Public Document Pack

Healthier Communities Select Committee Supplementary Agenda

Wednesday, 14 January 2015
7.00 pm,
Committee Room 3
Civic Suite
Lewisham Town Hall
London SE6 4RU

For more information contact: Timothy Andrew (02083147916)

This meeting is an open meeting and all items on the agenda may be audio recorded and/or filmed.

Part 1

Healthier Communities Select Committee Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Wednesday, 14 January 2015.

Barry Quirk, Chief Executive
Thursday, 8 January 2015

Councillor John Muldoon (Chair) Councillor Stella Jeffrey (Vice-Chair) Councillor Paul Bell Councillor Bill Brown Councillor Ami Ibitson Councillor Alicia Kennedy Councillor Jacq Paschoud Councillor Pat Raven Councillor Joan Reid Councillor Alan Till Councillor Alan Hall (ex-Officio) Councillor Gareth Siddorn (ex-Officio)	

Lewisham and Greenwich NHS
NHS Trust

One Trust…

…serving our local communities

CQC Trust Improvement Plan

Lewisham Overview and Scrutiny Committee

14th January 2015

Agenda Item 3

The CQC identified 7 overall themes

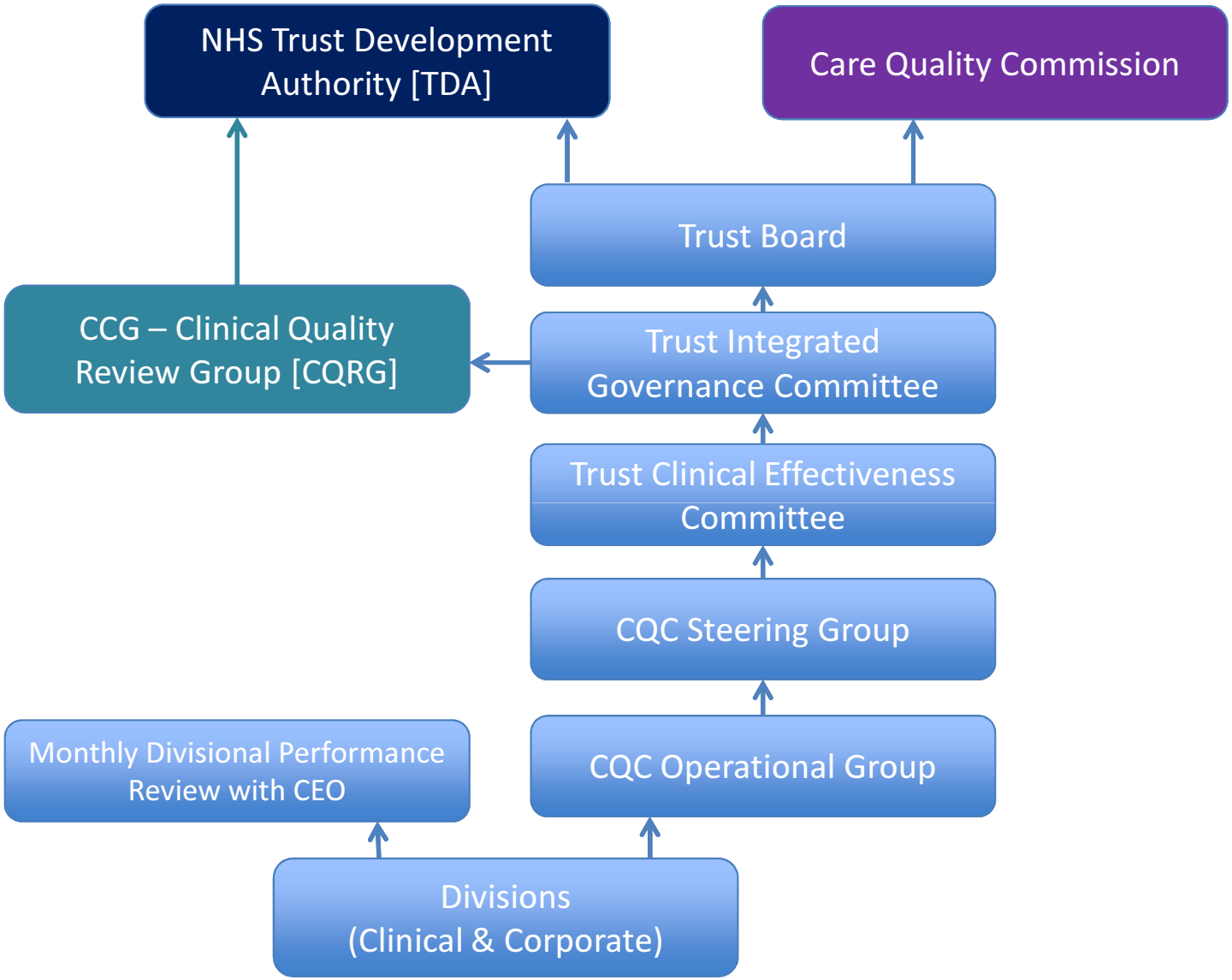
1. Improve the Accident and Emergency Department at the Queen Elizabeth Hospital
2. Improve our patient journey, from admission and ED, through to the transfer to another service, discharge or to the end of life
3. Improve the numbers and core skills of all of our staff
4. Improve our management of clinical waste
5. Improve our hand hygiene compliance
6. Improve the knowledge we share with our staff about our mistakes and how we handled them
7. Improve the availability of our medical equipment and clinical devices and how we maintain them and check their suitability

