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City of Westminster

Committee Agenda

Title:	**Health & Wellbeing Board**
Meeting Date:	**Thursday 18th January, 2018**
Time:	**4.00 pm**
Venue:	**Rooms 3.6 and 3.7, 3rd Floor, 5 Strand, London WC2 5HR**

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
John Forde	Tri-borough Public Health
Bernie Flaherty	Bi-borough Adult Social Care
Melissa Caslake	Bi-borough Children's Services
Tom McGregor	Housing and Regeneration
Dr Philip Mackney	West London Clinical Commissioning Group
Janice Horsman	Healthwatch Westminster
Jackie Rosenberg	Westminster Community Network
Dr David Finch	NHS England
Dr Joanne Medhurst	Central London Community Healthcare NHS Trust
Anne Mottram	Imperial College NHS Trust
Maria O'Brien	C & NW London Foundation Trust

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: 020 7641 8470; Email: thowes@westminster.gov.uk
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Note for Members: Members are reminded that Officer contacts are shown at the end of each report and Members are welcome to raise questions in advance of the meeting. With regard to item 2, guidance on declarations of interests is included in the Code of Governance; if Members and Officers have any particular questions they should contact the Director of Law 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 - 22)**

(a) To agree the Minutes of the meeting held on 16 November 2017.

(b) To note progress in actions arising.

PART A

4. UPDATE ON PROGRESS IN 2017-18 ON THE HEALTH AND WELLBEING STRATEGY, INCLUDING DISCUSSION ON THE LONDON HEALTH DEVOLUTION MEMORANDUM OF UNDERSTANDING **(Pages 23 - 32)**

To consider an update on the Health and Wellbeing Strategy and the implications of the London Health Devolution Memorandum of Understanding.

5. INTEGRATED CARE AND OUTCOMES FRAMEWORK **(Pages 33 - 46)**

To consider an update on the Integrated Care and Outcomes Framework.

6. WHOLE SYSTEMS INTEGRATED CARE DASHBOARD PRESENTATION **(Pages 47 - 66)**

To consider a presentation on the Whole Systems Integrated Care Dashboard.

PART B	
7. VERBAL UPDATE ON THE WORK OF THE SAFER WESTMINSTER PARTNERSHIP To consider and update on the Safer Westminster Partnership.	**(Pages 67 - 86)**
8. SUICIDE PREVENTION STRATEGY REFRESH To consider the Suicide Prevention Strategy Refresh.	**(Pages 87 - 130)**
9. ANY OTHER BUSINESS	

Stuart Love
Interim Chief Executive
12 January 2018

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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 16th November, 2017**, Rooms 3.6 and 3.7, 3rd Floor, 5 Strand, London WC2 5HR.

Members Present:
Chairman: Councillor Heather Acton, Cabinet Member for Adult Social Services and Public Health
Clinical Representative from the Central London Clinical Commissioning Group: Dr Mona Vaidya (acting as Deputy)
Cabinet Member for Children, Families and Young People: Councillor Richard Holloway
Minority Group Representative: Councillor Barrie Taylor
Tri-borough Public Health: Mike Robinson
Bi-Borough Adult Social Care: Bernie Flaherty
Bi-Borough Children's Services: Annabel Saunders (acting as Deputy)
Housing and Regeneration: Tom McGregor
Clinical Representative from West London Clinical Commissioning Group: Dr Naomi Katz (acting as Deputy)
Healthwatch Westminster: Janice Horsman
Chair of Westminster Community Network: Jackie Rosenberg
Central London Community Healthcare NHS Trust: Darren Jones (acting as Deputy)
Imperial College NHS Trust: James Mac (acting as Deputy)
Central and North West London NHS Foundation Trust: Maria O'Brien

Also Present: Chris Neill (Interim Deputy Director, NHS Central London Clinical Commissioning Group) and Louise Proctor (Managing Director, NHS West London Clinical Commissioning Group).

1 MEMBERSHIP

1.1 Apologies for absence were received from Dr Neville Purssell (NHS Central London Clinical Commissioning Group), Melissa Caslake (Bi-borough Children's Services), Dr Philip Mackney (NHS West London Clinical Commissioning Group), Dr Joanne Medhurst (NHS Central London Community Healthcare NHS Trust) and Anne Mottram (Imperial College Healthcare NHS Trust).

1.2 Dr Mona Vaidya (NHS Central London Clinical Commissioning Group), Annabel Saunders (Tri-borough Director of Commissioning, Children's Services), Dr Naomi Katz (NHS West London Clinical Commissioning Group), Darren Jones (Central London Community Healthcare NHS Trust) and James Mac (Imperial College Healthcare NHS Trust) attended as Deputies respectively for Dr Neville Purssell, Melissa Caslake, Dr Philip Mackney, Dr Joanne Medhurst and Anne Mottram.

1.3 The Chairman welcomed Bernie Flaherty (Bi-borough Children's Services) and Tom McGregor (Housing and Regeneration) as new Members to the Board, replacing Sue Redmond and Barbara Brownlee respectively.

2 DECLARATIONS OF INTEREST

2.1 There were no declarations of interest.

3 MINUTES AND ACTIONS ARISING

3.1 Dylan Champion (Head of Health Partnerships) confirmed that the Better Care Fund Plan for 2017/19 had been approved by NHS England.

3.2 **RESOLVED:**

That the Minutes of the meeting held on 14 September 2017 be signed by the Chairman as a correct record of proceedings.

3.3 **RESOLVED:**

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

4 CHAIRMAN'S VERBAL UPDATE

4.1 The Chairman began by informing Members that Westminster had the fourth highest rate of tooth decay in London amongst young children. In order to address this, the Council had launched an oral health campaign targeting 3 to 7 year olds. Communications and Public Health were in the process of producing a short animation, warning of the risks of tooth decay and this would be made available in schools, libraries and local events, whilst a micro website would also be developed. The Chairman stated that the animation could be made available to nurseries too. Ezra Wallace (Head of Corporate Strategy) added that the animation would be circulated to the Board. Members welcomed the oral health campaign.

4.2 The Chairman advised that another initiative, the 'My Time Active' service was promoting physical activity and healthy eating to tackle childhood obesity and participants had seen an average of 56% reduction in their body mass index and a 42% reduction in their waistline. In relation to stop smoking services, the proportion of smokers in Westminster had fallen to a record low of 13%, down 9% from 22% 5 years ago. The Chairman also advised that the Council was considering ways to tackle shisha smoking as there was a link to mouth

cancer with this activity. The Chairman added that she was due to meet NHS Property representatives and she would report back to the Board on the discussions at the next meeting.

5 PHARMACEUTICAL NEEDS ASSESSMENT

5.1 Mike Robinson (Director of Public Health) presented the report and began by advising that the Board was statutorily required to consider the Pharmaceutical Needs Assessment (PNA). The PNA helped inform NHS England as a market tester for pharmacies. The report was in draft form and was due to be subject to a 60 day public consultation, subject to the Board's agreement. Mike Robinson advised that the PNA was required to be completed by April 2018. He then welcomed comments from the Board.

5.2 The Chairman added that Westminster would also receive the draft PNA for each of its neighbouring boroughs and vice versa in order that they could consider any potential implications for their respective boroughs. She emphasised the need to work more closely with pharmacies. The Chairman mentioned an initiative in Ealing that offered translation of labels on medication. It is reported this this improved health outcomes and compliance and she suggested that a similar initiative could be considered in Westminster. It was remarked that there was not presently sufficient dialogue with the relevant organisations and residents to fulfil an accountability model.

5.3 Chris Neill (Deputy Managing Director, NHS Central London Clinical Commissioning Group) emphasised that the PNA was a good opportunity to engage with local pharmacies and they should form part of the Board's overall engagement with relevant organisations and stakeholders. A Member suggested that pharmacies representatives could be invited to attend future Board meetings where the PNA was to be considered. Mike Robinson replied that he would contact NHS England if this was considered appropriate as he felt that engagement with the Local Pharmaceutical Committee was already adequate.

5.4 Members acknowledged that there had already been considerable work undertaken and that it was important to encourage pharmacies to work more closely together as part of the primary care model. A translation of information on medicines on matters such as dosages could also be beneficial for languages such as Arabic. A Member suggested that the PNA could include guidance on disposing of sharp instruments for pharmacies. It was also commented that there was a need to improve coverage for 24 hour access to pharmacies as this was currently quite patchy. A Member stated that demand for emergency contraception for young adults was high in some areas and efforts should be made to make such contraception more widely available and at more affordable prices in pharmacies.

5.5 Ashlee Mulimba (Director of Healthy Dialogues) welcomed the suggestions in respect of translating medicine labels and guidance on disposing of sharp objects and these could be looked at further. She advised that emergency contraception was fairly widely available, however costs remained high and consideration needed to be given as to how these costs could be reduced.

5.6 The Board agreed that the draft PNA as proposed commence to the 60 day statutory consultation from 1 December 2017.

6 ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2016-17

6.1 Mike Robinson presented the final version of the Annual Report of Public Health for 2016-17, following comments and suggestions made at the previous Board meeting on 14 September. Mike Robinson stated that the report presented a call for action to provide the sufficient platform and resources to ensure an effective approach to prevention and maintaining wellbeing. He drew Members' attention to the next steps in the report, including a recommendation that the Board commission a Joint Strategic Needs Assessment (JSNA) on mental health and wellbeing. Mike Robinson also asked that the Board explore the feasibility of using the 'Roads to Wellbeing' infrastructure to develop an asset based resource. He confirmed that the annual report had been published.

6.2 During discussions, Members welcomed the use of case studies in the report and acknowledged the role the voluntary and community sector had played in providing these. Members commented that the report was user friendly and well-illustrated. A Member commented on the importance of placing emphasis on prevention and the benefits this would bring rather than placing undue focus on the treatment process. Preventative initiatives in respect of mental health were particularly important and he felt that overall, the report was going in the right direction. Members expressed their support for the proposed JSNA on mental health and wellbeing and emphasised that this should address all age groups. A Member spoke of the need to look at building up community resilience and consider how social interventions could work to help achieve this.

6.3 A Member stated that there was an opportunity to look into more integrated commissioning across a number of areas and she welcomed using 'champions' to promote wellbeing. Another Member commented that organisations needed to have sufficient infrastructure to be able to recruit and train champions. Champions could also be brought into a model in respect of commissioning which could help reduce costs. She added that maternity champions had worked well and was am affordable option for wide outreach.

6.4 The Chairman informed Members that she had chaired a session on "green prescribing" at a Mayoral event where evidence that green and blue spaces contributed to better mental and physical health for residents. The London Conference had also identified that healthy people also benefitted the economy. The Chairman thanked officers and complemented them on the report, however she emphasised that there was now much work to do.

7 CHILD AND ADOLESCENT MENTAL HEALTH SERVICES TRANSFORMATION PLAN

7.1 Angela Caulder (Child and Adolescent Mental Health Services Joint Commissioning Manager) introduced the report and advised that the

Transformation Plan had been published and submitted to NHS England. The report highlighted achievements to date and Members heard that the focus from 2017 onwards would be on integrating services.

7.2 Jackie Shaw (Director, Child and Adolescent Mental Health Services, Central and North West London NHS Foundation Trust) then elaborated on the achievements in 2017. She began by stating that the voluntary and community sector had provided a number of creative offers, including art therapies. An out of hours crisis service had been piloted, where children would be seen by a Child and Adolescent Mental Health Services (CAMHS) professional, and 715 children had been seen to date. Consideration was being given as to how to expand the service and an additional 8 staff were to be appointed. Efforts were also being made to reduce the average length of stay when children were admitted to hospitals. A children's eating disorder service was being developed and had been commissioned through NHS Central London Clinical Commissioning Group. The service had a highly trained team and was performing well. Jackie Shaw also informed the Board that 94% of urgent cases were seen in under a week, one of the best performances in London.

7.3 During Members' discussions, it was commented that there was a gap in services in between end age for CAMHS services and start age for services for adults and it was asked what steps were being taken to bridge this gap. The Chairman mentioned that the Council was working on developing services for those in transition from adolescence to young adulthood. A Member sought further details as to what the expected outcomes were from the principal objectives and how would success be monitored. Members asked if the lives of children and young people were being tracked and could comparisons be made as to where they are in 5 years' time. The importance of measuring outcomes was also emphasised.

7.4 In reply to issues raised by Members, Jackie Shaw advised that an all ages service was being developed in respect of the eating disorder service. The Vincent Square Centre was now making plans for families and although the scheme was in infancy, it was hoped it would continue to develop. Family care in relation to eating disorders was also being looked at.

7.5 Angela Caulder advised that CAMHS was looking to develop all age services across the range of services and it also had a national learning programme. She advised that there were key performance indicators for all of the objectives to measure success and Members noted that Westminster had one of the lowest waiting times in the country. CAMHS was also working closely with the voluntary and community sector in respect of keeping well, staying well schemes.

7.6 Annabel Saunders (Bi-borough Children's Services) advised the Board that Children's Services had interviewed around 300 children last summer to check on their wellbeing and a range of guidance treatments were available. Positive feedback was also being received from staff and parents in respect of under 5s children's centres.

7.7 The Chairman welcomed the achievements to date.

8 ANNUAL REPORT OF THE SAFEGUARDING ADULT EXECUTIVE BOARD 2016-17

8.1 Helen Banham (Adult Social Care Strategic Lead – Professional Standards and Safeguarding) presented the fourth annual report of the Safeguarding Adult Executive Board (SAEB) and explained that the SAEB was required under the Care Act 2014 to review cases where a person had died or experienced serious abuse or neglect. The Safeguarding Adult Strategy had been refreshed this year and Helen Banham advised that the focus was on prevention and less focus on process. She advised that the SAEB's approach was to "lead, listen and learn."

8.2 During discussion, the Chairman enquired whether the SAEB would remain a tri-borough organisation. In relation to the number of safeguarding enquiries as set out in page 219 of the report, Chris Neill asked whether these were figures that were to be expected. Members felt that the work of the SAEB to date had left a good legacy, although there was no room for complacency. The issue of 'drift', the time taken for referrals to be looked into until they closed, was an issue nationally and it was important to address this. Members stated that safeguarding was a role that needed to be undertaken throughout the Council and communication between Council service areas was vital. Robust safeguarding training also needed to be provided and lessons learnt from the SAEB could help inform the Local Safeguarding Children Board.

8.3 In reply to the issues raised, Helen Banham advised that the SAEB would remain on a tri-borough basis for the time being, although this would be reviewed. She advised that Westminster was in the middle compared to the other two boroughs in respect of safeguarding enquiries. Nationally, there was some variance in interpretation of what constituted a safeguarding enquiry, however Helen Banham confirmed that she had no particular concerns about the numbers reported for Westminster. Nationally, there was a dropping off of enquiries and this could be attributable to better safeguarding as people became more aware of what it entailed.

8.4 The Chairman welcomed the report and felt there were good examples included in it. On behalf of the Board, the Chairman thanked Helen Banham for all her work for the City Council before her retirement.

9 NEXT STEPS WITH INTEGRATED HEALTH AND SOCIAL CARE IN WESTMINSTER

9.1 Dylan Champion (Head of Health Partnerships) introduced this item and stated that both NHS Central London and NHS West London Clinical Commissioning Groups (CCGs) had drafted comprehensive strategies for integrating health and social care which set out plans for the next 2 years. Both strategies were committed to the same better outcomes. Dylan Champion stated that the strategies had developed considerably since work had started on them in July.

9.2 Chris Neill then presented NHS Central London CCG's strategy and stated that it was acknowledged that there were significant health inequalities in Westminster. There was a need for community care to be more connected with local communities, whilst considerable financial challenges also needed to be addressed. Furthermore, action needed to be taken in the context of the recent announcement confirming the devolution of healthcare in London. Chris Neill stated that there was opportunity to work in a different way, including how buildings were used. He confirmed that the strategy's final business case was due to be submitted in summer 2018.

9.3 Jayne Liddle (Assistant Director, Integrated Care, NHS West London Clinical Commissioning Group) then presented NHS West London CCG's strategy. She advised that the CCG was building an evidence base and she emphasised the importance of co-locating teams. Key approaches of the strategy included multi-disciplinary working and a focus on promoting self-care.

9.4 During discussions, the Chairman welcomed the close working between the CCGs and the Council and she asked what were the main objectives in terms of co-commissioning. She felt that the first steps had been encouraging and suggested that other partner organisations also start to work closer together with the CCGs and the Council in future. Members asked what engagement with organisations such as Healthwatch would take place to get feedback from patients and what impact would the strategies have on them. It was remarked that the shortfall in funding for social care was a big factor to take into consideration. The approach taken by both CCGs was welcomed and it was acknowledged that changing people's behaviour through cultural change would be a tough challenge.

9.5 Members acknowledged that there were significant financial pressures that the CCGs faced, however this could help stimulate change. Cultural change was very important and the challenges could not be underestimated and developing and implementing the strategies would be a huge piece of work. It was remarked that the voluntary and community sector was represented on the Partnership Board and as the primary care model was rolled out, organisations from this sector would be able to provide services to the community as part of the offer and this would represent a good opportunity for greater joint working.

9.6 Members commented on the importance of engaging with people to see what outcomes they would like themselves. It was emphasised that the initial focus should be on patient outcomes, whilst putting together the structure to achieve this should follow after. The strategies also needed to align with the North West London Sustainability and Transformation Plan. It was suggested that there needed to be more discussions on identifying the needs of children. A Member also felt that change would happen once staff felt they could achieve this and that they would receive the necessary support to do so. Another Member stated that there were already changes taking place on the healthcare workforce, with staff becoming younger and who may be more open to change.

9.7 Louise Proctor (Managing Director, NHS West London Clinical Commissioning Group) advised that lessons were being learnt from the 'My Care, My Way' initiative, which looked at how people could be supported to lead the lives they wished to lead. She added that the existing organisational approaches had to change and it was imperative to take a joined-up approach.

9.8 In reply to issues raised by the Board, Chris Neill advised that the CCG was already involving Healthwatch in respect of identifying what patients needed, however it was acknowledged that there was a lot more work to do on this issue and the Partnership Board was looking into this. He welcomed the views from providers and thanked the Board for their feedback. The challenges in considering how to use property differently was recognised and consideration was being given to the commissioning process. In respect of services for children, Chris Neill advised that the CCG was working with various Council service areas to identify what needed to be provided and the intention was to develop an ambitious and broad service.

9.9 The Chairman confirmed the Board's commitment to supporting the strategies for changes to health and social care and welcomed progress to date.

9.10 **RESOLVED:**

1. That NHS Central London Clinical Commissioning Group's Central London Accountable Care Commissioning Strategy as attached as appendix 1 of the report be endorsed.

2. That NHS West London Clinical Commissioning Group's Integrated Care Strategy as attached as appendix 2 of the report be endorsed.

3. That it be recognised that the need for a whole system solution is required to ensure that all Westminster residents, whether they live in the north of the borough or the south, receive a high quality and consistent health and social care service.

4. That it be agreed that the Board play the lead role in shaping and overseeing the delivery of both strategies, receiving regular updates and providing endorsement to proceed following the achievement of key milestones.

10 ANY OTHER BUSINESS

10.1 The Chairman stated during a recent meeting of the Senior Citizens Forum that she had attended, it had been remarked from someone who had visited hospital that there appeared to be a significant amount of waste created, such as the use of paper thermometers and the throwing away of crutches. In reply, Mona Vaidya advised that paper thermometers were accurate, inexpensive and bio-degradable. She acknowledged that some crutches were disposed of. Louise Proctor added that crutches were re-used where possible and some were given to other organisations, such as the Red Cross.

10.2 A Member commented that some private hospitals were advertising private urgent care centres, which he felt could undermine the NHS. The Chairman replied that she had met with the architects of a private hospital and was impressed with what she saw and she felt there was scope for the NHS to learn from the private sector.

The Meeting ended at 6.05 pm.

CHAIRMAN: _____ **DATE** _____

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WESTMINSTER HEALTH & WELLBEING BOARD
Actions Arising

Meeting on Thursday 16th November 2017

Action	Lead Member(s) And Officer(s)	Comments
Chairman's Verbal Update		
Chairman to update Board on meeting she had with NHS Property representatives at next Board meeting	Chairman	To be provided at next meeting on 18 January 2018
Pharmaceutical Needs Assessment		
Mike Robinson to contact NHS England to see if inviting pharmacy representatives to a future Board where the Pharmaceutical Needs Assessment is an item on the agenda is appropriate.	Mike Robinson	

Meeting on Thursday 14th September 2017

Action	Lead Member(s) And Officer(s)	Comments
Sustainability and Transformation Plan		
Presentation on Sustainability and Transformation Plan to be circulated to the Community Safety Partnership.	Jane Wheeler / Chris Neill	
Draft Annual Report of the Director of Public Health 2016-17		
Members to make any further comments and suggestions about the draft annual report to Mike Robinson prior to the next Board meeting.	All Board Members / Mike Robinson	Completed.

Meeting on Thursday 13th July 2017

Action	Lead Member(s) And Officer(s)	Comments
Update on Development of Better Care Fund Plan 2017-19		
Better Care Fund Plan for 2017-19 to be circulated to Members for further comments and final approval to be delegated to Councillor Heather Acton and Dr Neville Purssell before the 11 September deadline.	Councillor Heather Acton / Dr Neville Purssell / Dylan Champion	Completed.
Work Programme		

Clarification to be provided on whether the meeting scheduled for 22 March 2018 needs to be moved forward.	Councillor Heather Acton / Dylan Champion	Alternative date being sought.

Meeting on Thursday 25th May 2017

Action	Lead Member(s) And Officer(s)	Comments
Delivering the Health and Wellbeing Strategy for Westminster		
Information dashboard being developed by North West London Clinical Commissioning Groups' Strategy Transformation Team to be circulated at next meeting.	Harley Collins (Health and Wellbeing Manager)	To be provided at a future meeting.
Healthwatch to circulate research undertaken on behalf of the North West London Sustainability Transformation Plan that identified gaps in the Community Independence Service to Members.	Healthwatch	Completed.
Specific priorities and projects within the Strategy to be updated to incorporate suggestions made by Members.	Dylan Champion	To be provided at a future meeting.
Work Programme		
Updated work programme to be circulated to Members.	Dylan Champion	To be provided at a future meeting.
Primary Care Strategy to be circulated to Members.	Chris Neill (NHS Central London Clinical Commissioning Group)	

Meeting on Thursday 2nd February 2017

Action	Lead Member(s) And Officer(s)	Comments
Health and Wellbeing Strategy for Westminster 2017 – 2022 Implementation		
A joint implementation paper setting out a clear governance structure and providing details of actions being taken by NHS Central London and NHS West London Clinical Commissioning Groups to help deliver the implementation plan to be provided at next meeting.	Ezra Wallace, Chris Neill (NHS Central London Clinical Commissioning Group) and Louise Proctor	Completed.

	(NHS West London Clinical Commissioning Group)	
Pharmaceutical Needs Assessment – Introduction		
Report on implications for funding for community pharmacies being reduced for 2016/17 and 2017/18 to be provided at a future meeting.	Colin Brodie	To be provided at a future meeting.

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	Completed.

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)	Completed.
Work Programme		
Board to receive first report on the next Pharmaceutical Needs Assessment at next meeting.	Mike Robinson / Colin Brodie	Completed.

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	Completed.
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 weeks.	All Board Members / Anna Waterman	Completed.

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	Completed.
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	Completed.

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	Completed

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	Completed.
Meenara Islam to circulate details of proposals discussed at an engagement plan meeting between Council and Clinical Commissioning Group colleagues.	Meenara Islam	Completed.
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	Completed.
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	Completed.

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	Completed.
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	Completed.
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	Completed.

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	Completed.
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	Completed.
Update on the Programme to be reported at the next Board meeting.	Adult Social Care	Completed.
Dementia Joint Strategic Needs Assessment – Commissioning Intentions and Sign Off		
Board to receive and update at the first Board meeting in 2016.	Public Health	Completed.

