **three times more common in women age 16-24 (26.0%) than men (9.1%). The gap has grown since 1993, when 16-24 year old women were twice as likely (19.2%) as 16-24 year old men (8.4%) to have symptoms of CMD.**

Figure 5 Common Mental Disorders prevalence in 18-24s, estimated using 2014 APMS and 2015 ONS population projections

Local authority	Male	Female
Hammersmith and Fulham	**890**	**2,616**
Kensington and Chelsea	**701**	**1,883**
Westminster	**1,255**	**3,133**

4.1.4 *Improving Access to Psychological Therapies (IAPT)*

IAPT is the primary care service for CMD. Data was available for the use of the IAPT service in Kensington and Chelsea and Westminster IAPT service January-December 2015. This showed that young men constituted only 35% of referrals in Kensington and Chelsea, and 34% in Westminster, which matches the rates of CMD by gender found in the APMS.

However, of those who entered treatment, the completion rate was 67% for females and only 33% for males in Kensington and Chelsea (this data was not available for Westminster). Young adults age 18-25 were less likely than the general adult population to complete treatment.

4.2 Recommendations

Gap / challenge	Potential solution / recommendation
The current model of primary care is not well suited to young adults, who are overall less satisfied with their GP than older adults and more likely to use walk-in centres and urgent care than other age groups. Young adults would benefit from GP services configured to their health needs, such as at The Well Centre in Lambeth. Co-location has come up across chapters as an effective way of increasing young adults' uptake of appropriate services, particular in hard to engage cohorts such as care leavers.	1. Pilot an integrated primary care model at one or more GP practice in each CCG with a high number of young adult patients. Consider services which could have a presence, such as sexual health services, eating disorder services and talking therapies. Offer training for GPs in young adults' health. a. Consider opportunities for this approach in other contexts with target populations, such as co-location of health services at care leaver peer support groups.
Small changes that all GP practices can facilitate would make a positive difference. The AYPH's primary care guidance has been endorsed by the Royal College of General Practitioners (RCGP) and contains actions all GPs could carry out to improve primary care services for young people.	2. Train local GPs and GP practice staff in the GP Champions for Youth Health Project's *Toolkit for General Practice*[5]. CCGs should make use of the GP Champions for Youth Health Project's *Commissioning Effective Primary Care Services for Young People*[6].

[5] GP Champions for Youth Health Project. *Toolkit for General Practice (online)* http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/GPToolkit_ONLINE.pdf (accessed 14.12.16)

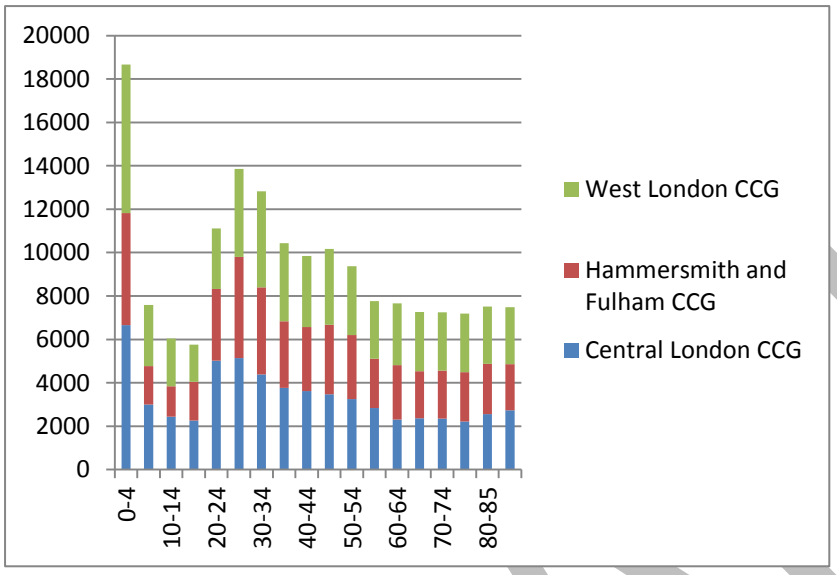
[6] GP Champions for Youth Health Project. (online). *Commissioning Effective Primary Care Services for Young People* http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/Commissioners_ONLINE.pdf (accessed 14.12.16)

4.3 A&E and Urgent care use

4.3.1 Urgent care

There is a significant spike in Urgent Care Centre use at age 20-24 as shown in table 4 below. In consultation with young people, many said that they preferred to use A&E or urgent care than GPs.

Table 4 Non-elective Attendances of all Urgent Care Services in the Three Boroughs (2014/15)



When looking at the rates of use (per 1,000 people) of Urgent Care Centres (UCC), A&E and Walk-in Centres (WiC), urgent care is the preferred unplanned secondary care service for young adults. Table 5 shows that the rate of attendances at walk-in centres is significantly higher amongst young adults than all age groups, however urgent care centre use is even higher in young adults. A&E use is lower amongst young adults than the general population, as the older populations have more co-morbidities and so are frequent users of A&E services.

Table 5 Rate per 1,000 people of users among 18-25 year olds from the three boroughs compared with all age groups (2015/16)

	A&E		UCC		WiC	
	18-25	All other ages	18-25	All other ages	18-25	All other ages
Rate of attendances per 1000 population	**238.2**	287.1	**351.5**	243.5	**57.5**	31.1

4.3.2 Accident and & Emergency (A&E) use

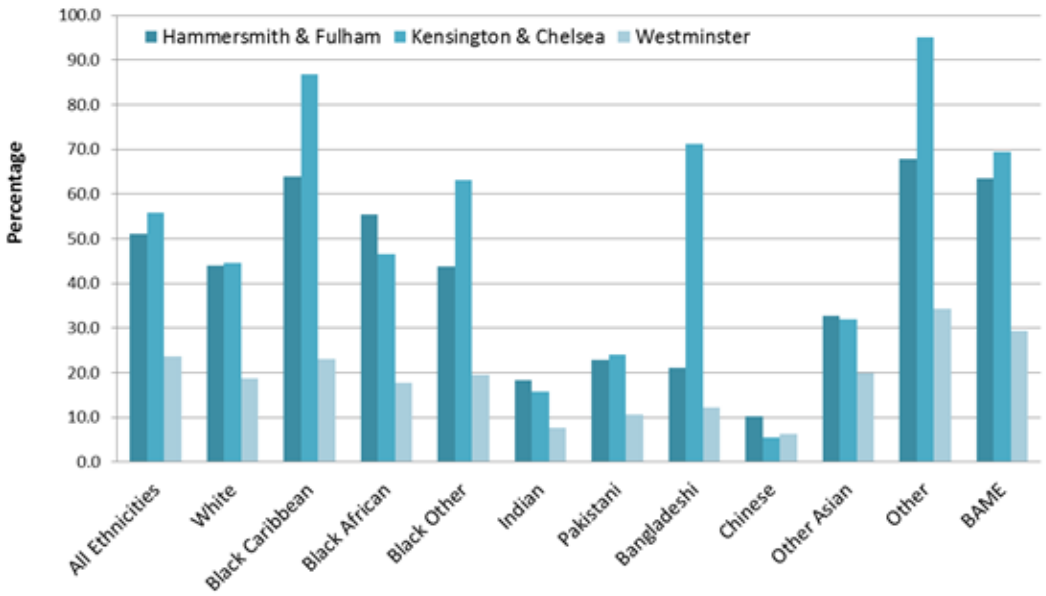
In 2015/16, there were 27,221 A&E attendances from the populations of the three boroughs aged 18-25, **11.5% of the total attendances.**

Figure 6: Numbers of A&E attendances in young adults age 18-25 by local authority and gender, 2015/16

The majority (80%) of A&E attendances in young adults were first attendances; 1% were follow-up attendances and 19% were not coded. **There was a higher number of females attending A&E in all three boroughs.**

The chart below shows A&E attendances in young adults by ethnicity, as a proportion of the resident young adult population. There is a high proportion of young adult population in the Other, Black Caribbean and Bangladeshi groups that have attended an A&E department in the last year, in particular in Kensington and Chelsea. However, the numbers may be skewed by individuals with high attendance rates in those ethnic groups.

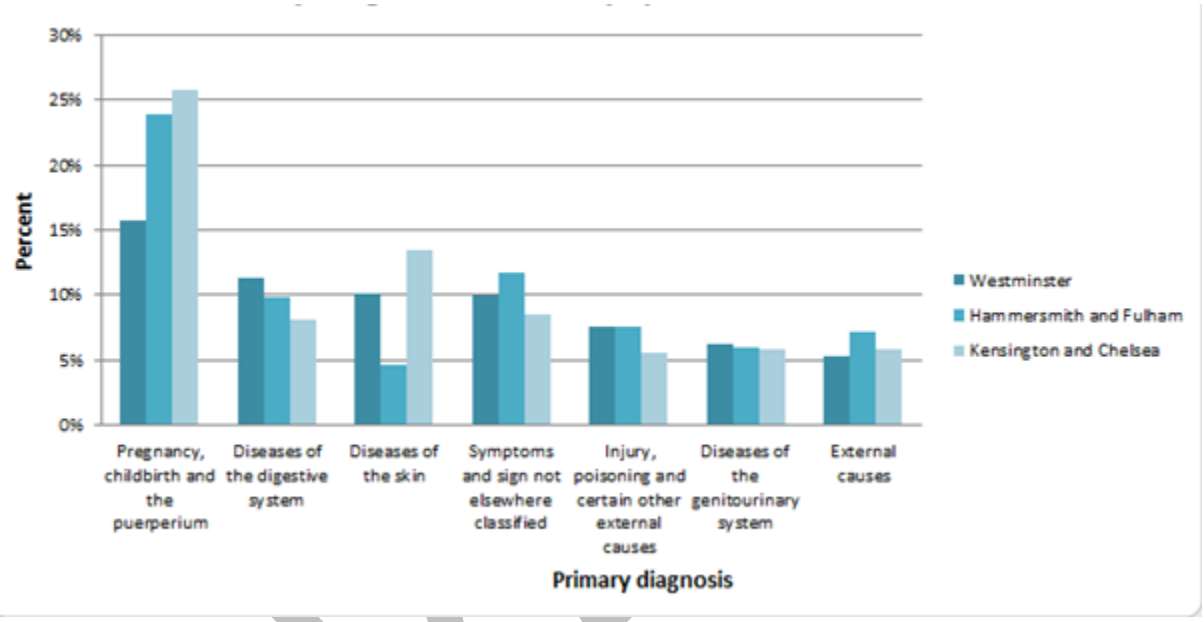
Figure 7: A&E attendances as a proportion of resident population by ethnic group, 2015/16



4.4 Inpatient admissions

Figure 8 below shows the most common primary diagnoses in young adult inpatients in each local authority. The top five diagnoses make up 54.6% of young adult inpatient admissions in Westminster, 60.0% in Hammersmith and Fulham and 61.5% in Kensington and Chelsea. "Pregnancy, childbirth and the puerperium" is the number one reason for admission in the young adult population in all three boroughs. There are higher hospital admissions in BME groups, due to their lower average age of pregnancy.

Figure 8: Young adult hospital admissions by main primary diagnosis and local authority, 2015/16



The most common inpatient diagnoses highlight some key themes that will be investigated further in this report, such as diseases of the genitourinary system (see sexual health chapter 8), injury, poisoning and certain other external causes (see substance misuse chapter 7) and diseases of the digestive system (likely to be alcohol related – see substance misuse chapter 7).

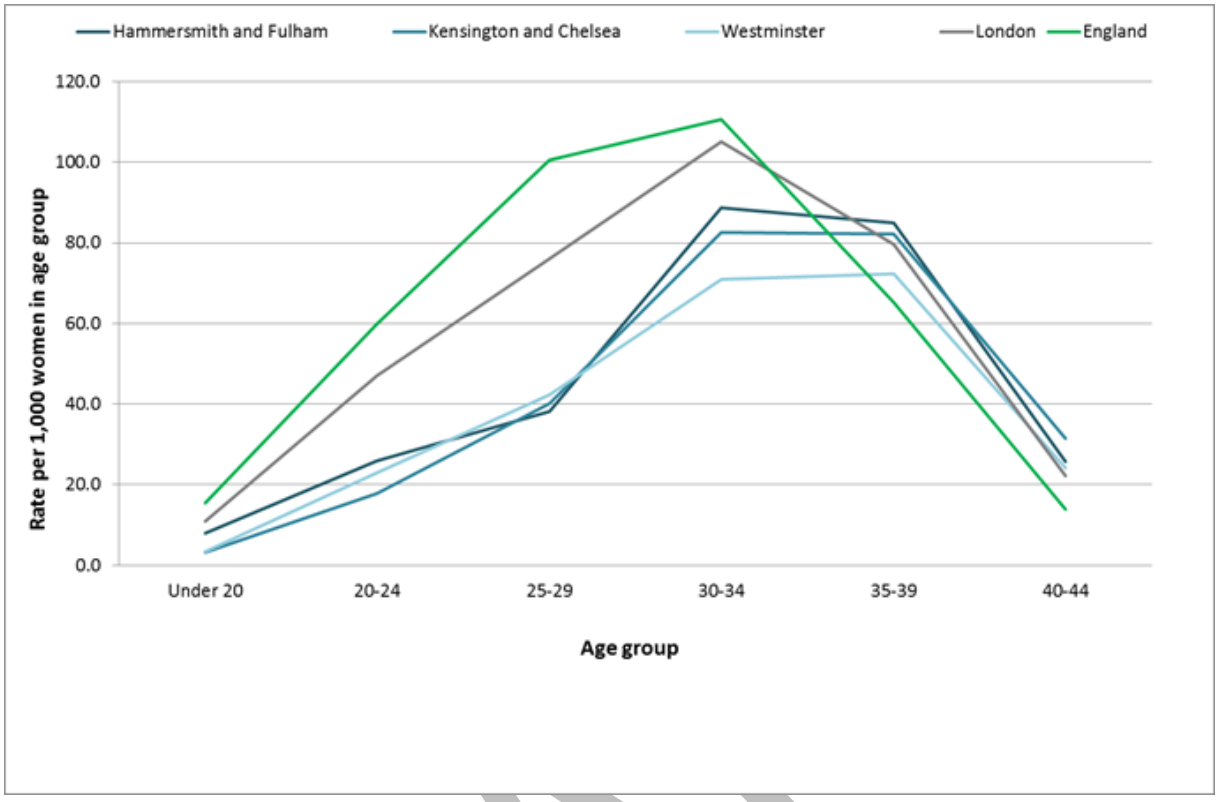
4.4.1 Births

The rates of births to mothers age 18-25 are lower in all three boroughs compared to London and England averages. Hammersmith and Fulham has higher numbers, particularly in mothers under the age of 20.

In 2014, there were 160 mothers age 20-24 in Central London, 232 in Hammersmith and Fulham and 229 in West London.

Figure 9 below compares the distribution of birth rates by age of mother between local boroughs, London and England. **Compared to the London and England average, all local boroughs have a lower birth rate among mothers aged less than 30 years.**

Figure 9: Live birth rates per 1,000 females by age of mother, 2014



Source: ONS Live Births by Area of Usual Residence

5 Eating disorders

5.1 What is the issue?

Eating disorders are illnesses which disproportionately affect adolescents and young adults, and so constitute a key area of investigation in this report.

Eating disorders are mental health disorders that are characterised by an attitude towards food that causes people to change their eating habits and behaviour. Someone with an eating disorder may have a preoccupation with their weight and/or body shape which may lead to harmful eating habits, impacting negatively on their physical health and sometimes proving fatal.

The long-term negative effects of eating disorders can be seen across education, employment opportunities (lost employment is estimated to account for 69% of the total cost to society of eating disorders (McCrone, Dhanasiri, Patel, Knapp, & Lawton-Smith, 2008)), fertility, relationships and parenting. It puts a huge burden on family and carers (PricewaterhouseCoopers, 2015). Comorbidities commonly associated with eating disorders include depression and obsessive-compulsive disorder.

Table 4: Types of eating disorders

Eating disorder	Symptoms
Anorexia nervosa	Seeking to maintain a low body weight as a result of a preoccupation with weight: either a fear of fatness or a pursuit of thinness.
Bulimia nervosa	Recurrent episodes of binge eating and then trying to prevent weight gain through any one or a combination of behaviours, such as vomiting, fasting, or excessive exercise.
Binge eating disorder	Recurrent episodes of binge eating without compensatory behaviour (e.g. vomiting, fasting, or excessive exercise).
Atypical eating disorders	May closely resemble anorexia nervosa, bulimia nervosa, and/or binge eating, but do not meet the precise diagnostic criteria.

5.2 What do we know nationally?

5.2.1 Prevalence and incidence

Although eating disorders are not considered common, **over 1.6 million people in the UK are estimated to be affected**, and are most common in teenagers and young women. **For every male with anorexia or bulimia, there are 10 females** (Joint Commissioning Panel for Mental Health, 2013; NICE, 2014a).

Atypical eating disorders are the most common, followed by binge eating disorders and bulimia nervosa. **Anorexia is least common, but has the highest mortality amongst all psychiatric disorders**. Research has shown that incidence of eating disorders (in particular atypical eating disorders) has been increasing (Micali, Hagberg, Petersen, & Treasure, 2013).

5.2.2 Link to substance misuse

Eating disorders show high levels of comorbidity with substance abuse disorders, depression, and anxiety disorders (World Health Organization, 2004). Individuals with eating disorders were up to 5 times as likely as those without eating disorders to abuse alcohol or illicit drugs, and those who abused alcohol or illicit drugs were up to 11 times as likely as those who did not to have had eating disorders. Up to 50% of individuals with eating disorders abused alcohol or illicit drugs, compared to 9% of the general population. Up to 35% of individuals who abused or were dependent on alcohol or other drugs have had eating disorders, compared to 3% of the general population (National Center on Addiction and Substance Abuse at Columbia University, 2003).

5.2.3 Causes of eating disorders

The evidence base on what causes an eating disorder is weak as is the evidence for successful prevention, but positive body image and healthy eating messages are thought to help. However, professionals should understand common risk factors to help identify an eating disorder:

- Family history of eating disorders, depression or substance misuse
- Gender – women and girls are more likely to develop eating disorders
- Age – eating disorders tend to present in adolescence and young adulthood
- Adverse life events, particularly involving relationships with close family or friends
- Socio-cultural factors such as the pressure to be thin
- Premorbid characteristics – perfectionism, low self-esteem [7]

5.2.4 Effective treatment

Treatment of eating disorders requires co-ordinated and multidisciplinary care across primary, secondary and tertiary care. Psychological interventions seek to address the core attitudes and improve longer-term outcomes for patients.

Existing good practice

Vincent Square uses guided self-help with a book for patients with low level needs. This is an evidence-based approach which is cost effective as each book is approximately £12, compared to £100 per person cost for web based self-help with lower engagement.

[7] NICE Clinical Knowledge Summaries. *Eating disorders (online).* https://cks.nice.org.uk/eating-disorders (accessed 19.12.16)

NICE set guidelines of evidence-based effective treatment in 2004 for all tiers[8]; an update is expected in 2017. In addition the Joint Commissioning Panel for Mental Health has produced guidelines for commissioning mental health services for people with eating disorders (2013).

Evidence- based treatment for eating disorders such as Cognitive Behavioral Therapy (CBT) should be available in a primary care setting. NICE guidance states that for people presenting in primary care, GPS should take responsibility for the initial assessment and coordination of care, and determine the need for emergency medical or psychiatric assessment.

Early detection and treatment may improve outcomes and so a key theme for effective treatment across eating disorders and levels of severity is waiting times. NICE advise that people with eating disorders should be assessed and receive treatment at the earliest opportunity. The more entrenched the illness, the less likely it is to be treatable. The FREED study demonstrated higher uptake of treatment when waiting times were greatly reduced and illness was in its first 3 years (Glennon, South London and Maudsley NHS Foundation Trust, & King's College London, 2015).

Good practice case study: Bristol

Bristol's Student Health Service initiated a discussion with Bristol Primary Care Trust (PCT) to set up an additional eating disorder service outside of secondary care, for people with less severe eating disorders who may not have been seen by the existing service, for example if they did not meet BMI criteria. The service had its pilot year in 2009 and has now been rolled out to the whole of Bristol due to its success. This service is a satellite of the main service and managed by the same provider, delivered in a timely way and crucially in partnership with GPs.

The GP can refer any suspected eating disorder patient to a specialist rapid assessment and triage service with the appropriate skills level (more specialist than a normal IAPT practitioner), which will either continue to see the patient in a primary care setting, or refer them onto the specialist secondary care service if appropriate. It is important that high need patients are not treated in this service without the expertise and wrap-around support of the secondary care service.

The service provides evidence that a primary care-based service can offer an appropriate and highly cost effective assessment process. Further, where interventions can be appropriately provided in primary care (i.e. for less complex cases) this too is more cost effective alternative than a referral to secondary or tertiary services. This allows the secondary care service to focus on offering a specialist, multi-disciplinary approach to those who need it most. It is estimated that the service is about 1/3 of the price per patient than the secondary care service. Additionally, it prevents cases from worsening to the point where secondary care is inevitable.

The service has received positive feedback from service users and local GPs, and effectively stitches together primary and secondary care for eating disorders.

[8] NICE Pathways. *Eating Disorders (online)* https://pathways.nice.org.uk/pathways/eating-disorders (accessed 14.12.16)

There is a clear pattern of delay in seeking help for eating disorders, which in turn delays diagnosis and treatment, creating more severe and long term impacts. A recent survey of eating disorder patients indicates that the speed at which help is initially sought has a material impact upon likelihood of relapse (PricewaterhouseCoopers, 2015). Effective treatment needs to take into account other health impacts such as dental issues and substance misuse for people with bulimia nervosa (NICE, 2004).