Trust Wide Improvement Plan

- This was transformed into an Trust Wide Improvement Plan with 6 themes (Theme attachments 1-6 in pre-read) (it was not possible to discuss ED improvements without also discussing patient pathways) and 140 separate metrics
- There is an update report produced monthly
- The live document undergoes continuous refinement even as the actions are being completed and monitored
- Each theme and each division has a separate metric card, from which scorecards have been derived
- The scorecards give much greater detail about the improvements made and the steps needed to complete the actions

On-going Assurance

- Oversight of the improvement metrics and scorecards is monitored by the Trust CQC Operational group – general and governance managers and the heads of nursing and midwifery who are transforming the paper aspirations to actions on the ground and audit from there. Actions will not be closed until the evidence has been scrutinised
- Strategic monitoring and assurance is managed via the current CQC Project Steering group – divisional directors and heads of department who are accountable for the actions proposed
- Monitoring, assurance and audit of evidence is reported via the Trust Integrated Governance framework, to the Board and is externally monitored through the CQRG (includes CCGs, TDA, NHSE, Healthwatch) .


NHS Trust Development Authority [TDA]
Care Quality Commission
Trust Board
CCG – Clinical Quality Review Group [CQRG]
Trust Integrated Governance Committee
Trust Clinical Effectiveness Committee
CQC Steering Group
Monthly Divisional Performance Review with CEO
CQC Operational Group
Divisions (Clinical & Corporate)

On-going Assurance

- Re-inspection of quality and standards within clinical areas began on 28 July 2014 and 32 areas have been inspected to date
- Basic care has been good overall, with the majority of patients appearing cared for and well presented, reporting few problems and generally happy with the levels of care and the types of information they are receiving.
- Infection control was observed to be good on the whole, with the majority of staff observing Bare Below the Elbow and Hand Hygiene compliance but dress code and some areas of medical hand hygiene compliance is still an on-going issue, now managed by Divisional Directors
- All of the clinical waste areas in each area were checked for access and security and were found to be complaint.
- Equipment was checked and found to be in good working order with recent maintenance checks done
- Knowledge of MCA and IG weak in some areas
- Lack of PALS leaflets does arise in some areas, but this is being managed by the PALS dept
- Incomplete nursing assessments and fluid charts, this is now being addressed by additional training
- All Matrons & Heads of Nursing are involved in inspections and issues reported directly to them.
- We met with CQC in November and have established links with our local representative

Trust Quality Improvement Plan

The Care Quality Commission (CQC) has released its report into Lewisham and Greenwich NHS Trust, following the inspection carried out earlier in the year.

As a new organisation, we welcomed the CQC inspection. It complemented quality assessments we had been carrying out ourselves to ensure we have a good understanding of how our services are performing and to identify areas where we need to improve.

We were pleased to find that there were many positives recognised in the CQC's report. In particular, the inspectors said that we have hard working, loyal and caring staff who are committed to the highest quality of patient care. The report refers to a number of areas of best practice, and it is important we share this positive feedback and build on what we do well.

In other areas, the CQC report is less positive, and we need to work with you and with our partners to address these issues. We will be building on recent progress, including:

- Working with local Clinical Commissioning Groups to improve the emergency care pathway
- Continuing our recruitment and retention campaign to increase our establishment of staff
- Working with staff to improve our rating for hand hygiene compliance
- Continuing partnership work with Initial and ISS around the implementation improved processes for clinical waste.