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	Completed.
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	Completed.
Update on Preparations for the Transfer of Public Health Responsibilities for 0-5 Years		
Board to receive an update in 2016.	Public Health	Completed.

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	Completed.
Adult Social Care representative to be appointed onto the Transformation Board.	NHS North West London Adult Social Care	Completed.
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	Completed.
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	Completed.
Joint Strategic Needs Assessment		
Consideration be given to ensure JSNAs are more line with the Board's priorities.	Public Health	Completed.
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.		Completed.
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	Completed.

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	Completed.

Meeting on Thursday 19th March 2015

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

Meeting on Thursday 22nd January 2015

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

A further update on progress in Primary Care Co-Commissioning to be given at the meeting in March 2015.	Clinical Commissioning Groups. NHS England	Completed.

Meeting on Thursday 20th November 2014

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

Meeting on Thursday 18th September 2014

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

brought to a future meeting of the Westminster Health & Wellbeing Board in January 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.	Completed.
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.	Completed.
The Health & Wellbeing Strategy		
A further update on progress to be submitted to the Westminster Health & Wellbeing Board in six months.	Priority Leads.	Completed.
NHS Health Checks Update and Improvement Plan		
Westminster's Clinical Commissioning Groups to work with GPs to identify ways of improving the effectiveness of Health Checks, with a further report on progress being submitted to a future meeting.	Clinical Commissioning Groups	Completed.
Joint Strategic Needs Assessment Work Programme		
The implications of language creating a barrier to successful health outcomes to be considered as a further JSNA application. *Note: Recommendations to be put forward in next year's programme.*	Public Health Services Senior Policy & Strategy Officer.	Completed.

Meeting on Thursday 26th April 2014

Action	Lead Member(s) And Officer(s)	Comments
Westminster Housing Strategy		
The consultation draft Westminster Housing Strategy to be submitted to the Health & Wellbeing Board for consideration.	Strategic Director of Housing	Completed.
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:	18th January 2018
Classification:	**General Release**
Title:	Looking forward
Report of:	Bi-borough Executive Director of Adult Social Care
Wards Involved:	All
Policy Context:	Joint Health and Wellbeing Strategy
Financial Summary:	N/A
Report Author and Contact Details:	Harley Collins, Health and Wellbeing Manager, Harley.collins@lbhf.gov.uk

1. Executive Summary

1.1 This report summarises some of the findings and insights from national research into Health and Wellbeing Boards. It highlights some of the traits of effective boards and provides a narrative summary of the progress made by the City of Westminster Health and Wellbeing Board in 2017.

2. Key Matters for the Board

2.1 The Boards is invited to:

- consider the position of Health and Wellbeing Boards across the country, reflect on progress made to date and consider the traits of more effective boards
- Note policy and circumstantial developments and how the board will need to adapt to offer systems leadership in 2018 and beyond
- Agree to hold a workshop in early 2018 to develop the board's priorities, focus and work plan for 2018/19
- Identify HWB members responsible for the delivery of the Board's three main priorities and produce a review of performance to inform the workshop in March.

3. Background

3.1 Health and Wellbeing Boards were established by the Health and Social Care Act 2012 as a forum where local leaders from across local health and social care systems could come together with the voluntary sector and other stakeholders to improve the health and wellbeing of the populations they serve and promote integrated services.

3.2 Many Boards met in shadow form in 2012 prior to being placed on a full statutory footing in April 2013. Early research conducted by the King's Fund (October 2013) found that most Boards used this shadow year well. Against a backdrop of complex organisational change and financial instability, most Boards made good progress building the relationships at the heart of a successfully functioning Board and fulfilling core statutory duties such as the development of Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

3.3 Until recently, research into Health and Wellbeing Boards has found that whilst many had made good progress and had ambitions to assume a full systems leadership role, most were still on a journey and are very much a work in progress (London Councils, March 2015)

3.4 This changed following the devolution developments in Manchester, Leeds, London and elsewhere which offered local Health and Wellbeing Boards a new potential model to aspire to. One where substantial funds, powers and responsibilities for health and social care were devolved to accountable organisations and local leaders who are collectively responsible for improving the health and wellbeing of the populations they serve.

3.5 In December 2015, NHS England published *Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21* signalling a major shift in policy for the NHS. The guidance required NHS commissioners and providers to come together with local organisations, including local government, to develop five-year *place-based* Sustainability and Transformation Plans (STPs). STPs introduced an alternative focus for system leadership across a larger geographical footprint. The shift to a place-based approach to planning signalled an acknowledgement that widespread provider deficits could not be remedied by providers alone and instead required collective action and cooperation between commissioners, providers and local authorities managing common resources to secure a financially sustainable system (McKenna and Dunn. Feb 2016).

4. The Position of Health and Wellbeing Boards Nationally

4.1 There has been a considerable amount of research into the ambitions and effectiveness of Health and Wellbeing Boards since they were set on a statutory footing in April 2013. In 2012, shortly after Boards were established, the King's Fund published *Health and Wellbeing Board's: System Leaders or Talking Shops* which concluded that the single biggest test for health and wellbeing boards would be whether they could offer strong, credible and shared leadership across local organisational boundaries. (Humphries et al 2012).

4.3 In 2013, the King's Fund published *Health and Wellbeing Boards: One Year On* (King's Fund, Oct 2013) where it followed up its first report by looking at what had changed, how Boards had used their shadow year, what they had achieved and whether they could provide effective leadership across local systems of care. That research found that whilst there has been definite progress against a back drop of considerable organisational change and financial instability, particularly in areas such as relationship building and the delivery of core duties, Boards were still very much a work in progress. The research found that generally, reported relationships between CCGs and local authorities were good and improving and nearly all Boards had produced joint strategic needs assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS). (October 2013).

4.4 Public health and health inequalities tended to be the highest priorities in early health and wellbeing strategies indicating that public health was exerting real influence and impact on local authorities early on. However, there was little sign in 2013 that boards had begun to grapple with the immediate and urgent strategic and financial challenges facing their local health and care systems and the King's Fund report found that unless Boards did so, there was a real danger they would become a side show rather than a source of system leadership. (King's Fund, October 2013).

4.5 Despite important early progress, in-depth research conducted in 2015 by London Councils and Shared Intelligence found that the clear majority of London HWBs described their board as "being on a journey", with very few claiming it was yet fulfilling its full potential. And although most Boards reported aspirations to do so, researchers found little evidence of London HWBs providing genuine systems leadership across the piece (*Conquering the Twin Peaks* London Councils, 2015).

4.6 The Local Government Association's review of the second year of the national health and wellbeing board improvement programme found that Boards nationally could all be located somewhere on a spectrum of maturity and ambition, with progress best represented by a bell-curve rather than a linear graph. (*Stick with it: A review of the second year of the health and wellbeing improvement programme* Local Government Association, February 2015).

4.7 In March 2016, the tide began to turn with the Local Government Association (*The Force Begins to Awaken*, LGA, March 2016) finding that while the potential of many boards remained unfulfilled, considerable progress had been made in the last year and that a significant number of health and wellbeing boards were now beginning to play a genuine leadership role across local health and care systems. The litmus test of a more effective HWB was one that addressed health and wellbeing from a *whole place perspective* i.e. rather than focusing on specific issues such as diabetes or obesity and had a shared view of the future of the local health and care system.

4.8 *The Power of Place* (April 2017), the fourth report in the longitudinal study of Health and Wellbeing Boards for the LGA again reasserted that the Board's in the vanguard in terms of effectiveness were ones that were reasserting a focus on the wider determinants of health and exercising a place leadership role. By doing so, they had created a strategic framework to which STPs and action on the integration of health and social care must relate thereby gaining traction with STPs. This approach was manifesting itself in areas such as membership with many Boards now widening the membership to the police, fire brigade, housing, and employment seen by many as key elements of a place-based approach. Although the research found that many more boards were beginning to play a genuine leadership role than 12 months ago, it also found that some boards are still struggling, confining their role to either a small number of initiatives or receiving reports which have been generated elsewhere.

5. Characteristics of an effective Health and Wellbeing Board

5.1 HWB chairs were found to have the single biggest influence over a Board's focus and tone and the relationship between the council and CCG and between the chair (in most cases a senior councillor) and vice chair (often from the CCG) were also key markers of effectiveness.

5.3 A London Council's study suggested that effective boards: (i) create the conditions in which there is genuine collaboration between key players in the local health and wellbeing system; (ii) ensure the existence of effective systems leadership and ensure effective engagement with the public and other stakeholders. As a result, effective boards tend to display focussed, prioritised action which impacts on the wider determinants of health, a shared vision for the future of health and care in place, which has traction with the strategies and business planning processes of the key local organisations and a work programme to deliver and monitor this (London Councils, 2015).

5.4 Factors enabling boards to operate effectively also included: a shared purpose and tight focus i.e. a small number of priorities (typically between 3 and 5) with the discipline to stick to them; creating groups and forums for other related

conversations and activities; effective sub-structures and time to meet in informal settings; an ability to influence all the key players; and a shared strategy which secures action by relevant organisations (London Councils, 2015).

5.5 Features found to potentially impede boards' progress include pressures to address issues that are not a priority; a tendency to focus on the board as a meeting rather than as an institution with a wider reach; failure to engage with, or seem meaningful to, providers; and being by-passed, with key discussions taking place in other forums outside the board's ambit (London Councils, 2015).

6. Health Needs of the Westminster Population

6.1 Westminster is a global city at the heart of the nation's capital and home to a highly diverse resident population of around 240,000 people. The population during the daytime is approximately 900,000 which is the highest of any London Borough. The resident population has a high proportion of younger people of working age, with 49% aged between 18 and 44 years old.

6.2 Westminster has the highest level of international migration of any place in England. Just over half of the resident population was born outside of the UK. Black, Asian, Arabic and other minority ethnic groups comprise 30% of the population. There are also estimated to be over 10,000 lesbian, gay, bisexual or transgender (LGBT) people in the city.

6.3 Life expectancy can vary dramatically depending on where people live. Men living in the least deprived areas live nearly 17 years longer than men living in the most deprived areas. For women, this gap is nearly 10 years. Additionally, the most deprived 20% of the population are likely to begin experiencing long-term disability 10 years earlier than the least deprived.

6.4 Almost half of households are single person households, the third highest proportion in London. Westminster has the fourth highest proportion of households in the country that are occupied by lone pensioners with 40% of people aged over 65 living alone. It also has the highest level of rough sleepers of anywhere in the country with over 2,570 people being identified as sleeping rough in 2014/15.

7. Progress in 2017

7.1 The Health and Wellbeing Board undertook a wide-ranging consultation and analysis exercise in 2016 to develop a new Joint Health and Wellbeing Strategy 2017-22 (JHWS). The final JHWS was agreed by the Board, the Council Cabinet and the Governing Bodies of West London and Central London CCGs in

December 2016. It highlights throughout the Board's commitment to a preventative and proactive health and care system and has four overarching priorities:

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 outcomes through prevention and self-management**
4. **Creating and leading a sustainable and effective health and care system**

7.2 The JHWS was developed alongside the North-West London Sustainability and Transformation Plan (STP) and there is close alignment between local and regional plans. While focusing primarily on the local health needs of the Westminster population, the JHWS was also developed to enable the delivery of STP ambitions in the City of Westminster. By so doing, the Board has displayed two of the traits of effective Boards noted by the LGA research. Firstly, it has created a strategic framework (the JHWS) to which STPs and action on the integration of health and social care must relate (thereby gaining traction with STPs). Secondly, it has chosen priorities which are 'place-based' focusing as they do on large population cohorts rather than on specific conditions such as obesity or diabetes.

7.3 Following adoption and approval of the JHWS at the end of 2016, the Health and Wellbeing Board agreed to undertake further work to translate the ambitions in the JHWS into a concrete Delivery Plan.

7.4 In March, Councillor Acton was appointed as the new Chairman of the Board. Members of the Board met for two private briefings in March and April to discuss ways of working and to agree key areas of focus for the Board moving forward. It was noted that there was a considerable volume and scale of activity underway and that it was therefore necessary for the board to focus on areas where it could exercise system leadership and promote integrated solutions to issues. Following a short workshop and prioritisation exercise It was agreed that the board would focus on three areas in 2017/18:

- Care Coordination
- Children, young people, and prevention
- Mental health and wellbeing

7.5 Beyond this, the Board recognised the importance of, and inter-relationships between the Better Care Fund Plan, the STP and City For All and agreed it would continue to plan an active role in influencing and shaping the development of these plans.

7.6 Since then the Board has focussed on a number of key priorities including:

- Considering and overseeing the development and agreement of a Tri Borough Better Care Fund Plan, which has subsequently been fully assured by NHSE;
- Considering and agreeing the Health and Wellbeing Board Consultation and Engagement Protocol which will be used to support the delivery of the Health and Wellbeing Strategy;
- Considering the Annual Report of the Director of Public Health which focussed on the key priority are of mental wellbeing;
- Considering the Central London CCG Primary Care Strategy and subsequently the Integrated and Accountable Care Strategies developed by the two CCGs and the Bi Borough Partnership;
- Receiving an update on the delivery of the Mental Health Commissioning Strategy and also the Sustainability and Transformation Plan.

8 LOOKING TO THE FUTURE

8.1 There are a range of factors that are likely to influence how the health and care system will develop in Westminster in 2017/18 and beyond:

- the Government announcement in the 2015 Spending Review that it expects health and social care be fully integrated by 2020 with local plan for integration in place by 2018. To ensure that this is progressed the Board will continue to oversee this work and to ensure that it progresses in accordance with the aims set out in the Health and Wellbeing Strategy.
- The North West London Sustainability and Transformation Plan commits partners including Westminster to system wide changes across the health and care economy between now and 2022. This work will continue.
- In November 2017, the London Health and Care Devolution Memorandum of Understanding (MoU) was signed providing more impetus and opportunity for integrated health and social care in London. The MOU will provide greater powers for the Mayor and London Assembly to provide London-wide leadership and coordination, opportunities to change regulatory and procurement framework to support local collaboration and more integrated working, opportunities to manage NHS and public estate more effectively; sell assets and use the resources to invest in transformation, opportunities to use NHS and public estate for housing and a greater focus and coordination around prevention and public health.
- The decision to formally end the ‘tri-borough’ arrangement with Kensington and Chelsea and Hammersmith and Fulham councils announced in March 2017 has had a significant impact on the individual boroughs as they have sought to disentangle staffing and governance arrangements and establish new internal structures. The establishment of a new ‘bi-borough’ arrangements between Westminster and Kensington and Chelsea Councils, including the development of a new integrated adults and children’s

commissioning function, will continue into 2018. The Board will continue to oversee the impact of these changes on health and social care outcomes.

7 Legal Implications

7.1 None at this stage

8 Financial Implications

8.1 None at this stage

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

Harley Collins, Health and Wellbeing Manager

Email: [Harley.collins@lbhf.gov.uk **]**

Telephone: 0207 753 4750

BACKGROUND PAPERS:

- Ham, C and Alderwick, H (November 2015) *Place-based systems of care: A way forward for the NHS in England* The King's Fund (available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Place-based-systems-of-care-Kings-Fund-Nov-2015_0.pdf)
- Humphries et. al (October 2012). *Health and Wellbeing Board's: Sytem Leaders or Talking* Shops The King's Fund (available online at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/health-wellbeing-boards-one-year-on-oct13.pdf)
- Humphries, R. and Galea, A (October 2013). *Health and Wellbeing Boards: One Year On*, The King's Fund (available online at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/health-wellbeing-boards-one-year-on-oct13.pdf)
- (February 2015) *Stick with it: A review of the second year of the health and wellbeing improvement programme*, Local Government Association,
- (February 2015) Health and wellbeing self-assessment tool, Local Government Association, (available online at: http://www.local.gov.uk/documents/10180/6101750/Stick+with+it+-+a+review+of+the+second+year+of+the+health+and+wellbeing+improvement+programme/5a54723b-d235-48c3-a499-327a29ba272b)

- (March 2015) *Conquering the Twin Peaks*, London Councils (available online at: http://www.londoncouncils.gov.uk/our-key-themes/health-and-adult-services/health/health-and-wellbeing-boards/conquering-twin-peaks)
- GMCA (2015) *Greater Manchester Health and Social Care Devolution: Memorandum of Understanding*, (available online at: https://www.greatermanchester-ca.gov.uk/downloads/download/40/greater_manchester_health_and_social_care_devolution_memorandum_of_understanding)
- (December 2015) *London Health and Care Collaboration Agreement*, (available online at: https://www.london.gov.uk/sites/default/files/london_health_and_care_collaboration_agreement_dec_2015_signed.pdf)
- (December 2015) Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21, NHS England, NHS Improvement, Care Quality Commission, Health Education England, National Institute of Care Excellence, Public Health England (available at: https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf)
- McKenna, H. and Dunn, Phoebe (February 2016) *What the planning guidance means for the NHS: 2016/17 and beyond* The King's Fund (available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Planning-guidance-briefing-Kings-Fund-February-2016.pdf)
- (March 2016) *The Force Begins to Awaken*, Local Government Association
- (April 2017) *The Power of Place*, Local Government Association

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City of Westminster

Westminster Health & Wellbeing Board

Date:	18 January 2018
Classification:	**General Release**
Title:	Whole Systems Update and Outcome Framework
Report of:	Councillor Heather Acton, Chairman of the Health & Wellbeing Board Dr Neville Purssell, Chairman, NHS Central London Clinical Commissioning Group
Wards Involved:	All
Policy Context:	Health and wellbeing
Financial Summary:	N/A
Report Author and Contact Details:	Dylan Champion, Head of Health Partnerships, WCC (dchampion@westminster.gov.uk) Chris Neill, Deputy Managing Director, Central London CCG (chrisneill@nhs.net) Jayne Liddle, Director of Integrated Care, West London CCG (Jayne.Liddle@nw.london.nhs.uk)

1. EXECUTIVE SUMMARY

1.1 At its meeting on 16 November the Health and Wellbeing Board considered and endorsed the Integrated and Accountable Care Strategy presented by Central London CCG and the Integrated Care Commissioning Strategy presented by West London CCG.

1.2 This report provides an update of work that has taken place since then. In particular, West London CCG have led work with providers to consider how an Integrated Community Team might be established, initially using an Alliance Agreement and utilising existing contractual arrangements during 2018/19.

1.3 Central London CCG have led work to develop a Joint Outcomes Framework in order to ensure that residents across Westminster and Kensington and Chelsea experience similar service standards and that consistent priorities are set.

1.4 Work also continues to consider how Council services could be improved through a more integral approach and initial conclusions about this are anticipated in March 2018.

2. RECOMMENDATIONS

2.1 The Health and Wellbeing Board is invited to:

a) note and comment upon the early thinking for the Integrated Community Team set out in sections 4 and 5 of this report and highlight any priorities that need to be addressed;

b) consider and comment upon the patient case studies which will be presented at the meeting to identify challenges for the co-design process and opportunities for improving the quality of care;

c) note and comment upon the draft Outcomes Framework presented in section 6 and appendix 1 of this report.

3. BACKGROUND

3.1 At its meeting on 16 November the Health and Wellbeing Board considered and endorsed the Integrated and Accountable Care Strategy presented by Central London CCG and the Integrated Care Commissioning Strategy presented by West London CCG.

3.2 The proposed strategies committed the system to an approach which will be underpinned by the concept of:

'One system, One budget, Better outcomes'.

3.3 They also committed partners to a set of guiding principles:

- ✓ **Resident-focussed** – we expect all our residents to be supported by a single health and social care team, using a single assessment and support process, supported by a single care plan if necessary
- ✓ **Community-focussed** – the care system will by default provide support in the community and make use of hospital or other bedded care only when necessary
- ✓ **Geographically relevant** – the approach to care must recognise the unique geography of Westminster and provide tailored solutions for people living in the north, centre, and south of the borough
- ✓ **Collaborative** – local approaches to care must be co-designed with local people and a wide range of local interest groups
- ✓ **Preventative** – the care model will focus on prevention and self-help, giving residents power over their own choices, health, and wellbeing

3.4 The Health and Wellbeing Board noted that 50,000 residents living in Queens Park and Pimlico receive primary and community health services which are

commissioned by West London CCG while the remainder of Westminster residents receive primary and community health services funded by Central London CCG. It therefore requested and required that a single whole system solution be developed for all Westminster residents whether they live in the north of the borough or the south receive a high quality and consistent health and social care service.

3.5 This paper presents an update on the work that has taken place since then to develop the strategy further and to achieve the Health and Wellbeing Boards aim of an integrated solution for all Westminster Residents. Work has taken place in three areas:

- West London CCG have led work with providers to understand how services are currently provided and how under existing contractual arrangements and through establishing an **Alliance Arrangement** staff from different organisations might work together in local multi-disciplinary community teams to provide better services for residents through the establishment of an **Integrated Community Team**.

  Though contractual arrangements and the amount of available infrastructure and resource is different across Central and West London, work continues to examine the feasibility of replicating the West London model across Central London.

  Though at an early stage initial conclusions are anticipated in March 2018. More information about current thinking is presented below

- Central London CCG have led work on developing a shared **Outcomes Framework** across Central and West London CCG in order to ensure that wherever residents live in the two boroughs the quality of care they should expect and the service standards delivered should be the same.

  A draft **Outcomes Framework** has been developed and shared with key stakeholders for comment. This is presented below for consideration by the Health and Wellbeing Board.

  It is anticipated that a final draft of the **Outcomes Framework** and a summary of the comments submitted and chances made will be presented to the March meeting of the Health and Wellbeing Board. More information is presented below.

- Westminster City Council and the Royal Borough of Kensington and Chelsea have begun an in-depth examination of the existing approach to providing social care to consider the risks and benefits of participating in an integrated approach to health and social care.

  Initial conclusions are that closer working between different organisations should reduce referrals and duplication and improve the person

experience and the quality of care supported. However both council's have limited resources and need to ensure that they continue to provide high quality services and meet their statutory social care functions and so further work is required and underway to consider the practicalities of this approach.

4. VISION FOR INTEGRATED COMMUNITY TEAM

4.1 West London CCG have led work to develop proposals for a new Integrated Community Team (ICT) to be established utilising existing contractual arrangements and an "Alliance Agreement" from April 2018. This will involve a step by step approach but it could include staff working together from a range of different services including those currently working in community and specialist nursing, the 'My Care My Way' service, the Community Independence Service (CIS), the voluntary sector and potentially, some staff currently working in Adult Social Care.

4.2 A key element of the ICT proposal is the creation of an integrated multi-disciplinary management team which will help to reduce duplication through better management of local resources. This single management function will mean that, when a service user presents with a health or social care need, following a multi-disciplinary assessment the best person in the local Integrated Community Team will be identified and assigned to that person. This member of staff will then provide ongoing support for that person to coordinate their care and enable that person to take control of their own health and social care needs, by drawing on the wide range of skills and expertise within the ICT to support their care.

4.3 By providing continuity of care and through working as part of a local Integrated Community Team with other health and social care professionals, the professional designated to provide and co-ordinate support for the patient will ensure that the right support is provided more quickly, and without onward referral. For instance, the professional will ensure that if the person needs medication advice, then a pharmacist will be identified to deliver that advice; they will also ensure that if there are social care needs, these are arranged for the person. In other words, support will be tailored around the person, they will have a single main contact and less time will be spent passing responsibility for the person from one organisation to another.

4.4 This will be better because people, families and those who work in the community often find existing systems difficult to navigate and the specific responsibilities of different individuals and organisations difficult to understand.

4.5 The Integrated Community Team will be better for patients and carers by:

- Creating a system where service users and carers only have to tell their story once.
- Providing more timely interventions by reducing the delays to patient care caused by onward referrals between different community services.
- Sharing information more effectively so that service users' requirements and wishes are understood and respected.