5.3 What do we know locally?

5.3.1 Local service provision

Specialist: The eating disorder service for the three boroughs, Vincent Square Clinic, is provided by Central North West London Mental Health Foundation Trust (CNWL). Vincent Square Clinic provides inpatient and specialist outpatient care for children and adults in one service.

Other services: there are other services that identify patients with an eating disorder, but are not eating disorder specialists and may be unable to treat such patients. These include:

- Primary care - NICE recommends that GPs should take the responsibility for the initial assessment and coordination of care, as well as determining the need for emergency medical or psychiatric assessment. There must be a clear agreement between primary and secondary or tertiary care about who takes responsibility for monitoring people with an eating disorder.
- Dietetics – who will refer back to the GP to get a referral for eating disorder services.
- Talking Therapies (IAPT) – when an eating disorder is detected, they will refer back to the GP if this is the key presenting issue.

5.3.2 Gaps in local service provision

The only specialist eating disorder service for adults is in one secondary care clinic for all three boroughs. National and local strategies require the development of out of hospital services and early intervention to protect mental and physical health and wellbeing, so eating disorder patients should be able to receive treatment in the community closer to home – in particular patients who are not yet severely unwell or do not meet diagnostic criteria. Treatment in primary care is highly cost efficient and preferable for lower level patients. (see Bristol Case Study above).

Such a service would offer NICE recommended rapid triage and assessment by a skilled practitioner in partnership with GPs, without the need for referral to Vincent Square clinic, and, as clinically indicated, up to 26 weeks of CBT and GP-based support for those with emerging but not life-threatening Eating Disorders, or onward referral to Vincent Square for those who require it.

5.3.3 Numbers in eating disorder services

Table 7 below shows that the majority of patients are treated for anorexia nervosa and bulimia nervosa and 'unspecified' (which often resembles anorexia and bulimia but does not meet all of the diagnostic criteria such as BMI). Although anorexia nervosa is the least common eating disorder, it is the most common to receive treatment for locally and nationally due to the seriousness of the illness. The numbers receiving a service (Tables 7 and 8) is not a good measurement of local need, as demand is high and waiting times are long.

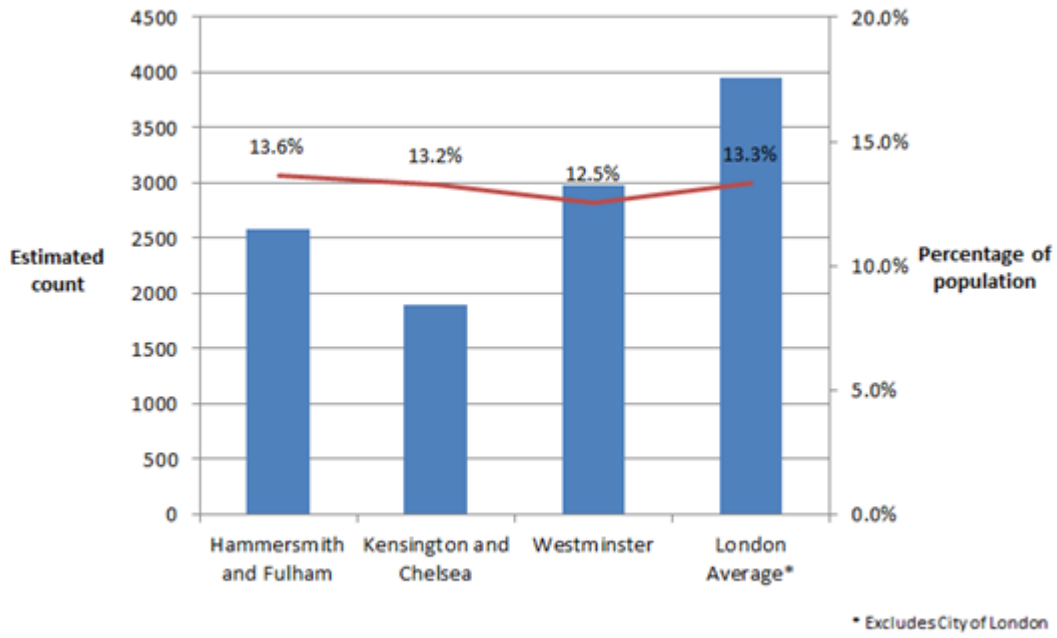
Table 5: Number of 18-25 year olds attending CNWL Eating Disorder clinics from 2013/14 to 2015/16 from the three local CCGs by type of diagnosis

Anorexia nervosa	Bulimia nervosa	Eating disorder, unspecified
80	90	62

5.3.4 Estimated prevalence

Scoring two or more on the SCOFF scale is the clinical threshold that should prompt a more detailed investigation to be undertaken to diagnose eating disorder, although not everyone scoring two or more on this scale would be eligible for a service. If more GPs were trained to use the SCOFF scale more actively, there would be an even greater pressure on the current service for assessments, but would importantly enable eating disorders to be picked up proactively before the condition deteriorates. Figure 10 below shows the estimated numbers of local people age 16-24 who score two or more on the SCOFF scale.

Figure 10: Estimated prevalence of potential eating disorders among young people



Using the estimates in Figure 10, table 8 shows clearly that the current service is only able to see a small fraction of the estimated number of people with an eating disorder.

Table 6: Number of 18-25 year olds attending CNWL Eating Disorder clinics from 2013/14 to 2015/16 by CCG

CCG	CNWL Patients	Estimated prevalence (borough)
Central London CCG / Westminster	126	2975
Hammersmith and Fulham CCG/ borough	87	2580
West London CCG / Kensington and Chelsea	79	1899

5.3.5 Referrals

The GP practices with the highest numbers of referrals to Vincent Square are the practices with the highest numbers of registered young adults in each CCG. However as a percentage of young adult population, **the highest patient referral rates came from Richford Gate (1.41%), Marylebone Health Centre (1.05%) and King's Road Medical Centre (1.06%).**

5.3.6 Access to services

Using a model that estimates ED prevalence based on ethnicity (Solmi, Hotopf, Hatch, Treasure, & Micali, 2016), it appears that **locally 'white' patients have a significantly better access to services than 'Black' or 'Asian' as well as 'Other'.**

Table 7: Ethnicity of Vincent Square patients from the three boroughs compared to estimated prevalence

Ethnicity	Number of patients	Estimated number of people with eating disorders	Estimated % accessing a service
White	207	2265	**9.1%**
Black	7	725	**1%**
Asian	18	1638	**1.1%**
Other	40	954	**4.2%**

5.3.7 Challenges identified by local practitioners

- **Waiting times for services**: Whilst the children's eating disorder service sees new referrals very quickly, particularly since the launch of the new rapid access service, the adult service has a waiting time of up to a year and frequently over 8 months. Whilst the secondary care service is very good, less severe patients would benefit from an early intervention community service based in primary care. As mentioned above, the less entrenched the illness, the higher the chance of recovery and patients seen within a short time of referral are significantly more likely to enter treatment.
- **Transfers of care:** Transitioning from the children's to adults' service works well locally as the provider is the same, but it is more challenging when a young adult moves to a different borough, which is common at this age (see figure 3 above - migration).
- **Liaison between services:** Good relationships and links between services are hindered by capacity. There is a lack of a network of professionals who come into contact with

Existing good practice

LBHF have a Child Health Network WhatsApp group through which professionals communicate about problems and advise each other.

eating disorder patients. Other services may be unaware of appropriate referral pathways.

- **Training:** Training was identified as a red flag for improvement in several areas. Clear guidance is needed on identifying and monitoring eating disorders.
  - Professionals outside of ED services are inconsistently knowledgeable of how to work with people with eating disorders, particularly if it is not the primary issue they are presenting with, and do not know the correct pathways. Clear guidance is needed on how to manage ED patients in primary care, e.g. how to monitor blood and weight, particularly as BMI isn't always the best indicator. **Free resources for health care professionals can be found here**.
  - Training for frontline staff in a motivational interviewing approach was identified by local experts as a positive opportunity to effectively upskill the workforce
- **Awareness:**
  - Many young people are not aware of the health risks of being underweight
  - Many people, including young adults, professionals and families, are not aware of the signs of eating disorders
  - There are opportunities to raise awareness amongst young people with eating disorders such as in bathrooms in colleges and university buildings.
- **Gender:** Young men are underrepresented in their estimated numbers in services. Local practitioners identified that boys and young men are not aware of having an eating disorder, but have similar characteristics related to an obsession with body image such as excessive exercising and not eating a healthy and balanced diet. However, they are less likely to engage with services. This perception is supported in recent research (Räisänen & Hunt, 2014; Strother, Lemberg, Stanford, & Turberville, 2012; Sweeting et al., 2015) which also highlights the potential impact that delayed help-seeking behaviour may have on treatment outcomes (Räisänen & Hunt, 2014).
- **System / Commissioning issues**: As NHS England commission the local specialist mental health service for eating disorders, the CCGs are less involved and do not receive monitoring information. Currently, there is only an eating disorder service in a secondary care setting.

5.3.8 Opportunities

The North West London CCG Collaborative mental health transformation programme Like Minded, of which *Serious and Long Term Mental Health Need* is a key population group has resources for transitional support until funding can be transferred from secondary care when demand is reduced.

5.4 Recommendations

Gap / challenge	Potential solution / recommendation
A small fraction of the estimated numbers of young adults with eating disorders are being seen in services. Additionally, evidence shows better outcomes when ED is treated promptly in the first 3 years of the illness, but waiting times locally are long.	1. Review the eating disorder pathway as part of Like Minded *Serious and Long Term Mental Health Need* population group Business Cases. Consider ways to provide an early intervention eating disorder service in primary care offering NICE recommended rapid triage and

National and local strategies require the development of out of hospital services and an early intervention approach to protect mental and physical health and wellbeing. There is currently only a service in secondary care. The exemplar primary care eating disorder service in Bristol provides cost-effective and well received help before the patient's condition deteriorates and requires treatment in secondary care.	assessment by a skilled practitioner in partnership with GPs for those with emerging but not life-threatening Eating Disorders. a. Such a service would then be capable of providing the leadership and momentum for the following recommendations.
Current NICE guidelines are from 2004, and new guidelines are expected in 2017.	2. Review existing services against new NICE guidelines when available in 2017.
Professionals outside of specialist ED services do not consistently understand what to do when an eating disorder is identified, and how to manage an eating disorder patient.	3. Map pathways and create a tool for professionals to use to enable appropriate and timely referrals.
	4. Offer guidance to GPs and other health professionals to identify and then work constructively and appropriately with people with an eating disorder. a. Identify GPs with high numbers of young adults and low referral rates to eating disorder services as a target group for training.

6 Care Leavers

Care leavers are a group of young people who are disproportionately affected by some of the issues discussed in this JSNA. Although their physical health has not been found to be substantially different to the general population, their mental health needs are higher and some lifestyle choices affect their health needs (such as higher usage of substances). Additionally, former unaccompanied asylum seeking children (UASC) have particular physical and mental health needs.

Care leavers are a highly transient population, and some will experience the breakdown of placements, which can cause interruption to health services they are receiving. These issues may shape their help-seeking behaviours.

Whilst many care leavers go on to have good health and wellbeing as adults, a number are more vulnerable and require consideration as a specific cohort. New research underway by The Care Leavers Association suggests that there may be more long-term impacts on the physical and mental health, later in life, of people who have been in care.

6.1 Who are Care Leavers?

The term 'care leavers' refers to a person aged 25 or under, who has been looked after by a local authority for at least 13 weeks since the age of 14. At age 18, a looked after child is no longer in care, but the local authority still has a responsibility to them as a care leaver until age 21, or up to age 25 if they are in full time education. Looked after children can stay in stable foster placements up to the age of 21, but those in residential care must leave at age 18 and are likely to be more vulnerable.

The definition also includes current and former Unaccompanied Asylum Seeking Children (UASCs), who are care leavers who have more particular health needs. UASC are defined as people under the age of 18, who are applying for asylum in their own right, and are separated from both parents and are not being cared for by an adult who in law or by custom has responsibility to do so. The number of UASC has almost tripled in the last two years. The Home Office statistics show that 61.3% of UASC are aged between 16 and 17 when they arrive, and so would go almost straight into leaving care services.

Young adults that the local authority has a responsibility towards because they have been remanded in Local Authority care or in a Young Offender institute for 13 weeks or more also become care leavers. Both groups have specific needs.

Care leaver statutory requirements are set out in the Children Act 1989 (Department of Education, 2014) and in the Children Leaving Care Act 2000[9].

New legislation is expected to come in 2017 following the *Keep on Caring* government strategy (HM Government, 2016) which will extend the duty on local authorities to provide a personal advisor and other services, such as training costs for apprenticeships, for all care leavers up to the age of 25

[9] HM Government. *Children Leaving Care Act 2000 (online)* http://www.legislation.gov.uk/ukpga/2000/35/contents (accessed 14.12.16)

(instead of 21). This will mean that the local authority will have a duty to a far greater number of young people, and will be unlikely to have more resources.

6.2 What do we know nationally?

Care leavers face complex psychological challenges. While most young people make a gradual transition to independence, supported by their family, care leavers often experience multiple, overlapping and simultaneous changes in their living circumstances.

National evidence shows that care leavers consistently experience some of the worst health, social, educational and employment outcomes in our society (Driscoll, 2011; Dunlop, 2013; Philip Mendes, 2009; P. Mendes & Moslehuddin, 2006). For example, **care leavers are more likely to have poor mental health, have poor dental health, experience homelessness, not succeed academically, live in poverty, and be more commonly represented in the criminal justice system**. **Additionally, nearly half of female care leavers are mothers by the age of 24** (Fallon, Broadhurst, & Ross, 2015). This is often a consequence of living a fragmented life, moving from one placement to another, and severing important relationships with family and support networks. The disadvantages that care leavers experience before entering care can then be compounded by their experiences in care (P. Mendes & Moslehuddin, 2006).

6.3 What do we know locally?

The numbers of current care leavers and LAC about to become care leavers can be seen in table 10 below. Table 11 shows that **33-45% of young people in the three boroughs come into the care system at age 16 and over**, which is when preparation for adulthood and leaving care takes place. This is compared to 20% nationally and 30% across London coming into care age 16+.

Table 8: Current numbers of LAC and Care Leavers in services (2015/16)

	Looked After Children age 15-17	Care Leavers age 18+
LBHF	94	165
RBKC	52	134
WCC	64	178

Table 9: Age at which children and young people enter care, by borough

Age (years)	Hammersmith & Fulham		Kensington & Chelsea		Westminster	
	2014-15 entries	as of 31/01/2016	2014-15 entries	as of 31/01/2016	2014-15 entries	as of 31/01/2016
0 to 15	66%	71%	57%	62%	62%	65%
16 and over	**33%**	**30%**	**43%**	**38%**	**39%**	**35%**

6.3.1 *Current and former Unaccompanied Asylum Seeking Children (UASC)*

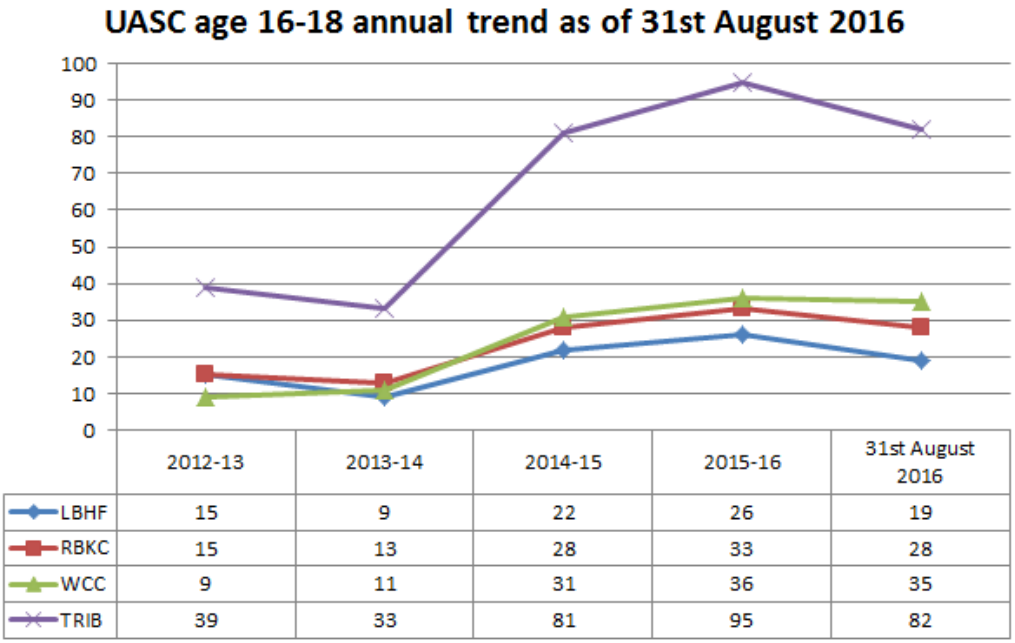
The number of care leavers who are either under the age of 18 and so still UASC, or 'former UASC' if over the age of 18 but with similar health needs, has also increased locally (see Figure 11 for UASC age 16-18).

Local Authorities are expected to take a number of UASC that equates to 0.07% of their child population. In the 16-18 age group, many of whom are in the process of becoming care leavers, Kensington and Chelsea and Westminster have higher numbers than their quota and so services will need to be particularly aware of their needs. However numbers are not expected to increase as sharply as they have over recent years as numbers above the 0.07% will be distributed to other local authorities.

Table 10: Number of former UASC care leavers by borough

Local Authority	Count as of 31st March 2016	% of all care leavers
Hammersmith and Fulham	52	31.5
Kensington and Chelsea	53	39.7
Westminster	29	16.3

Figure 11: Numbers of UASC looked after children age 16-18 in the three boroughs, 2010-31st March 2016 (Source: Frameworki)



	2012-13	2013-14	2014-15	2015-16	31st August 2016
LBHF	15	9	22	26	19
RBKC	15	13	28	33	28
WCC	9	11	31	36	35
TRIB	39	33	81	95	82

The UASC that the three local authorities have responsibility for are placed all over London, so are not concentrated in one particular area. NICE quality standards state that looked-after children and young people who move across local authority or health boundaries must continue to receive the

services they need.[10] However, an audit of UASC in England found that the receiving local authorities are rarely informed of these transfers and keep no record of unaccompanied children placed from other local authorities (Humphris & Sigona, 2016). Although the three local boroughs have a clear system for their UASCs placed out of borough, it could be inconsistent for care leavers from other boroughs placed within the three boroughs.

6.4 Care leaver health needs

An audit of the health records of care leavers in the three boroughs suggests that their physical health needs are not different from a normal child or young adult. However, they find it harder to engage with health services, so conditions deteriorate. Not having a parent-type figure telling them to go to a doctor can mean they are less likely to do so.

The health needs of care leavers are described below using: national evidence; evidence from a workshop for local professionals who work with care leavers; evidence from groups of care leavers consulted in the process of developing this JSNA; and evidence from the formal consultation held on health for each of the Corporate Parent Boards.

6.4.1 Mental Health needs

Children in care have higher rates of mental health problems than the general population; nearly half have a mental health disorder (HM Government, 2011, 2013). For many, this persists past the age of 18. The risks of not addressing mental health needs (including 'low level' mental health needs) are known to impact on physical health, education, employment, and relationships. **National and local evidence overwhelmingly supports the option to extend CAMHS for care leavers up to age 25 based on need:**

- The government report *Future in Mind* (Department of Health & NHS England, 2015) acknowledges that care leavers are more vulnerable to mental health problems and find it harder to access help, and that mental health services must get it right with this cohort. The report recommends promoting resilience, prevention, and early intervention for good mental health for all. The report adds that for many, adult services are either not available or not appropriate, and recommends flexibility around age boundaries and transition based on individual circumstances rather than age.
- In a 2015 report (Bazalgette et al., 2015) the NSPCC have described the withdrawal of CAMHS at 18 as a "cliff edge" and recommended that local authorities and health services should work together to provide mental health support for care leavers up to the age of 25. Extending mental health support for care leavers until the age of 25 was also included in the Alliance for Children in Care and Care Leavers' seven key recommendations to the House of Commons Education Committee report (House of Commons Education Committee, 2016).
- Locally, the Anna Freud Centre needs assessment of CAMHS recommends a 'tapered transition' to Adult Mental Health Services (AMHS) between the ages of 16-25, which would allow people already receiving CAMHS could continue even though they wouldn't meet the

[10] NICE (2013). *Looked-after children and young people (online)* https://www.nice.org.uk/guidance/QS31 (accessed 28.10.16)

eligibility criteria for adults. It would also allow a young person to choose whether to be seen in Children or Adult services if they are aged 16 or over when they first become known to mental health services.

- **Local practitioners identified that the biggest area of unmet need is in mental health needs that do not meet AMHS threshold or diagnosis criteria.** It is recognised nationally and by local practitioners that adults' services are very different to those offered to children, as CAMHS has a far lower eligibility threshold than AMHS. The tapered transition from CAMHS up to age 25 would make a significant difference, however, **professionals have identified that many young care leavers are only just ready to start engaging with CAMHS at the age of 18 or over.** This 'tapered' model would not allow them to start engaging with the service at that age – they could only continue an existing relationship. Additionally, LAC CAMHS provides a more specialist service with more therapeutic interventions and specialism in trauma, which is particularly needed with such high numbers of former UASCs.

Furthermore, CAMHS must be able to work flexibly with this cohort as some lead more chaotic lives and are more likely to miss appointments and prefer visits outside of clinical settings.

The consultations with care leavers discussed emotional wellbeing and mental health. A number of issues were reported:

- It can be difficult for an individual to recognise when they (or someone else) has a mental health condition
- Some lack of awareness of mental health, of services available, and of coping strategies such as mindfulness
- Mixed experience of therapies. One consultation reported that talking therapies were popular for emotional issues as young people said that they needed someone who would listen and be reliable. In the other group, all of those who spoke of counselling reported negative experiences and that it made matters worse.
- Young people didn't want to be told it is 'only mental health' in response to their emotional problems.