Over the next month, we will be working with you to develop an action plan in response to all the issues highlighted by the CQC. We look forward to delivering significant improvements for local people.

Working together to improve healthcare

CONTENTS

INTRODUCTION:

Lewisham and Greenwich NHS Trust is a new organisation, established on 1 October 2013. Lewisham and Greenwich NHS Trust was formed from the merger of Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital, formerly part of the South London Healthcare NHS Trust, which was dissolved following a decision of the Secretary of State for Health in January 2013.

The Trust has a recurrent turnover of around £460 million and employs around 6,000 staff. We provide a comprehensive portfolio of acute healthcare services to a critical mass of 660,000 people living across the London Boroughs of Lewisham and Greenwich, and the north Bexley area, together with a broad portfolio of community services, primarily, but not exclusively, for those living in Lewisham. Community services are provided across Lewisham and acute services are provided from two main hospital sites, University Hospital Lewisham and Queen Elizabeth Hospital. Some outpatient, maternity, elective surgery, and endoscopy services are also provided at Queen Mary's Hospital, Sidcup, and community services across Lewisham.

Our Trust is based in the South East London health economy, which encompasses parts of the London Boroughs of Lambeth, Southwark, Lewisham, Bexley, Bromley, and the Royal Borough of Greenwich, and is home to a diverse and growing population of c.1.7 million people. While there are areas of relative affluence, it also includes some of the most deprived communities in England. The areas of highest deprivation are those closest to our main hospital sites. Over the next five years, we expect demographic change to drive a 2.3% growth per year in our activity, with the largest absolute growth in younger age bands and the largest relative growth in adults over 85 years of age.

The Care Quality Commission (CQC) has released its report into Lewisham and Greenwich NHS Trust, following the inspection carried out earlier in the year.

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Many of the improvements that need to be made are the responsibility of the Trust. However, one of the major areas for improvement is the emergency care pathway. For this area, successful improvement needs our actions to fit into the health economy strategy and also needs the support of partners. The relationship between the improvement plan and the health economy strategy is described in the patient flow section, and the support required from partners will be detailed in the work stream plans.

EXECUTIVE SUMMARY

The inspectors arrived on 26 February 2014 and stayed for three days. During their visit, they used 115 pages of detailed data analysis; sought information from some national and professional bodies; asked patients and their families what they thought of the service in well-attended listening events and spoke to staff in focus groups throughout the hospitals during their visit.

Three separate reports were published for the organisation the 13 May 2014. All reports can be found by clicking here. The CQC have five themes against which they assess services – safe, effective, caring, responsive and well led.

This section provides a summary of the findings:

1. **Are Services Safe?**

   The CQC said that our adherence to hand hygiene was poor, putting patients at risk of catching infections. They found that one group of staff were particularly poor at hand hygiene.

   They also said that our policies and procedures about dealing with clinical waste were inadequate. The CQC found that members of the public had access to used sharps, that clinical waste bins had been left unlocked and that we had allowed public access to hazardous material.

   Where we had equipment in use, some of it had either not been checked or had not been checked for a long time. Other clinical areas told the CQC that they either had no access to equipment, or that equipment was obsolete. The CQC told us that we needed to make sure that staff had access to the proper equipment, and that we were sure that equipment was safe.

   The CQC identified areas where the volume of work had increased so significantly that there was little space to care.

2. **Are Services Effective?**

   The CQC told us that the pathways we have designed for patients, from admission to discharge, were not as effective as they could be, leading to patients being in hospital for longer than they would wish and making it difficult to find beds to admit new patients into. The CQC also commented that we did not have enough empty admission beds and that this created blockages elsewhere in our systems.

   While we did have sufficient staff numbers to provide safe services in the majority of areas, our staffing levels were a little lower that those needed to provide effective care, that is care that happens when the patient needs it to happen.

3. **Are Services Caring?**

We take a regular survey of patients which is published nationally called the Friends and Family test. The question is simple – would you, as a patient, recommend this service to people you love? The CQC told us that while some of our areas scored well, other areas needed help to achieve better scores.

The CQC also found that while we had high standards of care and that most of our staff provided care to our standards, there were some members of staff who let us all down. The CQC told us that we needed to help these members of staff understand and implement our standards.