- Enabling the system to respond more rapidly and appropriately to people's needs, by bringing together medical, nursing, therapy and social care professionals, to prevent hospital admissions;
- Reducing the number of professionals that the service user and their family have to interact with. Providing care in a range of venues, focused around our two Integrated Care Centres/ Health and Wellbeing Hubs (which are located in the North and South of RBKC) and also delivered through local 'spokes' and also offering home-based care to housebound patients.
- Offering proactive planned care to better prevent ill health and early escalation of risk when a patient becomes unstable.
- Offering a more personalised unplanned response by ensuring service users' case managers are involved as soon as possible when a patient requires unplanned care.
- Improving people's experience of the health and social care system by making delivery feel seamless.
- Creating a 'one system' ethos. This will be enabled by the development of an Alliance Agreement between existing providers, underpinned by a single Outcomes Framework (see below), to promote closer working.

4.6 An Integrated Community Team will be better for practitioners, staff and volunteers by:

- Shifting the focus of support from providing a specific, specialist intervention towards providing more long term, holistic person focussed support to meet wider health and care needs.
- Simplifying referral and clinical pathways and reducing bureaucracy by empowering teams to own and resolve service user needs themselves, without the need for onward referrals between different services.
- Spending less time doing administration – as records are shared and fewer people are involved in providing different elements of people's care;
- Having more contact with service users over a longer period of time;
- Working more closely with colleagues from other organisations and other professions – allowing for increased learning and development opportunities;
- Working with improved IT and digital solutions – e.g. virtual MDTs and shared records;
- Increasing skills and competencies of the workforce through more structured access to specialist colleagues and knowledge.
- Creating more opportunities for training, development and career progression;
- Making it simpler to provide the right care in the right place, removing bottlenecks and obstacles (e.g. strict referral criteria and cumbersome processes);
- Making it easier for practitioners, staff and volunteers to communicate with colleagues and access specialist advice;

5. CO-DESIGN PROCESS FOR ESTABLISHMENT OF AN INTEGRATED COMMUNITY TEAM

5.1 To assist with the development of thinking for the Integrated Community Team a comprehensive programme of engagement and co-design is now underway. So far, over 100 different individuals from a range of provider, commissioner and

patient organisations have been involved in the process and more than 30 co-design events facilitated.

5.2 The process as a whole has been overseen and coordinated by the West London Integrated and Accountable Care Alliance Leadership Group, which is made up of senior leaders and lay members from key provider, commissioner and patient organisations.

5.3 The process has included a review and analysis of best practice and learning from elsewhere. A number of areas have already tried and tested similar models of care, both in the UK and world-wide. We are taking into account the principles, ways of working and lessons learnt from these approaches, to ensure that the new model reflects all available best practice in the field. It has also drawn on the recently undertaken evaluation of existing arrangements undertaken by New Bucks University and in particular the key conclusions that have been made about the benefits of effective care coordination.

5.4 A second key focus of the co-design process has been an analysis and consideration of the existing and future arrangements on current service users. This has been undertaken by the development and review of a series of case studies which identify how currently individuals can be referred from one organisation to another and how the quality of care could be improved through the development and implementation of Integrated Community Teams.

5.5 The Health and Wellbeing Board is invited to consider and comment upon the patient case studies which will be presented at the meeting to identify challenges for the co-design process and opportunities for improving the quality of care.

5.6 Another key focus has been on looking in detail at existing arrangements through a series of 10 service or function specific “deep dive reviews”, which have been examining the strengths and weaknesses of existing arrangements, the challenges in referring people from one service to another and the opportunities for more joint working between one service and another.

5.7 This process is now reaching completion and the conclusions are being collated so that they can be used to develop detailed proposals and a business case which will be considered by the Governing Bodies and Board of Directors of each participating organisation. Following this process, the analysis, conclusions and recommendations will be presented to the Health and Wellbeing Board for consideration.

6. DEVELOPMENT OF A JOINT OUTCOMES FRAMEWORK

6.1 The prime objective of the two CCGs’ integrated and accountable care work programmes is to improve health and wellbeing outcomes for people in Westminster and Kensington and Chelsea.

6.2 This means that how care is commissioned and provided needs to start with the question of ‘What matters to you?’ rather than ‘What’s the matter with you?’

6.3 The document attached as appendix 1 is part of the draft Outcomes Framework shared with participants on the Westminster Partnership Board for Health and Care in December 2017. Central London CCG and West London CCG are now working together to develop a single joint Outcomes Framework, which sets out the ambitions for what care services will help people to achieve. The production of a single framework across the two CCGs is designed to support the delivery of high-quality and consistent health and social care service to all Westminster residents, given the position of Queen's Park Paddington (see paragraph 3.4).

6.4 The Outcomes Framework is rooted in the extensive public engagement undertaken as part of the CCGs' Whole Systems Integrated Care programmes, which is the starting point for this present work.

6.5 This engagement gave rise to a series of 'I' statements. These are useful ways of describing people's expectations of what receiving care will help them to do and feel. Examples for people receiving care include 'I can maintain my mobility and independence', 'I can live at home', and 'I feel respected for my own experience and knowledge'. Other example of statements for people delivering care are 'I am supported by people who work well together' and 'I feel that I get the support and resources I need to do my job well'.

6.6 As the table below shows, these statements have been grouped into five outcome domains:

- People have an overall quality of life;
- Care is safe, effective and people have a good experience;
- Professionals experience an effective integrated environment;
- Care is financially sustainable; and
- Care team is efficient, process defined and personalised.

6.7 Examples of proposed outcomes, indicators, and metrics that sit within each domain are shown in the table below. The full set is shown in appendix XXX. This is a long list, ready for further public and professional engagement (see below). A sub-set of the final outcomes framework will be subject to financial incentivisation to encourage the service redesign and investment necessary to support the achievement of the relevant outcomes.

Outcome domain	**Outcome**	**Indicator**
People have an overall quality of life	Taken together, my care and support gives me the opportunity to contribute and help me live the life I want to the best of my ability.	Potential years of life lost (PYLL) from causes considered amenable to healthcare
		Health related quality of life for older people. Average health status score for adults aged 65 and over as measured using the EQ-5D scale
		Adults using mental health services who live independently

		Unmet needs in domains of control, dignity, personal care, food & nutrition, safety, occupation, social participation, accommodation (from the adult social care survey)
Care is safe, effective and people have a good experience	I feel safe, in control and well-informed. I am respected for my own experience and knowledge. I know people are there when and where I need them.	Proportion of patients who at any point during a twelve-month period achieve (or exceed) a minimum increase in six points within Patient Activation Measure level 1 or 2
		Proportion of patients who, in last six months, felt they had enough support from local services or organisations to help manage their long-term condition(s)
		Proportion of people admitted in hospital for any ambulatory care sensitive condition
		Bereaved carers' views on the quality of care in the last three months of life
Professionals experience an effective integrated environment	Professionals involved with my care talk to each other. They all work as a team.	Professionals who agree they are working in an integrated way to support services users and carers
		Professionals are able to deliver the patient care they aspire to
		Professionals who would recommend their integrated care partnership as a place to work
Care is financially sustainable	The care I receive is part of a service built on long-term sustainability.	Shift in spend/activity from acute services to out-of-hospital services
		Reduction in emergency admissions for persons ≥65 years per 100,000 population
		For the population cohort managed by the [intensive community care teams], reduction in emergency admissions for people ≥65 years
Care team is efficient, process defined and personalised	I am supported by people who respect my time and I am not being admitted into hospital unnecessarily.	Reduction in emergency readmissions within 30 days of discharge from hospital for patients aged ≥65
		Proportion of older people (aged ≥65) who are still in a non-acute care setting (usual place of residence including own home, nursing home, residential home) 91 days after discharge from hospital into reablement services
		Weekend discharge rate % in comparison with weekday discharge rate %

6.8 This framework is a draft for further engagement with a wide range of stakeholders, including local residents and providers of care. This engagement will be taking place from January to March 2018.

6.9 Particular issues for consideration are:

- Do the domains reflect what we all want from a comprehensive community care across Westminster and Kensington and Chelsea?
- Are the indicators a fair reflection of the outcomes that the Health and Wellbeing Board would seek to achieve through a more integrated approach to health and social care?
- Should any other indicators should be prioritised, given local population needs?

7. FINANCIAL IMPLICATIONS

7.1 At this stage there are no direct financial implications arising from these proposals but it should be noted that the successful development of these proposals and in particular the success of the new arrangements in reducing demand on hospitals will play a key part in achieving the financial targets set out in the Sustainability and Transformation Plan.

7.2 In the short term all partners have a range of financial and savings targets which need to be delivered on 2018/19, which means that there are limited resources available to develop new ways of working and a likelihood that overall investment in community health services will reduce in 2018/19

8. LEGAL IMPLICATIONS

8.1 Careful consideration of the legal implications of adopting new ways of working will be required, including any procurement risks associated with putting in place an Alliance arrangement or extending, terminating or re-letting existing or new contracts. These will be considered as final proposals are developed and in parallel to considering detailed business cases.

Background papers:

Westminster Joint Health and Wellbeing Strategy 2017-21
Integration and Better Care Fund Plan 2017/18
NWL Sustainability and Transformation Plan
NHSE: Five Year Forward View
Central London CC Integrated and Accountable Care Strategy

West London Integrated Care Strategy

LIST OF APPENDICES:

Appendix 1: Draft Outcomes Framework

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

Dylan Champion

Interim Head of Health Partnerships

Email: dchampion@westminster.gov.uk

Appendix 1: Extracts from Draft Outcomes Framework

Outcome Domain		Outcome	Indicator	
1	People have an overall quality of life	Taken together, my care and support gives me the opportunity to contribute and help me live the life I want to the best of my ability.	1	Potential years of life lost (PYLL) from causes considered amenable to healthcare
			2	Healthy life expectancy at birth (male and female measures)
			3	Unmet needs in domains of control, dignity, personal care, food & nutrition, safety, occupation, social participation, accommodation (patient) Average quality of life score (based on patient responses to Adult Social Care Survey – eight domains) Of those who completed survey, % of patients scoring 14 or above (out of 24) for self-reported quality of life.
			4	Number of days in hospital (emergency)
			5	People with a care plan who have reported an improvement in quality of life an independence. ICP Care Planning Survey distributed to all patients who have received an initial ICR care plan or had a care plan review
			6	Health related quality of life for older people. Average health status score for adults aged 65 and over as measured using the EQ-5D scale
			7	Improved patient experience - Self-reported "I" statements (as part of patient surveys / interviews). ICP care planning survey distributed to all patients who have received an initial ICR care plan or had a care plan review
			8	Adults using mental health services who live independently
			9	Adults using mental health services who have a job
			10	Physical checks for people with severe mental illness
			11	Gap in employment rates - mental health

			12	Adults with a learning disability who live in their own home or with their family
			13	Adults with a learning disability who have a job
			14	Gap in employment rates - learning disabilities
2	Care is safe, effective and people have a good experience	I feel safe, in control and well-informed. I am respected for my own experience and knowledge. I know people are there when and where I need them.	15	Proportion of patients who at any point during a 12-month period achieve (or exceed) a minimum increase in 6 points within PAM level 1 or 2.
			16	Health literacy - enabler for prevention
			17	Reduction in number of non-elective admissions due to falls, for 65 years and over, per 100,000 population (develop as a lead indicator for flagging frailty factors affecting uptake of health and social care)
			18	Proportion of patients who, in last 6 months, felt they had enough support from local services or organisations to help manage their long-term condition(s)
			19	Proportion of patients who helped compile written care plan e.g. setting goals / choosing how to manage health
			20	Preferred place of death
			21	Proportion of people admitted in hospital for any ambulatory care sensitive condition (ACSC)
			22	Knowledge of prescribed medications
			23	Care planning goals
			24	In the past year, have you generally found it easy or difficult to find information and advice about support services or benefits?

			25	How confident are you that you can manage your own health?
			26	Quality of life for people who are carers. Carers can balance their caring roles and maintain their desired quality of life.
			27	Satisfaction with out-of-hours primary care
			28	Bereaved carers' views on the quality of care in the last 3 months of life
			29	Quality of palliative care
3	Professionals experience an effective integrated environment	Professionals involved with my care talk to each other. We all work as a team.	30	Professionals who agree they are working in an integrated way to support services users and carers
			31	Professionals are able to deliver the patient care they aspire to
			32	Professionals who would recommend their integrated care partnership as a place to work
4	Care is financially sustainable	The care I receive is part of a service built on long-term sustainability.	33	Shift in spend/activity from acute services to out-of-hospital services
			34	Reduction in emergency admissions for persons ≥65 years per 100,000 population
			35	For the population cohort managed by the [Care Connection Teams], reduction in emergency admissions for people ≥65 years
5	Care team is efficient, process defined and personalised	I am supported by people who respect my time and I am not being admitted into	36	Year-on-year impact on aggregate first to follow-up ratio
			37	Reduction in emergency readmissions within 30 days of discharge from hospital for patients aged ≥65
			38	COMMISSIONER BASELINE: delayed transfers of care (from hospital and those attribute to adult social care per 100,000 population)

		hospital unnecessarily.	39	PROVIDER BASELINES: delayed transfers of care (from hospital and those attribute to adult social care per 100,000 population)
			40	Proportion of older people (aged ≥65) who are still in a non-acute care setting (usual place of residence including own home, nursing home, residential home) 91 days after discharge from hospital into reablement services
			41	Weekend discharge rate % in comparison with weekday discharge rate %
			42	**[PLACEHOLDER]** Identification of the percentage of people aged ≥65 referred by MCP who access either short- or long-term social care services
			43	**[PLACEHOLDER]** Identification of the number of people accessing third sector services offered and outcomes from these interventions for individual users

North West London
Collaboration of
Clinical Commissioning Groups

Whole Systems Integrated Care

North West London Collaboration of CCG's

North West London
Whole Systems Integrated Care

Objectives of today's session

1. Introduce the WSIC Dashboards and how we share data across NWL
2. Explain how the dashboards are being used and show you some of the visualisations being developed on the personal health records
3. Explain how we are developing the product and supporting adoption across the system

Who is developing the WSIC Dashboards?

Key enabler to North West London's Sustainability and Transformation Plans (STPs)

Key facts • Over 2 Million People • Over £4bn Annual Health & Care Spend • 8 Local Boroughs • 8 CCGs & Local Authorities • Over 400 GP Practices • 10 Acute & Specialist Hospitals • 2 Mental Health Trusts • 2 Community Health Trusts

CCGs

- NHS Central London Clinical Commissioning Group
- NHS West London Clinical Commissioning Group
- NHS Hammersmith and Fulham Clinical Commissioning Group
- NHS Hounslow Clinical Commissioning Group
- NHS Ealing Clinical Commissioning Group
- NHS Brent Clinical Commissioning Group
- NHS Harrow Clinical Commissioning Group
- NHS Hillingdon Clinical Commissioning Group

Acute

- The Hillingdon Hospitals NHS Foundation Trust
- Chelsea and Westminster Hospital NHS Trust
- London North West Healthcare NHS Trust
- Imperial College Healthcare NHS Trust

Social Care

Brent · Harrow Council London · Hillingdon London · The Royal Borough of Kensington and Chelsea · City of Westminster · h&f hammersmith & fulham · London Borough of Hounslow · Ealing www.ealing.gov.uk

Mental Health

- Central and North West London NHS Foundation Trust
- West London Mental Health NHS Foundation Trust

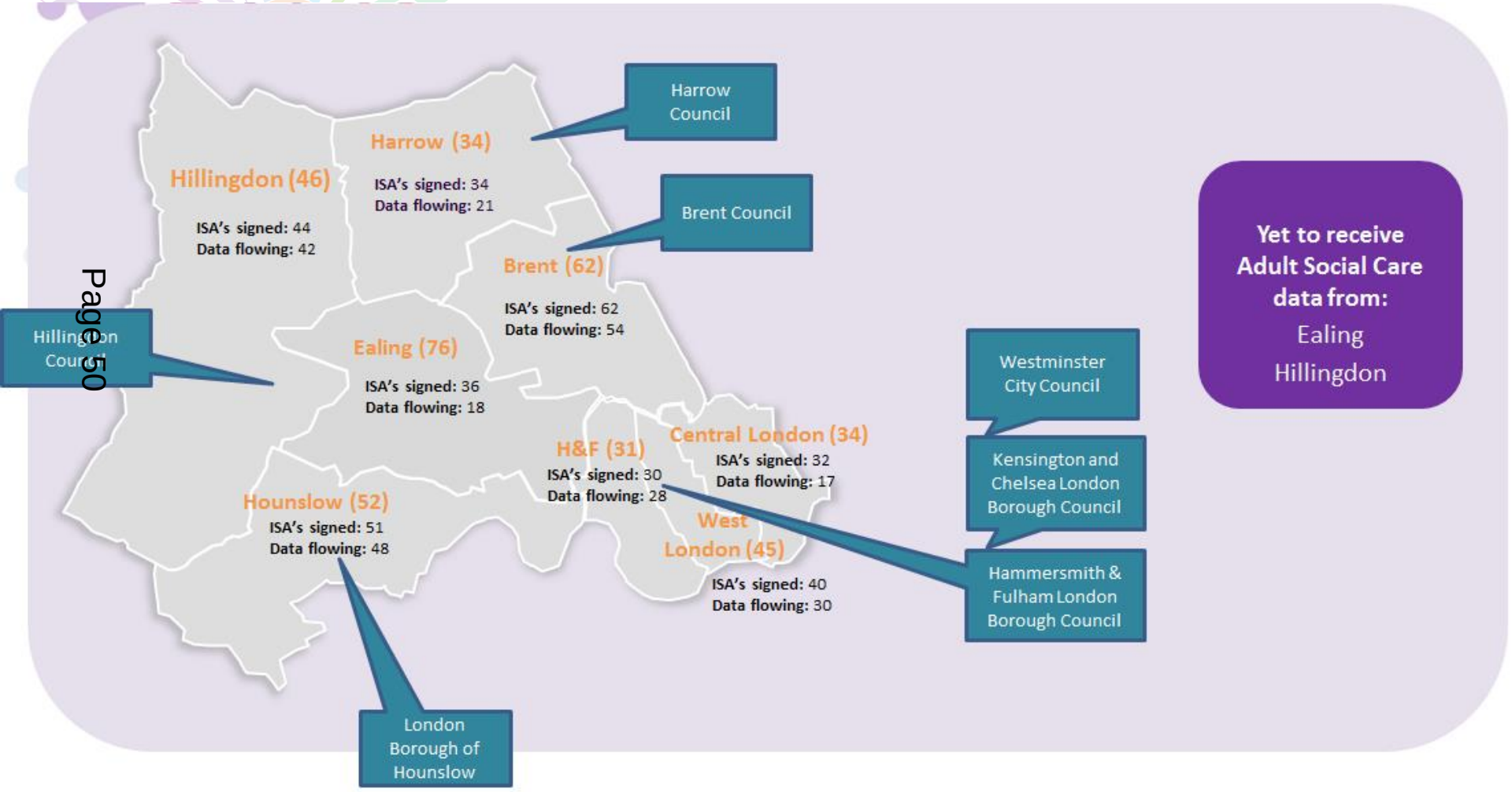
Community

- Central London Community Healthcare NHS Trust
- Hounslow and Richmond Community Healthcare NHS Trust

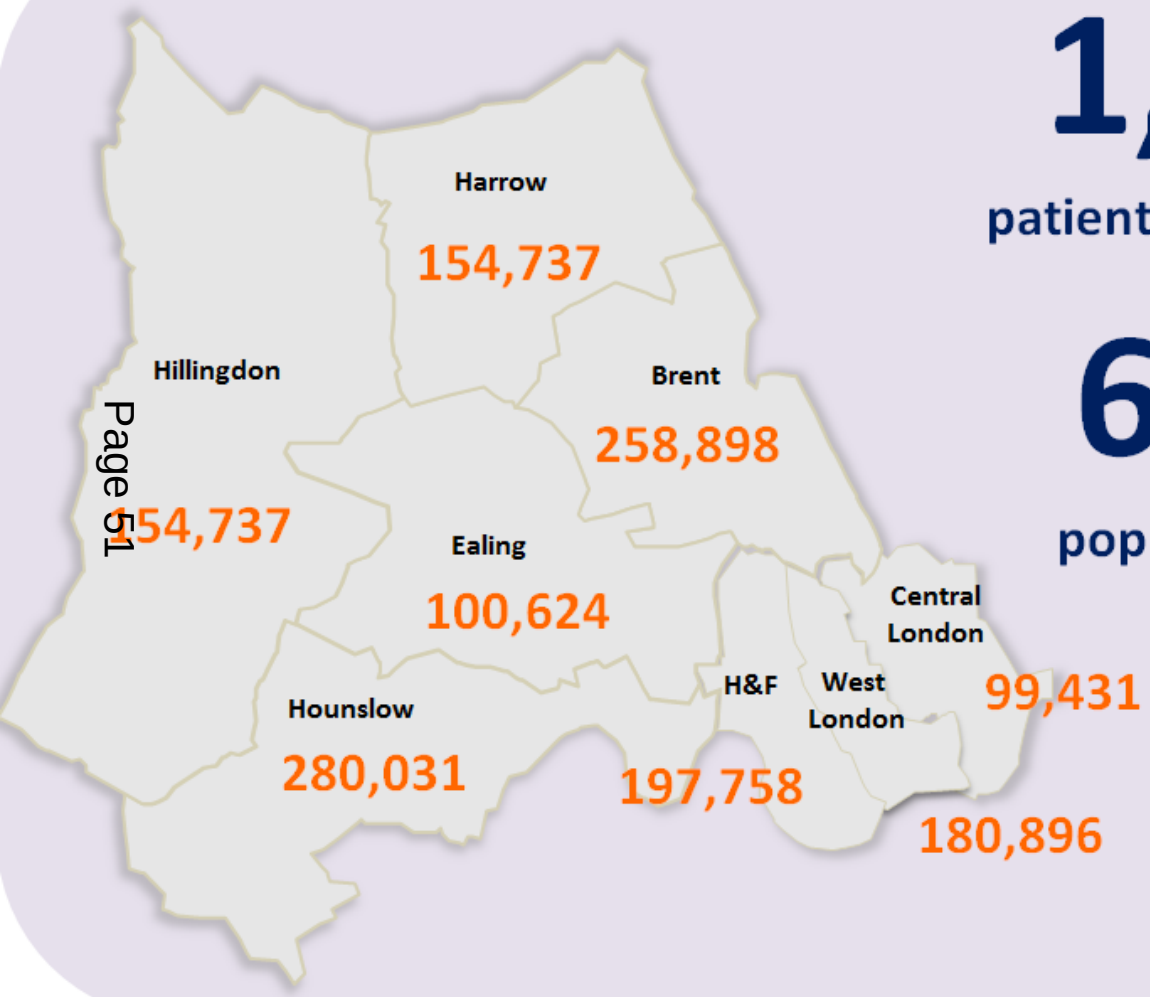
GPs

NWL ISA Heat Map

Digital Information Sharing Agreements (ISA) in place with 346 health and social care providers across the NWL system – covering over 1.5 million people to date



WSIC Data Warehouse population



1,533,724

patients in the WSIC data warehouse

67.0% of the patient population in North West London

Whole Systems Integrated Care (WSIC) solution

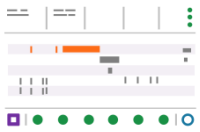
Derived Measures
Long Term Conditions
electronic Frailty Index (eFI)
Spend

Core Data
Activity
Prescriptions
Demographics

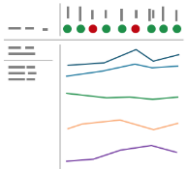
Reference Data
Organisation
BNF
Postcode 'out codes'

WSIC Data Warehouse

DE-IDENTIFIED

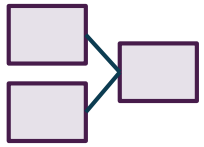

Integrated Patient Summary


Case Finding Tools


Long Term Condition Management Tools


Population Health


Benchmarking


De-identified dataset


District Nurses
Care Coordinators
GPs
Clinical teams in secondary care
ACPs
Researchers

North West London
Whole Systems Integrated Care

Analytics for Direct Care

How the WSIC Dashboards are being used to coordinate care for NWL patients

Meet Sam and Betty

Page 54

Using Betty's story…..