6.4.2 Alternatives to CAMHS / AMHS

In some cases, IAPT may be a suitable option and should be promoted to care leavers. A practitioner noted that IAPT is not popular with care leavers as it is not well understood as a service by professionals, who then do not advise care leavers to try it. However, IAPT is best suited to people with a structured definition of depression or anxiety, whereas **many care leavers' problems are emotional, behavioural and relational, but do not fit a diagnosis category.** Local clinicians reported that sometimes a diagnosis such as personality disorder is given to get the young person a service, but this may be unhelpful and carry a stigma.

> ***Local good practice***
>
> Local professionals noted that having a clinical psychologist in the Leaving Care team has made a noticeable difference just working 2/3 days a week in RBKC.

For some care leavers, **their need could be met outside a clinical setting**. A study of mentoring for young people leaving care concluded that mentoring offers them a different style of supportive relationship but one which complements formal professional support. In the study, 93% had some 'positive outcomes' from their mentoring relationship (Clayden, Stein, & University of York, 2005).

6.4.3 Emotional needs

Many care leavers are not mentally ill, but are emotionally vulnerable. There are a wide range of 'emotional ages' and the needs of care leavers will vary considerably.

The **quality of individual relationships** is very important to care leavers, and often requires great flexibility on behalf of the professional. Care leavers have a variety of people they may form a particularly close and trusting relationship with; this can be their social worker, personal advisor, a nurse, CAMHS worker, guardian or foster parent, or key worker from a provided service.

Continuity is felt to be incredibly important for people going through the transition of leaving care. For example, the Virtual Schools are felt to be effective, but the teachers want to continue to work with the young person after they turn 18.

Care leavers have less support infrastructure with more pressure than other people their age. Young care leavers often live alone at a far younger age than their peers, causing social isolation which is well evidenced to cause deterioration in health and wellbeing (Durcan, Bell, & UCL Institute of Health Equity, 2015).

The issue of confidentiality around physical and emotional health was important to care leavers, as this was not always possible when they were looked after children. The young people interviewed also had some flexibility in their views on confidentiality, stating that if it was "life or death" or "puts someone else at risk" then there may be exceptions to their confidentiality.

6.4.4 Substance misuse and chaotic lives

A small number of care leavers lead 'chaotic lives', bringing them into contact with a range of services and professionals. Substance misuse is often a symptom or cause of a chaotic lifestyle; it is estimated that 11% of care leavers have problematic alcohol use and 21% have problematic drug use. Care leavers are twice as likely to have used illegal drugs as the general population.

6.4.5 Dental health

Looked After Children have regular dental checks, however care leavers are more likely to experience poor dental health than their peer groups. During consultation with a group of local care leavers, none had been to the dentist in the last 12 months because of the cost.

6.4.6 Sexual health

The care leavers at the Corporate Parent Board consultation reported that the most talked about health topic was sexual health.

Professionals have identified that **'inappropriate' sexual relationships** which are not illegal present a challenge to professionals where they believe a young person is vulnerable, but has mental capacity. This links to the findings when discussing sexual health with young people around peer pressure (see chapter 8 – sexual health, where this topic is discussed in more detail), but may be more extreme in care leavers who have not seen a model of a positive relationship.

6.4.7 Pregnancies

A quarter of young women leaving care are pregnant or already mothers. **Almost half of female care-leavers become mothers between the ages of 18 and 24,** compared to 29% of women aged 24

or under in the general population.[11] Young people with a background in care are more likely to continue a pregnancy, planned or unplanned. This group is also more likely to experience poor outcomes including having a low birth weight baby, single parenthood, and symptoms of depression, and are more likely to smoke during pregnancy (Fallon et al., 2015).

Research also suggests that teenage motherhood (defined as conception under the age of 20) has a detrimental effect on later life outcomes. Teenage mothers, by age 30, experience lower rates of employment, lower wages, lower levels of educational attainment and higher benefits needs. This effect is more pronounced for young women who conceived between the ages of 18 and 20 (Walker, Goodman, & Kaplan, 2004).

6.4.8 UASC-specific physical health needs

UASC have very different physical and mental health problems to the indigenous population. Examination of the LAC nurse's records and relevant social work notes reveals a range of physical and emotional effects as a result of the journey, and sometimes of conditions and experiences in the young people's home countries beforehand.

Typically, the medical history of a UASC is unknown, including vaccinations. Common physical complaints, which seem to be the result of deprivation on the journey, are abdominal conditions and various musculo-skeletal issues. There also seems to be a high incidence of dental need, but it is not entirely clear whether these are the result of pre-existing conditions or as a result of the journey to the UK. Common low-level health problems are ringworm and scabies when UASC first arrive.

6.4.9 UASC-specific mental health needs

NICE states that UASCs have an increased likelihood of mental health problems, suicide attempts and mental illness, due to post-traumatic stress disorder and ongoing stress arising from language barriers, immigration systems and being separated from loved ones and community (Simmonds, Merredew, & British Association for Adoption and Fostering, 2010).

Separation, bereavement and uncertainty about the fate of loved ones often has a negative emotional impact. Additionally, emotional distress can sometimes be observed due to a lack of understanding of the situation after arrival due to language barriers.

Anxiety over the immigration process and the implications of getting a negative decision, such as the threat of an involuntary return to their home countries, are also influential factors on UASC's wellbeing. It has also been suggested by some practitioners that anxiety caused by the effort of maintaining a (potentially false) story to be conveyed to the Home Office may have a negative effect on wellbeing.

Several young people were supported to cope with the effects of these issues through LAC CAMHS specializing in trauma up to the age of 18, but are not necessarily eligible for adult mental health services.

[11] According to Community Care research article, citing earlier research briefing by SCIE. Available at http://www.communitycare.co.uk/2008/01/23/teenage-pregnancies-among-children-in-care-research/ (accessed 19.12.2016)

6.4.10 Care leavers in custody

The recent Ofsted inspection of the three boroughs' Children's Services noted that greater focus needs to be given to young care leavers in custody. Nationally, care leavers are over-represented in the criminal justice system. Research by the Ministry of Justice (Williams, Papadopoulou, & Booth, 2012) found that **24% of the adult prison population had been in care at some point as a child,** and reported that this was comparable with the 1991 National Prison Survey showing that 26% of adult prisoner were in care as a child (only 2% of the general population spend time in prison)**.** As discussed under 'mental health' above, there is also an over-representation of mental health needs in this cohort, and so early identification and better outreach should be done proactively with care leavers in custody.

6.5 Local service provision and use

Consultation with practitioners during the JSNA process has highlighted **tension between wanting to teach care leavers to be independent adults, and offering additional support**. Care leavers are the most vulnerable group of young adults; if services cannot be flexible to them, they will continue to fall between the cracks.

6.5.1 Services up to age 18

Up to age 18, the following services are used by Looked After Children and younger care leavers:

Service	Description
LAC CAMHS	Many care leavers would have accessed CAMHS up to age 18.
LAC Nurses	This service is only available to looked after children and care leavers up to the age of 18. The LAC nurses give annual health checks to young people and oversee regular dental checks. In practice, LAC nurses often give ongoing support and advice and communicate with their patients' personal advisors
Healthcare summaries	At the request of young people, care leavers are offered a health summary when they leave care.
Focus on Practice clinicians/ family therapist	Work with young people to provide an effective therapy service.

6.5.2 Care Leaver services

The following services are for care leavers over the age of 18:

Service	Description
Leaving care teams / Independence Support Team	Leaving care teams facilitate the transition for a young person from being 'looked after' to being a 'care leaver'.
Care Leavers Child Psychologist (RBKC only)	One psychologist placed within the Leaving Care team
Personal Advisors / keyworkers / foster carers	Provide health and wellbeing support such as healthy eating classes

The Children's Services and Leaving Care services have been recently rated as 'Outstanding' and 'Good' by Ofsted.[12] Local professionals have noted that the quality of social work has improved, particularly since the Focus on Practice training.

A challenge that has been identified locally is that care leaver services are provided during the week during working hours, however care leavers often need support 'out of hours' too.

6.5.3 Access to universal services

The key issue highlighted throughout the development of the JSNA was the transition from children's services to adults (over 18s) and the different inherent philosophies – under-18 services focus on the family unit, while adult services focus on the individual self-managing. Young adults' personal motivation and confidence to seek help and support may be in its infancy, and therefore they may not take up services that are geared towards self-determination and self-help. As a result, there can be issues with care leavers (and young adults generally) engaging with services. This is particularly prevalent when attempting to access mental health assessments.

Local good practice

Outreach work by LAC nurses has a positive impact, especially where the nurse is able to discharge to a GP with an understanding of young adults, and is able to discuss the transition with the care leaver at an early stage so they know how to independently access adult general health services.

A number of barriers to accessing services were reported by the small group of care leavers in Westminster, including:

- cost of certain services, particularly dentistry/oral health
- not always able to make an appointment with GP
- not always able to see the same GP or other health professional – continuity was important for care leavers
- transition from children's services to adult services was highlighted as an important issue (for example from CAMHS to adult mental health services).

When asked about developing health services for young people, awareness about drugs and smoking was suggested (for more information on substance misuse, see chapter 7).

At the consultation for the Corporate Parent Boards the majority of young people rated health as important. However barriers to prioritizing health included:

- the cost of gyms
- being busy with other things such as work or college
- living on a very tight budget.

6.5.4 Help-seeking behaviour

Most of the care leavers in Westminster reported waiting until a problem is severe before seeking help, and would often go directly to A&E rather than their GP. This was partly due to previous negative experiences with GPs.

[12] Inspection reports can be viewed on the Ofsted website https://www.gov.uk/government/organisations/ofsted (viewed 28 October 2016)

When seeking advice on health issues, care leavers mentioned non-health professionals such as social workers, personal advisors, key workers and carers. **The importance of a strong and trusting relationship with a professional or guardian/foster parent to help care leavers through different challenges in life was a recurring theme.**

A recommendation from one of the consultations was use of a health app for young people with tailored information. NHS Go provides this platform, and promoting it and ensuring local services have up to date information on NHS Choices (the information source for NHS Go) would be more cost effective than creating a new app.

6.5.5 Communication and Co-location of services

Communication between children's services and adults' services was highlighted as an area for improvement. Although good practice exists, it is not always consistent between all relevant services.

Co-location was consistently discussed as an effective way to improve communication and encourage young adults to access a range of appropriate services. Young adults are more likely to miss appointments and less likely to visit GPs to obtain referrals, which has been improved in other areas through co-location. (See case study in chapter 6, primary care).

Co-location local good practice

Care leaver group drop-in sessions in Westminster which take place one evening a week have been used by staff to have 'health days': care leavers visit stations relating to different health issues such as oral health and sexual health. The group sessions have other positive impacts; participants are encouraged to discuss their feelings and build a peer support network.

6.6 Recommendations

Gap / challenge	Potential solution / recommendation
Looked after children have higher rates of mental illness than the general population; nearly half have a mental disorder. During consultation with care leavers, there was a lack of awareness of mental health and coping strategies. However, some may not want help in a clinical setting. National evidence suggests good outcomes for mentoring, which may be more appropriate where psychological therapies are not wanted.	1. Actively promote resilience, prevention and early intervention for good mental health for all in generic services for care leavers. a. Review current and past mentoring and peer mentoring schemes in the three boroughs for care leavers and / or young adults.
The greatest area of unmet health and wellbeing needs of care leavers is mental health and emotional wellbeing that would not meet the threshold for Adult Mental Health Services.	2. Extend existing CAMHS or LAC CAMHS services to a tapered service for 16-25 year old care leavers to give continuity to those with a relationship with the

The Anna Freud Centre needs assessment for CAMHS recommended a tapered transition from age 16-25. LAC CAMHS see children over long time periods and specialise in trauma, which is most appropriate to this cohort. Some care leavers have existing relationships with LAC CAMHS staff which they would benefit from continuing; other are not ready to engage with counselling services until they are age 18 or above.	service, and extend the offer to include care leavers age 18-25 not already open to LAC CAMHS who are not eligible or suitable for Adult Mental Health services. a. The offer to care leavers should include flexibility if appointments are missed or service users don't want to be seen in a clinical setting.
A significant proportion of local care leavers are former UASCs, and have specific health and care needs.	3. Professionals including Leaving Care teams to be fully trained on NICE guidance for unaccompanied asylum seeking and trafficked care leavers
Consultation with care leavers identified that many sought advice from non-health professionals who they had a trusting relationship with e.g. their social worker. Although almost all are registered with a GP, most prefer to use walk in centres, A&E and urgent care. The needs and preferences of care leavers vary significantly from person to person, meaning a specific service may not be appropriate.	4. Non-health professionals working with care leavers e.g. personal advisors and key workers should routinely take an active role in the health of care leavers, such as taking them to the GP, and encourage seeking help in the appropriate setting. a. Pilot a personal budget for care leavers, where an assessed physical or mental health need is established, to allow them to choose a relationship with the professional that best meets their needs.
A small number of care leavers have significant multiple complicated physical, mental and social care needs, and a large number of professionals become involved in their case.	5. Pilot a transitions panel similar to the disabled children's panel for cases of care leavers with multiple or complicated needs.

7 Substance misuse

7.1 What is the issue?

Substance and alcohol misuse is a key issue for adolescents and young adults. The level of any drug use in the last year was highest among 16 to 19 year olds (18.8%) and 20 to 24 year olds (19.8%). In contrast, the level of drug use was much lower in older age groups (2.4% of 55 to 59 year olds). **5.1% of young adults aged 16-24 were classed as frequent drug users. Drug related deaths reached record levels in 2015;** 3,674 drug poisoning deaths involving both legal and illegal drugs were registered in England and Wales in 2015, the highest since comparable records began in 1993 (Lader & Home Office, 2015).

Cannabis, ecstasy and powder cocaine are most commonly used by 16-24 year olds, with **16.3% using in the last year,** compared with 6.7% for the general population (Lader & Home Office, 2015).

Drug and alcohol interventions can help young adults get or stay in education, employment and training; prevent homelessness; and improve family relationships key to recovery, bringing a total lifetime benefit of up to £159m. **Every £1 spent on young adults' drug and alcohol interventions brings a benefit of £5-£8** (Public Health England, 2014)**.**

Figure 12: National age-specific trends in drug use

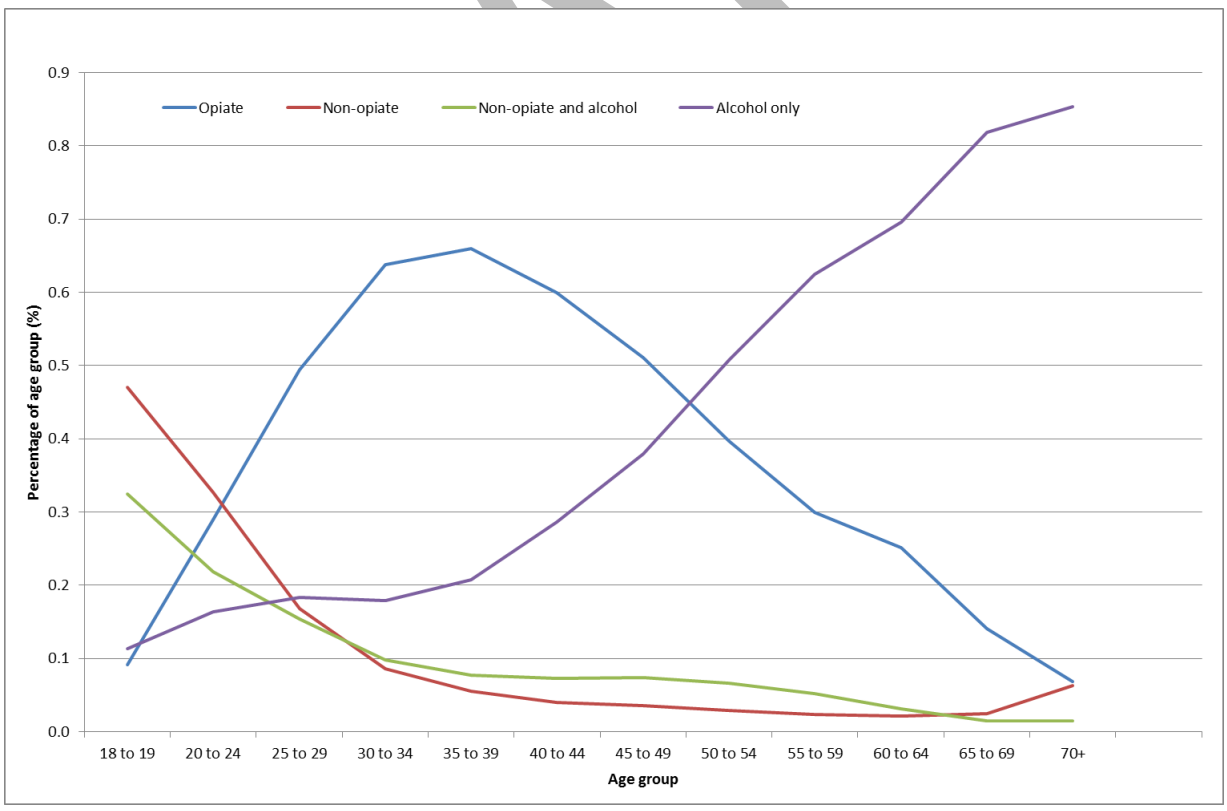


Figure 12 above shows that the key drug that adults present for treatment is opiates, however this is only the case after the age of 24. **For 18-24 year olds, non-opiates and combined non-opiates and alcohol are the primary drugs. This information is based on treatment population, so although it**

may not necessarily be indicative of need in the wider population, it does highlight the disparity around the substances which bring people into services.

Links to other chapters

As discussed in chapter 5 on Eating Disorders, those who abused alcohol or illicit drugs were up to 11 times as likely as those who did not to have eating disorders - up to **35% of individuals who abused or were dependent on alcohol or other drugs have had eating disorders, compared to 3% of the general population** (National Center on Addiction and Substance Abuse at Columbia University, 2003).

As discussed in chapter 8 on sexual health, there is a strong link between alcohol abuse and poor sexual health outcomes, including unplanned teenage pregnancy and sexually transmitted infections (P. Cook et al., 2010).

7.2 National strategy and guidance

7.2.1 Drug Strategy 2010

The Government's 2010 Strategy (Home Office, 2010) stated that specialist interventions should prevent young people's drug and alcohol use from escalating, reduce the harm young people can cause to themselves or others, and prevent them from becoming drug or alcohol-dependent adults.

7.2.2 *NICE Guidance: Substance misuse interventions for vulnerable under 25s*

Chapter 6 highlighted that care leavers have higher rates of substance misuse, which is true of other vulnerable groups. NICE has produced evidence-based public health guidance (NICE, 2007) which focuses on reducing substance misuse among vulnerable under-25s with a number of recommendations. This includes pathways for both alcohol use disorders[13] and drug misuse[14].

The guidance recommend that local authorities should **develop a local strategy** that will help them to reduce substance misuse in vulnerable young people in their area. Services and professionals should **identify young people who are at risk of using drugs**, and refer them to services that can support them. These services should include **family based support** and **parental skills training**. Psychosocial interventions ('talking therapies') such as CBT and motivational interviewing, which explore the underlying causes of the substance misuse and seek to change the young person's attitude and behaviour towards drugs and alcohol, are considered to be most effective.

7.3 What do we know nationally?

7.3.1 Alcohol

Nationally, in the short term **1/4 of all deaths among 16-24 year old men** are attributable to alcohol. Alcohol use in adolescents and young adults causes long term health problems including **risks to**

[13] NICE Pathways. *Alcohol use disorders (online)* http://pathways.nice.org.uk/pathways/alcohol-use-disorders (accessed 16.12.16)

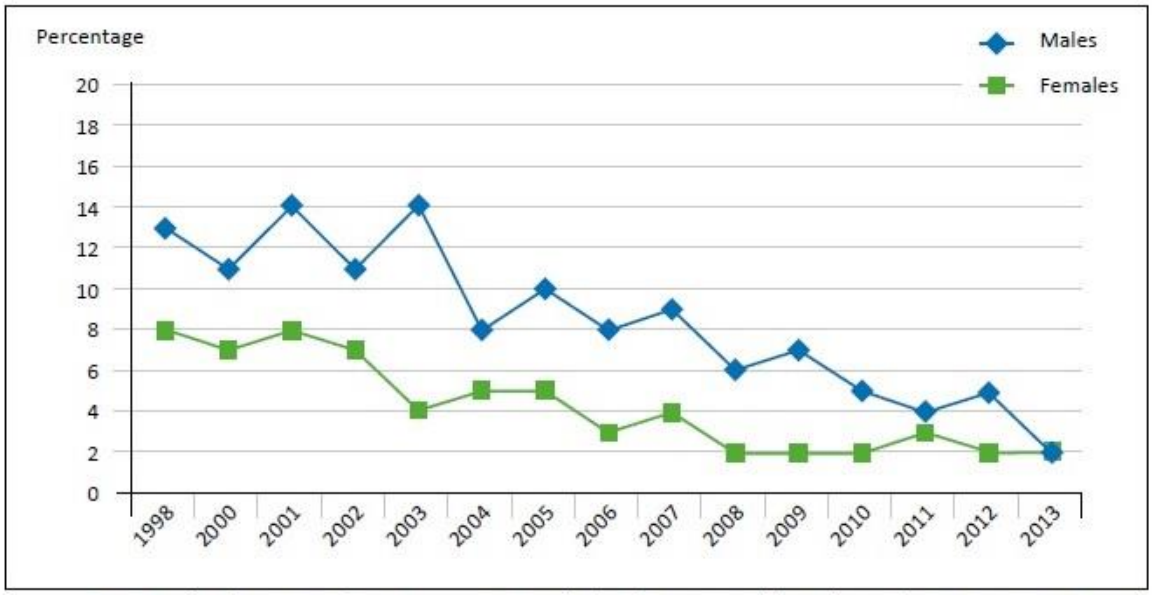
[14] NICE Pathways. *Drug misuse (online)* https://pathways.nice.org.uk/pathways/drug-misuse (accessed 16.12.16)

brain development and long term memory, **mental health disorders and social problems**, and **increased risks of teenage pregnancy and contracting sexually transmitted infections (STIs)**.