4. **Are Services Responsive?**

The CQC told us that our pathways and shortage of admission beds were creating blockages elsewhere in our systems, and one of those areas was the Emergency Department, where waiting times were outside the national and local averages. Our facilities at the Queen Elizabeth Hospital meant that long waits were uncomfortable for patients and did not protect their dignity and privacy.

The CQC identified high bed occupancy as leading to insufficient capacity for patients' needs.

The CQC inspection team also found that there were delays and excessive waiting times in our outpatient and radiology clinics which we needed to resolve.

5. **Are services well-led?**

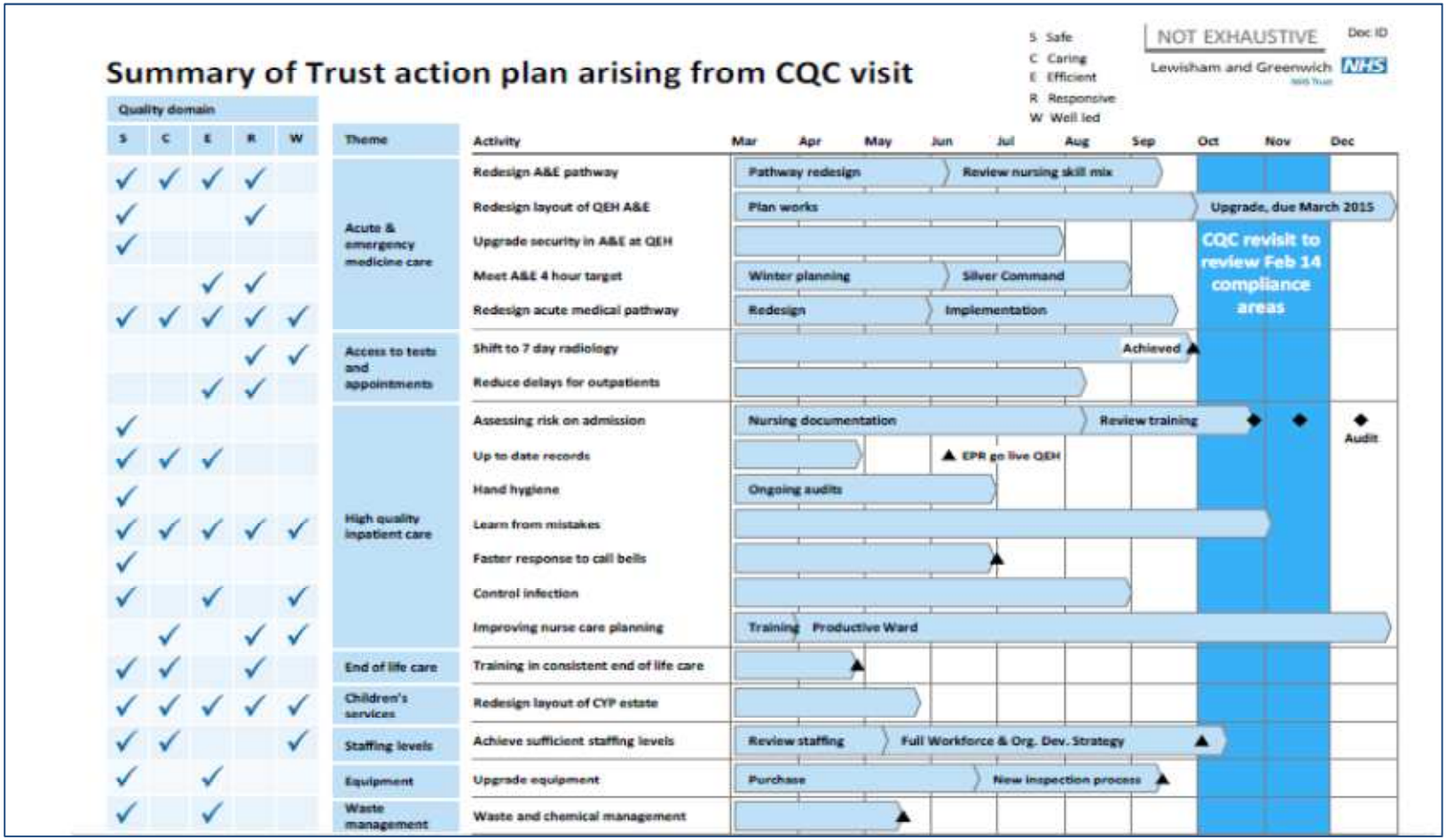
While the CQC identified the need for greater staffing numbers, they acknowledged that shortages of appropriately qualified and experienced staff is a national problem, however they also found that there were barriers to recruitment and retention of staff that hadn't been resolved.