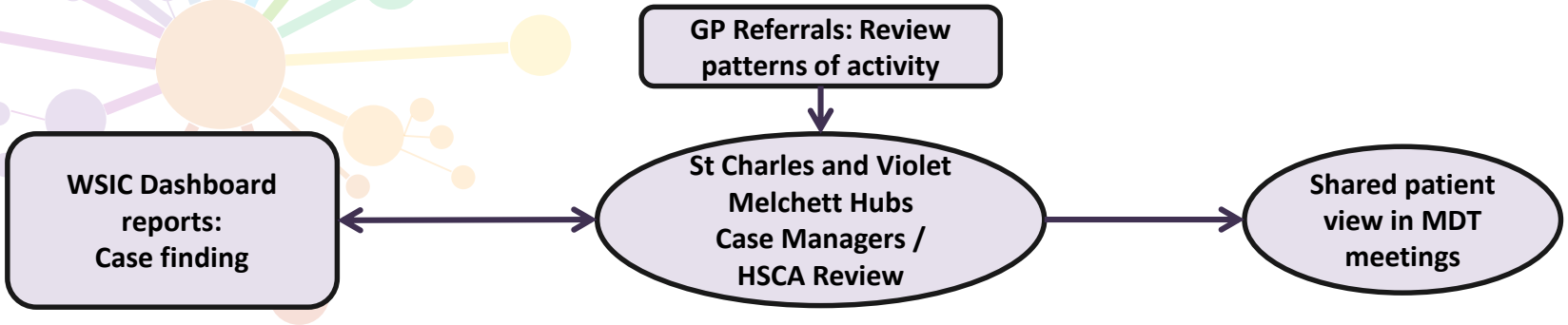
- Betty 87, suffers from COPD, Type 2 diabetes and arthritis.
- Coping well until Sam passed away, but now lonely and increasingly depressed.
- Frequently visits her GP and if she can't get hold of her GP in a crisis calls for an ambulance.

Using the WSIC Dashboards

- Care coordinator identifies Betty as a frequent A&E user and regular inpatient user on the patient radar
- Her activity timeline shows the care coordinator:
  - A sudden increase in her activity across the system, including a number of inpatient stays and A&E visits over the weekends;
  - She has not been treated for anything major in hospital;
  - She had a referral to social care but did not attend her appointment; and
  - She is attending at the practice weekly.

Use of the WSIC Dashboards

The WSIC Dashboards are used by My Care My Way staff regularly to check patients that they are due to see to understand patterns of system activity and to case find using the reports detailed below



Case Managers use the WSIC Dashboards to create the following reports…	Timeframe	Where information will be found in the WSIC Dashboards
Care Plan tracking - List of patients with out of date care plans	Monthly	Using the 'Care Plan out of date' Watch List
Review of most expensive patients - Case find expensive patients that have not been referred into My Care My Way (WL WSIC Hub)	Fortnightly	Use the 'High Cost' filter in the Patient radar
Produce list of patients with recent LTC diagnosis - use list a case finding pointer or prompt for care plan review	Monthly	Using the 'Recently Diagnosed with a LTC' Watch List
Produce list of regular In patient users - use list as case finding pointer or prompt for care plan review	Monthly	Using the 'Regular Inpatient attender' filter in patient radar
Produce list of most frequent A&E attenders - Review as a prompt for Care plan review and case finding	Monthly	Using the 'Frequent A&E attendee' Watch List
Produce LTC care plan out of date lists for follow up	Monthly	Using the 'Care Plan out of date' Watch List

All WLCCG practices incentivised to use the WSIC Dashboards in CLS Plan for 2017/18 to identify top 25 high cost patients for review

Use the drop down menu below to choose your time period and hover over a bar to see more information...

View time period

Last 2 years

Latest available data ranges from 28/02/2017 to 25/03/2017.
Hover over the "i" button below for more detail.

Patient Example
123 456 7890

Long term condition(s):
Asthma COPD Dementia
Diabetes Hypertension

Lives in care home

PAM Score & Level

PAM Score	14.5
PAM Level	1.0

15 Jun 16 20 Jun 16

Key outcomes

Days not in hospital: 670 / 730

Total spend: £115,203

EFI: 0.47 (Severe Frailty)

Has GP care plan	
Care plan up to date	
Community care user	
Mental health user	
Social care user	

Click on a traffic light to view the trend of that indicator for the selected patient

GP Practice: (All) | Diabetes Type: (All) | Sort by: Latest Blood Pressure | Outstanding care process: None selected

398 patients on list

Patient Name (demo)	Age	# of LTCs	Diabetes Type	# of A&E visits	# of Care Processes incomplete (past year)	Care Process: BMI	HbA1c	Blood Pressure	Cholesterol	eGFR	Urine ACR	Retinal Screening	Smoking Status	Foot check	Self Care: Diabetes Education	Care Planning	Patient Goals
Patient Name	78	10	Type 2	0	4												
Patient Name	36	3	Type 2	0	9												
Patient Name	79	7	Type 2	0	4												
Patient Name	65	5	Type 2	0	2												
Patient Name	72	4	Type 2	0	0												
Patient Name	58	5	Type 2	0	3												
Patient Name	63	2	Type 2	0	9												
Patient Name	76	4	Type 2	0	9												

Patient: Patient Name, 79 (F)
Smoking Status: Non-smoker
Completed: 23 Sep 2015

GP Practice: NWL Medical Centre (E00000)

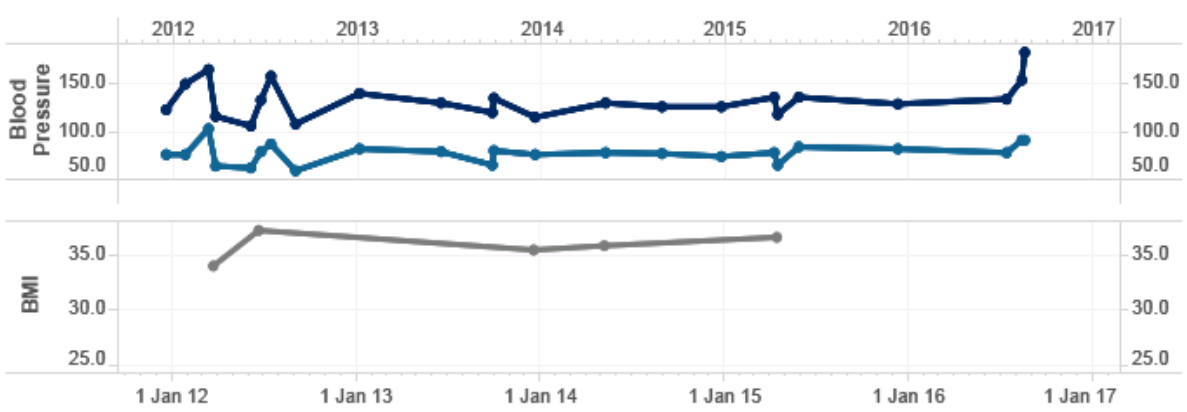
- Last activity in past 12 months
- Last activity in past 12-15 months
- Last activity > 15 months old

Forename Surname, 79 (F)

NHS #: NHS Number

Long term conditions:

Anxiety Asthma CKD Depression Diabetes Hypertension Obesity



Systolic BP | Diastolic BP

Analytics for Population Health Management

ACP dashboard | Population overview

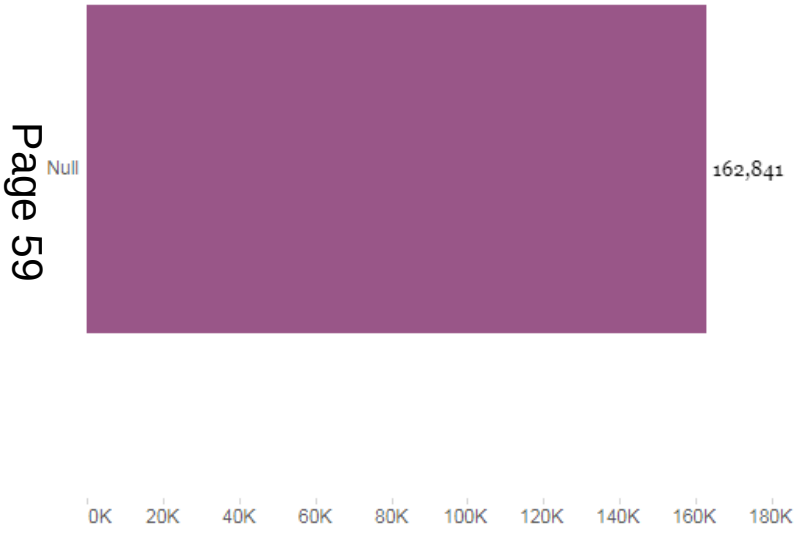
Understand your population needs and demographics

Use the drop down menus below to filter...

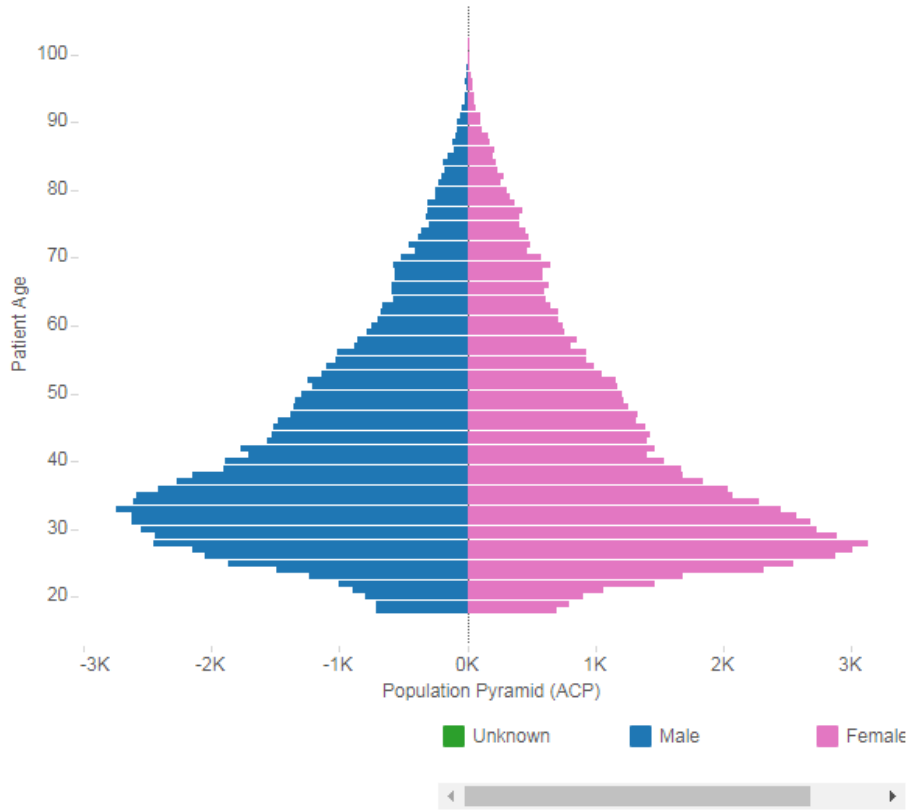
Select segment	Select condition	Select fiscal year	Select GP	Select GP network
(All)	All	2016-17	(All)	(All)

Latest available data ranges from 12/31/2016 to 2/14/2017.
Hover over the "i" button below for more detail.

Needs group comparison - your ACP against selected comparator (Whole of NWL)
Click to filter the page



Population pyramid comparison - your ACP against selected comparator (Whole of NWL)
Click to filter the page



Number of patients in selection: **162,841**
This total includes categories that may have been filtered for information governance reasons

H&F ACP dashboard | Overview for the current year

Use the drop down menus below to filter...

Select LTC	Gender	Population Count	Patient Spend
All	(All)	638,996	4,707,412,433

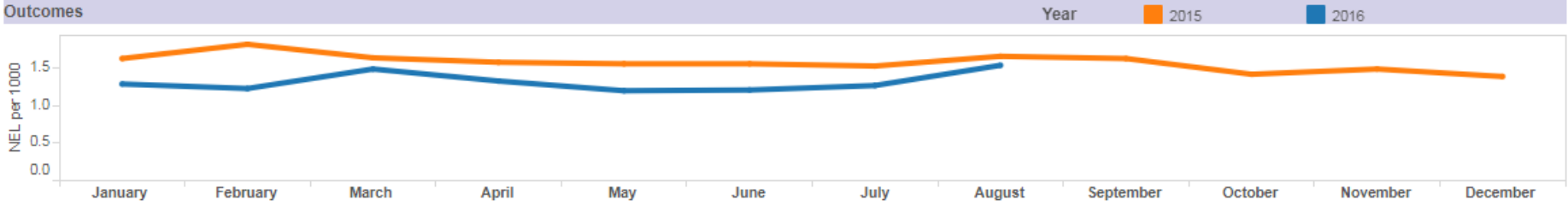
Latest available data ranges from 12/31/2016 to 2/14/2017.
Hover over the "i" button below for more detail.

Population

Spend

Setting of Care	19-29	30-39	40-49	50-64	65 plus
Acute A&E	22,611,345	23,913,622	21,910,080	30,624,005	63,700,563
Acute Critical Care	3,950,463	6,234,667	8,965,999	24,484,321	63,792,994
Acute Direct Access	5,840,674	9,452,651	11,111,652	18,105,145	43,628,245
Acute Elective	37,294,126	59,620,905	85,901,311	182,454,492	387,829,244
Acute Maternity	115,456,258	203,750,522	33,498,406	511,578	320,199
Acute Non Elective	54,284,795	67,394,789	73,177,905	148,831,575	543,198,592
Acute Outpatient	57,335,916	95,476,202	104,324,140	190,430,255	416,339,809
Community	10,397,860	14,126,664	19,054,992	47,866,463	255,813,735
GP	94,586,937	112,254,680	108,637,228	157,167,795	317,597,079
MentalHealth	17,705,592	21,372,746	25,784,145	31,256,438	38,369,784
Other	26,023,699	39,508,575	25,672,167	42,855,244	85,603,165

Outcomes



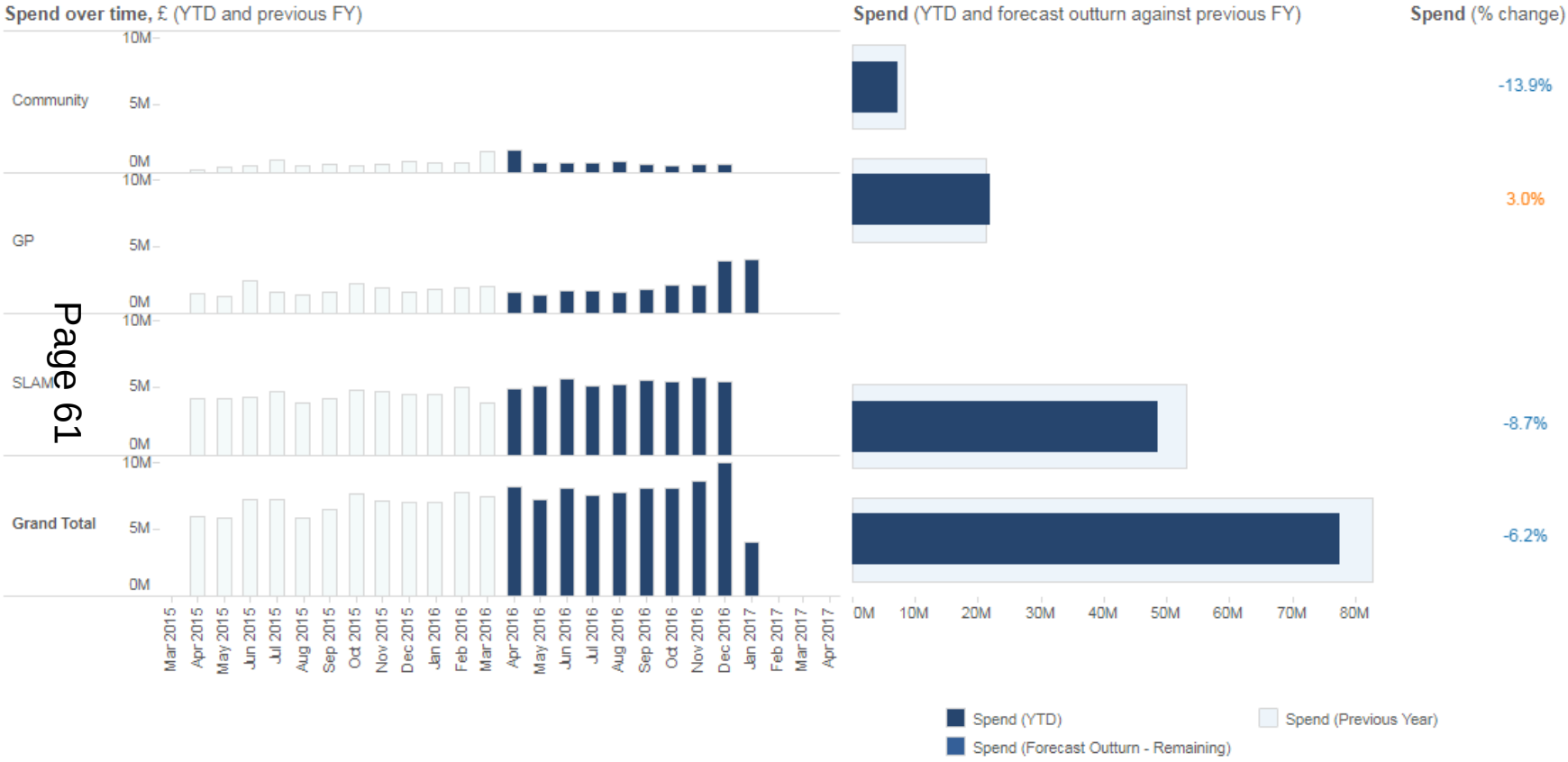
ACP dashboard | Spend overview

Track your population's spend across care settings and over time. Note: only ACP-relevant spend is included (see notes in information box)

Use the drop down menus below to filter...

Select segment	Select condition	Select fiscal year	Select comparator	Select GP	Select GP network
(All)	All	2016-17	Whole of NWL	(All)	(All)

Latest available data ranges from 12/31/2016 to 2/14/2017.
Hover over the "i" button below for more detail.



Current FY: 2016

Provider | POD level 1 | POD level 2 | GP | Needs group

ACP View | GP Weighted Overview

Cost overview for GP's broken down by ACP, Network, GP Name and Setting of Care.

Use the drop down filters to make your selection.

CCG Name	Practice Network Name	Practice Name	Setting Of Care	Full Date	
NHS HAMMERSMITH AND FULHAM CCG	(All)	(All)	(All)	4/1/2016	3/31/2017

Plans for product development

1. Working with providers to develop use cases for both direct care and population health data.

2. Prioritising the most useful LTC patient radars to add to the WSIC Dashboards and align to the delivery areas in the NWL STP

3. Developing predictive analytics

4. Setting up direct provider data feeds to provide more frequent data flows for the purpose of direct care

5. Applying advanced analytics to inform understanding the population health to support accountable care development across NWL.

Embedding and supporting adoption across the NWL health and social care system

- Focus to date has been on embedding the dashboards as the primary patient selection tool in the ***care coordination teams*** established across NWL

- Moreover in recognition of the potential benefits in the WSIC Dashboards, NWL CCGs are implementing incentives for GP practices as part of the Local Schemes

- Targeting clinical teams across primary, community, acute and social care who work as part of the Diabetes pathways in NWL for adoption of the Diabetes dashboards (and then other LTC pathways as new dashboards are developed).

Thank you for your time today

For more information on the WSIC Dashboards contact

WSIC.Dashboards@nw.london.nhs.uk

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Safer Westminster Partnership Strategy 2017 - 2020

Making Westminster safer by working in partnership to reduce the risk and harm of crime and ASB, focusing on protecting the most vulnerable within our communities.

June 2017

Contents

Foreword

This strategy for the Safer Westminster Partnership sets out our vision and how we will work in partnership, i.e. the local authority, police, probation, fire service, clinical commissioning group and Mayor's Office of Policing and Crime to make Westminster Safer over 2017-20.

These are challenging times with the recent terrorist attacks across the country and in Westminster and the continuing squeeze on public sector funding making it more important than ever to work in partnership in an evidenced based way to keep our residents and those who work and visit here safe.

Cutting crime and improving safety is not only about effective policing; it relies upon understanding the factors that enable crime and anti-social behaviour to take place, working together we can make a bigger difference than working is isolation. We have used the evidence base from our strategic assessment to develop our vision and strategy for the next three years.

We have developed a vision *'Making Westminster safer by working in partnership to reduce the risk and harm of crime and ASB, focusing on protecting the most vulnerable within our communities'.* This shows how we want to prioritise our resources towards those who are most vulnerable within Westminster. In particular we want to intervene early to reduce the risk of victimisation and prevent offending.

The key priorities and action plans outlined within this strategy reflect the strength of the Safer Westminster Partnership to join forces to make Westminster a safer place to live, work and visit.

Peter Ayling Westminster Police Borough Commander,

Chair of the Safer Westminster Partnership

Introduction

The Safer Westminster Partnership (SWP) is the statutory Community Safety Partnership (CSP) for Westminster. The aim of the SWP is to ensure the responsible authorities work together to reduce crime and disorder in Westminster. CSPs were set up under Section 5 – 7 of the Crime and Disorder Act 1998 and are made up of representatives from the 'responsible authorities', which are;

- Police Service (Metropolitan Police Service);
- Police and Crime Commissioner (Mayor's Office for Policing & Crime (MOPAC));
- Local Authority (Westminster City Council);
- Fire and Rescue Service (London Fire Brigade);
- Clinical Commissioning Groups (Central London Clinical Commissioning Group);
- National Probation Service (London Probation Trust); and
- Community Rehabilitation Company (MTC Novo).

The Police and Justice Act (2006) brought in new statutory requirements for CSPs and have been updated by subsequent legislation until the Crime and Disorder Regulations 2011. The requirements of this legislation is to produce an annual strategic assessment of crime and disorder, this provides the evidence base for setting a strategy and refreshing annually a partnership plan.

These are challenging times as budgets and funding streams continue to be cut across the partnership. That is why it is more important than ever to continue to work in partnership in an evidenced based way to have the greatest impact upon reducing crime and ASB in Westminster.

This strategy represents a commitment to work in partnership to prioritise working with the most vulnerable within our communities to reduce crime and ASB across Westminster. We will do this by intervening early with families and young people to reduce their risk of victimisation and prevent offending, and by working in collaboration with partners to focus on the key contributing factors evidenced to reduce victimisation and offending. This strategy is based upon evidence from our annual strategic needs assessment and will focus upon the four identified priorities:-

1. Identifying and working with repeat victims to reduce their vulnerability;
2. Working with the most problematic offenders to reduce their re-offending;
3. Reducing high harm crime in Queens Park and Church Street wards and the West End;
4. Enhancing the partnership response to countering terrorism.

Each priority will have a detailed action plan that will identify how we will put our commitments into action. The delivery of the plan will be overseen by the Safer Westminster Partnership board which is chaired by Peter Ayling the Westminster Metropolitan Police Borough Commander. The Board will review and report on progress of the plan and it will also be subject to scrutiny by the Adults, Health and Public Protection Policy and Scrutiny Committee.

Evidence

A strategic assessment was produced in October 2016 with the aim to identify the key crime and anti-social behaviour issues affecting Westminster. Cutting crime and improving safety is not only about effective policing; it relies upon understanding the factors that enable crime and ASB to take place, working in partnership to neutralise those factors and doing so in a reasoned and evidence based way. The strategic assessment drew from a range of data across the partnership. Using this evidence base the vision, goals and priorities for the SWP have been set and are detailed below.

Vision and goals

Making Westminster safer by working in partnership to reduce the risk and harm of crime and ASB, focusing on protecting the most vulnerable within our communities.