The highest levels of alcohol dependence in women is amongst those aged 16 to 24 (9.8%), however they are under-represented within services. In men the highest levels of dependence were in those aged between 25 and 34 (16.8%) (National Centre for Social Research & University of Leicester, 2009).

There has been a fall over time in regular drinking (5 or more days per week) in 16-24s. However, young drinkers were more likely than any other age group to consume more than the weekly recommended limit in one day. **Among 16 to 24 year old drinkers, 17% consumed more than 14 units compared with 2% of those aged 65 and over** (Office for National Statistics, 2016).

Figure 13: Young people aged 16-24 years drinking on 5 days per week or more, Great Britain, 1998-2013



Source: Office for National Statistics, Opinions and Lifestyle Survey, Adult Drinking Habits in Great Britain, 2013

7.3.2 Cannabis and synthetic cannabinoids

Cannabis is particularly harmful in under-18s in terms of physical impact on health, as well as social impacts from misuse. A study in New Zealand found that adolescents who used cannabis regularly were at **risk of cognitive impairment including reduced intelligence, memory loss, and reduced attention span** (Meier et al., 2012)**.**

Most young adults in England smoke 'skunk', a higher grade and more chemically based version of cannabis produced in the UK, which has a severe impact on frequent users including mood swings and loss of motivation. Although cannabis is not considered addictive, frequent users feel dependent.

Synthetic cannabinoids such as 'Spice' and 'Black Mamba' are significantly more potent than cannabis, have a drastic impact on behaviour and are highly addictive. They have been legal until

recently, and different versions may emerge which are not yet illegal. Synthetic cannabinoids are more likely to lead to emergency medical treatment than any other drug.[15]

7.3.3 New psychoactive substances (NPS)

Estimating the prevalence of NPS usage is often a challenge, especially through general population surveys. One insight is provided by the 2014 Flash Eurobarometer, a survey of just over 13,000 young adults aged 15–24 in the EU Member States, which asked about the use of NPS. It found that 8% of respondents had used an NPS at least once, with 3% using them in the last year (European Monitoring Centre for Drugs and Drug Addiction, 2015).

The majority of deaths from NPS (a total of 114 in England and Wales in 2015) reference mephedrone (a stimulant) and GHB (a sedative). According to the Global Drug Survey, in the UK patients are 3 times more likely to end up seeking emergency medical treatment with NPS than traditional drugs.

7.3.4 Inequalities

- Vulnerabilities increase likelihood of young people using drugs and alcohol. Care leavers and victims of domestic abuse, sexual assault and/or sexual exploitation are disproportionately likely to be seen in services, as are people with lower socio-economic status.
- Issues may differ by gender. There is a far higher rate of substance misuse amongst young men compared to young women.
- Gay or bisexual adults were more likely to have taken any illicit drug in the last year than heterosexual adults. In particular, gay or bisexual men were the group most likely to have taken any illicit drug in the last year (33%), with higher levels of illicit drug use than gay or bisexual women (23%) and heterosexual men (11%) (Health and Social Care Information Centre, 2014).

7.3.5 Risk factors

Risk factors include neglect, truancy, offending, early sexual activity, antisocial behaviour and being exposed to parental substance misuse (Donaldson, 2009). Mental health is a key factor in problematic substance misuse as both cause and effect.

The strongest single predictor of the severity of young people's substance misuse problems is the age at which they start using substances (Public Health England, 2016).

7.3.6 Protective factors

Physical and mental wellbeing, and good social relationships and support are all key protective factors of problematic substance misuse. Important predictors of wellbeing include positive family relationships, a sense of belonging at school and in local communities, good relationships with adults outside the home, and positive activities and hobbies.

[15] Global Drugs Survey. *Global Drugs Survey 2016 (online)* https://www.globaldrugsurvey.com/past-findings/the-global-drug-survey-2016-findings/ (accessed 16.12.16)

7.3.7 Barriers to accessing substance misuse services

The authors of a review of the characteristics, needs and perceptions of 18-25 year old drug users in Liverpool identified the following potential barriers to accessing services:

- **Age restrictions or cut-offs for services:** users stated that services needed to listen to them more. Passing them on when they reached a certain age was a barrier to staying in treatment.
- Differences in the **definition of a 'young person**' among young people and service providers alike could lead to confusion as to which service they should attend and how **transition** should be managed.
- Adolescents and young adults are more likely to seek advice **from family or friends** than from professionals**.**
- Poor attitudes of some service providers act as a barrier, as young adults find it important to have someone that they can rely on and trust.
- Services focusing on single needs (e.g. drug use) – services should address a **range of needs.**
- Lack of 'joined-up' services and multiple points of entry – it would be preferable to have a single source organisation instead of having to move from one service to another. (Wareing, Sumnall, & McVeigh, 2007)

7.4 What do we know locally?

Each borough provides a substance misuse service for young people under the age of 18 and a range of adults' services for over 18s.

7.4.1 Specialist services: Young People Services

Each borough provides a service for children and adolescents.

- **Insight Blenheim – RBKC, up to age 24**
- **Hungerford Turning Point – WCC, up to age 18**
- **Children's Services – LBHF, up to age 18**

In H&F, Public Health contributes the funding of Hammersmith and Fulham Children's Services for young people's sexual health and drug/alcohol misuse provision for residents. In RBKC and WCC, Blenheim and Turning Point are commissioned to provide specialist interventions and training to professionals to aid identification. Services are provided through satellites and both agencies work closely with other young peoples' services.

The services provide both preventative interventions and treatment for young people. They run hot cafés, weekly workshops and a variety of health and wellbeing activities. They go into schools and colleges to undertake training sessions for parents, foster carers and teachers.

The Hammersmith and Fulham service works across statutory and voluntary services including Youth Offending Teams, Family Support and Child Protection, CAS, Early Help services in the north and south of the borough, and Family Assist. They also provide support to looked after children, attend parenting groups to provide substance misuse education, and deliver training to professionals within the borough around substance misuse.

7.4.2 *Specialist services: Adult Services*

The three boroughs have jointly commissioned adult drug and alcohol services for people over the age of 18. The treatment system was reconfigured in April 2016, with the new model focusing on transforming services to ensure they are responsive to local need, embed a culture innovative service user involvement, and embody an ethos of ambition for individual success.

Drug & Alcohol Wellbeing Service (DAWS): Turning Point and Blenheim jointly run the DAWS service in Hammersmith and Fulham, Kensington and Chelsea and Westminster, providing support for those using drugs and/or alcohol.

Change Grow Live (CGL): There is a separate alcohol-specific service which also operates in Hammersmith and Fulham, Kensington and Chelsea and Westminster.

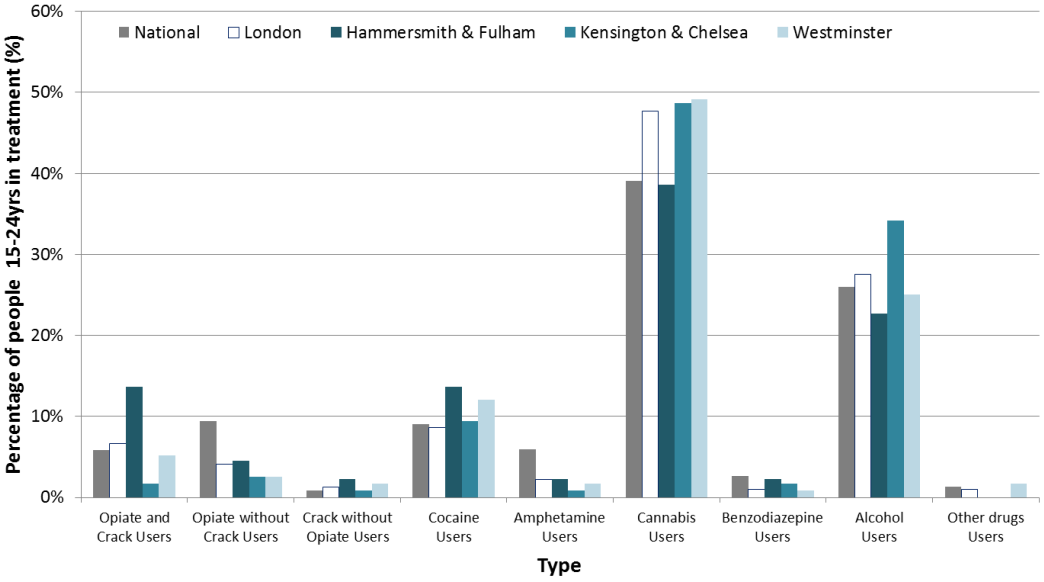
Club Drug Clinic: Provided by CNWL, this service covers the three boroughs and focuses on 'club drugs' such as MDMA, cocaine and ketamine as well as NPS use. It also offers a bespoke service for those from LGBT communities, especially men who have sex with men.

Primary Care Support Service: The Blenheim service works in partnership with GPs and primary care staff across Hammersmith & Fulham, Kensington and Chelsea, and Westminster. It offers a free, friendly and confidential service which is open to people aged 18 or above who have alcohol or drug problems.

7.4.3 *Specialist Service use*

The majority of 15-24 year olds receiving a service in the three boroughs do so for cannabis, followed by alcohol, as is the case nationally. The numbers receiving a service for crack and opiates are small. Figure 14 shows Bulls Eye data on what young people are being treated for, obtained from services through the National Drug Treatment Monitoring System (NDTMS).

Figure 14: Bulls Eye data, 15-24 year olds receiving treatment, NDTMS



7.4.4 Club Drug Clinic use by young adults

The Club Drug Clinic (CDC) is an innovative service for adults in the three boroughs who have developed problems with club drugs and new psychoactive substances (NPS). Established in 2010, the clinic has seen over 700 clients, of which a relatively small percentage has been aged 18-24. Research tells us that NPS use seems to be concentrated among young adults between the ages of 16 to 24 years, which is more than 3 times higher than adults in general. It is also particularly so among young men. It can be assumed that most young people who use NPS will do so without any significant acute harm or long-term effects. However, some will suffer from adverse effects, which can be severe. It is in no doubt that more research is needed on the specific needs of young adults.

The CDC is actively involved in research and hosts Project NEPTUNE, the comprehensive clinical guidance on NPS. It is therefore well placed to identify new and emerging drug trends. The main drugs used by the 18-24 year old cohort of clients to date are MDMA, ketamine, LSD and mephedrone.

The experience of the CDC service also suggests that some young people may have problems associated with hallucinogenic drugs. 15% of clients presented with symptoms of hallucinogen persisting perception disorder (HPPD). This is a condition characterized by a continual presence of sensory disturbances, often visual, that can be experienced for up to two years after using hallucinogenic substances.

7.4.5 Prevalence of opiate, cocaine and crack use

Service use does not necessarily reflect needs. Although we don't often see residents aged 18-25 years olds accessing services for support with opiates, cocaine and crack, there is a local need. In 2011/12 when prevalence estimates were last updated, prevalence of **opiate and crack cocaine use in 15-24 year olds was estimated (per 1,000 population) as H&F – 69, RBKC – 54, WCC – 130**.[16]

It is known that many people do not seek help from a service until reaching a crisis point, but start using substances a long time before – see figures in section 7.1 above showing that drug use is highly prevalent in this age group. Adult treatment data collects information on the age that the first problematic substance was used. Table 10 shows that **the majority of people receiving a service for opiates, cocaine and crack started using in their early twenties.**

Table 11 Age that first problematic substance was used, 2012-13 NDTMS

		H&F	RBKC	WCC
Opiates	% who began use aged 25 or under	64%	70%	76%
	Mean age	24 years	24 years	22 years
Powder Cocaine	% who began use aged 25 or under	85%	81%	87%
	Mean age	22 years	21 years	20 years
Crack Cocaine	% who began use aged 25 or under	76%	52%	65%
	Mean age	20 years	27 years	24 years

[16] NTA. *Facts and figures: prevalence data (online)* http://www.nta.nhs.uk/facts-prevalence.aspx (accessed 19.12.16)

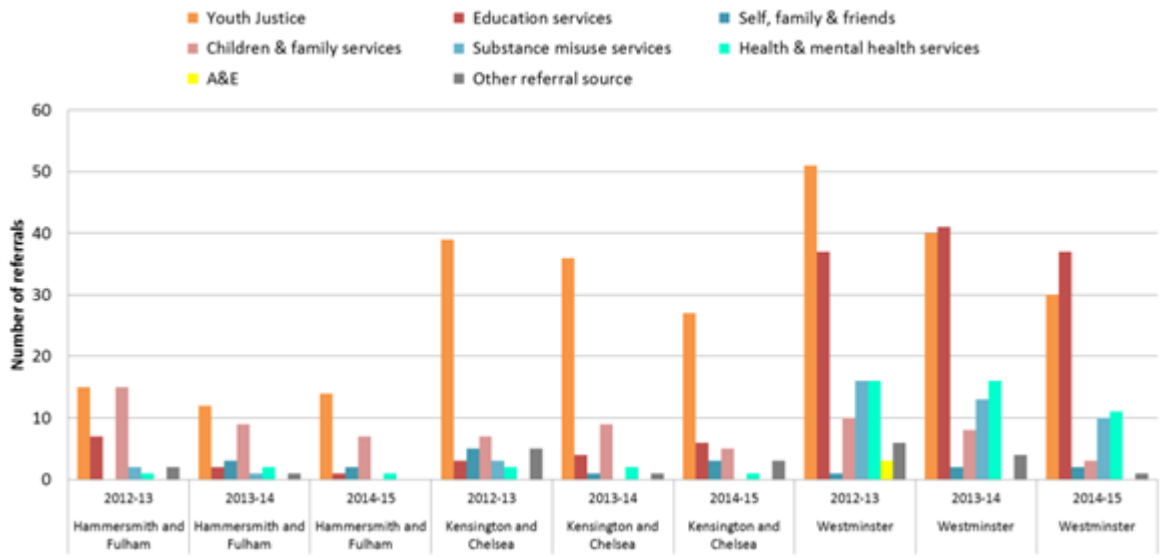
While cannabis and alcohol tend to be the substances that young people present to services with, there is a wider need. The service offer for residents aged 15-24 therefore needs to be flexible and able to respond to a range of needs. Proactive preventative outreach work and harm reduction, such as needle exchanges, therefore need to be available for people not yet in touch with services.

7.4.6 Referral sources to specialist services

Substance misuse services work closely with a number of other services. Figure 15 below shows that common referral sources are from Youth Justice and Education services, as well as Children and Family Services. Referrals also come from GPs, Leaving Care teams, homeless hostels, schools, mental health services, as well as referrals from family, friends and self-referrals.

Differences in the numbers accessing services or referral pathways are often indicative of changes to process or service design. The reduction in referrals in RBKC and WCC, and the historically low level of referrals in H&F, reflects the increased emphasis on training other professionals to identify misuse and provide tailored harm reduction and brief interventions. Referral sources are heavily impacted by resources and location. For example, Westminster's benefit from the secondment of a CAMHS worker means referrals from mental health services look comparatively high. Changes to young people's housing provision can grow or shrink a referral route.

Figure 15: Numbers of young people up to age 18 referred for treatment 2012/13 to 2014/15



7.4.7 Primary care

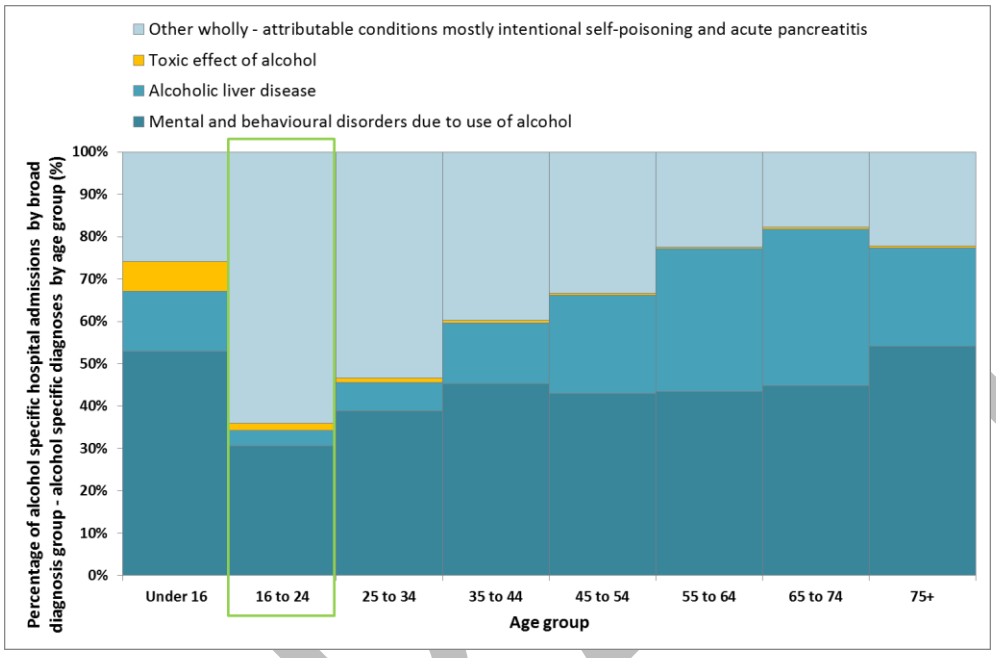
Currently, there is a relatively low number of referrals into services through GPs. As substance misuse is relatively common in young adults, although not necessarily identified as problematic, it is important that GPs are comfortable proactively discussing substance and alcohol misuse with young people. Many young adults are not aware that they have an issue until they reach a crisis. GPs must be aware of new trends in substance misuse, such as the emergence of new psychoactive substances.

However, GPs should be aware that young adults may be concerned about visiting their GP because of confidentiality/privacy fears at practices that relatives also visit. (See chapter 4 – Primary Care).

7.4.8 Alcohol misuse treatment in secondary care

Anecdotally, it is known that many young adults are misusing alcohol but do not proactively engage with services; however, a number of people will attend hospital services due to alcohol-specific causes or alcohol-related conditions. Figure 15 below shows how this affects 16-24 year olds differently from other age groups nationally. This shows that alcoholic liver disease is low in young adults, and so successful early intervention at this age will prevent alcoholic liver disease later in life.

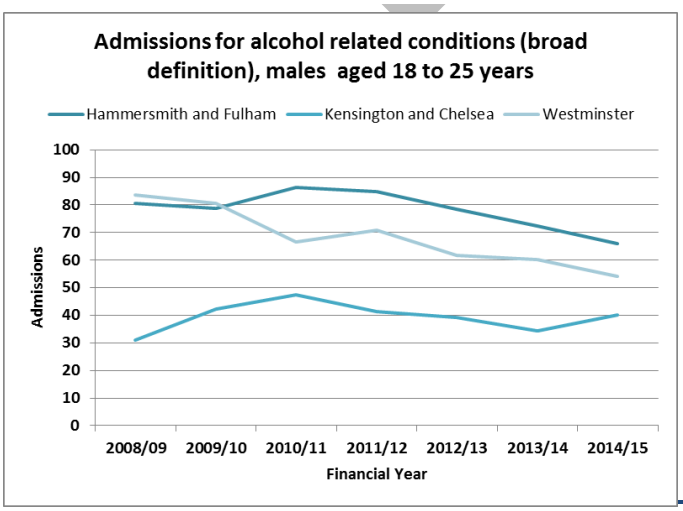
Figure 16 Distribution of alcohol specific diagnoses by broad type: National

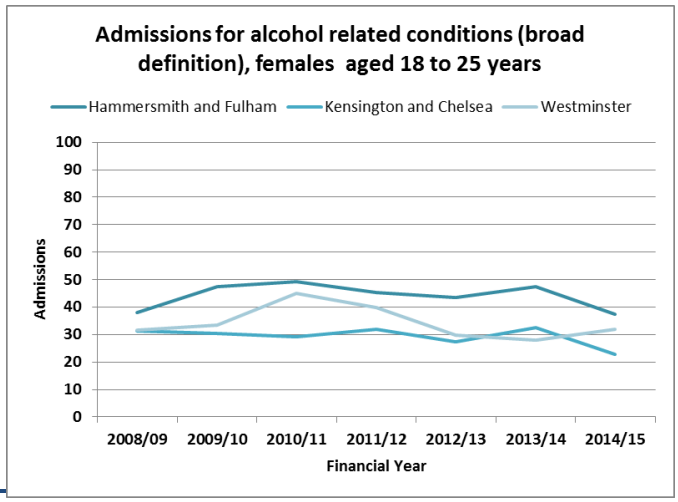


SOURCE: LAPE

Figure 17 shows the number of alcohol related hospital admissions by borough for males and females respectively. The data relates to the 'broad' definition of alcohol related hospital admissions. For both sexes, numbers are higher in Hammersmith and Fulham and lowest in Kensington and Chelsea. Levels of admissions are generally higher for males but have fallen more rapidly than for females over the 7-year period. Rise in male admissions in Kensington and Chelsea and females in Westminster are noted in the most recent period.