The CQC told us that the non-clinical workforce felt undervalued.

We informed the CQC that our governance teams were integrated during the October merger, however the CQC still found that staff perceived that we were running a dual service and that the arrangements were separate. The CQC told us that this could lead to confusion and ultimately poor reporting.

We have taken four themes from the information the CQC gave us and are using this to make our services as safe as possible, so that we can care effectively, placing the patient at the centre of everything that we do, be responsive to the needs of our patients and their families, all the while improving how we lead and develop our new organisation.

The diagram below illustrates the summary of the Trust action plan arising from the CQC visit



These themes are:

1. PATIENT FLOW

i) Improving the Emergency Department at the Queen Elizabeth Hospital:

The Emergency Department (ED) no longer has adequate capacity for the population of Woolwich and Greenwich, to provide 24-hour care which treats the urgent and emergency needs of adults and children. This has created delays for ambulance patients and ambulatory patients alike.

Our objective is to improve all of the facilities at the A & E department, making sure that ambulances can deliver patients in a safe and timely fashion to obtain rapid assessment and treatment, that our facilities protect the privacy, dignity and independence of our patients and that they are all seen and their problems resolved or the patient journey begun within mandated waiting times.

ii) Improve our patient journey, from admission and ED, through to the transfer to another service, discharge or to the end of life:

Our pathways mean that we are not always effective at moving patients along their pathway to health and wellness. This means that sometimes, patients requiring specialist care experience delays in being assessed, intensive care beds are used for patients who don't need them; operations have to be cancelled as we are not able to move patients from the recovery room back to the ward; some patients who are due to go home have their discharges delayed; patients attending outpatients miss work and have severe delays because of our appointment systems; and that not all of the staff who need to implement end of life care are confident in how this can be achieved well.

Our objective is to review and streamline our pathways for all of our patients*. We will improve the way that we *assess people when they come to hospital, and to work with our community services to significantly improve the pathway for frail older people. We will reduce admissions, and ensure people do not spend avoidable time in hospital by changing processes, behaving as one team across organisations and making better use of community services to provide care and assessment that currently takes place in an acute bed. We will support this with a new model of clinical are for patients who do need to be in acute beds, being seen daily by a consultant 5 days a week and moving to 7 days a week across more wards. We will overhaul the way we plan and manage outpatient appointments to make them more effective. For day care surgery, we will improve the environment, reduce the number of cancelled operations and improve care for patients after surgery. For patients facing the end of their lives, we will strive to make this a better, more peaceful experience.

2. WORKFORCE

i) Improve the numbers and core skills of all of our staff:

In order to make the pathway improvements possible and to provide effective care, we need more appropriately qualified, experienced and enthusiastic staff.

Our objectives are to increase the number of staff, attract more permanent staff to work here; instil our behaviours and values, and keep staff for longer.

3. SAFETY

i) Improve our management of clinical waste:

Unintentionally, we exposed our service users, their families and our staff to hazardous materials, used sharps and clinical waste. We did not have procedures in place which would protect the hospital community and we were not able to assure ourselves that our policies were known to the staff who are tasked to implement them, that staff knew how to handle clinical waste and hazardous materials and that we had live data to show that our policies were being adhered to.

Our objectives are to establish a safe environment, and to assure ourselves that all of our staff have the knowledge, training and experience to maintain that safety for the entire hospital environment.

ii) Improve our hand hygiene compliance:

Although we have hand hygiene policies in place and compliance audits which assess our compliance with the policies, our staff were seen failing to adhere to these.

Our objective is to ensure that all of our staff know and understand what our policies are on hand hygiene and that they need to comply with these policies.

iii) Improve the availability of our medical equipment and clinical devices and how we maintain them and check their suitability

Not all of our staff had access to equipment and devices necessary to make their work either possible or to simplify tasks for them. Some of the equipment that was available had not been regularly maintained. The CQC were not able to assure themselves that this equipment was safe or accurate. The CQC also had no assurance that the staff using our equipment had the necessary training to use equipment in a manner that was safe for both staff and patients.