This vision highlights the priority of the SWP to focus resources towards protecting the most vulnerable within Westminster, in line with the MOPAC London Policing Plan[1]. Often vulnerability, crime and deprivation can come together creating a cycle of offending and victimisation. The SWP wants to work together to break that cycle.

Underpinning this vision is two cross cutting principles that apply to the Victim, Offender, Location and CONTEST delivery groups that drive delivery of the SWP priorities.

Intervening early with families and young people to reduce their risk of victimisation and prevent offending.

'Early intervention is not a 'nice to have' added extra to the justice system, it is vital if we are ever to break the cycle of crime, punishment and more crime'. Secretary of State Liz Truss, 13 February 2017

Working in collaboration with partners to focus on the key contributing factors that reduce victimisation and offending.

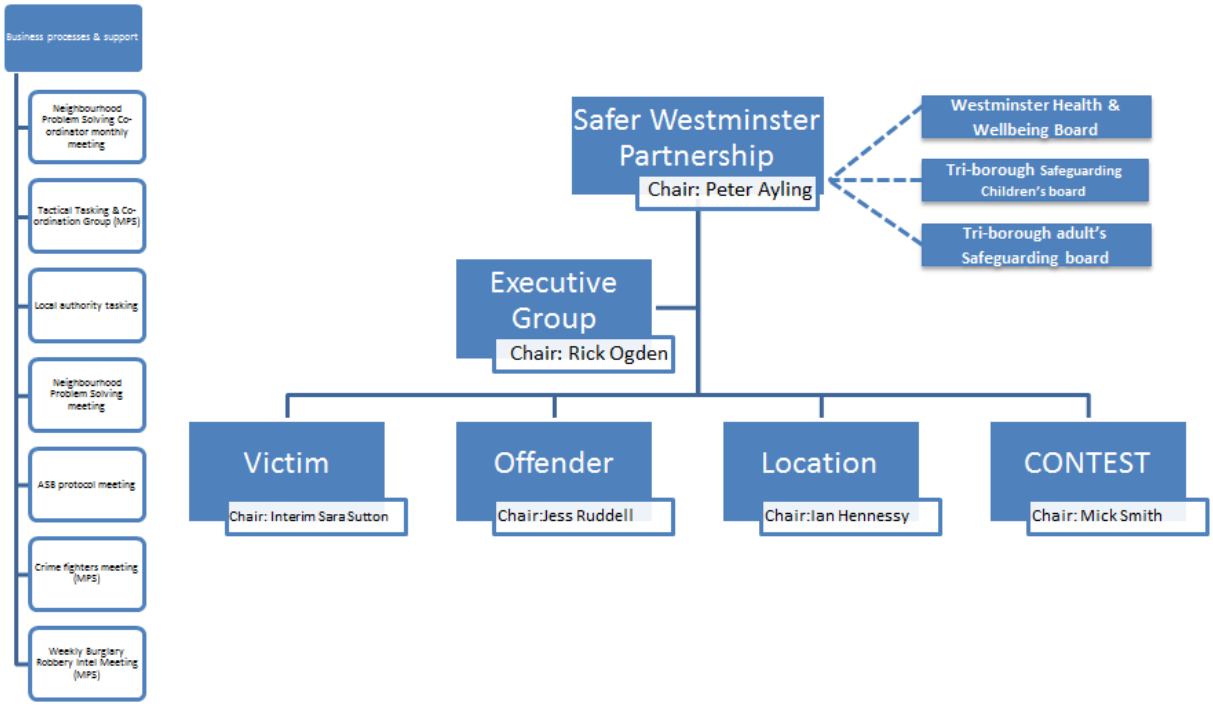
As resources continue to be cut across the public sector it is more important than ever to ensure we work as a partnership in an evidenced based way to achieve the greatest impact upon reducing crime and improving safety in Westminster.

How will we deliver this?

The structure of the SWP has been refreshed this year to ensure it is evidence based and that its work is centred upon the most prolific offenders, work with the highest repeat victims and target resources in vulnerable/high crime locations. Adopting this problem oriented approach will ensure the overarching structure will not need to change whilst the specific priorities beneath may do.

This more streamlined problem oriented approach enables cross cutting themes such as employment and mental health to be discussed in relation to all victims or offenders rather than just specific groups. The new structure is shown overleaf.

[1] https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/police-and-crime-plan-safer-city-all-londoners



The introduction of an Executive Group will be the driving force to delivering the SWP priorities. Made up of the Chairs of each of the delivery groups and chaired by the Fire Service this group will challenge performance and look for synergies, risks and issues across the groups.

The main focus of the delivery groups is to;

- Victim - Identify and work with repeat victims to reduce their vulnerability;
- Offender - Work with the most problematic offenders to reduce their re-offending;
- Location - Reducing high harm crime in Queens Park and Church Street wards and the West End;
- CONTEST - Enhancing the partnership response to countering terrorism.

Feeding into all of the Delivery Groups will be the business process and support groups that will be instrumental in identifying emerging crime and disorder risks that the SWP may need to consider and prioritise.

Whilst Section 17 of the Crime and Disorder Act 1998, as amended by the Police and Justice Act 2006 requires all responsible authorities to consider crime and disorder and the misuse of drugs, alcohol and other substance in the exercise of all their duties, activities and decision making, the structure chart shows the dotted links into the main statutory partnership boards which have regular cross over with the work of the SWP.

Objectives

This section details the evidence behind the SWP objectives and what the SWP will do to address them. The action plans for each of the respective delivery groups can be found in the Appendix.

Victim – Identifying and working with repeat victims to reduce their vulnerability

Improving co-ordination across the partnership to identify all repeat victims and ensure they have access to appropriate services;

Reducing repeat victimisation should be at the heart of any action taken to work with victims, as we know previous victimisation is the single best predictor of future victimisation. Police data showed 14% of victims of crime had been repeat victims within the last 12 months. Concentrating resources on this cohort will have the greatest impact upon reducing further victimisation. Data shows many of these victims are not just victims of one specific crime and therefore a more co-ordinated approach to tackling repeat victims needs to be taken. Work has been on-going across the partnership to address repeat victims of ASB and Domestic Violence this needs to be expanded to ensure all repeat victims have access to appropriate services.

Housing providers deal with a lot of low level ASB issues which if ignored can progress into more serious crimes. We will develop a minimum set of standards for housing providers for dealing with victims to ensure all victims are treated equitably.

The success of these actions will be evidenced as a reduction in repeat victimisation rates.

Provide bespoke support to those most at risk of domestic violence to reduce high levels of repeat victimisation;

It is estimated 8.5% of the female population and 4.5% of the male population suffer some form of domestic abuse[2]. 16 – 19 year olds are more likely to be victims of domestic abuse than any other age group highlighting the importance of early intervention. On average high risk victims live with domestic abuse for 2.6 years before getting help[3]. On average 22% of victims of domestic abuse in any given month are repeat victims of this type of abuse. Angelou Partnership has been commissioned to provide specialist front line support for survivors and their families across the Tri-borough. Over 2016 they received 1,107 referrals to the service from Westminster. They are delivering excellent results with 96% of women reporting a reduction in abuse due to support and advice received from Angelou and therefore we will continue to fund them.

Standing Together is commissioned across the Tri-borough to co-ordinate MARAC conferences and two domestic violence courts including one at Westminster Magistrates Court. The multi-agency risk assessment conference (MARAC) is a local multi agency victim focused meeting where information is shared on the high risk cases of domestic abuse between statutory and voluntary sector agencies. The number of cases being referred to the MARAC has increased slowly however the number of repeats has decreased and is 18%, considerably lower than nationally (25%) evidencing that the approach taken in Westminster is working. We will continue to fund Standing Together to deliver this important service and will monitor the success by tracking the number of repeat victims coming through the MARAC.

Provide bespoke support to vulnerable young victims i.e. those aged under 24 who are at risk of serious youth violence;

There are a number of indicators that help to identify young people who are vulnerable to becoming victims of crime. This includes being a looked after child and going missing from either school or home. These factors

[2] ONS (2015), Crime Survey England and Wales 2013-14, London: Office for National Statistics
[3] SafeLives (2015), Insights IDVA National Dataset 2013-14; Bristol: Safe Lives

also greatly increase the risk of becoming a victim of child sexual exploitation. Police data showed that people aged 20 -24 are significantly more likely to be victims of crime than the average population, this is most pronounced for female victims. Police data also showed young people are more likely to be victims of sexual offences and robberies.

The ASB team and Integrated Gangs Unit (IGU) will work with Victim Support to improve linkages and ensure young people are accessing support. The IGU will continue to fund a young women's advocate to support young women affected by gangs and youth violence, in particular those who have experienced or are at risk of sexual violence and exploitation. We will monitor the success by ensuring that 80% of all young people accessing the service achieve a positive outcome.

Gain a greater understanding of the level and quality of pan London provision for victims in Westminster;

MOPAC assumed responsibility for commissioning victims' services in London in October 2014 and victims form the heart of their Policing and Crime Plan. Whilst pan London commissioning of services is welcomed boroughs do not receive any feedback on the impact or who in their communities these services have affected. This is important for us to understand any gaps in provision and also to ensure that our victims are receiving a quality service.

Victim Support will be a vital member of the Victims delivery group and will provide quarterly performance data to enable us to a gain a greater understanding of the victims of crime to inform future Strategic Assessments. The development of a directory of victim's services for partners and agencies to access will be undertaken to raise awareness of services available.

Review the SWPs compliance with the Victims Code of Practice;

The Code of Practice for Victims of Crime is the statutory code that sets out the minimum level of service that victims should receive from the criminal justice system. The Victims' Code applies to all criminal justice agencies and sets out what each criminal justice agency must do for victims and the timeframe in which they must do it. To ensure that we are getting the basics right it is important to understand that all partners are adhering to the code.

We will assess how each agency is performing and identify any gaps or performance issues to ensure victims are treated fairly by the criminal justice system. We will work to improve the victim journey by ensuring accurate and timely information sharing to guarantee they only share their story once; assessing all vulnerabilities at the outset so the most appropriate agency retains the lead.

The quarterly public attitude survey results will identify if these actions have been effective.

Early intervention to prevent victimisation.

Prevention is better than cure and therefore early intervention is a cross cutting principle for the SWP. A variety of programmes are delivered through schools to prevent crime and children becoming victimised, we as a partnership will ensure this work is co-ordinated and we prioritise the most important messages. We will also explore the use of civil interventions against people who exploit vulnerable members of our community.

The Strategic assessment identified that older people had an increased risk of victimisation of theft and fraud. Developing bespoke crime prevention messages and working with trading standards will help to tackle this.

Offender – working with the most problematic offenders to reduce their re-offending

Ensure adequate commissioned services for the most prolific and vulnerable offenders to address their criminogenic needs, in particular around substance misuse and accommodation;

Half of all crime is committed by people who have already been through the criminal justice system and a small proportion of these offenders are responsible for a significant volume of crime. Fundamental to this is addressing their criminogenic needs of which substance misuse in particular opiate misuse and accommodation were identified as the greatest issues.

The Integrated Offender Management scheme targets these prolific offenders and we have commissioned Starting Over through the Drug and Alcohol Wellbeing Service to provide additional support through two key workers to work with up to 30 offenders at a time to address their criminogenic needs. Starting Overs approach has been evidenced to be successful in reducing re-offending as their previous contracted work with Short Sentence Prisoners saw a 42% reduction in re-offending. They will also provide a housing worker post that is split across the Tri-borough. The provision of suitable accommodation may not reduce reoffending by itself, but it can be seen as a necessary, if not sufficient, condition for the reduction of reoffending[4]. Through Starting Over we will expect to see a reduction in those charged and ultimately a reduction in re-offending.

Offenders have many needs and will not just be known to offender based services, a review of commissioned services will assist in identifying any duplication in service provision and to identify any gaps. This will result in a comprehensive list of services available to share with partners.

Provide bespoke support to vulnerable young offenders i.e. those aged under 24 who are at risk of or are committing serious youth violence;

Whilst the number of young people entering the youth justice system is falling, those that remain are often some of the most challenging and vulnerable young people in society and have the highest recidivism rates.

The Integrated Gangs Unit (IGU) aims to identify and work with vulnerable and exploited young people involved in violence, to improve their life choices, social integration, reduce associations with gangs and reduce incidences of serious youth violence.

An IGU Evaluation found there was a highly significant reduction in the volume and severity of crime following engagement with the IGU. Following interviews with a number of clients who participated in the programme identified some of the key aspects to the programme's success; being a non-statutory agency, being available when and where participants feel comfortable such as a coffee bar and not in an office and being independent. This independent, flexible, informal approach was also identified as the success to reducing offending in Tri-borough adult short sentence prisoners.

We will continue to fund a number of posts in the IGU such as gangs exit, employment support, mental health support and youth outreach workers. As a result we will expect to see a reduction in serious youth violence, robbery and a reduction in the level of concern about gang and gang violence.

[4] Maguire & Nolan (2007) 'Accommodation and related services for ex-prisoners', in Hucklesby & Hagley Dickenson (Eds) Prisoner Resettlement: Police and Practice, Devon: Willan.

Improve offender cohort co-ordination to ensure clarity of partner's roles and responsibilities and gain a greater understanding of what works;

A lot of intensive work is undertaken with the various offender cohorts such as prolific offenders through the Integrated Offender Management (IOM) scheme, Gangs through Gangs Multi Agency Panel (GMAP), high risk offenders through Multi agency protection panel arrangements (MAPPA) and the Youth Offending Service (YOS) and a considerable overlap is seen amongst the cohorts monitored and managed across the partnership, not just in the individuals but in the services commissioned to address their criminogenic needs. Greater co-ordination is needed to prevent any silo working to ensure no duplication in services provided or commissioned and it is clear which agency/cohort has primary responsibility for managing that individual, to prevent contradictory approaches to offender management.

We will develop a standardised performance framework to assess the effectiveness of the cohort management and report quarterly to the offender board. Process maps and procedures will be developed to show clear pathways and responsibilities for each of the cohorts. A review of information sharing agreements will occur to ensure offenders only tells their story once. At this first meeting key contributing factors to the offender's behaviour will be identified to establish who the lead agency should be.

Explore and tackle the issue of cross border and foreign national offending in Westminster, utilising every possible funding opportunity.

About half of the people who offend in Westminster do not live here and a significant proportion are foreign nationals. This is far greater than other boroughs as offenders generally do not travel far to commit crime. The volume of people passing through Westminster each day makes the borough attractive to offenders particularly for theft offences. Foreign nationals are responsible for a large proportion of ASB in particular begging and rough sleeping and theft from shops, enforcement action should continue against this cohort.

We will explore the use of the MOPAC co-commissioning pot to lead on work to address this. As our funding from MOPAC has been cut by 56% we will look to identify other potential funds to support the work to reduce re-offending.

Intervening early with young offenders at risk or in the criminal justice system to prevent future criminality.

We know the key factors that put someone at risk of offending or being a victim of crime, such as being in care or being a child in need. Early intervention and working with Children's services at the early signs of risk should play a key part in reducing or preventing offending.

We need to work more closely with the Tri Borough Alternative Provision Schools to deliver training on trauma. A review is on-going to identify how better to integrate the YOS, IGU and Early Help services to improve co-ordination of resources and identify other funding and co-commissioning opportunities.

Location – Reducing high harm crime in Queens Park and Church Street wards and the West End.

Develop a joint area action plan for Church Street, Queen's Park ward and the West End to reduce high harm crimes and reduce vulnerability in this area driven by business intelligence;

The vulnerable localities index is a method used to identify priority neighbourhoods that are places experiencing high levels of crime in residential areas, alongside problems of deprivation and demographic factors that influence the area's poor sense of community cohesion. 100 is the average VLI for all wards across London. Church Street had the highest score in Westminster at 126, Queen's Park 125. Therefore we need to prioritise these wards to prevent these factors from limiting the chances of the people living there or creating a cycle of offending or victimisation.

We will work in partnership to improve the employment opportunities within these areas through maximising the referral opportunities from the Westminster Employment Service. Drug dealing is prominent in these areas and we will work to prioritise crack house closures within these areas and ensure that vulnerable people are supported.

Deprivation causes mental and physical health problems. Good, positive, mental health and emotional well-being has a protective and beneficial role leading to an improved quality of life.[5] We are therefore looking to pilot or test enhanced mental health provision within these priority wards linking into the work of the Health and Wellbeing Board.

The SWP recognises the importance of early intervention, so we will look to intervene early to low level ASB, through family support and joint visits to identify what parental support is available. In conjunction we will review how joined up our tasking processes are at police and the local authority, with the aim of maximising opportunities to intervene early with low risk issues to prevent escalation. We will ensure that these areas are prioritised through the problem solving and tasking meetings.

To support this we will undertake a gap analysis of youth provision in Queens Park and Church Street to raise awareness of locally available services.

To support growth and development we will work with Business Improvement Districts (BIDs) to encourage their business and land owners to invest locally in these areas.

Over half of all crime in Westminster occurs within two of the twenty wards, i.e. West End (29%) and St James's (23%). These two wards are also the highest crime wards in London accounting for 4% al all London's crime. Looking at crime at a lower geographical area i.e LSOA[6] you can see just how concentrated crime is. Just three LSOA's contain 28% of all crime across Westminster, two in West End Ward and one in St James's. Targeting resources in these three crime concentrated areas will have a significant impact upon reducing overall crime levels.

To address community concerns re open drugs markets in Soho we aim to understand the impact and what can be done to address this. The West End forms part of the Impact Zone and we will take forward recommendations from the recent Impact Zone review.

[5] https://www.mentalhealth.org.uk/sites/default/files/mental_health_resilience_inequalities_summary.pdf

[6] *LSOA = Lower Super Output Area is a geographic area that contains a mean population of 1,500.*

Design has an important role to play in preventing crime and reducing criminal activity without compromising the enjoyment and usability of products, places and services by legitimate users. For it to be most effective, crime prevention needs to be designed-in at the start of a project. If designers consider the ways in which the object, systems or environments they are designing might be susceptible to crime early in the design process, they can prevent crime from occurring, or at least reduce the opportunities for offender behaviour. We will work with planning to ensure this is prioritised within these vulnerable areas.

Information sharing is fundamental to achieving all of this so we will review our information sharing agreements to see how effective we are as a partnership at sharing day to day information in a timely fashion. This will include developing a portal to facilitate information sharing across the partnership on Community Protection Notices (CPNs). CPN's aim to prevent unreasonable behaviour that is having a negative impact on the local community's quality of life.

To support some of this work we will link into the Young Westminster Foundation to look for opportunities for additional resources.

Counter Terrorism – Enhancing the partnership response to countering terrorism.

The national security threat level for International Terrorism remains at severe meaning an attack is highly likely. Islamist terrorism has remained the principal threat. The recent horrific terror attacks in the UK including Westminster reinforces why we need to work in partnership to mitigate this risk.

The local delivery of counter-terrorism activity follows CONTEST, the Government's counter-terrorism strategy. CONTEST is based on 4 areas of work:

- Pursue: to stop terrorist attacks;
- Protect: to strengthen our protection against a terrorist attack;
- Prepare: to mitigate the impact of a terrorist attack;
- Prevent: to stop people becoming terrorists or supporting terrorism;

Pursue

The aim of pursue is to stop terrorist attacks. This means detecting and investigating threats at the earliest possible stage, disrupting terrorist activity before it can endanger the public and, wherever possible, prosecuting those responsible. The police are the lead agency responsible for delivery of this strand of work.

Protect

Understanding the threat we all face and of the ways we can mitigate it can help keep us safer. Everyone can play a role in this effort by taking steps to help boost their protective security whether that's at work, at home or away; when travelling, when out and about or just simply when online. Having better security for all these areas makes it harder for terrorists to plan and carry out attacks. It also helps reduce the risk of other threats such as organised crime[7]. Much of the partnership's activity in this area is to inform, advise and support others regarding the local threat picture and on ways in which they can develop and maintain plans to reduce or mitigate their vulnerabilities.

We will work to provide advice and guidance to businesses and other organisations around the terrorist threat and on the importance of having appropriate security plans.

We will proactively work with locations considered to be more vulnerable in order to review their protective security and advise on measures that may mitigate or reduce those vulnerabilities.

We will develop a local Protect plan for the threat-led deployment of police and other resources.

Prepare

The purpose of prepare is to mitigate the impact of a terrorist attack where that attack cannot be stopped. This includes work to bring a terrorist attack to an end and to increase our resilience so we can recover from its aftermath. An effective and efficient response will save lives reduce harm and aid recovery.

We will continue to increase awareness of Westminster's Emergency Planning Procedures through training a wider group of officers and delivery training exercise to test that knowledge.

[7] NACTSO (2017) 'Crowded Places Guidance for the UK'

Ceremonial plans will be updated including carrying out inspections of the routes to ensure no changes to the street scape will impact on the plan when implemented and undertaking a table top exercise.

Awareness training will be delivered to the London Fire Brigade to ensure they have a better understanding of the role of Westminster City Council at an incident.

A clear strategy will be developed for the testing of Business Continuity Plans and Executive Business Impact Assessments, this will include working regularly with business continuity champions.

If required the Chief Executive will be provided with support in his role of London Local Authority Gold. A call out rota will be created to detail who will be required to support the Chief during his period as London Local Authority Gold.

Prevent

Prevent aims to stop people becoming terrorists or supporting terrorism, in all its forms. Prevent works at the pre-criminal stage, using early intervention to encourage and empower individuals and communities to challenge extremist and terrorist ideology and behaviour. The delivery of Prevent is led by local authorities. In delivering the strategy in Westminster, staff work closely with a wide range of sectors and institutions; these include but are not limited to: education, criminal justice, faith, charities and government departments, in addition to community organisations. Vulnerability to radicalisation and extremism is not limited to any particular part of Westminster's diverse communities and Prevent is concerned with all types of extremism. Local delivery of the Prevent Strategy is focused on the local threat picture and on local needs and vulnerabilities.

We will commission a range of projects in order to support and empower Westminster's communities. These projects are designed to address the Prevent Strategy objectives (above) but often also address wider needs and vulnerabilities.

Through community engagement activity, we will continue to build and strengthen our understanding of Westminster's diverse communities and also develop partnerships with local community and charitable organisations.

We will support Westminster's institutions in the delivery of Prevent, providing advice, guidance and training.

Through the Channel and wider Prevent safeguarding processes, we will work closely as a partnership to support and safeguard individuals potentially vulnerable to extremism or radicalisation.

Appendix Action plans

Victim

Chair Interim, Sara Sutton

Aim ***Identifying and working with repeat victims to reduce their vulnerability.***

Cross Cutting Principles ***Intervening early with families and young people to reduce their risk of victimisation and prevent offending.***

Working in collaboration with partners to focus on the key contributing factors that reduce victimisation and offending.