Figure 17: Alcohol related admissions: males and females, aged 18-25 (Source: LAPE, 2015)





Alternatives to secondary care: Soho Alcohol Recovery Centre (SARC) Pilot

The SARC pilot project ran in 2010 around Christmas time to relieve pressure on A&E and the London Ambulance Service (LAS). It comprised of a single site in the centre of Soho staffed by LAS. **58% of the patients were in the 18-25 age group**, with an equal gender split. Based in the West End, the service was created to address the medical needs of intoxicated patients which can be effectively dealt with outside a hospital environment and without an ambulance. The project used Alternative Response Vehicles known as the 'Booze Bus', instead of ambulances, which can take up to 5 people at a time.

The Centre successfully treated 88% of those who required sobering up, with no further medical intervention required. At particularly busy periods such as New Year's Eve, **treating patients in the Centre was more than half the estimated cost of treating them in A&E.** On less busy nights, the costs were similar to A&E but analysis shows wider benefits beyond savings to A&E such as identifying high risk drinkers. The **evaluation highlighted the need to develop initiatives to reduce the likelihood of re-presentations amongst under- 25s.**

7.5 Challenges and barriers identified by local commissioners and practitioners

Practitioners from substance misuse services, social work teams, the community and voluntary sector, and other related services discussed the services in a workshop in July 2016. A number of challenges were identified for young adults specifically.

7.5.1 Challenges with specialist services

Local good practice

The new adult substance misuse services have a single triage form to ensure that a service user doesn't have to complete multiple assessments if they enter the service at the wrong point.

Appropriate settings for treatment: As discussed above, the majority of young adults in services are receiving treatment for cannabis or alcohol, which is the focus of the young people's services (as opposed to the adult service which focusses on crack and opiates). Services should be needs led, and allow flexibility for whether a young person would be best treated in an adult service or a young person's service. Flexibility should also be offered in the setting for care; if a young person is uncomfortable in a certain building because of other service users, services should be available in the community. Practitioners also identified that the 'emotional age' and needs of young adults differ widely, and many young adults prefer the more creative style of the young people's services.

Challenge of reciprocal arrangements with other borough and integrated services: substance misuse services are provided by the council for residents only, however health professionals including GPs have a large registered population who do not live within the boroughs, particularly in central London with registered students (see chapter 3 – Population Profile). Effective recovery from substance misuse may require the cooperation of professionals across organisations, and the disconnect between health and council-provided services could hinder recovery if not well coordinated. As Kensington and Chelsea and Westminster have more young adults registered with GPs in the borough than actually living in the borough, they must receive treatment for substance misuse in their borough of residence. Services not being integrated also presents as a barrier and

may mean some young adults fall between the cracks, and so it is important that professionals foster strong reciprocal relationships, in particular GPs with substance misuse services in other boroughs.

'Postcode Wars': For a few very vulnerable young adults, it may be unsafe to travel to particular areas due to gang tensions. If a young person is moved outside of the borough (e.g. 'Tom' from the case study below) further complications arise with their treatment.

Identifying with diagnosis: Some people, particularly those who are still considered highly functioning, find it difficult to identify and accept that they have an unhealthy relationship with substances. They are therefore more challenging to work with and engage. Substance problems may remain unapparent in university students due to a culture of widespread alcohol misuse and the unstructured nature of university life. They are more likely to enter treatment services after a hospital visit.

Cross agency working: The case study below highlights how many different professionals may be involved with a young person with substance misuse. However, there are safeguarding issues regarding whether sensitive patient information can be shared between services.

1.1.1 Case study

'Tom' was referred to the LBHF substance misuse worker from the Early Help team as his cannabis use was impacting on his engagement with education or employment; he had begun using and dealing cannabis, where he became indebted to the people he was dealing for. He disengaged with the service when he was confronted directly about his dealing.

Tom was arrested and the substance misuse worker worked with the Youth Offending Team (YOT), and successfully reengaged with Tom's parents, who soon informed the worker that Tom was a risk to the family home and could not remain there. Tom stayed briefly with other family members, but the relationships soon broke down, and he was placed in a young person's hostel. He continued to use cannabis, and hostel staff suspected he had restarted dealing. At this point, Tom was being supported by the substance misuse worker, his allocated YOT social worker, a specialised worker in violent offences and young people (as Tom had been arrested and had also admitted to dealing), his hostel worker, and an allocated social worker from Children's Services.

Tom was stabbed following direct orders from people he had known and associated with, who believed that he still owed a debt.

He was then moved out of borough due to concerns about his life, however there were disputes across borough around providing the funding for Tom to reside in his new safe hostel. He was granted LAC status and was able to remain in his chosen hostel where he is engaging well with services but socially isolated, which escalated his cannabis use.

Tom has now turned 18 and the substance misuse worker is obliged to close the case. Drug services in Tom's new area are limited, and focussed on people using crack and heroin.

Funding for Preventative Work: Service specifications and contracts must incentivise or support prevention and early intervention so services do not only cater to people with high support needs.

7.5.2 Challenges with key related services

- **Training**: Professionals working with or close to young adults (e.g. health professionals including GPs, social workers, family, carers) need to be well educated in substance misuse in order to identify it and react appropriately.
- **Housing:** The key area of the environment where change is needed for a young person to change their lifestyle, but equally is very difficult to change.
- **A&E:** Young adults are more inclined to visit A&E or urgent care in a crisis or with substance-related issues than engage proactively with substance misuse services, so good referral routes from secondary care into specialist services need to be in place such as through alcohol liaison nurses.
- **Dealing:** Responsibility for addressing drug dealing lies with youth offending or substance misuse teams. Funded tailored interventions for those who are dealing would be more effective. There are more complex issues around dealing such as the 'grooming' of young men, who are then very vulnerable once they start dealing but are criminalised rather than supported to escape that lifestyle.
- **Prevention work in schools:** From January 2017, school nurses will be required to deliver substance misuse teaching as part of the school health offer. This may have a positive impact on preventing harmful substance misuse in young adults if tackled effectively whilst the young person is still in school.
- **Prison:** Some staff report working with individuals who go into prison and come out heavy drinkers or substance users, particularly of Spice (synthetic cannabinoids). There is a feeling that more support is required to work with this group perhaps before they go into prison.

1.1.2 Local good practice

Outreach work works well with young people such as treatment services within the local community. For example, the MetroSexual Centre and St Georges encourage clinicians to ensure that thorough questions about the bigger aspects of person's health are asked about rather than just the presenting issue.

7.5.3 Youth Council feedback

Members of the Westminster Youth Council confirmed many of the points made above, including that cannabis use had become normalised, with many young people believing it was not really illegal and daily expenditure on cannabis of over £20 was common, funded through dealing. The young people consulted as part of this project were not aware of substance misuse services but supported the principle of young adults being treated in appropriate settings.

It was noted that advice in the case of substance-related sickness or overdose is not easily or quickly accessible to find good quality information and advice. First-aid training specific to these types of incidents was recommended.

7.5.4 Recommendations

Gap / challenge	Potential solution / recommendation
The majority of young adults in treatment for substance misuse are addressing cannabis and alcohol issues, however adult services cater predominately to crack and opiate users.	1. Review adult and young people's service offer to ensure a flexible, responsive and coordinated service is available to meet the needs of young people who use a range of substances. Allow flexibility in the young people's substance misuse services to provide for young adults up to the age of 25, based on a professional appraisal of where their need can best be met.
Vulnerable groups are more susceptible to harmful substance misuse.	2. Develop a local strategy to reduce substance misuse among vulnerable and disadvantaged under-25s as recommended by NICE (2007).
Although numbers in services are relatively small, substance misuse is widespread amongst young adults. There is significant variation between the boroughs in their referral rates into substance misuse services from key partners.	3. Continue to develop awareness and training for a broad range of professionals in contact with young adults to enable conversations to be started earlier, rather than when a problem has taken hold. Training should include building resilience in young people to resist pressures in their social groups, schools and universities. a. Work with young people's services, GPs and hospitals to embed effective pathways and interventions which target those most at risk of substance misuse.

8 Sexual Health

National statistics show that young people aged 15-24 experience the highest rates of new sexually transmitted infections (STIs) than other age groups. As with substance misuse, this is characteristic of more risk taking behaviour in young adults. The consequences of poor sexual health can be serious as many sexual infections have long-term health impacts, such as infertility and cervical cancer. Furthermore, there are inequalities in sexual health – there is a clear link between social deprivation and poor sexual health. Women, gay men, young people and people from Black and Minority Ethnic (BME) groups are disproportionately affected by poor sexual health.

8.1 Link to substance misuse

Sexual health issues are linked to alcohol and substance misuse. Earlier alcohol use is associated with early onset of sexual activity and is a marker of later sexual risk-taking, including lack of condom use and multiple sexual partners. Sexual assault is strongly correlated with alcohol use by both victim and perpetrator (Royal College of Physicians, 2011).

Although a causal link cannot be proven, 16-24-year-olds are among the highest consumers of alcohol in the UK as well as having the highest rate of sexually transmitted infections. Young people are also more likely to become re-infected with STIs. In a review of 11 studies on the subject, 8 were found to show a significant relationship between alcohol consumption and at least 1 STI. This did not appear to vary according to gender or pattern of alcohol consumption (R. L. Cook & Clark, 2005).

Alcohol is also often given in interviews as a factor contributing to teenage pregnancy. 85% of the increase in alcohol-related hospital admissions that occurred between 2005/2006 and 2006/2007 in 15–17-year-olds was in the local authorities with the highest teenage pregnancy rates (RCP 2011). In young adults, alcohol is a key causal factor in unplanned pregnancies.

8.2 Best practice guidelines

In 2011 the government published *You're Welcome - Quality criteria for young people friendly health services* (Department of Health, 2011). These standards are largely in line with the NICE guidance on contraceptive services for the under-25s (NICE, 2014b). The Department of Health *Framework for Sexual Health Improvement for England* (Department of Health, 2013) sets out ambitions for improving sexual health outcomes for 16-24 year olds.

These criteria include assurances of confidentiality for young people (as far as safeguarding allows) and the routinely offered opportunity for patients to be seen without a parent or carer present. It is advised that staff receive training on young people's health needs, and in supporting young people to make their own, informed choices about their health and care. Vulnerable groups (including care leavers and UASC) may also need specialist services made available to them according to their particular needs.

STI testing and treatment (or 'seamless' referral to a more relevant service) and opportunistic chlamydia screening should be offered to young people. Free contraception, condoms, pregnancy testing and emergency hormonal contraception should be made available, including to young people who are not ordinarily patients of that service. Referrals for abortions and antenatal care should be offered when appropriate; in the case of unplanned pregnancy it should be possible for young

women to immediately be seen by an impartial practitioner (e.g. with no ethical opposition to abortion).

The Framework promotes resilience by enabling young people to make informed decisions and prioritise prevention through information as well as access to appropriate sexual and reproductive health services.

Other criteria refer to staff training in speaking to young people about sexual health issues, contraceptive options, and STI and pregnancy prevention. This should be sensitive to the person's age, gender, sexual orientation and ethnicity.

8.3 What do we know locally?

The percentage of new STI diagnoses made in GUM clinics of patients aged 15-24 were 31% for Hammersmith and Fulham, 27% for Kensington and Chelsea and 25% for Westminster compared to an average of 46% in England.

Reinfection rates among our resident in this age group, within a 5 year period, varies from **20% to 18.4% for women and 17.5% and 16.5% for men.**[17]

The *Framework for Sexual Health Improvement in England* (Department of Health, 2013) outlines several ambitions specific to the improvement of sexual health outcomes for 16-24-year-olds. These include rapid access to appropriate sexual and reproductive health services and the prioritisation of prevention. Reduction of unwanted pregnancies (in women of all fertile ages) is also cited, and is linked to the ambition to ensure young people are aware of the risks of unprotected sex.

Measures such as chlamydia detection rates, rates of repeat abortions in under-25s, and conceptions in 15-17-year-olds are indicative of how well these ambitions are being achieved. Data presented below is taken from Public Health England's *Sexual and Reproductive Health Profiles*[18].

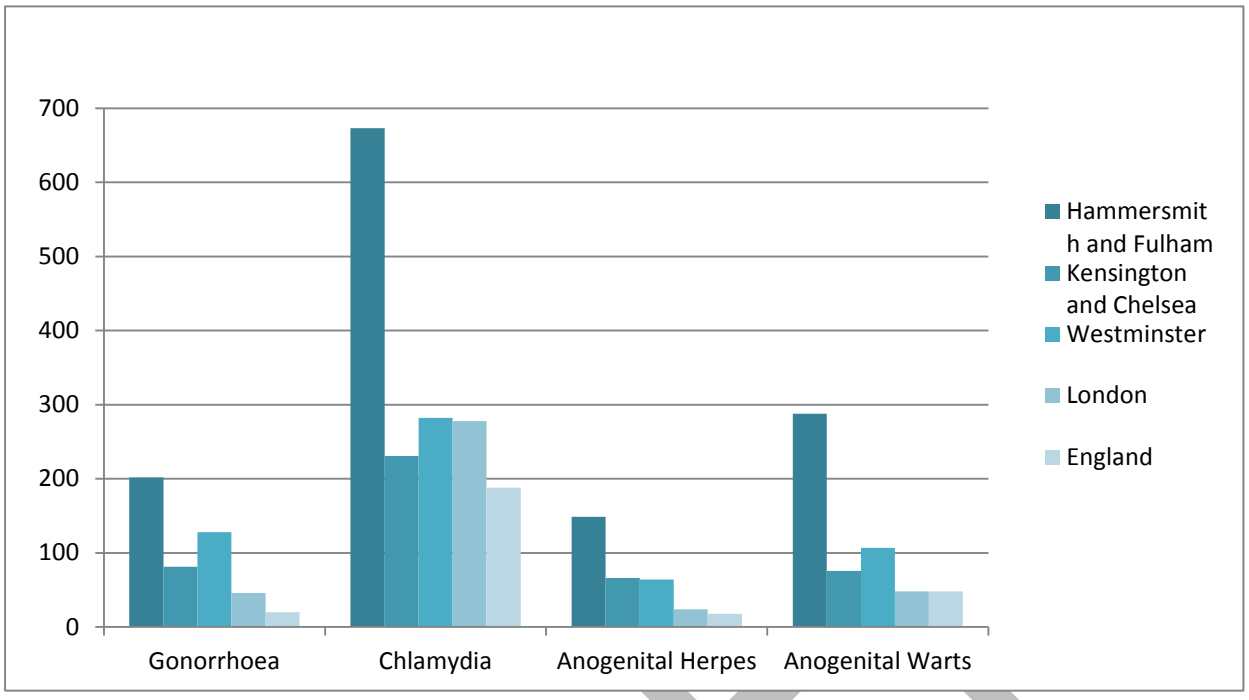
8.3.1 STI Diagnosis rate

As shown in figure 18, sexual health outcomes for the three boroughs vary according to the metric of measurement but broadly perform well against London averages, with the exception of Westminster's chlamydia detection rate.

[17] Public Health England (2015). Local Authority HIV, sexual and reproductive health epidemiology report (LASER): 2014.

[18] Public Health England. *Sexual and Reproductive Health Profiles* http://fingertips.phe.org.uk/profile/sexualhealth/ (accessed 16.12.16)

Figure 18: Rates of STI diagnosis per 10,000 16-24-year-olds (2014/15) (GUMCad)

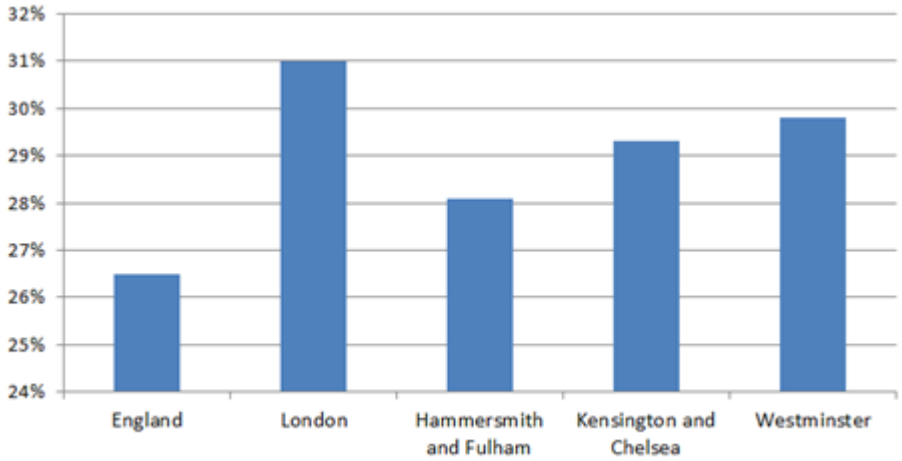


As chlamydia is most often asymptomatic, a high detection rate reflects success at screening coverage which will aid identification of infections that, if left untreated, may lead to serious reproductive health consequences. **The detection rate is not a measure of prevalence**. PHE recommends that local areas achieve a rate of at least 2,300 per 100,000 resident 15-24 year olds, a level which is expected to produce a decrease in chlamydia prevalence. Areas already achieving this rate should aim to maintain or increase it; other areas should work towards it. Figure 18 shows that Hammersmith and Fulham are performing well at detection rather than having significantly higher prevalence. Westminster's detection rate requires improvement.

8.3.2 Unplanned pregnancies

There is a public health need to ensure that rates of abortion and repeat abortion in women of all ages, but particularly young women, are managed. Although the three boroughs are doing better than the average for London, figure 19 shows that they are behind nationally.

Figure 19: Percentage of repeat abortions* in under-25s (2015 data, PHE)



*The percentage of women having an abortion who have had at least one abortion in any previous year

8.3.3 *Contraception*

Long Acting Reversible Contraceptives (LARCs) offer young women an effective choice and in so doing, reduce rates of unplanned pregnancy. LARCs are also known to be highly cost effective. However, the rates of LARC prescription in Hammersmith and Fulham are below average, and are the lowest in London and England for Kensington and Chelsea and Westminster. Improving the rate of LARC prescription will contribute to ensuring that rate of under-18s conceptions and repeat abortions is maintained and further reduced.

Table 12 rate per 1,000 of Long Acting Reversible Contraception 2014 (PHE Sexual and Reproductive Health Profiles)

Borough	LARCs rate /1,000
Hammersmith and Fulham	29.9
Kensington and Chelsea	18
Westminster	20
London	35.3
England	50.2

8.4 Youth Council feedback

8.4.1 *Services*

Discussion with the Westminster Youth Council revealed a sense of there being a lack of reliable access to good sexual health information, advice and support. It was felt that by the time sexual health among teenagers and young people ceased to be a taboo, sexual activity had already become normalised. Difficulty in accessing contraceptives was raised and the Come Correct scheme[19], offering free condoms to young people aged 13-24, was mentioned; however, the three boroughs

[19] Come Correct http://www.comecorrect.org.uk/ (accessed 16.12.16)

are not participating at present. Freedoms provides our local condom distribution service. This service is available, although not targeted at young people.

8.4.2 Psychosocial issues

Confidence, peer pressure and technology were discussed at length. It was mentioned that girls often concede to pressure to have unprotected sex or be filmed or photographed in sexual situations, which can then be used for blackmail or circulated on social media. One participant recommended that instilling confidence, and in particular empowering girls to say 'no', should be prioritised over 'online safety' education. Teaching a better understanding of the consequences of sharing material online was also suggested.

This consultation informed that there is a common issue of distribution of sexual images of under 18s around schools in the borough (usually female, and without the consent of the person pictured), which raises legal and safeguarding concerns.

8.5 Recommendations

Gap / challenge	Potential solution / recommendation
Sexual health is a key health issue for the vast majority of young adults.	1. Ensure all commissioned sexual health services adhere to the You're Welcome standards.
There is a strong link between substance misuse and risky sexual behaviour.	2. Consider integration of substance misuse and sexual health services for young people.
There are clear inequalities in sexual health, particularly in socio-economic status. Care leavers have significantly higher rates of unplanned pregnancy than the general young adult population.	3. Work with young people's services to embed effective pathways and interventions which target high risk groups including care leavers.
Young people consulted reported that adults and professionals over medicalise what to them is a social issue.	4. Develop sexual health services to proactively address the psychosocial aspects of sexual health.
The *Framework for Sexual Health Improvement in England* recommends the prioritisation of prevention and that all young people are informed to make responsible decisions, and are aware of the risks of unsafe sex.	5. Collaborate with other London boroughs to prioritise prevention and provide consistent health messages to enable young people to make informed and responsible decisions**.**
	6. Improve local prescription of Long Acting Reversible Contraception (LARCs).

9 Wider determinants of heath

Housing, employment and crime and safety are key health and wellbeing issues for young adults. Each of the three boroughs is tackling these issues through local authority departments in slightly different ways.

9.1 Crime and safety

There is a well evidenced link between crime and safety, and health and wellbeing (P. S. M. Marmot, 2010). This applies to young adults both as being a victim of crime, as well as perpetrators, and particularly the issue of gang life and the risk of violence for this age group. Drug and alcohol misuse (chapter 7) has a significant impact on violent crime.

Gang crime

Gang crime is an important issue in the three boroughs. As well as the severe impact and consequences for the victims of gang crime, there is evidence that those involved in gang crime have poor health outcomes. 2015 research from John Moores University on males aged 18 to 34 years found that those who were gang members had significantly higher levels of mental illness than both men in the general population and non-gang affiliated violent men. Using standardised screening tools, 86% of gang members were identified as having antisocial personality disorder, 67% alcohol dependence, 59% anxiety disorder, 58% drug dependence, 34% suicide attempt, 25% psychosis and 20% depression (Centre for Public Health, 2015).

A 2013 report undertaken by the Public Health (Madden, 2013) team highlighted that young people in gangs had higher rates than the general population or offender population of antisocial personality disorder; anxiety disorders; psychosis; and suicide attempts. In addition, young people involved in gangs have higher rates of drug and alcohol misuse.

This is a cohort who do not engage conventionally with universal mainstream services, especially where any stigma on mental health exists. Consideration needs to be given on how to help this cohort access support.

Student crime

Crimes involving the student population are hard to identify. The *Complete University Guide*[20] has produced heat maps based on crime statistics described as the most relevant to students – robbery, burglary, and violence and sexual crimes - for the previous 12 months, based on student term-time addresses. However, the figures are for all victims, not specifically students.

Most support services linked to the juvenile justice system only cater for young people up to the age of 18. In contrast, there are relatively few programmes specifically targeted at the rehabilitation of young adults aged 18-20 who are in transition from Young Offenders' Institutions to adult prisons, where conditions and treatment can be remarkably different (Garvey et al., 2009).

[20] Complete University Guide. *Crime in student cities and towns (online)* http://www.thecompleteuniversityguide.co.uk/crime-in-university-towns-and-cities/ (accessed 16.12.16)

9.2 Housing

The evidence relating good quality, appropriate housing and health is well evidenced (Building Research Establishment, 2008; Leng, 2011; M. Marmot et al., 2010). Any young adult age 18-25 is likely to be living independently for the first time and so the associated challenges of managing finance, bills and regular payments may be difficult due to lack of experience. Whilst there is a lot of good advice on these matters, signposting to it is important for any health and wellbeing service that regularly comes into contact with young adults.

The boroughs cover one of the most densely populated areas in the country and demand for accommodation is very high, as reflected in house and rent prices. There is limited housing which is affordable on low incomes, benefits or student loans, and demand for social and affordable housing outstrips supply, leading to long waiting times. In addition, a large proportion of properties in the private rented sector are in poor condition.[21]

By 2020, it is estimated that there will be a significant decrease in young adults owning their own properties and having their own social rented tenancies. Private renting is estimated to increase, as are young adults living with parents in all accommodation types (Clapham, Mackie, Orford, Buckley, & Thomas, 2012). Housing benefit payments are restricted to the rate of a single room for people under 35, which many young adults find undesirable.

Some groups of young adults are particularly vulnerable to housing problems and homelessness, including NEETs, care leavers, former unaccompanied asylum seekers, ex-offenders, young parents and people with disabilities. Leaving care is a time that young adults are more vulnerable to homelessness. Whilst some care leavers go into specialist supported accommodation, many move into social housing, and increasingly commonly in the three boroughs into shared houses due to high costs. Chaotic housing pathways and homelessness are predicted to increase (National Youth Agency).

Research led by the National Housing Federation shows that those aged 16 to 24 and living in social housing often face specific difficulties in managing their finances (National Youth Agency).

Homeless young people may experience vulnerabilities that are less common amongst the general population of young people. For example, to try and support themselves, homeless young people may be tempted towards the opportunistic sale of drugs or sex. This clearly adds to the vulnerabilities experienced by young people who are homeless including of sexual exploitation. It is known that some sub-populations of young people such those who are LGBT are at particular risk of homelessness or hostile housing environments. Additional factors such as sexuality and gender may further exacerbate the vulnerability of those young people to exploitation.

Young adults are also vulnerable to fuel poverty. Although this is commonly associated with older people, it is also common amongst students. Though the health impacts are less severe in young adults, it impacts negatively on health and wellbeing.

[21] Housing and Care JSNA www.jsna.info/housingandcare (accessed 16.12.16)

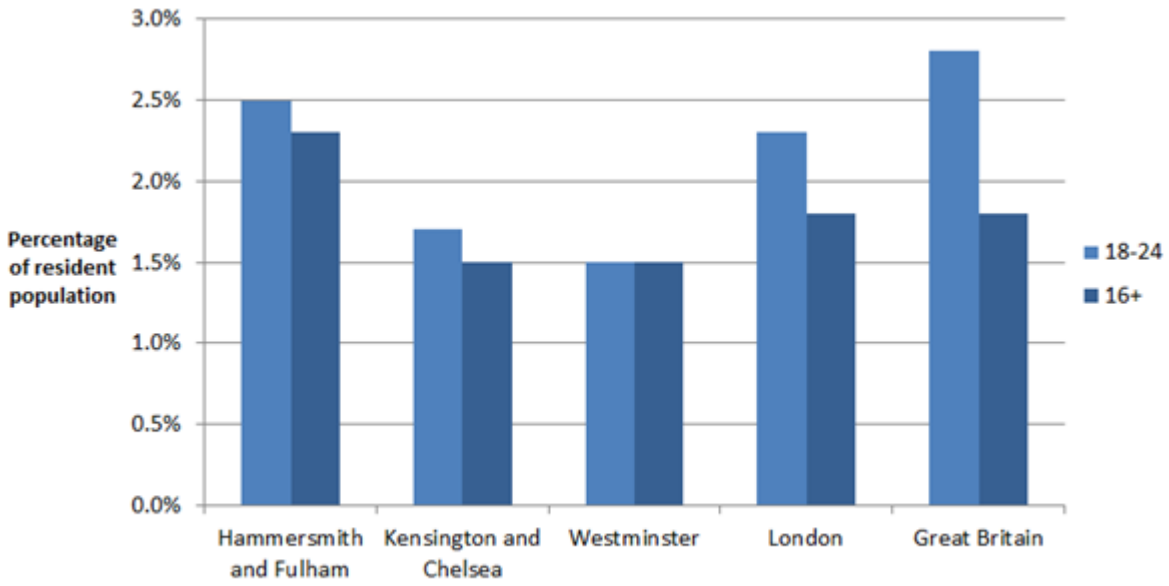
9.3 Employment

The relationship between employment and good health outcomes is well understood, and this link is particularly pronounced among young adults. According to a 2014 evidence review (Allen & UCL Institute of Health Equity, 2014), unemployment is linked to premature death, deteriorating mental health and increased suicide risk. Young men not in employment, education or training (NEET) were three times more likely to be depressed than those who were not. Unemployment is also linked to increased unhealthy behaviours (such as substance misuse) and to having a criminal record, although the causal relationship is hard to establish. Those who have been supervised by a Youth Offending Team and/or have disclosed substance abuse are over twice as likely to be NEET for six months or more.

Young adult unemployment is a risk factor for long-term unemployment. Those who are NEET at the age of 18-19 are 28% more likely than others to be unemployed five years later, and 20% more likely to be unemployed ten years on.

The effects are extremely persistent, with evidence showing that unemployment under the age of 23 can still lower health status and life satisfaction over twenty years later. It is also the case that young people with a history of unemployment tend to then move into low-paid jobs, which are themselves associated with poorer health outcomes.

Figure 20: Claimant count by age across the three boroughs, September 2016



Source: Nomis local authority profiles

As shown, with the exception of Westminster, the claimant count is higher (as a proportion of population) among 18-24-year-olds. However, this contrast is less marked than that between the target group and general population in both the London and Great Britain averages.

10 Summary of Recommendations and Conclusion

10.1 Recommendations

The recommendations emerging from throughout this report are summarised here by chapter.

Topic	Gap or challenge	Potential solution/recommendation	Supporting Evidence in JSNA	Implementation lead
Primary Care	The current model of primary care is not well suited to young adults, who are overall less satisfied with their GP than older adults. YA would benefit from GP services configured to their health needs, such as at The Well Centre in Lambeth. Co-location has come up across chapters as an effective way of increasing young adults' uptake of appropriate services, particular in hard to engage cohorts such as care leavers. Small changes that all GP practices can facilitate would make a positive difference.	1. Pilot an integrated primary care model at one or more GP practice in each CCG with a high number of young adult patients. Consider services which could have a presence, such as sexual health services, eating disorder services and talking therapies. Offer training for GPs in young adults' health. a. Consider opportunities for this approach in other contexts with target populations, such as co-location of health services at care leaver peer support groups.	Section 4.1 – YA less satisfied with GPs, number of issues e.g. Confidentiality Section 4.3 indicates high usage of urgent care and A&E among this age group	Hammersmith and Fulham CCG - Toby Hyde West London CCG – Rachel Krausz – Strategic Delivery Lead Central London CCG - Chris Neill
		2. Train local GPs and GP practice staff in the GP Champions for Youth Health Project's *Toolkit for General Practice*. CCGs should make use of the GP Champions for Youth Health Project's *Commissioning Effective Primary Care Services for Young People*	Section 4.1 – the GP Champions for Youth Health Project	

Eating disorders	A small fraction of the estimated numbers of young adults with eating disorders are receiving a service. Additionally, evidence shows better outcomes when ED is treated promptly in the first 3 years of the illness, but waiting times locally are long. National and local strategies require the development of out of hospital services and an early intervention approach to protect mental and physical health and wellbeing. There is currently only a service in secondary care. The exemplar primary care eating disorder service in Bristol provides cost-effective and well received help before the patient's condition deteriorates and requires treatment in secondary care.	3. Review the eating disorder pathway as part of Like Minded *Serious and Long Term Mental Health Need* population group Business Cases. Consider ways to provide an early intervention eating disorder service in primary care offering NICE recommended rapid triage and assessment by a skilled practitioner in partnership with GPs for those with emerging but not life-threatening Eating Disorders. a. Such a service would then be capable of providing the leadership and momentum for the following recommendations.	Section 5.3 – in particular 5.3.2 indicating estimated prevalence and 5.3.3 for numbers being treated in Vincent Square clinic Section 5.2.4 for importance of early treatment (national evidence and guidance) Section 5.2.4 Effective Treatment – Bristol case story	West London CCG and Central London CCG – Glen Monks, AD for Mental Health LBHF CCG – Julie Scrivens, Head of Planned Care and Mental Health
	The current NICE guidelines are from 2004, over a decade old, and are currently being updated with publication expected in 2017.	4. Review existing services against new NICE guidelines when available in 2017.	Section 5.2.4 (national guidance)	

Eating disorders	Professionals outside of specialist ED services do not consistently understand what to do when an eating disorder is identified, and how to manage an eating disorder patient.	5. Map pathways and create a tool for professionals to use to enable appropriate and timely referrals. 6. Offer guidance to GPs and other health professionals to identify and then work constructively and appropriately with people with an eating disorder. a. Identify GPs with high numbers of young adults and low referral rates to eating disorder services as a target group for training.	Section 5.3.6 and 5.3.7. Qualitative evidence Identified through consultation with local stakeholders	
Care Leavers	Looked after children have higher rates of mental illness than the general population; nearly half have a mental disorder. In consultation with care leavers, there was a lack of awareness and coping strategies. However, some may not want help in a clinical setting. National evidence suggests good outcomes for mentoring, which may be more appropriate where psychological therapies are not wanted.	7. Actively promote resilience, prevention and early intervention for good mental health for all in generic services for care leavers. a. Review current and past mentoring and peer mentoring schemes in the three boroughs for care leavers and / or young adults.	Section 6.3.1. National evidence and supported by local qualitative evidence through consultation. Mentoring supported by evidence in section 6.4.2	3B Leaving Care teams, Helen Farrell - Assistant Director for LAC and Care Leavers

Care Leavers	The greatest area of unmet health and wellbeing needs of care leavers is mental health and emotional wellbeing that would not meet the threshold for Adult Mental Health Services. Nationally, 'Future in Mind' and locally, The Anna Freud Centre needs assessment for CAMHS recommend a tapered transition from age 16-25. LAC CAMHS see children over long time periods and specialise in trauma, which is most appropriate to this cohort. Some care leavers have existing relationships with LAC CAMHS staff which they would benefit from continuing; other are not ready to engage with counselling services until they are age 18 or above.	8. Extend existing CAMHS or LAC CAMHS services to a tapered service for 16-25 year old care leavers to give continuity to those with a relationship with the service, and extend the offer to include care leavers age 18-25 not already open to LAC CAMHS who are not eligible or suitable for Adult Mental Health services. a. The offer to care leavers should include flexibility if appointments are missed or service users don't want to be seen in a clinical setting.	Section 6.3.1 and 6.3.2. As above - national evidence and supported by local qualitative evidence through consultation	Steve Buckerfield – Head of Children's Joint Commissioning Angela Caulder - CAMHS commissioner
	A significant proportion of local care leavers are former UASCs, and have specific health and care needs.	9. Professionals including Leaving Care teams to be fully trained on national guidance for unaccompanied asylum seeking and trafficked care leavers	Section 6.4. Combination of national evidence and local evidence from practitioners (LAC nurse records and social work notes)	3B Leaving Care teams, Helen Farrell - Assistant Director for LAC and Care Leavers

Care Leavers	Consultation with care leavers identified that many sought advice from non-health professionals who they had a trusting relationship with e.g. their social worker. Although almost all are registered with a GP, most prefer to use walk in centres, A&E and urgent care. The needs and preferences of care leavers vary significantly from person to person, meaning a specific service may not be appropriate.	10. Non-health professionals working with care leavers e.g. personal advisors and key workers should routinely take an active role in the health of care leavers, such as taking them to the GP and encourage seeking help in the appropriate setting. a. Pilot a personal budget for care leavers, where an assessed physical or mental health need is established, to allow them to choose a relationship with the professional that best meets their needs	Section 6.3, 6.5.3 and 6.5.4. Evidence largely drawn from consultation with professionals and care leavers but also supported by national evidence	3B Leaving Care teams, Helen Farrell - Assistant Director for LAC and Care Leavers Steve Buckerfield – Head of Children's Joint Commissioning
	A small number of care leavers have significant multiple complicated physical, mental and social care needs, and a large number of professionals become involved in their case.	11. Pilot a transitions panel similar to the disabled children's panel for cases of care leavers with multiple or complicated needs.	Section 6.2 – national evidence of care leavers chaotic lives Section 6.4 wide range of care leaver mental and physical health needs	3B Leaving Care teams

Substance misuse	The majority of young adults in treatment for substance misuse are addressing cannabis and alcohol issues, however adult services cater predominately to crack and opiate users.	12. Review adult and young people's service offer to ensure a flexible, responsive and coordinated service is available to meet the needs of young people who use a range of substances. Allow flexibility in the young people's substance misuse services to provide for young adults up to the age of 25, based on a professional appraisal of where their need can best be met.	Section 7.1 drawn from national data and reflected in 7.4.3 from local service data	Gaynor Driscoll, Head of Commissioning for Substance Misuse and Sexual Health
	Vulnerable groups are more susceptible to harmful substance misuse.	13. Develop a local strategy to reduce substance misuse among vulnerable and disadvantaged under 25s as recommended by NICE (2007).	Section 7.3.3 drawn from national data from HSCIC on inequalities	
	Although numbers in services are relatively small, substance misuse is widespread amongst young adults. There is significant variation between the boroughs in their referral rates into substance misuse services from key partners.	14. Continue to develop awareness and training for a broad range of professionals in contact with young adults to enable conversations to be started earlier, rather than when a problem has taken hold. Training should include building resilience in young people to resist pressures in their social groups, schools and universities. a. Work with young people's services, GPs and hospitals to embed effective pathways and interventions which target those most at risk of substance misuse.	Section 7.1 widespread substance misuse amongst young adults. Section 7.4 numbers in local services Section 7.5.2 flags training as an issue – drawn from local stakeholders Section 7.4.5 Local data showing referrals from key partners locally	

Sexual Health	Sexual health is a key health issue for the vast majority of young adults.	15. Ensure all commissioned sexual health services adhere to the You're Welcome standards.	Section 8. National evidence show that 15-24s experience highest rate of STIs.	Gaynor Driscoll, Head of Commissioning for Substance Misuse and Sexual Health
	There is a strong link between substance misuse and risky sexual behavior.	16. Consider integration of substance misuse and sexual health services for young people.	Section 8.1 National evidence of link between substance misuse and risky sexual behavior.	
	There are clear inequalities in sexual health, particularly in socio-economic status. Care leavers have significantly higher rates of pregnancy than the general young adult population.	17. Work with young people's services to embed effective pathways and interventions which target high risk groups including care leavers.	Sexual health and pregnancies for care leavers drawn from national and local research and highlighted in section 6.3.5 and 6.3.6. Sexual health and inequalities described in Section 8.	
	Young people consulted reported that adults and professionals over-medicalise what to them is a social issue.	18. Develop sexual health services to proactively address the psychosocial aspects of sexual health.	8.4 Youth council feedback	
	The *Framework for Sexual Health Improvement in England* recommends the prioritisation of prevention and that all young people	19. Collaborate with other London boroughs to prioritise prevention and provide consistent health messages to enable young people to make informed and responsible decisions**.**	Section 8.2, 8.3 give more information on the Framework	

	are informed to make responsible decisions, and are aware of the risks of unsafe sex.	20. Improve local prescription of Long Acting Reversible Contraception (LARCs).	Section 8.3.3 low rates of local LARC prescription.	
General	There is existing good practice guidance for services working with young adults on transitions and service design.	21. Health and care services should self-assess against the NICE guidance on transition from children's to adults' services for young people using health or social care services, and services that young people access should adopt the Government's '*You're Welcome*' quality criteria to be more suited to young adults.		ALL Service Leads
	Young adults are particularly difficult to involve in participation and engagement exercises in the typical ways that services engage patients and users.	22. Coproduce the redesign of services with young people.		ALL Service Leads

10.2 Conclusion

In conclusion, many of the recommendations include flexibility in the age restriction on services to incorporate young adults into young people services, early intervention, adaptation of current service models to better meet the needs of young adults, and upskilling health and care professionals with knowledge and skills to recognise and address young adults' needs. The chapters all had strong crossovers with each other, and so co-location, collaboration and joint working is key.

These approaches are not always easy to implement, especially where they have not been done before. For example, young people's services that accept adults may need to consider adequate child protection and safeguarding. However, it is clear that better person-centred care and health outcomes can be achieved when services focus on the needs of the individual, not strict age criteria.

11 Resources for professionals

11.1 Resources for professionals

11.1.1 Eating disorders

- Free resource for health care professionals, patients and carers on support for Eating Disorders **http://www.network-ed.org.uk/**
- Joint Commissioning Panel for Mental Health. (2013). Guidance for commissioners of eating disorders services. 2013: Joint Commissioning Panel for Mental Health.

11.1.2 Substance misuse

- Public Health England. (2016). Young people – substance misuse JSNA support pack 2017-18: commissioning prompts. Good practice prompts for planning comprehensive interventions. London: Public Health England.

11.1.3 Primary care

- The GP Champions for Youth Health Project's Toolkit for General Practice
- GP Champions for Youth Health Project's Commissioning Effective Primary Care Services for Young People
- NHS guidelines on funding care for transient populations

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13 List of figures and tables

Figures

Tables

Appendices

13.1 Appendix 1: Engagement

13.1.1 Professionals workshop: Care Leavers

A workshop was held with professionals from the three boroughs who work with care leavers.

13.1.2 Professionals workshop: Substance Misuse

A workshop was held with professionals from the three boroughs who work with substance misusers.

13.1.3 Professionals workshop: Eating Disorders

A workshop was held with professionals from the three boroughs who work with people with eating disorders.

13.1.4 Westminster Youth Council

A workshop was held at Westminster Youth Council with 17 year olds.

13.1.5 Hammersmith and Fulham Youth Council

A workshop was held at Hammersmith and Fulham Youth Council with 14-17 year olds.

13.1.6 Westminster Care Leavers group

A workshop was held with a group of care leavers in Westminster at a peer support group.

13.1.7 Central London CCG Transformation Redesign Group (TRG)

The TRG was consulted and feedback was incorporated into the final draft.

13.1.8 Hammersmith and Fulham CCG Governing Body Development Session

The Governing Body was consulted and feedback was incorporated into the final draft.

13.1.9 West London CCG Transformation Board

The Transformation Board was consulted and feedback was incorporated into the final draft.

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City of Westminster

Westminster Health & Wellbeing Board

Date:	2 February 2017
Classification:	General Release
Title:	Contributing to health and wellbeing through investment in housing
Report of:	Barbara Brownlee, Director of Housing
Wards Involved:	All
Policy Context:	Health and wellbeing; housing renewal
Financial Summary:	N/A
Report Author and Contact Details:	Tony Hutchinson, Housing Regeneration Programme Director thutchinson@westminster.gov.uk 020 7641 1688

1. Executive Summary

1.1 The purpose of this document is to consider and highlight how investment in the Council's housing stock contributes to delivery of the Health and Wellbeing Strategy for Westminster 2017-22.

1.2 The Housing Renewal Strategy launched in 2010 has the following priorities

- To increase the supply and quality of affordable homes to meet a variety of local needs, including housing for families
- To improve the quality of the local environment with outstanding green and open spaces and housing that promotes low energy consumption and environmental sustainability
- To promote a high quality of life for people of all ages and backgrounds, in safe, cohesive and healthy neighbourhoods, supported by a range of high quality housing and excellent community facilities

- To enable people to maximise economic opportunity in Westminster with support for training, employment and enterprise, and housing tenures which help those in work to remain in the City
- To create a more distinct sense of neighbourhood, ending the physical divide between Westminster's estates and surrounding local streets

1.3 The Health and Wellbeing Strategy for Westminster 2017-22 launched in December 2016 sets the following objectives:

1. Improving outcomes for children and young people
2. Reducing the risk factors for, and improving the management of, long term conditions such as dementia
3. Improving mental health through prevention and self-management
4. Creating and leading a sustainable and effective local health and care system

1.4 There is a direct and positive relationship between implementing the housing renewal strategy and achieving the objectives of the Health and Wellbeing Strategy. The Housing Renewal Strategy has as its central focus improving the quality of life for residents. It is delivered in collaboration with residents and seeks to improve life chances across health, economic activity and social inclusion.