	Objectives	Actions	Lead	KPI	Deadline
1	Improving co-ordination across the partnership to identify all repeat victims and ensure they have access to appropriate services;	Development of a minimum set of standards for housing providers for dealing with victims of crime and ASB	Serena Simon	# of housing providers signed up to standard	Mar-18
		Ensure processes are in place to identify repeat victims of crime and ASB and to offer additional support as appropriate	Serena Simon / Adam Taylor	Repeat victimisation levels	Mar-18
2	Provide bespoke support to those most at risk of domestic violence to reduce high levels of repeat victimisation	Continue to provide a multi-agency response to high risk / high need victims of domestic and sexual violence through the MARAC process	Adam Taylor	Safelives monitoring data	Quarterly reporting
		Continue to provide a specialist response to victims of all forms of violence against women & girls through the Angelou Partnership	Adam Taylor	Women report increased physical safety and /or psychological safety and feelings of safety as measured by exit surveys/ closing assessments	Quarterly reporting
		Review of contractual options for VAWG as a result of changes in LCPF and potential co-commissioning funds.	Adam Taylor	Sustain services through to 2021	Annual review
3	Provide bespoke support to vulnerable young victims i.e. those aged under 24 who are at risk of serious youth violence.	Improve linkages between SWP commissioned work with victims and victims support - including ASB, IGU, and VAWG	Serena Simon / Adam Taylor / Victim Support	Referral levels between commissioned services and victim support	Nov-17
		Young womens advocate to support young women affected by gangs.	Serena Simon	KPI from the service	Quarterly reporting
4	Gain a greater understanding of the level and quality of pan London provision for victims in Westminster	Victim support to provide quarterly Westminster data to the Group incorporating demographics of those accessing services to support the production of the Strategic Assessment.	Victim Support	Victim support service user data	Quarterly reporting
		Produce a directory of victims services for partners and agencies to access to raise awareness of services available.	Serena Simon	Directory published	Dec-17
		Lobby MOPAC for performance data from Victim services they commisison.	Adam Taylor	TBD	Mar-18
5	Review the SWPs compliance with the Victims Code of Practice	Assess how each agency is performing and identify any gaps or performance issues.	Serena Simon	Number of complaints received.	Mar-18
		Improve victim journey by ensuring accurate and timely information sharing, and clarity of peoples roles and responsibilities.	Serena Simon / Adam Taylor	Public attitude survey	Quarterly
		Improve the victim journey at the initial point of contact assessing all vulnerabilities and identifying the most appropriate agency as lead.	Serena Simon / Adam Taylor	TBD	Mar-18
		Explore the option of peer support to increase victim engagement in the CJS.	Serena Simon	TBD	Mar-18
		Improve Tri-borough legal knowledge of ASB cases to ensure prompt action.	Serena Simon	TBD	Mar-18
6	Early intervention to prevent victimisation	Ensure victim based support across schools is joined up.	Adam Taylor / Serena Simon / Richard Stanley	Number of young people accessing support services	Sep-17
		Ensure partners understand the thresholds of referrals for safeguarding.	Angela Flahive	Take-up of training by community safety partners	Mar-18
		Deliver crime prevention messages to older population to prevent vicitmisation of theft and fraud.	Trading standards		Ongoing
		Explore the use of civil interventions to people exploiting vulnerable people	Serena Simon		Mar-18
		Discuss with communications and planning the using of signage to prevent victimisation in high victimisation areas.	Mick Smith		Nov-18

Offender

	Chair	**Jess Ruddell**			
	Aim	***Working with the most problematic offenders to reduce their re-offending***			
	Cross Cutting Principles	***Intervening early with families and young people to reduce their risk of victimisation and prevent offending.***			
		Working in collaboration with partners to focus on the key contributing factors that reduce victimisation and offending.			
	Objectives	**Actions**	**Lead**	**KPI**	**Deadline**
1	Ensure adequate commissioned services for the most prolific and vulnerable offenders to address their criminogenic needs, in particular around substance misuse and accommodation	Continue funding Starting Over to provide 2 key workers and 1/3 housing worker to provide additional support to members of the IOM cohort who have health and social care needs.	Angela Lambillion	A reduction in charge data by what %? Up to 30 clients are engaged at any one time. Number of housing needs met	31/03/2018
		Using MOPAC LCPF provide Employment Training & Education support in partnership with Westminster Employment Service.	Angela Lambillion	A KPI from the service	31/03/2018
		A review of the partnerships commissioned services to support offenders to ensure no duplication of services and identify any gaps in provision.	Angela Lambillion	Review complete	31/10/2017
		Provide a comprehensive list of services available within Westminster to support offenders	Angela Lambillion	List complete	30/06/2017
2	Provide bespoke support to vulnerable young offenders i.e. those aged under 24 who are at risk of or are committing serious youth violence.	Fund a youth resettlement worker to work with young offenders sentenced to custody or on remand in custodial institutions to improve ETE and resettlement into the community with support from peer mentors.	YOS	Reduce the use of custody for all young people in the borough. % accessing ETE	31/03/2018
		Fund youth outreach workers to assess, engage and motivate young people to access support.	IGU	Reduction in serious youth violence, robbery reduction in level of concern about gang and gang violence.	31/03/2018
		Commission Gang Exit provision - an ex offender from St Giles to assist exiting young people from gangs or from preventing them being caught up in this lifestyle.	IGU	A target from the commissioned service	31/03/2018
		Employment Support – A dedicated family and children's employment coach to support young people into training and employment	IGU	A target from the commissioned service	31/03/2018
		Mental Health support – part time support from a mental health nurse in CAMHS to support young people who have experienced trauma	IGU	A target from the commissioned service	31/03/2018

3	Improve offender cohort co-ordination to ensure clarity of partners roles and responsibilities and gain a greater understanding of what works	Develop a standardised performance framework to assess the effectiveness of the cohort management and to report quarterly into the offender board.	Iain Keating/Lilly Harrington/Angela Lambillion	Use IDIOM - reduction in charge rates, reduction in severity and frequency of offending.	30/09/2017
		Increase the number of officers trained in IDIOM	Claire Kelland	Number of officers trained	31/08/2017
		Recruitment of an Offender Co-ordinator to review and analyse all offender related data in particular around offender cohorts and commissioned services.	Angela Lambillion	Post recruited to	31/10/2017
		Quarterly performance reports to be produced to inform the offender delivery group.	Offender co-ordinator	Performance reports produced	In line with meeting dates
		Process maps and procedures to be developed to show clear pathways and responsibilities for each of the cohorts and that appropriate Information Sharing Protocols are in place. Minimise agency involvement with individuals. Identify key contributing factors to establish who the lead agency should be.	Iain Keating/Lilly Harrington/Angela Lambillion	Clear process maps and procedures shared with partners.	30/09/2017
		All groups to review membership Terms of Reference and to track attendance of agencies at: MAPPA, IOM, GMAP.	Chairs of MAPPA, IOM and GMAP	Review complete by July meeting. Feedback to quarterly meetings of agency non attendees	31/03/2018
		Monthly/quarterly checks to be made to assess the overlap of all offender (and victim?) cohorts including; IOM, Gangs, MAPPA, YOS, Missing Children, MACE, MARAC, Unite, ASB, Channel?	Offender co-ordinator	Monthly/quarterly report produced and circulated to key individuals.	31/03/2018
		Review of pathways/referrals between MAPPA and MARAC to ensure agencies are aware of/monitor violent offenders who are not on license.	MARAC & MAPPA chairs	Review complete	31/08/2017
		Review of ASB - CBO and CPN processes across the partnership to ensure they are aligned.	Police who?/Serena Simon/Claire Hardy	Review complete	31/10/2017
4	Explore and tackle the issue of cross border and foreign national offending in Westminster, utilising every possible funding opportunity;	Explore use of MOPAC co-commissioning pot to lead on work to address cross border offending.	Angela Lambillion/Adam Taylor	Review complete	30/09/2017
		Bid to Controlling Migration Fund to secure additional funds to support work of Operation Unite.	?		
		Identify other potential funds to support the work to reduce re-offending.	Angela Lambillion	Funding identified	31/03/2018
5	Intervening early with young offenders at risk or in the criminal justice system to prevent future criminality	Work with schools in particular TBAP to identify those at greatest risk of offending. Training to be delivered to TBAP on trauma.	?	Reduction in truancy levels	
		Work with young people identified witih key risks to offending i.e. LAC, child in need. How does this link into work of Early Help?	Early Help		
		Review how better to integrate our YOS, IGU and Early Help services to improve co-ordination of resources and identify other funding and co-commissioning opportunites.	YOS/IGU/Early Help	Review complete	
		Due to an increase in younger people involvement in the CJS YOS to undertake a mapping exercise to identify who/where across the partnership manages this risk. Journey map 10 young people.	Kiran Hayer	Mapping complete	30/06/2017

Location

Chair Ian Hennessy

Aim ***Reducing high harm crime in Church Street and Queen's Park wards and the West End.***

Cross Cutting Principles ***Intervening early with families and young people to reduce their risk of victimisation and prevent offending.***

Working in collaboration with partners to focus on the key contributing factors that reduce victimisation and offending.

	Objectives	Actions	Lead	KPI	Deadline
1	Working in partnership to reduce the vulnerabilities in Church Street, Queens Park and the West End	To improve employment opportunities and maximise referral opportunities promote the Westminster Employment Service within Queens Park and Church Street wards. A briefing session arranged to key partners.	Beth Coyne	KPI's for the Church Street employment service are 65 programme starts, 30 interims and 25 job starts.	Dec-17
		Metropolitan Police Service to prioritise Crack House Closures in Queens Park and Church Street and ensure vulnerable people are supported.	Police	Number of closures.	Jul-17
		Pilot or test enhanced mental health provision within these priority wards, through linking in with the work of the Health and Wellbeing Board. Generate funding to provide support. Or commission support.	Ezra Wallace (awaiting confirmation)	Awaiting confirmation	Mar-18
		Deliver training to MPS, CWH, Residential Services, City and West End Operations managers and produce ASB protocols to deal with low level behaviour.	Serena Simon	Training sessions delivered. Protocol produced.	Aug-17
		Intervene early to low level threshold ASB, through family support and joint visits to identify what parental support is available.	Terry Abbot City West Homes Clare Hardy	No of interventions	Mar-18
		Link into the Young Westminster Foundation to look for opportunities for additional resources.	Adam Taylor/Angela Lambillion/Mark Chalmers	Links made	Oct-17
		Corporate social responsibility - interest from BIDs to ensourage their business and land owners to invest locally.	Mommna Nasir	Investment made	Sep-17
		Work to address community concerns re open drugs markets in soho, to understand the impact and what can be done to address this.	Steve Manger	Reduction in community concern?	Jul-17
		Take forward recommendations from the Impact Zone review that require greater partnership response.	Steve Manger	Recommendations completed	Jul-17
		What can we do as a partneship to support the work of the West End Partnership?	Richard Cressey	Activity delivered	Sep-17
		Review how tasking processes are joint up at police and local authority. To maximise opportunites to intervene early with low risk issues to prevent escalation.	Mick Smith Steve Manger	Review undertaken	Oct-17
		Effective ASB case management across the partnership which support ASB protocols	Serena Simon Clare Hardy	No of cases logged	Sep-17
		Review of information sharing agreements and how effective we are at sharing day to day information in a timely fashion.	Adam Taylor	Review undertaken and ISA's established	Oct-17
		Ensure priority areas are prioritised through problem solving and tasking meetings.	Ian Hennessy	Number of problems successfully delivered. Compare number of actions in vulnerable areas with those not.	Mar-18
		Gap analysis to review youth provision within Queens Park and Church Street and raise awaresness locally of services available. Provide recommendations to SWP.	Jayne Vertkin	Report produced.	Before school summer holidays
		Business Crime Reduction Partnership event - educating and information sharing with business on crime reduction initiatives.	Greg Ward	Businesses informed	Mar-18
		Develop a portal to ensure information is shared across the partnership on CPN's	Clare Hardy	Portal developed	Sep-17
		Develop seasonal joined up plans to reflect partnership activity in particular in the vulnerable areas.	Steve Manger	Plans developed	Before school summer holidays
		Designing out crime - review with planning the process this is done to enusre is undertaken in vulnerable areas. Link into the refreshed City Paln.	Patrick Ransom	Plans delivered and activity undertaken	Dec-17

Contest

Chair Mick Smith

Aim *Enhancing the partnership response to countering terrorism*

Cross Cutting Principles *Intervening early with families and young people to reduce their risk of victimisation and prevent offending.*

Working in collaboration with partners to focus on the key contributing factors that reduce victimisation and offending.

	Objectives	Actions	Lead	KPI	Deadline
	Protect				
1	We will work to provide advice and guidance to businesses and other organisations around the terrorist threat and on the importance of having appropriate security plans.	Deliver Project Griffin CT Awareness Training Sessions	Mick Wright	Number of Sessions Number of people trained	31/03/2018
		Deliver Project Argus CT Awareness Sessions	Mick Wright	Number of Sessions Number of organisations trained	31/03/2018
		Review current activity regarding security and awareness raising for businesses and organisations, identifying areas for improvement	Mick Wright, Mike Wilkins		30/09/2017
		Develop and deliver an action plan for improving awareness raising amongst businesses and organisations	Mick Wright, Mike Wilkins		31/03/2018
2	We will proactively work with locations considered to be more vulnerable in order to review protective security and advise on measures that may mitigate or reduce those vulnerabilities.	Undertake security assessments of all sites identified as vulnerable, providing site owners with detailed reports and recommendations	Mick Smith	Percentage of site assessments completed	31/03/2018
		Develop Council processes for the consideration of service requests in relation to protective security, producing and delivering an action plan to improve those processes.	Mick Smith	N/A	31/03/2018
		Work as a partnership to consider, and if appropriate implement, measures to improve the protective security of the public realm	Mick Smith	N/A	31/03/2018
3	We will develop a local Protect plan for the threat-led deployment of police and other resources.	Produce a monthly threat assessment	Mick Wright	N/A	Monthly
		Review deployments of PSO and other resouces on a monthly basis	Mick Wright	Number of Stop & Search Number of Stop & Account Number of s43 Stops Suspect Package Calls CT Intelligence Reports Number of vehicle stops	Monthly
		Review deployments and activity in light of significant changes in threat or attack methodology	Mick Wright	N/A	On Exception
	Prepare				
1	Increase awareness of Westminster's Emergency Planning Procedures	Carryout internal Emergency Planning training to a wider group of officers at all levels (Strategic, Tactical and Oeprational)	Peter Reeves		31/03/2018
		Following on from the training deliver sufficient exercises to test the training and understaning of the City Council's Emergency Response Plans	Gareth Morgan		31/03/2018
		Carryout a specific exercise in relation to the Local Disaster Mortuary Plan	Mike Wilkins		30/11/2018
2	Update Royal Ceremonial Plans	Ensure the service plans are up to date in line with any changes to the Ceremonial Plans.	Mick Smith / Peter Reeves		On going
		Attend Multi Agency Planning meetings to maintain awareness of changes throughout the year at all levels.	Mick Smith / Peter Reeves		On Going
		Carryout inspections of the routes to ensure no changes to the street scape will impact on the plan when implemented.	Peter Reeves / Gareth Morgan		July / November / March
		Meet with service leads to ensure plans are up to date.	Mick Smith / Peter Reeves		June / December
		Carryout a minimum of one tabletop exercise per year involving all service leads.	Peter Reeves		30/06/2017
3	Deliver Awareness Training to the London Fire Brigade	Arrange with the Station Managers of Paddington, Soho, Lambeth and Kensington Fire Stations to arrange awareness training to the Watch Managers at each station to have a better understating of the role of Westminster City Council at an incident.	Peter Reeves		31/07/2017
4	Develop a clear strategy for the testing of	Work with Business Continuity Champions to ensure EBI's are in place, up to date and that there is an understanding across the service area of their BC responsibilities.	Stephen Ansah		31/10/2017
		Hold regular Business Continuity Champions Meetings	Stephen Ansah		Quarterly
		carryout at least one exercise a year involving all service areas	Stephen Ansah		31/03/2018
5	Support the Chief Executive in his role of London Local Authority Gold	Provide Effective Support to the CEO if called out as LLAG	Peter Reeves		
		Ensure an a call out rota is created and shared with relevanty officers who will be required to support the CEO during his period as LLAG	Peter Reeves		08/06/2017

	Prevent				
1	Commission a range of projects in order to support and empower Westminster's communities.				
2	Build and strengthen our understanding of Westminster's diverse communities and also develop partnerships with local community and charitable organisations.				
3	Support Westminster's institutions in the delivery of Prevent, providing advice, guidance and training.				
4	Support and safeguard individuals potentially vulnerable to extremism or radicalisation.				

City of Westminster

Westminster Health & Wellbeing Board

Date:	18th January 2017
Classification:	**General Release**
Title:	Suicide Prevention Action Plan 2018 -2021
Report of:	Public Health Department
Wards Involved:	All
Policy Context:	In January 2017 the third progress report of the cross-government suicide prevention strategy included an update to the 2012 strategy. One of the areas for action was better and more consistent local planning and action by ensuring every local area has a multi-agency suicide prevention plan, with agreed priorities and actions. Westminster has an existing multi-agency suicide prevention action plan and the document brought forward for consideration is a refreshed action plan.
Financial Summary:	N/A
Report Author and Contact Details:	Elizabeth Dunsford Senior Strategic Relationships and Outcomes Officer edunsford@westminster.gov.uk Tel; 020 7641 4655

1. Executive Summary

1.1 This is the second suicide prevention action plan for Hammersmith & Fulham, Kensington and Chelsea, City of Westminster and it seeks to build on the progress made so far.

1.2 The document includes a summary of progress made under the current action plan, a refresh of the analysis of the data and a new 3-year action plan. The development of this multi-agency plan has been led by public health with the suicide prevention working group and was consulted on at a multi-agency stakeholder event in November.

1.3 The working draft action plan is brought before the Health and Wellbeing Board for their comment and steer. Subject to any amendments required, the action plan will

then proceed for the endorsement of the action plan at the March meeting of the board.

2. Key Matters for the Board

2.1 The board are requested to provide comment and steer on the draft action plan and in particular:

2.1.1 Does the report include the correct priorities?

2.1.2 Will the actions deliver a reduction in the number of suicides?

2.1.3 Are there organisations or actions missing from the plan?

2.1.4 Is there capacity to deliver on this plan?

2.1.5 The plan requires sub-regional work coordinated by Like Minded on setting up suicide surveillance systems and the cooperation of the other boroughs in North West London.

2.1.6 The plan requires engaging Thrive LDN and the GLA in taking leadership on working with the media on responsible reporting.

3. Background

3.1 This is the second suicide prevention action plan for Hammersmith & Fulham, Kensington and Chelsea, City of Westminster and it seeks to build on the progress made so far.

3.2 Work to prevent suicide in the three boroughs is co-dependant on existing and developing work to promote good mental health, in particular amongst men, young people and minorities.

3.3 The last Annual Report from the Director of Public Health took mental health as its focus. Key recommendations from that report on the production of a mental health JSNA and subsequently the development of a mental health strategy will be essential elements in achievement of effective, long term, upstream suicide prevention.

4. Options / Considerations

4.1 *See section 2.1*

5. Legal Implications

5.1 Not applicable

6. Financial Implications

6.1 Not applicable

APPENDICES:

TOWARDS ZERO SUICIDE; A SUICIDE PREVENTION NETWORK ACTION PLAN (draft version 7) for London Borough of Hammersmith & Fulham, Royal Borough of Kensington and Chelsea, City of Westminster 2018-2021

BACKGROUND PAPERS:

Suicide prevention: developing a local action plan, published by Public Health England in 2016.
https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

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TOWARDS ZERO SUICIDE

A SUICIDE PREVENTION NETWORK ACTION PLAN (draft version 8)

for

London Borough of Hammersmith & Fulham,

Royal Borough of Kensington and Chelsea,

City of Westminster

2018-2021

Contents

Foreword

My annual report for 2016/2017 focused on the importance of protecting and improving our own mental wellbeing, and that of the people around us – our families, friends, neighbours, and local community.

Good mental wellbeing is important for us to lead happy, healthy lives. It is often defined as 'feeling good' and 'functioning well' – so is not only about feeling happy or content, but also about how we cope and engage in the world around us.

The costs of suicide to families and wider society are significant. A conservative estimate is that for every person who dies at least 10 people are directly affected. The economic cost of each death by suicide of someone of working age is estimated to be £1.67 million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering.

At the consultation event held in November 2017 for this suicide prevention action plan, Sarah Anderson from the Listening Place summed up the challenge we have before us as follows:

"People who die by suicide don't want to die, they just cannot bear the idea of continuing to live feeling the way they do."

There is good evidence to show that suicide is preventable. It will require the combined efforts of health and social care, voluntary and private sector organisations which are detailed in this plan. But it will also require the mobilisation of families, friends, neighbours and local community so that each and every one of us feel valued and supported in both the good and bad times of our lives.

Dr Mike Robinson
Director of Public Health

1.0 Background

Every day in England around 13 people take their own lives. The effects can reach into every community and have a devastating impact on families, friends, colleagues and others. Each one of these deaths is a tragedy. Preventing suicide requires the combined actions by local authorities, mental health and health care services, primary care, community based organisations and voluntary agencies, employers, schools, colleges and universities, the police, transport services, prisons and others.

Local Authorities are well placed to prevent suicide because their work on public health addresses many of the risk factors, such as alcohol and drug misuse, and spans efforts to address wider determinants of health such as employment and housing. There are also important and varied opportunities to reach local people who are not in contact with health services through on-line initiatives or working with the third sector. To this end Hammersmith & Fulham, Kensington and Chelsea, City of Westminster councils commit to coordinating the suicide prevention strategy in their boroughs and in particular building the partnership of organisations to work together on this important agenda. Accountability for the suicide prevention strategy and its associated action plan lies with the health and wellbeing boards of the respective boroughs.

The first suicide prevention action plan for Hammersmith & Fulham, Kensington and Chelsea, City of Westminster was published in 2013. This second suicide prevention action plan seeks to build on the progress made so far. Work to prevent suicide in the three boroughs is co-dependant on existing and developing work to promote good mental health, in particular amongst men, young people and minorities. The last Annual Report from the Director of Public Health took mental health as its focus. A key recommendation from that report was the production of a mental health JSNA and subsequently the development of a mental health strategy. The actions from the mental health strategy will deliver the wider work to achieve of effective, long term, upstream suicide prevention, which are outside the scope of this action plan.

Both this action plan and the future mental health strategy will seek to capitalise on Thrive LDN which is supported by the Mayor of London. It strives for London to be:

1. A city where individuals and communities are in the lead
2. A city free from mental health stigma and discrimination
3. A city that maximizes the potential of children and young people
4. A city with a happy, healthy and productive workforce
5. A city with services that are there when and where needed
6. A zero suicide city

2.0 How this Action Plan has been Developed

The production of this action plan has been overseen by the multi-agency Suicide Prevention Working Group which has representation from mental health trusts, the local authority public health department, third sector and the CCGs. Its development has been informed by the Public Health England guidance, Local Suicide Prevention Planning-a practice resource, Oct 2016 and through two local multi-agency discussions, one held in January 2017 and one held in November 2017. A working draft is being presented to the Health and Wellbeing Boards for their comment and steer with the intention of bringing a final document back for ratification in May 2018.

3.0 10 things that everyone needs to know about suicide prevention[1]

The effects of suicide can reach into every community and have a devastating impact on families, friends, colleagues and others.

1. Suicides take a high toll

There were 4,575 deaths from suicide registered in England in 2016 and for every person who dies at least 10 people are directly affected.

2. There are specific groups of people at higher risk of suicide

Three in four deaths by suicide are by men. The highest suicide rate in England is among men aged 45-49. People in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic areas group living in the most affluent areas.

3. There are specific factors that increase the risk of suicide

The strongest identified predictor of suicide is previous episodes of self-harm. Mental ill-health and substance misuse also contributes to many suicides. Suicide prevention strategies must consider and link to programmes of early identification and effective management of self-harm, mental ill-health and substance misuse.

4. Preventing suicide is achievable

The delivery of a comprehensive strategy is effective in reducing deaths by suicide through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. Directors of public health and health and wellbeing boards have a central role. Their involvement is crucial in co-ordinating local suicide prevention efforts and making sure every area has a strategy in place.

5 Suicide is everybody's business

A whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play. Suicide prevention can also be part of work addressing the wider determinants of health and wellbeing.

[1] Local Suicide Prevention Planning-a practice resource, Oct 2016, PHE

6. Restricting access to the means for suicide works

This is one of the most evidenced aspects of suicide prevention and can include physical restriction, as well as improving opportunities for intervention.

7. Supporting people bereaved by suicide is an important component of suicide prevention strategies.

Compared with people bereaved through other causes, individuals bereaved by suicide have an increased risk of suicide and suicidal ideation, depression, psychiatric admission as well as poor social functioning.

8. Responsible media reporting is critical

Research shows that inappropriate reporting of suicide may lead to imitative or copycat behaviour.

9. The social and economic cost of suicide is substantial and adds to the case for suicide prevention work.

The economic cost of each death by suicide of someone of working aged is estimated to be £1.67million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings and the intangible costs associated with pain, grief and suffering.

10. Local suicide prevention strategies must be informed by evidence

Local government should consider the national evidence alongside local data and information to ensure local needs are addressed.

4.0 2013-18 Suicide Prevention Progress Review

This suicide prevention network action plan builds on the action plan from the 2013-18 suicide prevention strategy which had four overarching goals:

- Timely communication and information sharing between agencies on identification of at risk individuals and care pathways.
- Public education and awareness of suicide and/ or mental health promotion through community outreach, anti-stigma campaigns etc.
- Promotion of existing suicide prevention resources, interventions and support services e.g. the Maytree Respite Centre, telephone helplines operated by the Samaritans or Campaign Against Living Miserably (CALM)
- Priority training for frontline workers (GPs, A&E and concerned others) through programmes like mental health first aid or applied suicide intervention skills training.

Highlights of progress against the 2013-18 action plan are detailed below and include training from front line workers, mental health trusts developing their own action plans and the completion of a coroner's audit. Challenges have included information sharing about services. Though a service mapping was conducted it was not published as planned on a website due to lack of resource. Engagement with employers to raise the issue of mental health and suicide was also attempted but was not successful and it was decided that a better vehicle would be the Healthy Workplace Charter.

Highlights from Multi-agencies

NWL Collaborative of Clinical Commissioning Group's Training programme

Suicide awareness training and suicide intervention training was commissioned by Central London Clinical Commissioning Group on behalf of the three boroughs. The first year was paid for by Central London Clinical Commissioning Group, the second year by Hammersmith and Fulham Clinical Commissioning Group.

There were two face-to-face courses for clinicians and front line staff – one 'lite' half day course and a more comprehensive full day course.

A train the trainer course has been run in 2017 to train GPs to provide suicide intervention training in the future. In addition, an eLearning course has also been commissioned with 700 places available. This will be rolled out in the near future for GPs, their front line staff and voluntary sector workers.

The training delivered so far has been found to be successful in reaching out to all sectors. Therefore, in the action plan it is recommended that it continues alongside the Like Minded Mental Health Awareness training, particularly to community groups/members in the North Kensington area.

Public Health Commissioned Suicide Prevention

The Local Authority Public Health department currently commissions the Campaign Against Living Miserably (CALM): a service targeting men at risk of suicide which provides a telephone helpline and social marketing techniques to raise awareness of depression.

Coroner's Audit

A suicide audit of coroner's data was completed by Public Health in 2014 to improve our understanding of the population characteristics and circumstances of the cohort to improve targeting of prevention work. Findings from that audit are in included in section 5.

Children and young people

The Three Borough Local Safeguarding Children's Board completed a Task and Finish Group on preventing suicide with children and young people, by educating schools on the pathways and referral mechanisms and this was then included in the LSCB training programme.

British Transport Police (BTP)

The BTP published a new strategy "From Crisis to Care, A Strategy for Supporting People in Mental Health Crisis and Prevention Suicide on the Railway 2016-2019". It has 7 theme areas for action;

1. Data and analysis
2. Upstream prevention
3. Restricting access to means
4. Safeguarding and crisis care
5. Managing the consequences
6. Tackling suicide contagion
7. Enabling and education

The strategy recognises that the police have a role to play in responding to people in crisis and in referring vulnerable people to support services. The police also have responsibility to support local authorities in their multi-agency work to manage the risk of suicide, by dealing with threats, attempts and completed acts of suicide, and standardising their approach to the recording, management and sharing of data so that communities can be protected.

Metropolitan Police

The Metropolitan Police have focused on improving care whilst individuals are in custody firstly through comprehensive risk assessments for all detainees, by the custody sergeant and secondly ensuring access to mental and physical health care professionals in custody suites. The Metropolitan Police are implementing Dedicated Mental Health Liaison officers

in each area; working to highlight Protecting Vulnerable People (PVP) vulnerabilities with a view to partnership resolution; and working closer with BTP to assist suicide prevention.

Central & North West London NHS Foundation Trust and West London Mental Health Trust

The Central & North West London NHS Foundation Trust and West London Mental Health Trust made the progress against the four overarching goals of the 2013-18 Suicide Prevention Strategy. In addition, they worked on a fifth goal on targeted interventions for at risk groups.

Goal One: Timely communication and information sharing between agencies on identification of at risk individuals and care pathways

- All known Mental Health patients with acute or severe and enduring mental health problems (and their carers), who are at high-risk of self-harm or suicide, have their care co-ordinated through the Care Programme Approach

- A member of the clinical team completes a follow up contact within 7 days of discharge from acute mental health admission wards

- Home Treatment Teams have capacity to effectively follow-up high-risk patients discharged from acute mental health services in their homes.

- Both trusts have introduced the Single Point of Access and CNWL have Rapid Response Teams available 24 hours a day to assess and support those who have been referred by the Single Point of Access (SPA)

- Treatment plans include psycho-social interventions where appropriate, to comply with NICE Guidance.

- Teams follow the Care Act with a person-centred approach which has a recovery focus, so that the individual needs are met and collaborative working to ensure involved in decision making over care plans and safety planning. Families/carers are involved where possible as this supports safer care.

Goal 3: Promotion of existing suicide prevention resources, interventions or support services

Ligature risk assessments are now expected as part of inpatient mental wards and every ward have a Ligature Risk Management Plan. These are audited and as additional risks are identified these are mitigated and plans to address where possible. It is not possible to remove every risk, so staff have to understand how to manage the risks to low. These Ligature Risk Plans are reviewed in CQC inspections.

Goal 4: Training for frontline workers through programmes

Connecting with People is an evidence-based training package for all organisations working with people who are at risk of suicide. CNWL have trained 8 staff and are licensed to train other staff in the Trust over the next 3 years.

The Clinical Risk Training which is mandatory at WLMHT has been revised to enhance the focus on the assessment and management of suicide risk and guidance of use of clinical formulation

Goal 5: Targeted interventions for at risk groups (bereaved families, people from BME background, people with mental health issues, people known to mental health services, etc.).

- Risk training highlights the high risk groups identified in the National Confidential Inquiry (October 2016) e.g. men in middle age, LGBT who have recently migrated to this country in the last 5 years, recent moves from local geographical area, older adults and those who live alone – and the need to improve social support to reduce social isolation.

- Crisis plan, cards and relapse signatures are developed /completed with the service user so that they develop a safety plan and identify signs that can be highlighted to families/services should they become unwell and contact numbers for services.

- If a suicide occurs, In CNWL, a Family Liaison Officer is appointed to link with the family while the incident is investigated and to support them gaining access to relevant services. We offer support for bereaved families through Psychology Services, if required. In WLMHT, a clinician is appointed to liaise with and support the family, during the investigation and both trusts facilitate contact with CRUSE and would continue to support families after the event on an individual basis.

Multi-agency Suicide Prevention Working Group

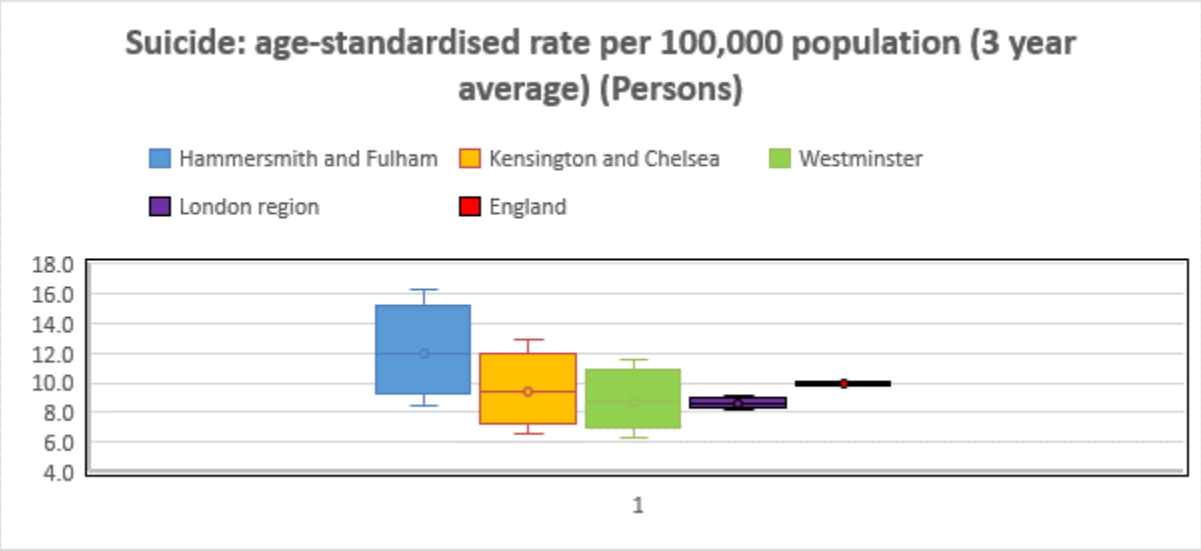
Since 2011 when the need for a multiagency approach and the development of a suicide prevention strategy was identified, Public Health established, lead and co-ordinated a multi-stakeholder Suicide Prevention Working Group across the three boroughs. This group had membership from voluntary sector, CCGs, the local authorities, mental health trusts and the Metropolitan and British Transport Police. Leadership of the group transferred to the CCGs in 2013. After an interregnum the group was reconvened in July 2017 by Public Health and it has met regularly to steer the production of this new action plan. The working group has no resources allocated to it at present.

5.0 The Local Need for Suicide Prevention Multiagency Plan

Suicide has a devastating social, emotional and economic impact and is a leading cause of years of life lost. A person who commits suicide in London typically loses 23 years of their life. For the Hammersmith and Fulham this is 28.2 years, Kensington and Chelsea 28.3 years, Westminster 25.5 years (source: Public Health England Suicide Prevention Profile[2]). This report gives an update on the latest suicide data published by the Office for National Statistics and Public Health England. It compares local suicide rates to the London and national average, reports on trends over time and compares suicide rates by age and sex.

In 2016 there were 12 suicides in Hammersmith and Fulham, 10 in Kensington and Chelsea and 10 in Westminster. The rates for Kensington and Chelsea and Westminster are similar to the London average. Rates in Hammersmith and Fulham are higher than the average for London (see Figure 1), but are not significant due to the small number of deaths. The suicide rate in Hammersmith and Fulham has been consistently higher than the London average over the last 14 years (see Figure 2).

Figure 1 Age standardised suicide rates, three year aggregate 2014-2016



Hammersmith and Fulham: 11.9 (95% confidence interval 8.4-16.3); Kensington and Chelsea: 9.3 (6.5-12.9); Westminster: 8.7 (6.3-11.6); London 8.7 (8.2-9.1); England: 9.9 (10.1-9.8)
Source: Office for National Statistics, Suicides in England and Wales by local authority, 2002 to 2016

The London suicide rate is significantly lower than the England average. While previously the suicide rate showed a downward trend in London (see Figure 2), in 2015 the number of suicides increased by 33% to 735 compared to 552 in 2014 (This is not seen on Figure 2 as this is graph shows a three year rolling average.) But the confidence intervals overlap so this may be due to chance. There has been no significant change over time in the suicide rates

[2] https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

for Hammersmith and Fulham, Kensington and Chelsea and Westminster as numbers are relatively small.

The following groups are at higher risk of death by suicide: men (15 to 59 years), looked after children, older people, black and minority ethnic communities, people with previous suicide attempts and people in crisis (for example bereaved by suicide, relationship breakdown, loss of employment). For further information, go to the JSNA. https://www.jsna.info/document/suicide-prevention.

Figure 2 Trend in age standardised suicide rates, three year aggregates 2001-2003 to 2013-2015

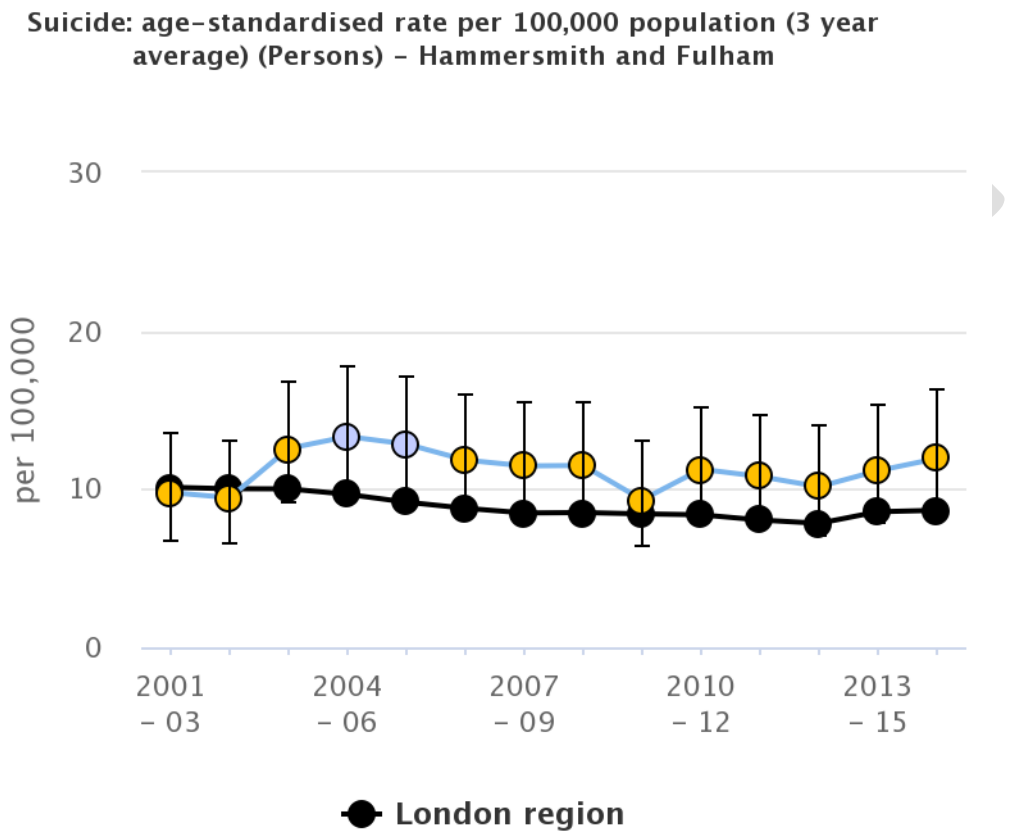
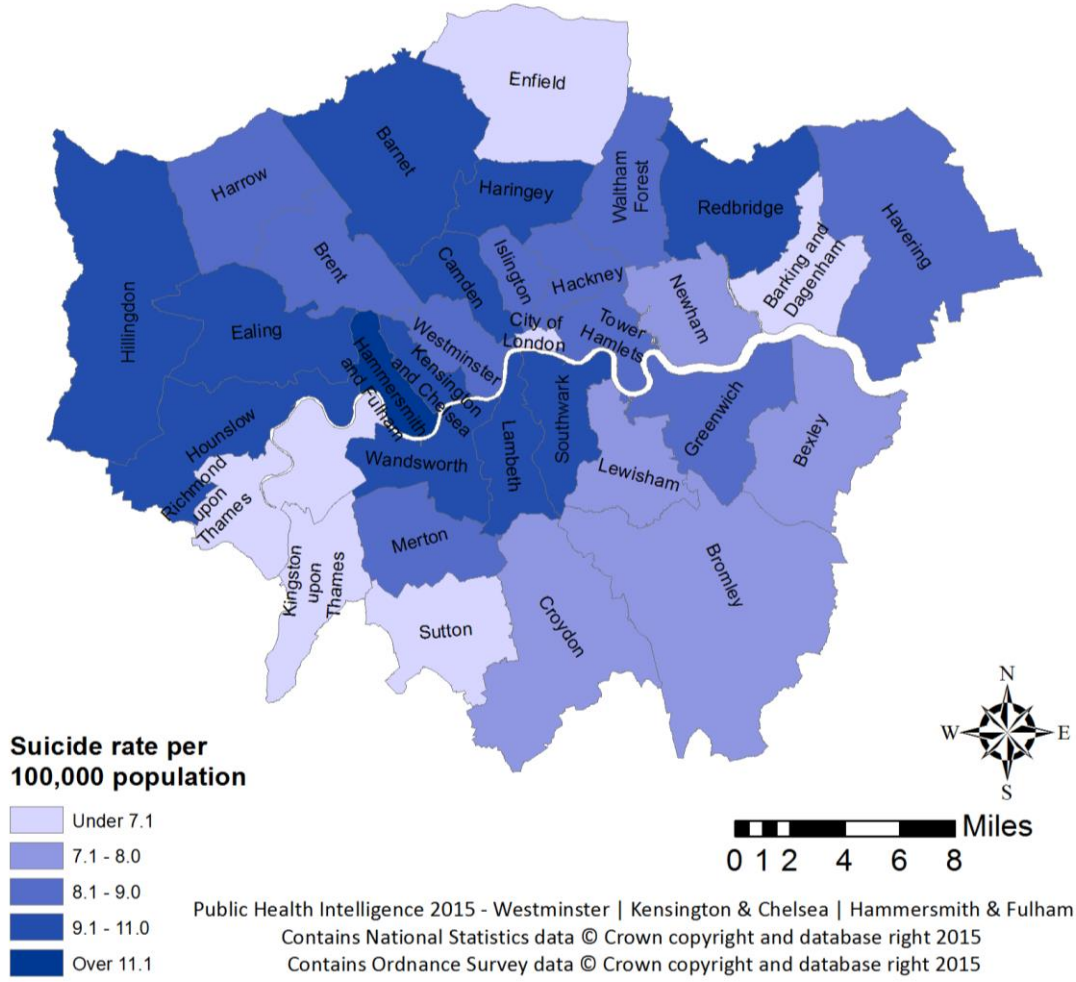


Figure 3 Variation in suicide rates among London Boroughs, three-year aggregate age-standardised rates 2014-2016



Note: none of the differences shown above are statistically significant

Source: taken from the London Assembly Health Committee data from the Office for National Statistics

Coroner's Audit Findings

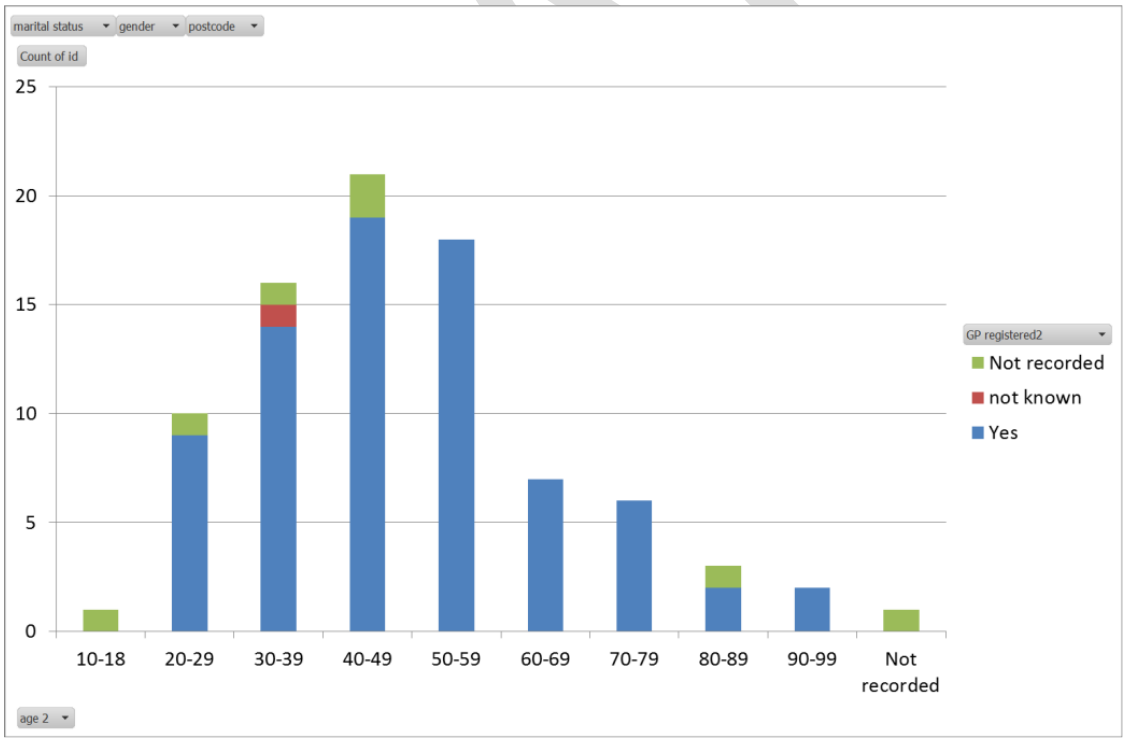
A suicide audit of coroner's data was completed by Public Health in 2014. The audit highlighted that the majority of deaths from suicides locally was attributable to men: 55 of the 85, with the majority being aged between 30-60 years of age. 95% of people who completed suicide were registered with a GP, showing that most deaths occurred amongst the registered resident population.

Though there is a high proportion of BME community groups in acute mental health services suicide rates are low. The breakdown of death by suicide according to ethnicity in the audit was Ethnicity Caucasian/White (78%) followed by Asian and Other (8%), mixed at 2% and black at 1%.

In general White, single, middle aged men; white, single, younger, females and white, married, middle aged women formed the majority of people who died by suicide.

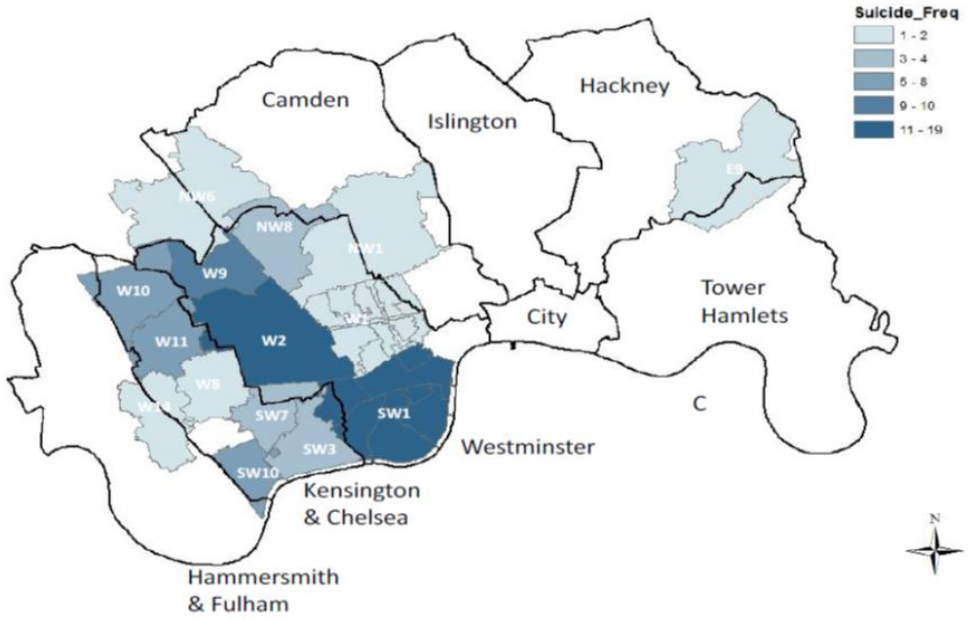
The audit has shown a high prevalence of suicides (83%) occurring at home, with a number of these known to housing services. Likewise, W2 and SW1 feature predominantly in complete suicide cases. However, these are small numbers.

Figure 5 Deaths by age and GP registration in Inner North West London



Source: Coroners Audit of Suicides in Inner North West London, 2014

Figure 6 Suicides Inner North West London Coroner – place of death mapped by postcode



Source: Coroners Audit of Suicides in Inner North West London, 2014

British Transport Police

The British Transport Police (BTP) collect data on suspected suicides, injurious attempts, and pre-suicidal/mental health incidents that have occurred on BTP jurisdiction. The data below is from the National Suicide, Pre-suicide and Mental Health Profile August 2017.