1.5 The attached report outlines the areas of work that are delivering the council's housing renewal programme and contributing the following outcomes:

Health and Wellbeing Strategy Objectives	**Housing Renewal Outcomes**
Improving outcomes for children and young people	Investment in new and improved homes to reduce overcrowding, address fuel poverty and reduce respiratory disease
Reducing the risk factors for, and improving the management of, long term conditions such as dementia	The quality of housing is important for health outcomes in general. Improved and adapted homes can increase opportunities for people to remain in their own homes and reduce the need for residential care
Improving mental health through prevention and self-management	Integration of active lifestyle opportunities and employment support into regeneration programmes
Creating and leading a sustainable and effective local health and care system	Integration of active lifestyle opportunities, health care provision and employment support into regeneration programmes

2. Key Matters for the Board

2.1 The Health and Wellbeing Board is asked to:

A. Note the programme of housing renewal; and

B. Consider how partners could contribute to supporting housing renewal deliver health and wellbeing outcomes for the city's community

Housing Renewal in Westminster
Report to the Health and Well Being Board
Housing and Health &Wellbeing Shared Outcomes

Contents

1 Housing Renewal

1.1 Church Street

1 Church Street Vote Booklet

The regeneration of Church Street is a mammoth task; leading up to the vote a vision for how the ward could evolve was built up in consultation with residents and other stakeholders. Expectations were raised about swift progress on the transformation of the neighbourhood. Moving into delivery mode proved more challenging, the difficulties of making substantial change in a densely developed area had not been foreseen, this has led to frustration and cynicism amongst residents. The team have sought to address this through being open and accessible to residents and their representatives, ensuing there is a regular flow of information through newsletters, and participation in local events.

Over the last 18 months, considerable efforts have been made to:

- Identify and remove obstacles to progress, including providing additional resources to deliver the programme and try to set out a more logical plan
- Complete projects that had stalled (Orchardson Street flats and Face Forward for example) or pause projects that were being done in the wrong sequence (Public realm design on Church Street East or the District Energy scheme)
- Refresh the community engagement strategy and membership of the steering group, including appointing a new chair
- Refresh the strategy set out at the time of the vote through a master planning exercise focused on how changes can be made (such as how can the market be kept operational through a major process of demolition and rebuilding)
- Develop an outcomes framework, setting out what is being achieved and evaluating progress, helping to guide investment decisions

- Bring in new ideas and partners to stimulate activity

Some projects have proved more complex to deliver than was anticipated; the most obvious is the replacement of Penn House with a new residential tower at Lisson Arches. The site has a number of strategically important services, gas, water, electricity and telecommunications running through it, the bridge that carries Lisson Grove over the former railway line is in poor condition and the site is very tightly constrained adding to the difficulty of sequencing works. Ward members in particular see the delays to this project as emblematic of the whole programme. There is an emotional content, as the new flats will replace poor quality bedsits for older people in Penn House, who are becoming frailer as the work progresses.

A programme of this scale attracts interest from developers. For the Cosway Street site this led to a potential developer approaching the council with a very good offer that needed to be explored in detail, delaying progress. This is now back on track and approval to progress the scheme will be sought in early 2017. Others who have expressed interest include Berkeley Group who are developing the West End Green site on Edgware Road and hope to acquire Paddington Green Police Station for a mixed office and residential development. Dialogue is maintained with a number of interested parties to encourage interest in the programme when tender opportunities are released.

Luton Street, another important project, needed significant preparatory works, including building a new nursery and relocating some market facilities, as well as a complex process to procure a development partner, prepare a design with input from residents and complete the development agreement. The agreement is due to be signed in January and a planning application submitted in late spring.

Central to the transformation of the neighbourhood is improving the health of residents; Church Street is not a healthy place to live. Analysis of Citywide public health spending demonstrates significantly higher costs in the area compared to the Westminster average. A pivotal project is creating a Community Health and Well Being Hub. This had been planned for a site at the corner of Lisson Grove and Lilestone Street to include a reprovided health centre (moved from Gateforth Street) and community facilities including a community café to provide advice on healthy eating, complementary therapies and counselling. This site will be vacated when the flats at Lisson Arches are completed and Penn House is decanted. However, as population and needs in the area have changed since the proposals were made; it is unlikely that the required health and wellbeing provision for the area could now be accommodated on that site. In addition to this, there has always been a link between this site and the re-provision of services and office space from the Lisson Grove site. The wider Council and public sector agenda on co-location of services into hubs also has an impact. Therefore, as part of the master planning process, alternative locations for provision of these services are being considered.

The site freed up by the relocation of the Lisson Grove/Frampton Street offices will be redeveloped for housing maximising the benefit of the canal side location. Discussions are in hand with Sanctuary Housing Association owner of the adjacent estate to see if a joint development would be possible and desirable, adding value to the neighbourhood.

2 Publicity for the Arts Fund

Projects that are moving forward effectively are:

Tresham Nursery – completed on time using a modular construction system this building now houses two nurseries moved from the Luton Street site and a church moved from Dudley House

Arts Fund – This funding scheme is designed to create a programme of creative activities that local people of all ages and backgrounds can take part in. Examples of creative activities funded so far are theatre, , film and photography, visual art, creative writing, crafts. All activities must benefit the local Church Street ward or ward residents.

Green Spine – design work for this new green space running from Lisson Street along Salisbury Street and through the new Luton Street development is well advanced and has attracted positive feedback from most stakeholders

Community engagement – the contract with Vital Regeneration to provide support to the residents steering group and other engagement activities ends in January 2017 and this is being brought in house and delivered from our office at 99 Church Street.

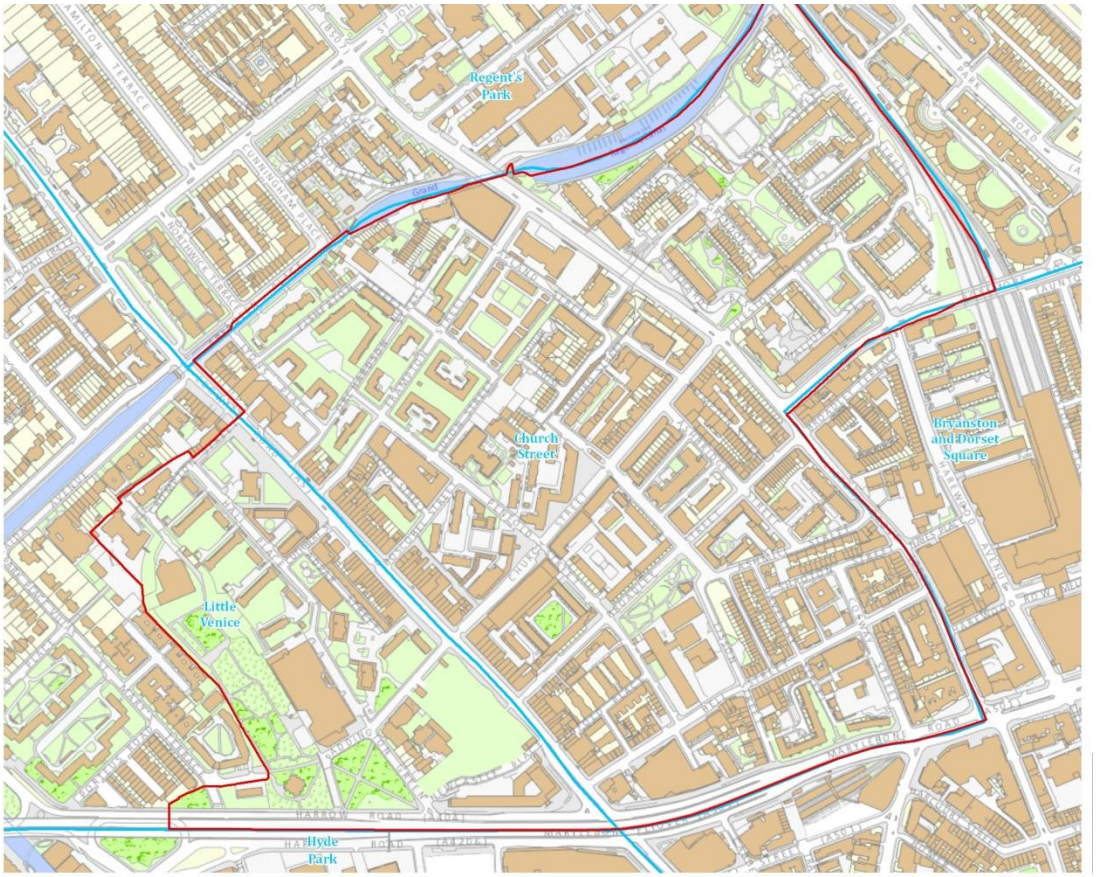
Neighbourhood Keepers – this is a crucial aspect of the promises made in the Vote Booklet and after a false start in 2015/16 a revised model is being developed that enables specific initiatives to be developed, the focus is on animating public spaces, community gardening and promoting more active lifestyles. The previous approach involved a third party organisation taking a management role in the project. However a decision has now been taken to bring this in house and operate a commissioning model, focusing the funding (from the Church Street Dowry) on smaller projects to allow a phase of testing and refining requirements.

Community Champions - are local people who volunteer their time and connect friends, families and neighbours with local services, and spread important messages about health and wellbeing. The time and energy the Champions put in is really appreciated and repaid through access to training, support and guidance to help them progress their own careers and goals. The local insight and knowledge of Champions is valued and used to influence and shape how local services are delivered. The Council and other housing providers fund the programme , which works alongside other community initiatives in Church Street.

Business engagement – the business community in Church Street is diverse, international architects and galleries to market traders, multi-generational family firms to new start-ups. We developing links that focus on what Church Street can and should be, moving away from discussing business as usual issues around parking, rents and cleaning. The team are backing initiatives to stimulate footfall and widen the appeal of Church Street, such as a music event linked to London Jazz Week and performances at the Cockpit Theatre or a proposed brocante event in May initiated by an antique trader. They are also working with partners such as the GLA to develop proposals for co-working space.

Employment coaches – two highly skilled coaches are working with people in Church Street who find it difficult to become economically active. This requires careful work with individuals to understand their specific needs and help them to address them. They work alongside other services in the neighbourhood to support tailored to individual needs.

Church Street ward plus the part of Little Venice Ward covered by the Futures Plan are now a Housing Zone as shown below. This has secured £25.5 million in GLA soft loans to assist with Lisson Arches and leaseholder buybacks on subsequent phases. We are discussing the terms of repayment of these loans with the GLA.



3 Edgware Road Housing Zone

We are discussing with the Metropolitan Police the use of 66-872 Church Street or another premises in the street as a community policing venue whilst their building at Paddington Green is redeveloped. This will combine a base for the borough Safer Neighbourhoods teams (about 60

officers working shifts) and a community police station. Whilst this loses an amount of retail space there will be significant investment in the building, a rental receipt and increased spend in the neighbourhood due to the officers who will be in the area. A frequent complaint from traders and residents is lack of police presence in the market. This project will go some way to addressing that perception. However, this has not proven popular with ward members or some members of the Futures Steering Group and so all options are being considered.

A further project under consideration is to bring a major employer to the corner of Edgware Road and Church Street. Their development will bring about 650 employees and about 250 studio flats for young professionals (similar to the Collective at Old Oak Common). This would involve the demolition of Blackwater House, losing 18 rented and 11 leasehold flats and 13 retail units, including our Regeneration Base. The developers will also acquire properties on Edgware Road. This proposal is still being discussed and no decisions have been taken on whether to progress it. However, in any scenario, planning policy would require the re-provision of the lost affordable homes

1.2 Ebury Bridge

Ebury Bridge has proved to be a complex and challenging project. It is one of the most valuable locations in the Council's ownership, adjacent to Chelsea Barracks and the new Sir Simon Milton UTC.

Figure 4 Aerial view of Ebury Bridge Estate

After residents voted for regeneration the Council's architects prepared and secured planning for a scheme that met the residents' wishes for the site including refurbishment of 5 blocks funded from the development surpluses made by demolishing and rebuilding to a higher density 8 blocks (including properties that needed to be acquired from Soho Housing).

Work began with residents at Ebury Bridge in 2010 following launch of the Housing Renewal Strategy, this led to a vote for regeneration in 2013, then a planning application was approved in June 2014. In 2015, the project was soft market tested with the Councils' Development Partner Panel, there was no appetite amongst panel members to implement the scheme in the form proposed.

Since then the Council has looked at the scheme is considerable detail with the goal of delivering the promises made to residents within a deliverable scheme. A number of options have been considered and it seems clear that the way forward involves achieving a higher density on the site through, in part, demolishing more existing homes. This allows greater height along the railway frontage and a more straightforward phasing of the development. Deloitte Real Estate have been advising the Council on options for delivery of Ebury Bridge, the proposed scheme suggested is set out below:

A series of appraisal sensitivities are now being run on different tenure mixes to develop a scheme that is both commercial viable and maximises levels of affordable housing.

Running in parallel to this is a new Community Engagement strategy for Ebury Bridge which goes beyond the "bricks and mortar" elements of the regeneration and focuses on building a sustainable local community. Included in this will be health and wellbeing measurements around improvements in quality of life, reductions in social deprivation and enabling better collaboration between local service providers and third sector organisations. In the meantime, resident events built around the themes of employment and health are taking place on the estate.

1.3 Tollgate Gardens

The contract with Clarion (formerly Affinity Sutton) is now unconditional and Keepmoat, their design and build contractor is on site. Demolition has commenced, with a practical completion planned for 2019. When the site is cleared, an initial payment for the site of £1.6m will be due to the HRA.

The scheme will provide

- 195 new homes in total
- Off which 86 will be affordable homes including 10 shared equity loan homes for returning leaseholders (these are now 8 Shared Ownership being delivered by Clarion and 2 social rent as no leaseholder wished to take up the equity loan offer)
- A new larger community hall
- Remodelling to the existing Tollgate House to create three more flats and external cladding to improve thermal efficiency

5 Artist's impression of new development

The new development will ensure that there is no loss of social rented homes, there will be 27 more sub-market homes on the site when it is finished and that the quality of the homes retained within Tollgate House is improved. Planning permission for the recladding of Tollgate House has been approved; this will improve thermal efficiency, mitigate condensation risks and reduce heating bills for residents.

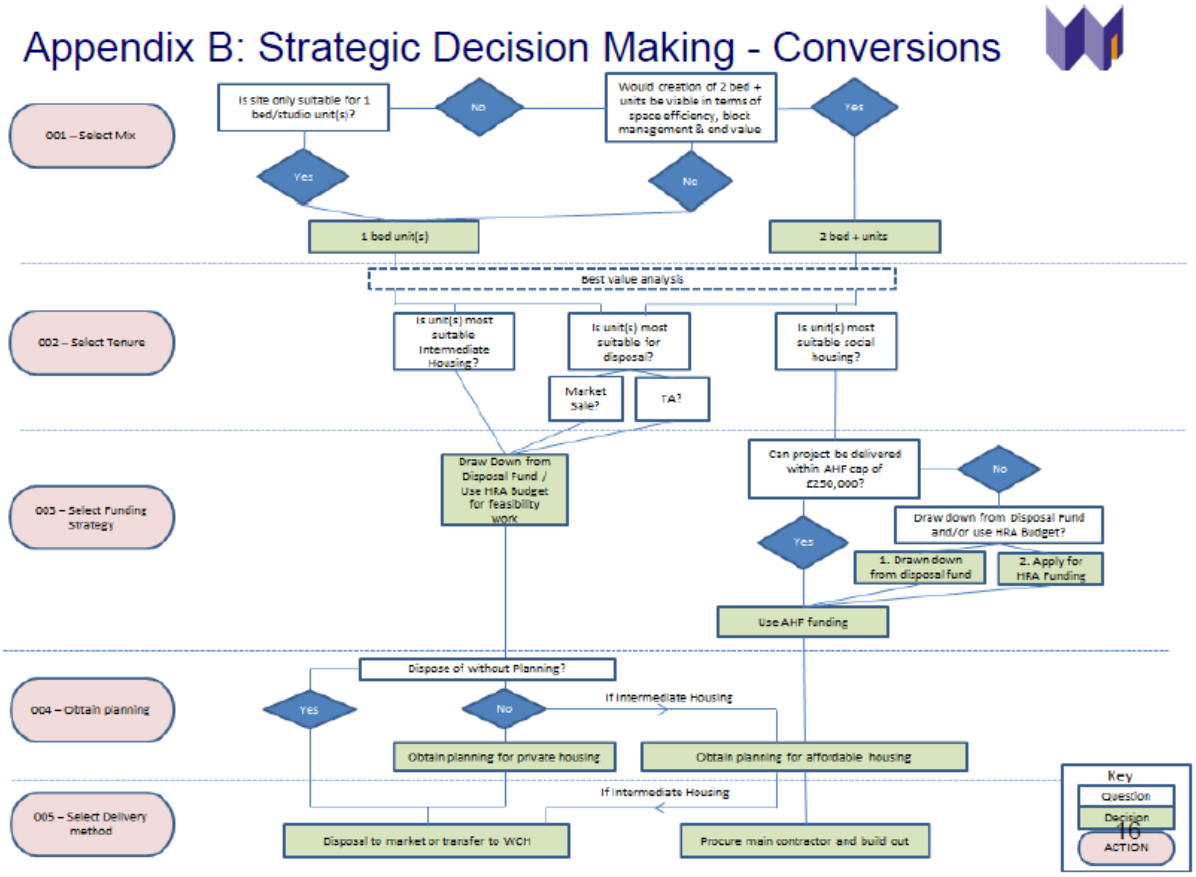
The new community centre will provide opportunities for community and social activities.

1.4 Infill Housing

A significant challenge is delivering new homes quickly and effectively, one option that is being pursued vigorously is to identify within the Council' housing assets opportunities to turn underused space into new homes for sale or rent. The types of asset being used range from basements to laundry rooms, offices and parking areas.

A revolving fund of £10m has been created within the HRA to enable projects to be identified, assessed and delivered. Some costs are recovered from sales of development opportunities for private development where the homes are either too small for our needs or in locations where Council ownership is low. Projects that can provide 2 bed homes or larger are developed for retention within the Council's stock at social or intermediate rents.

City West Homes is carrying out a review of all the estates in management to identify opportunities. These are assessed through dialogue with the Council using a decision tree to ensure a consistent approach.



The first wave of the programme is summarised below:

The programme delivers 26 social housing properties, creating 118 bed spaces, up to September 2018. This also includes obtaining planning permission for a further 8 units which will be disposed of in order to cross-subsidise the delivery of the new homes.

This £13.1M programme requires the following sources of funding:

- £6,500,000 Affordable Housing Fund (£250k for each new tenancy)
- c.£2.75-£3m capital receipt from disposal of units with planning approval for owner development
- £3,773,000 of HRA capital

Programme meets its original key objectives of:

- Increasing the supply of affordable housing on HRA land
- Optimising the value of HRA assets
- Improving the quality of the HRA portfolio
- Creating a better match between housing need and housing supply

In terms of the Health and Wellbeing Strategy, the Infill programme provides improved homes for families, in some cases these are wheelchair accessible, reducing overcrowding.

2 City West Homes Investment Programmes

2.1 Context

This section considers how WCC's housing investment programme delivered through CityWest Homes contributes to the improvement of health outcomes for residents. This covers:

- 'Condensation / Damp & Mould' investment programme;
- General major works investment programme, specifically where it impacts on warm / dry / safe homes as a consequence of investment; and
- Aids and Adaptions to meet the needs of the occupier

2.1.1 Condensation Investment Programme

In April 2015, WCC decided to seek to address problems associated with condensation and mould in its tenanted housing stock. It set aside a £12m "condensation budget" for CWH to spend over the next 5 years.

Initially, CWH identified buildings and generic building types that are – or could be – at greater risk of condensation, mould and excessive cold. In addition, advice has also been sought from front-line staff and their on-the-ground experience of WCC's estates. Further training was also given to housing managers, to enable them to identify homes at risk and report their findings. This was in preparation for the 2016 residents' survey, where one of the new questions asked was: "Does your home affect your health?"

As a result of this, over the next twelve months, CWH plan to visit 100 "vulnerable" homes that identified condensation and mould as being an issue. The "at risk" building list has been passed to the Capital Programme team so that measures identified in improvement trials can be integrated into projects going forward where possible. Further, as part of the next 10 year programme of investment, a stand-alone project to address ventilation in buildings that are not currently part of already identified projects is being initiated.

Alongside these physical interventions, are the on-going home visits made by CWH's Condensation Manager. These are well received by residents, feedback including:

- "Condensation was explained to me clearly and helped me understand what to do in the future and what to look out for, what to do and what not to do. I was left with some really useful items too. A win win situation."
- "I didn't understand previously what makes condensation worse, the advice I was given has helped me to avoid the appearance of mould."
- "Just changing the timing and duration of the heating really made a difference, we are seeing no new mould growing."

This helps avoid unnecessary works and expenditure. Behavioural change is perhaps the hardest intervention of all, but can be the most rewarding and cost-effective solution.

Trials are continuing for various products and systems relating to ventilation and insulation. The market is constantly seeing improvements in this area as the problem of condensation and mould

has become more widely acknowledged across the UK. Results have generally been positive thus far, including:

- At Odhams Walk, residents have made such comments as: “Thank you, you have changed my life”; and “Thank you, my children haven’t been to the doctors in a year, I have been able to buy them a new mattress as I know it won’t rot with mould.”
- With a system called “Q-Bot,” residents’ feedback was that they noticed an improvement the same night the works were completed, with the house staying warmer longer and fewer draughts.

This is very much a work-in-progress. Currently, 1,200 homes have been identified for a potential expenditure of just under £1m, predominantly for enhanced ventilation interventions. These properties include the likes of distributed street in Queen’s Park, Hallfield, Grosvenor and Regency, Scottish Towers, Odhams Walk. Another 700+ homes will be shortly added to the condensation list.

So far, approximately 95 homes have been identified as containing the more vulnerable residents. By far the majority of these have come from Environmental Health Officer referrals, The rate of referrals depends on the ability of the EHO team to respond to request for assistance from residents. To help compensate for this, CWH has undertaken an internal and external (i.e. resident newsletter) “marketing campaign” to raise the profile of condensation. This, along with the annual resident survey feedback, should maintain a flow of referrals, which are generally the more vulnerable residents.