Figure 7 The number of pre-suicidal/mental health incidents, lifesaving interventions, s136[3] detentions and S136 detentions made by British Transport Police in 2016/17

	Pre Suicidal/Mental Health Incidents	Life-Saving Interventions	S136 Detentions	S136 Detentions (BTP)
Hammersmith and Fulham	45	10	16	12
Kensington and Chelsea	35	8	7	7
Westminster	278	33	126	111

When looking at the number of suspected suicides and injurious attempts per 100,000 of the population, the majority of areas with the highest rates tend to be in London (Camden, Westminster and Kingston upon Thames). With respect to the time of year, peaks were seen in April and October, whilst drop were seen in February and June. The largest proportion of incidents occurred on Monday, with fewer incidents occurring at the weekend. The largest

[3] Section 136 is part of the Mental Health Act. The police can use Section 136 to take a person to a place of safety if they think they have a mental illness and need care or control

proportion occurred in the morning period between 10.00 and 12.00 or in the evening period between 17.00 and 19.00. The most common risk factors for suicide on the railway include: a history of mental health issues (60.5%), alcohol and /or drug abuse (18.4%), relationship issues (10.7%) and family issues (7.5%).

London Underground has seen a notable increase in the number of suspected suicides over the past three years and is disproportionate to the rise in the total population of London. Part of this rising trend on London Underground relates to an increase in individuals under the age of 30. 2015/16 saw 15 individuals in suspected suicides or injurious attempts under the age of 30 whilst 2016/17 saw 25.

Summary

The data we currently have available indicates that there has been no significant decrease over time in the suicide rates for Hammersmith and Fulham, Kensington and Chelsea and Westminster. Therefore, the need for multi-agency action on prevention appears to be as great as ever. Men continue to make up the vast majority of those who die by suicide in the three boroughs. Therefore, the action plan includes priority focus on men. The rise is suspected suicides and injurious attempts in under 30 in London Underground is an area of concern and requires monitoring and investigation.

5.0 Priorities for the strategy

The priorities for the action for 2018 -2021 seek to build on the progress that has been undertaken to date, ensure that those gains are held and concentrate efforts on a limited number of achievable areas. Tackling suicide prevention will be an iterative process over the long term across many settings. Action will also be taking place on a number of levels, working with partners at London Region, at North West London and at borough level. Priority setting has been informed by local data, national guidance and through discussion in the Suicide Prevention Working Group and with the wider suicide prevention partnership of organisations including at a consultation event held on 7th November 2017.

The three borough level priorities areas for 2018-2021 are:

- Reducing risk in high-risk groups
- Tailoring approaches to improve mental health in specific groups
- Provide better information and support to those bereaved or affected by suicide
- Promotion of a multiagency approach

The North West London sub-regional priority area for 2018-21 is:

- Improving data collection and monitoring

The London Regional level priority area for 2018-21 is:

- Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

Indicators for Success

Indicators for success
-10% annual reduction in the overall suicide rate - At least 10% reduction in male suicide rate - Reduction in recorded attempted suicides - Reduction in self-harm (A&E attendances and hospital admissions)
Process Indicators
- Resources identified for delivery and oversight of Suicide Prevention Plan by March 2019 - Action plan agreed and signed off by the Hammersmith & Fulham, Kensington and Chelsea and City of Westminster Health and Wellbeing Boards by May 2018

Multi-agency Suicide Prevention Working Group

The Director of Public Health is the lead for suicide prevention in the Local Authority. He has established a suicide prevention working group. This is a multi-agency group that meets quarterly. A range of agencies operating in the area that have a strategic interest in promoting mental wellbeing are invited to the meeting. These include local NHS mental health trusts, London Underground, NHS acute trusts, local authority, public health, police (British Transport and Metropolitan), clinical commissioning groups, academic institutions, community providers. The working group also plans to include representation from families bereaved by suicide.

The group seeks to promote effective inter-agency working in communicating, managing and preventing suicide incidents in the three boroughs. The group will also take responsibility for monitoring the progress of the implementation of the Suicide Prevention Action Plan and report to the Health and Wellbeing Boards of the respective boroughs who are responsible for the strategy on an annual basis.

Links to the wider health and wellbeing agenda

Suicide is a complex issue and this prevention strategy recognises the importance of tackling factors that can lead to suicide in order to be most effective. With this in mind suicide prevention will need to be incorporated in other key strategies including:

- Mental Health JSNA
- Mental health and wellbeing strategies
- Sustainability and transformation plans
- Local transformation plans for children and young people's mental health and wellbeing
- Commissioning of alcohol and substance misuse service
- Commissioning of the adult mental health service and Child and Adolescent Mental Health Services (CAMHS)
- Adult social care commissioning
- Crisis Care Concordat action plan

A Suicide Prevention Plan for the population affected by the Grenfell Fire

A plan has been developed aiming to reduce the risk of suicide within the population affected by the Grenfell fire. It builds upon the offer already in place and sits within and is supported by the overall strategy for suicide prevention in the three boroughs.

All partners supporting the crisis and recovery response after the Grenfell Fire are very concerned about any potential risk for an increase in the number of suicides and attempted suicides, and the potential for the development of 'suicide clusters'. Whilst studies show different patterns of suicide mortality following natural disasters,[4] clearly every disaster is unique and potential outcomes difficult to predict. The Grenfell Mental Health Delivery Group will be responsible for coordinating the implementation of the Grenfell Suicide Prevention Action Plan, with reporting responsibility to the Grenfell Health and Wellbeing Subgroup of the Community and People Programme Board. The Grenfell Mental Health Delivery Group will work in close liaison with the Suicide Prevention Strategy Steering Group for the three boroughs, recognising that at times greater impacts can be achieved through working at a broader rather than local level.

NHS Mental Health Services

The two main providers of mental health services in the boroughs are West London Mental Health Trust for Hammersmith & Fulham and Central and North West Mental Health Trust for Kensington and Chelsea and the City of Westminster. Both trusts have their own suicide prevention plans in place and will provide annual progress reports to the Suicide Prevention Steering Group.

Summary

This document is a work in progress which has been developed through dialogue with key stakeholders, the Suicide Prevention Working Group. The outline priorities and actions were discussed added to at the Suicide Prevention Consultation event which was run on 7th November 2017 and attended by a wide range of partners including from health, police, the third sector and the local authorities.

Questions for the Health and Wellbeing Board are:

- Have we got the right priorities?
- Have we got the right actions to deliver improvements against the identified priority areas?
- Are we tackling actions in the right order and with appropriate/feasible timescales?
- Are there sufficient resources available to deliver this action plan particularly from the Public Health Department? What other resources will be required or can be offered?

[4] http://www.wageningenacademic.com/doi/abs/10.3920/978-90-8686-806-3_8

7.0 Suicide Prevention Action Plan

This action plan contains actions already underway or whose funding has been signed off as well as ideas proposed by the working group and from wider the consultation.

Action Area 1: Reduce the risk of suicide in key high-risk groups:

Taking cross-cutting and coordinated approaches to address high risk groups is critical to maximising efforts to reduce suicide and improve mental health. Groups that have been chosen to focus on for the next three years include:

- Men aged 15 to 59
- People who have attempted suicide
- Substance misusers

Area for action	Key issue/target group	Intervention description	Suggested lead and key partners	Delivery time frame	Outcome/Impact
1.1	Reducing risk in men especially in middle age, with a focus on: economic factors such as debt; social isolation; drugs and alcohol; developing treatment and support settings that men are prepared to use.	Working group to draw up proposals for how to increase help seeking by men, in particular single white men aged 15-59 and MSM, including CAMHS for those young men aged 15-17. Identify individuals with lived experience for representation on working group.	**Public Health**, CALM, PAPYRUS, Working with Men, Opportunity for All, local football clubs, housing, major employers,	Working group formed by May 2018.	Report recommendations to inform future commissioning to the Suicide Prevention Working Group by July 2018.

1.3	People who have attempted suicide	Review and strengthen pathway for people attending A&E departments following suicide attempt. Ensure GPs are contacted with details of suicidal/vulnerable person so that appropriate help and support can be offered e.g. Public Protection Unit/Liaison Team	**NHS Acute Trusts** CNWL and WLMHT **CCG**	New 24/7 Crisis and Urgent Care delivery and pathway developing with integrated outreach team for CYP	Audit to investigate whether all those attending A & E Departments who have attempted suicide placed on the Crises Care and Urgent Care Delivery Pathway. CCG Audit to investigate whether GPs are contacted with details of suicidal/vulnerable people who have attended A & E departments so they can provide follow-up.
1.4	People who self-harm	Identify gaps in care relating to preventing and responding to self-harm, with a range of services for adults and young people in crisis, and psychosocial assessment for self-harm patients.	**NWL Collaborative of CCGs**, mental health trusts, school nursing	Ongoing, new24/7 Crisis and Urgent Care delivery and pathway developing with integrated outreach team for CYP	Care for people who self-harm in line with NICE Guidance.

		Explore establishing a peer to peer support group for self-harm based on recommended good practice.	PHE, CCG and CNWL	Start December 2018	Peer to peer support model established
1.5	Commissioning	Use contract mechanisms to ensure suicide awareness training is built into all contracts. Review current commissioned services for suicide prevention	**LA Commissioners** **CCG Commissioners**	CCG commissioners to discuss with contract leads for WLMHT and CNWL for insertion into 2017-19 contracts. By end of March 2018 LA commissioners to discuss with current providers and include in all new contracts.	All new contracts issued to include a requirement for suicide awareness, prevention and intervention training for all staff working with at risk groups. Develop a 'kitemark' standard to recognise /quality assured training providers.
1.6	First Responders	Suicide prevention and intervention training for all front line police, fire brigade and ambulance service staff.	**Public Health** Metropolitan Police, London Fire Brigade,	From December 2018	Increased reports of interventions.

		Mental Health and Suicide course for all BTP officers which will consist of 2 days of awareness and practical application of powers. This will be for every front line officer.	London Ambulance Service British Transport Police	From December 2017	
1.7	Voluntary sector to ensure a wide range of support is available in addition to the statutory services.	Work with the third sector to ensure that there is appropriate support for those who do not access traditional services. Work with universities and colleges to review their current arrangements for students in crisis.	**MIND, Samaritans**, Public Health, School Nurses, Educational Psychology, 'Kooth' on-line counselling for young people. **Public Health** Universities and colleges.	March 2019 March 2019	Report produced mapping the support available, and identification of gaps to inform commissioning intentions. Review completed and recommendations implemented by the universities and colleges.
1.8	Training	Roll out e-learning and face to face training to wider groups: banks, pubs, betting agencies, hostels, homeless shelters, licencing department Westminster City Hall	Suicide Prevention Group **Public Health**	December 2018 March 2019	Suicide Prevention Group to develop a suicide prevention training plan For example: Pilot engagement with

			Local Authority Licensing		Banks to include suicide prevention awareness as part of a wider mental health strategy. For example: CCG E-learning available to staff in hostels and homeless shelters For example: Work with a pub/bar chain to pilot mental health first aid and suicide prevention training. Report on the pilot to be shared with the Suicide Prevention Group. For example: Work with Samaritans to expand 'small talk, saves lives' media campaign directed at banks, pubs, betting agencies, hostels etc. ?

1.9	Mental health services- West London Mental Health Trust	West London Mental Health Trust have their own WLMHT Suicide Reduction Implementation Plan. The two action areas below include joint work with other organisations. • Reduce self-poisoning through reducing use of high risk medications and developing new prescribing guidance with CCGs. • Develop and implement an Information Sharing Policy with other professional including criminal justice agencies of in- patients with suicidal ideation.	**West London Mental Health Trust**	December 2019 December 2020	West London Mental Health Trust to share their Suicide Reduction Implementation Plan with the Suicide Prevention Group and report progress annually.
	Mental Health Services – CNWL NHS Foundation Trust	CNWL NHS Foundation Trust have their own suicide prevention action plan are included below include joint work with other organisations. • Working with Imperial College Patient Safety Collaborative on reducing suicide, implement an evidence based suicide prevention programme called Connecting with People.	**CNWL NHS Foundation Trust,** Imperial College Health Partners	Roll out of the learning from Brent pilot to other CMHTs – Sept 2018 – Sept 2019 December 2017 – December 2018	CNWL to share their Suicide Reduction Plan with the Suicide Prevention Group and report progress annually.

		• Improvement of safe leave and reduction of absent without leave or failure to return from leave. • Review of Clinical Risk Assessment and Management Policy and the use of additional tools for robust assessment of suicide risk and safety planning and this will be linked to SystmOne, which will embed the tools.		November 2017 – May 2018 review of policy and tools Training produced by February 2018 Trainer the trainer sessions March 2018	

Action Area 2: Tailoring approaches to improve mental health in specific groups

Area for action	Key issue/target group	Intervention description	Suggested lead and key partners	Delivery time frame	Outcome/Impact
2.1	Schools and Early Years	Healthy Schools and Healthy Early Years Partnerships to provide advice, guidance and recognition of achievement through the Bronze Silver and Gold Awards on emotional health and wellbeing and building resilience.	**Public Health Commissioners** / Healthy schools and Healthy Early Years Programmes	Ongoing March 2018	95% of primary schools and 80% of secondary schools to achieve and maintain Healthy Schools Bronze Award. Conferences focusing on Mental Health for both Healthy Schools and Healthy Early Years to promote improve practice and share learning and to include suicide prevention.
		0-19 Healthy Child Programme services (Health Visiting and School Nursing), commissioned by LAs require all front line staff to be trained tier 1 mental health workers.	**Public Health Commissioners**	October 2018	0-19 Healthy Child Programme Services contract requirement that all front line staff are Tier 1

					mental health worker trained.
2.2	Ensuring up to date information on services is easily accessible for individuals, care givers and service providers.	Update the mapping of services available from health, social care and third sector and ensure the information is easily available and effectively communicated.	**Public Health**/ Social Care Services/HealthWatch	Commissioned by September 2018 Published by November 2018	Information on services easily available for both residents and service providers in a variety of formats.
2.3	To better understand the mental wellbeing needs and issues for the local population.	The Health and Wellbeing Boards to commission a Joint Strategic Needs Assessment (JSNA) on mental health and wellbeing.	**Public Health**/Health and Wellbeing Boards	March 2019	JSNA completed and informs the Health and Wellbeing strategy.
2.5	Provision of specialist mental health promotion services for target groups	Review commissioned services which target the mental health of men, BME groups and those facing domestic violence e.g. CALM and Opportunity for All, highlighting suicide prevention interventions/effectiveness	**Public Health Commissioners**	April 2018	PH services for men and BME groups recommissioned, ensuring inclusion of suicide prevention specification.

Action Area 3: Provide better information and support to those bereaved or affected by suicide

Post-suicide interventions at family and community level are essential to deal with the effects of suicide, the risk of contagion and cluster suicides and the on-going impact on the mental health of the bereaved. There is a key role here for the police and the Coroner's office in offering immediate help to bereaved families in access to information and to find support from local and national organisations.

Area for action	Key issue/target group	Intervention description	Suggested lead and key partners	Delivery time frame	Outcome/Impact
3.1	Provide effective and timely support for families bereaved or affected by suicide	Immediate outreach after suspected suicide through a liaison role (with a named individual who is responsible for suicide bereavement support)	**Metropolitan Police/Coroner's Office**	July 2018	Police suicide liaison role established in each local authority area.
3.2	Those bereaved /affected by suicide	Critical incident response service to schools - Support offer to schools and siblings of those who have died by suicide Develop a pathway to improve the provision of support and information to those bereaved by suicide including provision of information e.g. "Help is at Hand" leaflet as well signposting to Samaritans/other charities	**Educational psychology service** to schools and Sixth Form colleges. **Public Health**, Police, Coroner, Registrar, GPs, Acute Health Trusts, Funeral Directors, Social Care	**Ongoing** **Pathway agreed by September2018** **Implemented by December 2018**	All schools aware that they can request support for themselves and for the siblings of those who have died by suicide. All those bereaved by suicide provided with the appropriate support and information.

		Survivors of Bereavement by Suicide (SOBS) peer support group to be set up.	**MIND/PAPYRUS**	**September 2018** **October 2018** **April 2019**	Plan for a SOBS peer support group drafted and presented to the Suicide Prevention Steering Group. Business Case Developed to secure funding. Survivors of Bereavement by Suicide (SOBS) peer support group established and widely promoted.

Action Area 4 Promoting a multiagency approach

Area for action	Key issue/target group	Intervention description	Suggested lead and key partners	Delivery time frame	Outcome/Impact
4.1	Improving sharing of information	Set up a mechanism to share confidential and other information between agencies on suicide prevention e.g. data, services.. e.g. website, sharepoint.	Public Health	December 2019	Increased appropriate referrals to services.
4.2	Ensuring the voice of the bereaved is heard	Agreement on a process for involving the bereaved in the suicide prevention working group.	Public health	September 2018	Action plan implementation reflects local need

Action Area 5 Improving data collection and monitoring

Reliable, timely and accurate suicide statistics are the cornerstone of any suicide prevention strategy and are of tremendous Public Health importance. Analysis of the circumstances surrounding suicides in an area can inform strategies and interventions, highlight trends and changes in patterns, identify key factors in suicide risk and enhance our understanding of high risk groups, evaluate and develop interventions to reflect changing needs and priorities, and develop the evidence base on what works in suicide prevention. An individual borough alone is too small an area to be able to collect sufficient data to be able to analyse for trends. It is therefore recommended that the boroughs of North West London collaborate to create a real time suicide surveillance mechanism.

Area for action	Key issue/target group	Intervention description	Suggested lead and key partners	Delivery time frame	Outcome/Impact
5.1	Real-time suicide surveillance for North West London	Establish a multi-agency approach to collecting real-time information about suicides and attempts.	**Like Minded,** LA Public Health Departments	April 2018 September 2018 September 2018	Suicide Surveillance Group established and meeting regularly Real-time suicide surveillance process in place. Data-sharing channels established within the correct information governance framework.

5.2	Managing suicide clusters and risk of contagion	Establish management of suicide clusters in line with recent national guidance (*ref*)	**Public Health** Roll out the work from the Grenfell Suicide Prevention Action Plan.	March 2020	Proccesses in place to manage suicide clusters.
5.3	Suspected suicides, injurious attempts and pre-suicidal/mental health incidents that have occurred on BTP jurisdiction	British Transport Police are working closely with the Samaritans to train staff and identify hotspots. Once locations are identified BTP and NWR/TfL to inform the Suicide Prevention Steering group. Establish a single point of contact in Public Health to link into the BTP early warning system. BTP and NWR/TfL to share their reports on suspected suicide or injury attempts with the Suicide Prevention Steering group.	**British Transport Police**, Metropolitan Police, TfL, CCG, Mental Health Trusts,	June 2018 April 2018	Multi-agency meeting held about hot-spots and a plan developed for their mitigation and management. Early warning system for suspected suicide or injury attempt agreed with the Public Health Department and in place. Reports presented to the Suicide Prevention Steering Group by the BTP on each suspected suicide/injurious attempt. Lessons learned from the report implemented.

Action Area 6: Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour

The media – including newspapers, magazines, movies, advertising, websites, TV, radio and social media – are an important source which impacts how people perceive the world around them. Insensitive reporting around a suicide can have a wide range of negative impacts – both in terms of emotional impact particularly on those affected and on vulnerable groups, and in playing a role in potential suicide 'contagion'.

Journalists have a responsibility to report sensitively about suicide, whilst balancing this with keeping the public informed. The Samaritans have published guidance on media reporting of suicide, including both factual reporting of events and dramatic portrayal. Key points include:

- Avoid giving too much detail, such as the method, exact location or specific life circumstances of the person who has died by suicide
- Never say the method is quick, easy, painless or certain to result in death
- Avoid over-simplifying the context of the suicide
- Steer away from melodramatic depictions of suicide or its aftermath
- Do not sensationalise reports – avoid using words such as 'hotspots' or 'epidemic'
- Educate and inform – about wider associated issues, and always include helpline numbers
- Do not glamorise suicide – and do not say it is 'successful'

Area for action	Key issue/target group	Intervention description	Suggested lead and key partners	Delivery time frame	Outcome/Impact
6.1	London and national print; television and radio	Work with the GLA to organise a 'sign-up' event where the Samaritans can provide a 'refresher' of their guidance and ask outlets to sign a pledge to	**Local Authority Comms**, Like Minded, Thrive LDN, Samaritans, London Councils, GLA	June 2018	Sign-up event has been held with a number of media outlets attending and signing up to a

		report responsibly on mental health and suicide. Use similar Grenfell sign-up event as a template.			responsible reporting pledge.
6.2	Challenging Reporting	Complaints to be made to the Press complaints commission. Complaints to be co-ordinated to maximise impact.	Communication departments for Local Authority, GLA, CCG, NHS providers and voluntary sector.	October 2018	Complaints submitted in a timely and coordinated fashion.
6.3	Social media campaign	Capitalise on Thrive LDN which is supported by the Mayor of London.	**LA Comms, Like Minded**	April 2018	LA comms incorporate promotion of Thrive LDN in their comms plans
6.4	Social media	Explore the potential for social media platforms to come up with an automatic prompt " You look like you are having a hard time" directing people to sources of support in response to searches and key words.	Thrive London, Like Minded, PHE, Samaritans	June 2018	LA Public Health to discuss with Thrive LDN an approach to social media platforms about directing people to sources of support.

8.0 Grenfell Suicide Prevention Action Plan

The Grenfell Suicide Prevention action plan **(add hyperlink)** sets out a plan aiming to reduce the risk of suicide within the population affected by the Grenfell Fire, and builds upon the offer already in place. It is important to bear in mind that not everyone affected by Grenfell is either from (or remain in) the local area. There may have been visitors to the area at the time of the fire, and those who are suffering the loss of family and friends may be distributed both nationally and internationally. People who were resident in the tower or nearby at the time of the fire will not necessarily continue to live in the local area. This is a major challenge for both the monitoring of suicidal behaviour and for the provision of an offer to all those affected.

Whilst the action plan discusses specific interventions to reduce the risk of suicide, it is also considering a more upstream approach, which looks at how to improve mental wellbeing and resilience to avoid people developing suicidal thoughts in the first place. As such, in addition to the implementation of suicide-specific strategies, attention is given to the continuing development of the good work already occurring to support the community, in order to support a holistic and more effective approach.

The Strategy and Action Plan have been developed in conjunction with this Suicide Prevention Strategy, Community Engagement Plan and multi-agency Communications Plan and was ratified by the Communities & People Board on 7th December 2017.

9.0 Appendix A

NICE Guidelines

NICE guidelines related to suicide prevention:

Self-harm in over 8s: short-term management and prevention of recurrence (2004) NICE guideline CG16

Depression in adults: recognition and management (2009) NICE guideline CG90

Self-harm in over 8s: long-term management (2011) NICE guideline CG133

Borderline personality disorder: recognition and management (2009) NICE guideline CG78

Bipolar disorder: assessment and management (2014) NICE guideline CG185

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (2011) NICE guideline CG115

Depression in adults with a chronic physical health problem: recognition and management (2009) NICE guideline CG91

Common mental health problems: identification and pathways to care (2011) NICE guideline CG123

Antisocial behaviour and conduct disorders in children and young people: recognition and management (2013) NICE guideline CG158

Psychosis and schizophrenia in adults: prevention and management (2014) NICE guideline CG178

Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (2015) NICE guideline NG11.

Mental wellbeing in over 65s: occupational therapy and physical activity interventions (2008) NICE guideline PH16

Social and emotional wellbeing in secondary education (2009) NICE guideline PH20

Mental wellbeing at work (2009) NICE guideline PH22

Alcohol-use disorders: prevention (2010) NICE guideline PH24

Looked-after children and young people (2010) NICE guideline PH28

NICE guidance on the experience of people using the NHS:

Patient experience in adult NHS services (2012) NICE guideline CG138

Service user experience in adult mental health (2011) NICE guideline CG136

Medicines adherence (2009) NICE guideline CG76

NICE guidance on community engagement:

Community engagement: improving health and wellbeing and reducing health inequalities (2016). NICE guideline NG44

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