2.1.2 General Major Works Investment Programme

The 2016/17 HRA Business Plan sets out the projected 30-year investment plan for the Council’s managed housing stock. This totals slightly more than £1.41billion. It could be said that the majority of works contained within HRA Business Plan will indirectly contribute towards maintaining the stock to current regulations / standards, to ensure that they are warm, dry and safe.

That said, the table below outlines those elements that can be directly related to making homes warm, dry and safe:

Works contributing to warmer, dryer and safer homes

• Smoke Detection & Fire Risk Assessment (FRA) Works	£53,950,000
• Electrical Works	£57,700,000
• Heating Works	189,600,000
• Windows & Roofs	£153,000,000
• Front Entrance Doors	£15,000,000
• Warden Call Systems	£1,500,000
• Security Systems & Entry Phones	£20,950,000
• Floor Covering (inc. non-slip)	£3,500,000
• Total	£495,200,000

2.1.3 Aids & Adaptations Investment Programme

All residents in England are legally entitled to adaptations funded by a Disabled Facilities Grant (DFG) subject to them meeting the statutory requirements. In Westminster, the Occupational Therapy

assessments for Council tenants are referred directly to CWH to carry out the adaptation without the need for a DFG application. There are an estimated 200 adaptations cases referred to CWH annually. Since 2014, there complexity of the case being referred has increased. complex cases referred. This is has led to greater inter-service working to come up with imaginative and practical ways to enable people to remain in their homes.

The Housing Revenue Account (HRA) funds adaptations for Council tenants. The Council requires CWH to maintain an annual budget for adaptations. The budget for 2016/17 is £1.2m.

2.1.3.1 Adaptations Process

Westminster's Adult Social Care service refers residents to Able2 to carry out occupational therapy assessments. If an adaptation is required to a Council home, then Able2 refers residents to CWH for adaptation. CWH then commissions EffectAble to carry out the works. This diagram below details the basic process for an adaptation:

2.1.3.2 Referrals and Current Budget Position

The table below details the number of cases over the last five years.

Number of cases/referrals	2012/13	2013/14	2014/15	2015/16	2016/17
Total referrals	202	224	214	198	156 (as at 12 Jan, forecast 200 by 31/3)
Total adaptations completed/closed cases	152	151	190	191	131
Budget	£850K	£850K	*£1.3m	£1.2m	£1.2m
Spend	£970,046	£988,000	£1.26m	£1.37m	£925,540

* As a result of a business case presented to the Cabinet Member for Housing in December 2014, the budget was increased in 2014/15 from £800K to £1.3m to clear the backlog of cases accrued over several years.

The total number of referrals is consistently around 200 cases per year. Generally, older people aged between 51 and 80 request adaptations. In terms of type of work, 69% of major adaptations are for wet rooms and level access showers; and 7% for stair lifts and hoists. In recent years, CWH has seen around a 20% increase in the demand for door entry, ramp and visual impairment adaptations and recommendations from WCC. As part of the business planning process and estate plans will be consideration of adding some of these works to appropriate void properties.

2.1.3.3 Working in partnership

CWH has established good and proactive working relationship with Social Care and Prevention Teams, Housing Options Services to review other options such as transfers and rehousing prior to major adaptations taking place.

For all major adaptations, the schedule and scope of works are submitted to WCC or Able2 for final approval before work orders are raised to EffectAble, this ensures that adaptations are essential and completed within the occupational therapy remit.

Westminster Major Adaptations Working Group meets regularly to report referral rates and performance. The group is made up of Tri-Borough Procurement and Contracts Manager, Social Service Team Leaders, Able2 OT Director and OT Manager, WCC Home Improvement Agency, HOS and CWH.

2.1.3.4 Forecast

The Care Act 2014 emphasises that the focus for housing authorities is to provide suitable accommodation when considering the provision of care and support. The provision of housing suitable to a person's specific needs can have a major impact on the extent and means to which their care and support needs can be met, or prevented, over time. These priorities will also influence the levels of demand for adaptations from 2017 onwards. It is anticipated that the number of referrals is likely to increase to 220 in 2017/18.

The maintenance cost for major adaptation renewals such as level access showers, stair lifts and hoists will also increase, placing pressure on the HRA budget. For example, in 2016/17, there are 50 level access showers in the planned maintenance programme due for renewal, at a cost of around £300,000 in the Business Plan.

3 Sheltered Housing Review

The Housing Learning and Information Network (LIN) and Arcadia Architects have been appointed to complete a review of the council's Community Supportive Housing (CSH) stock of over 1,000 properties. This is sheltered housing for those 60 and over (the Strategic Housing for Older People programme "SHOP" is outside the scope of the review). The Kings Fund is also acting as a critical friend to the project.

The need for a review was identified in the Housing Strategy Direction of Travel Statement 2015. It is due to be completed in May 2017, and will assess:

- How well CSH is meeting current demand and how well will it meet future demand
- How well it contributes to meeting the council's key priorities and objectives (officers will work with the consultants to identify the most important from Housing, Adult Social Care and Health and Wellbeing objectives)
- The changes that are needed (for the stock to meet current and future demand better the Council's priorities) and how can they be made.

The review is driven by:

- The majority of schemes now needing further investment such as to the lifts and decorations, despite a programme of upgrading and improvement in 2008-10
- Only 7% of CSH is wheel chair accessible and 42% is in the form of bedsits. Bedsits can be unpopular particularly to council tenants looking to downsize
- Demand from council tenants has been falling - while at the same time there is a shortage of family sized social housing - so there is a need for CSH to be attractive to under occupying older council tenants (61% of council tenants are over 50)
- Most demand (74%) currently comes from private tenants. While some properties were difficult to let in the past, there are no current problems, this is probably explained by a

rise in demand from private tenants who are more vulnerable. It is unclear if this trend will continue

- There is a shortage of housing for older people that would not be eligible for CSH as their needs could not be met there, for example older people with severe and multiple disadvantage (as identified by the Joint Strategic Needs Assessment 2016)
- The Adult Social Care budget is under considerable pressure, due to an improved life expectancy rate and demand for services for older people aged 65+. CSH might do more to reduce budget pressures and better contribute to Health and Wellbeing Strategy objectives around reducing risk factors for, and improving the management of dementia.

The review will involve assessing future demand for CSH from a range of older people in different tenures and with different needs such as; the social sector, the private rented sector, supported housing, ex rough sleepers and those with severe and multiple disadvantage. It will also include some qualitative research through focus groups with older people, both existing CSH residents and council tenants who may consider downsizing, about what they want from CSH. The facilities, activities and services provided are being looked at - taking into account exemplar schemes. An assessment of each building's functional suitability for meeting existing and future needs will be undertaken. Lettings and allocation processes will also be considered alongside a review of the council's working relationships to run CSH i.e. between Adult Social Care and Housing. Finally the review will also look at how well placed the service is to adapt to the introduction of Direct Payments and Individual Budgets, where people may have to choose to receive a service from a range of services.

The final report will include options and recommendations (including potential funding sources and partnership opportunities to facilitate change) on:

- Whether any schemes should be decommissioned and/or remodelled either to bring them up to modern standards or used to accommodate a different client group
- Any improvements which could be made to help CSH better meet; older people's needs and aspirations, good practice/exemplar schemes and the council's objective.

A workshop is planned for March 2017 with key council officers and the Cabinet Member for Housing will be invited to this, a representative of the Health & Wellbeing board will be invited also . It will consider the consultant's early findings and test out initial responses. Given the review covers recommendations for decommissioning or remodelling schemes it could be sensitive and may be considered by the Housing, Finance and Corporate Services Policy and Scrutiny Committee.

4 Rough Sleeping

In parallel with the investment in improving the housing stock contributing to health outcomes across the City work with Rough Sleepers represents significant investment that improves health outcomes.

Westminster has a significant proportion of the country's rough sleepers and as such, we work in very close partnership with Central London CCG and NHS England to address the health needs of

both those who are on the streets as well as those who are accommodated. However, there are a number of work streams and evidence gathering exercises that fall outside of the statutory work.

It can be very difficult to gather statistics about the health needs of people on the streets given that the group are transient, fall in and out of services and their health conditions are self-reported via CHAIN (Combined Homelessness and Information Network) assessments with outreach workers. Given the difficulties in this, we work with partners to take pre-emptive action to avoid a crisis on the streets; some of these include:

- Weekly joint outreach shifts with GP's and Nurses from the Homeless Health Nursing Team (HHT) which target specific individuals who are clinical worries or whom outreach workers have identified as visibly worrying
- Commission the Joint Homelessness Team (JHT) to conduct mental health act assessments (MHAA) on the streets and to target individuals who social care agencies are concerned about
- Coordinate quarterly TB and BBV testing on the streets with rapid results to make certain that plans are in place to follow up any positive test results.
- Work closely on case management of rough sleepers who are registered with Dr Hickey's and Great Chapel Street surgeries to ensure that there are housing plans or a route away from the streets in place for everyone
- We have trained security firms, City Inspectors and Ambassadors who work across the city how to sign post people into services so each person is aware of their options for healthcare and assessment

When people are accommodated into one of our 415 commissioned bed spaces, we are then able to measure health outcomes and provide far more interventions. To achieve this, we commission a number of added value services. Examples of these are:

The Homeless Health Coordination Project (HHCP) was featured 5 times in the Health London Commissioning Guidance as good practice and provides:

- Coverage of 19 accommodation projects for rough sleepers
- Developed an online resource for all staff and service users identifying all health services available and provides online tool kits (eg referrals to Adult Social Care, how to refer to statutory mental health services appropriately)
- Coordination the completion of CHAT forms which identify all physical and mental health needs of service users
- Manages 30 medical student volunteers, occupational therapy students and counsellors who provide support to services
- Coordination of complex health related case conferences
- Coordination of free training on numerous health issues (ex. hearing voices, LAS call outs, medication support, complex trauma)

Evidence from the CHAT forms shows that:

- The Top 5 physical health issues are: (on descending order) respiratory conditions, infectious diseases (TB, HIV, Hep C), foot problems, heart problems and liver disease

- 93% of referrals to mental health services are now accepted (up 40%)
- 98% of residents are registered with a GP
- Oral health continues to be very poor

A member of the Rough Sleeping Team focuses on drawing in expertise around well-being and interventions to provide support to teams and service users. We have had successes in strands of work, which include:

- Intuitive Recovery – peer led capacity building work for service users who are contemplative of change; 80 people took part in the 10-week process
- Pre-treatment support – group work in hostels around anger management, understanding what detox and rehab may entail and preparing for it, gambling support, counselling for those who are not ready to stop using substances and peer led group work to increase social networks
- Autism research – pro bono resource allocated from academics to research the prevalence of autism in homelessness population
- Pregnancy protocol – a multi-agency protocol designed to provide wrap around support and guidance for female service users who find themselves pregnant
- Surgeries with a therapist who works with survivors of childhood sexual abuse designed for workers whose clients divulge this information; designed to offer a safe place to reflect and provide support.
- KUF training – designed to train workers in working with those who have personality disorders

The team have spent the last 6-8 months with a focus on addressing the rise in use of synthetic cannabinoids in both our street and accommodated population. The effect on our service users has ranged from psychotic breaks, extreme hallucinations, cardiac arrests and paranoia. A recent success has been that 1st, 2nd and 3rd generations of this drug have now been re-classified as Class B substances under the Misuse of Drugs Act.

We have identified gaps in the following areas and have plans in place to address them:

- Oral health – increasing engagement with dentistry services and attempting to source mobile dentistry to provide in-reach to hostels
- Increase in ambulance call outs and A&E non elective admissions
- A decrease in engagement with treatment services
- Complex physical health needs which require longer term care and/or residential settings

5 Conclusions

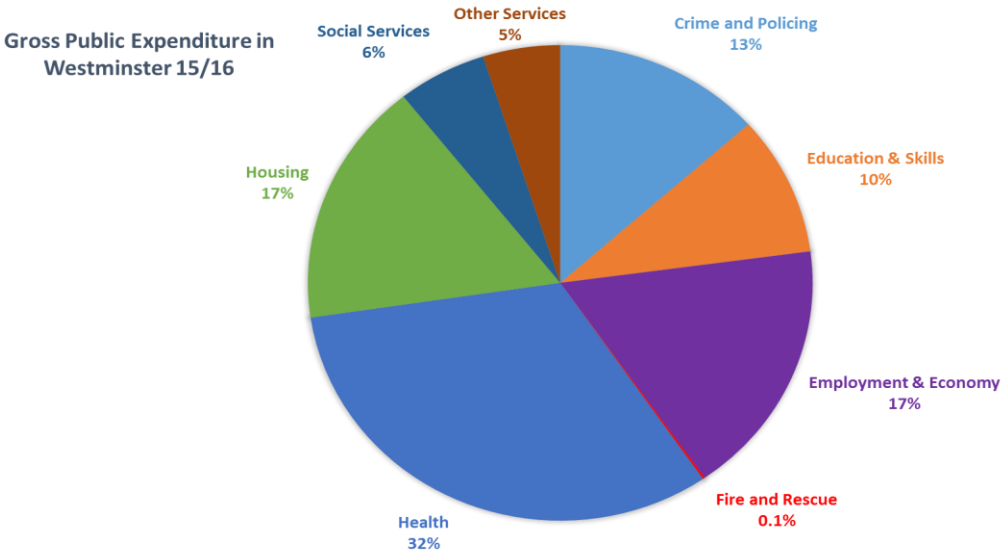
The policy context for housing is evolving; the passage of new legislation followed by a change in Government has created a complex and uncertain policy framework. A new Housing White Paper is expected shortly which will clarify which of changes in the 2015 Housing and Planning Act will be implemented. A sharpened focus on Starter Homes and on off- site construction have been trailed.

The demand for homes in Westminster continues to grow, despite our plan to invest £1.5 billion in new and improved homes through the HRA. The decisions to acquire homes in Hounslow for council tenants and to state publicly how we prioritise homeless households for assistance, including where we can find accommodation for them are examples of how the Council is seeking to explore new options to meet the challenges.

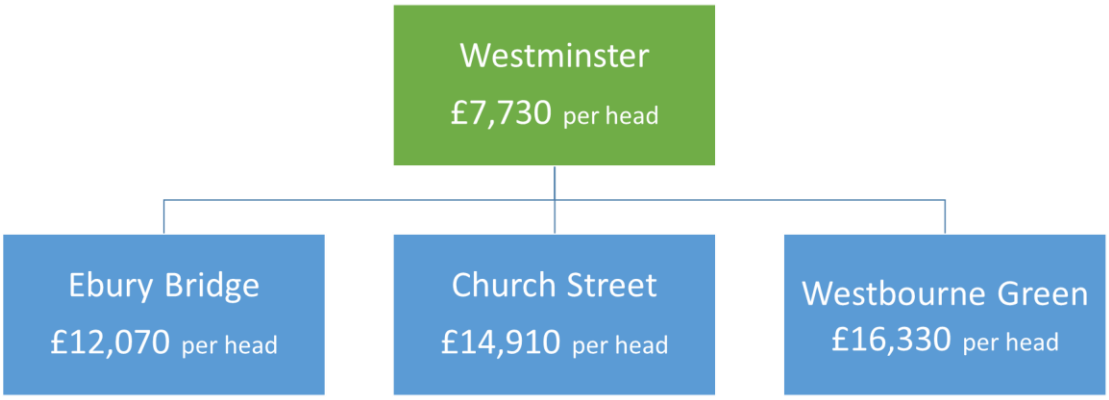
An example of rethinking the use of assets is through the Specialist Housing Strategy for Older People site at Beachcroft, Shirland Road site is a decant site for the existing residential care home facilities located at Carlton Dene and Westmead and once Shirland Road is completed and occupied by these residents, these donor sites will be developed separately. The existing facilities at Westmead and Carlton Dene are nearing the end of their designed usable life-cycle and as a result of this are experiencing increased maintenance and general upkeep costs. The Shirland Road site contains two existing buildings and a car park and walkway for Oak Tree house, all of which will be demolished. Once Beachcroft is complete Carlton Dene and Westmead will be redeveloped to provide further specialist accommodation.

When the new homes are completed at Lisson Arches the residents of Penn House will move to the new flats, allowing Penn House to be demolished. The site of Penn House will be developed as new offices, allowing the council office buildings at Lisson Grove/Frampton Street to be redeveloped as new homes. This development will provide a range of tenures with a focus on intermediate homes as has been agreed with the GLA through the Housing Zone programme.

Better homes are a major contributor to physical and mental health. Analysis of public spending across three housing areas shows that the average resident in Westminster costs the public purse £7,730 per year a total of £2billion.



Looking this in terms of what different areas cost reveals the following:



The key differentials are highlighted below. The spend through the housing capital programme seeks to address these differentials, through assisting residents to secure and sustain employment, addressing poor quality housing that exacerbates health and social care needs and designing out areas that create opportunities for crime plus making homes safer.

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Westminster Health & Wellbeing Board
Work Programme 2017

Agenda Item	Item
27 MARCH 2017	
BETTER CARE FUND UPDATE	**For decision**
LEARNING FROM THE LONDON DEVOLUTION PILOTS	**For discussion**
JOINT HEALTH AND WELLBEING STRATEGY IMPLEMENTATION	**For decision**
CCG OPERATING PLANS 2017/18	**For discussion**
HEALTH HUBS	**For discussion**
PHARMACEUTICAL NEEDS ASSESSMENT	**For decision**
UPDATE ON THE SUSTAINABILITY AND TRANSFORMATION PLAN	**For discussion**
25 MAY 2017	
JOINT HEALTH AND WELLBEING STRATEGY IMPLEMENTATION	**For discussion**
HEALTH HUBS	**For discussion**
PHARMACEUTICAL NEEDS ASSESSMENT	**For discussion**
13 JULY 2017	

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Joint Strategic Needs Assessment (JSNA) Steering Group

Thursday 15th December 2016 2.00-4.00pm

Kensington Town Hall

Minutes

In attendance	
Colin Brodie (CB) Chair	Public Health Knowledge Manager
Jessica Nyman (JN)	JSNA Manager, Public Health
Shad Haliban (SH)	Head of Organisational Development, SOBUS
Steve Bywater (SB)	Policy Officer, Children's Services
Angela McCall (AMc) Minutes	Business Support Officer, Public Health
Jackie Rosenberg (JR)	CEO, One Westminster
Becky Powell (BP)	ASC Commissioning
Apologies: Angela Spence; Meenara Islam; Louise Proctor; Alex Tambourides; Amina Khatun; Angela Spence; Angeleca Silversides; Stuart Lines; Ben Gladstone; Eva Hrobonova	

Minutes

1. Welcome and introductions

2. Minutes of last meeting and matters arising

Minutes agreed.

3. Updates from past projects:

Dementia JSNA

- A Dementia Programme Board was formed to implement the Dementia JSNA recommendations. The Board is taking an update paper to the Health and Wellbeing Boards.
- There will be one oversubscribed befriending programme due to termination of funding in JRs work. **JR** to look into how this can be funded strategically with the CCG lead commissioners, using the auspices of the JSNA.
- **CB** to feed this back to Ben Gladstone.
- **SH** to ask at H&F CCG to help find names of key people for a coordinated approach.
- **CB** to take this to the Dementia Programme Board for community based provision as there needs to be a community response.

End of Life Care JSNA

- This is going to the Scrutiny Committee in Hammersmith and Fulham to review implementation, and it will go to

the H&WBBs as part of a 12-month review.

4. Update and feedback/discussion on current projects

Young Adults JSNA

- Going to the January and February H&WBBs.
- JN asked for comments on the recommendations.
- Primary care recommendations – there is buy in from the GPs to deliver, particularly in WCC. CCGs would have to adapt it to their needs.
- Mark Jarvis was happy with the recommendation on extending the eating disorder services.
- JN is hoping to get some patient experience videos for the Health and Wellbeing Board. **All** to let JN know of any possible links, i.e. the Care Council, Family Nurse Partnership.

Online JSNA highlight reports

- **JN** to circulate links when the sites are ready.
- **CB** to check RVSC on community based provisions.
- Links could be included to the online directories of People First, Turning Point etc. to show that provision is not just formal health provision.
- **SH** to see if the Red Cross directory could be shared.
- **SB** to share child poverty information.
- The Online JSNA should summarise trends over time and unexpected outcomes - would be useful.

5. Proposal for new deep dive: Children with Complex Needs

This is needed to back up a lot of work that has been going on, particularly on the Children's and Families Act. Quality of data will be a key challenge. Local levels of prevalence needs to be worked out as well as local provision so there is lots of joint, coordinated planning. Children & Families teams across the 3 boroughs should be involved to make good sense of the needs locally.

The Task and Finish Group will start meeting in January then there will be a wider stakeholder engagement workshop late January, to pull the knowledge of everyone and develop some more specific research questions. The fundamental principles need to be right, and with special needs, every child is different. Parental consultation is vital in understanding the need.

6. AOB

- SH is working on the Older People's Strategy trying to meet regularly with the 3 CCGs to confirm funding for the most disadvantaged. Open Age does a telephone befriending service, which SH could tap into this.
- An LBHF Young People's Youth Foundation has been founded. There is real concern around securing funding.

- SH has the Child Poverty Strategy in circulation, which was kicked off by the Child Poverty JSNA.
- The Pharmaceutical Needs Assessment is being refreshed.
- A JSNA around faith and health was suggested as it could pick up a lot on the communities that are missed. SH can give links for PREVENT. There is good work going on with faith groups on specific things i.e. FGM, however there is not much engagement around general health, like using an asset-based approach to tackle issues. **JN & CB** to look into scoping the usefulness of this.

Date of next meeting: Thursday 23rd February, 1400-1600, venue tbc.

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