Our objectives are to ensure that we continually audit all of our equipment and interrogate the maintenance logs to ensure that we are not using poorly

maintained and potentially dangerous devices. We will then ensure that all of our staff using our devices has been training in their appropriate use so that privacy, dignity and independence are maintained. Finally, we will make the process of ordering and bidding for equipment easier and more transparent so that all of our clinical areas have the equipment levels that they need.

4. ORGANISATIONAL LEARNING

i) Improve the knowledge we share with our staff about our incidents, complaints and the learning gained from them.

We do have governance arrangements across the sites which work well in helping staff to report incidents, accidents, near misses, alerts, patient safety recommendations and complaints. We also have good arrangements to share learning from this with divisions and directorates. The CQC found that although good governance arrangements were in place, they found that we did not have a robust pathway which ensures all learning is shared across the organisation with all members of the staff body.

Our objective is to ensure that staff working most closely with our service users and their families, have access, are able to discuss and utilise the knowledge and learning that comes from these valuable sources.

1. Patient Flow

Action proposal one and two have been merged as it is not possible to discuss changes to the physical layout of the hospital without discussing the plans to alter and streamline the patient flow within the department and discharged either into the local community or to be admitted as an inpatient. Similarly, some of the capacity issues of the Emergency Department, identified by the CQC were as a direct result of inadequate discharge arrangements.

Why this is important.

The CQC found that our Emergency Department (ED) at Queen Elizabeth Hospital was unfit for the number of people that attended on a daily basis. It found that of the constraints volume of patients attending, the physical layout of the department and the lack of capacity, we were unable to attend to ambulance patients in a timely manner and that we could not protect the dignity and privacy of our ambulatory patients. The CQC suggested that some of our practices may put patients and their families at risk from contracting infections carried by other patients.

The CQC found that:

- In A & E, patients were waiting significant amount of time on ambulance trolleys, causing delays in the assessment and treatment of patients.
- People who use services and others were not protected against the risks associated with lack of capacity in A & E
- Capacity and timely response from the A & E service must meet the of the service user. There must be an escalation strategy and cross site working policy.
- Following an incident in QEH ED, where a patient had left the department unnoticed, the Trust had agreed to fit keypad access to prevent a recurrence. This had not happened and there was free access to all areas.
- In A & E, the area known as the grey chairs was being used to treat people, which compromised their privacy and dignity. People being cared for seated in chairs who may have benefitted from being able to lie on a trolley or bed and patients who may have been infectious were being cared for there
- Capacity and timely response from the radiological service must meet the needs of the service user
- Our end of life care seemed to be inconsistent and not all of the staff who had to implement EOLC were confident in doing so
- In the children's department, the layout of the ward made it difficult for staff to achieve constant observation of patients.

Our assessment of the key issues:

- The QEH ED was built to service a projected population but planning did not predict the closure of the ED in Queen Mary's Hospital in Sidcup, which has significantly added to the numbers being seen. There was no additional capacity considered at the time of closure.

- The PFI nature of the QEH site will increase the difficulties in making changes to the physical layout of the ED

Our objectives are:

1. Redesign the ED so as to create an environment which enables the most efficient and effective flow of patients through the department, so that they are assessed rapidly, investigated where appropriate and discharged or placed where appropriate.
2. Join with health economy partners to reduce the numbers using the QEH ED.
3. Ensure that ambulance and urgent patients are seen, assessed and treated in a timely manner.
4. Ensure that our processes and pathways are streamlined for patients who are assessed within the ED, including use of the grey chairs and a defined pathway for gastroenterology patients requiring urgent care.
5. To ensure that we meet and exceeding our mandated targets to achieve excellence in emergency care.
6. Increase the number of senior ED medical staff through improved recruitment, training and job design.
7. Ensure that all of our sites protect the security of our service users.
8. We will ensure that our radiological services have the capacity for timely response to patients' needs.
9. Ensure that our patients facing the end of their lives are cared for in the place they want and in a manner that improves the experience for them and their loved ones.
10. Ensure that we are able to maintain line of site observation of our children and young person service users.

<u>Objective 1: Redesign layout of ED</u>

1.1 The redesign work has commenced with the recruitment of a design team, a redesign plan has been drawn up and planning has commenced for the relocation of main services which currently occupy locations which need to be redesigned. The planning phase is due to be completed by October 2014 and upgrade work to commence in March 2015.

<u>Objective 2: Join with health economy partners to reduce the numbers using the QEH ED</u>

1.2 The Trust has set up a Whole Systems Improvement Group [WSIG], led by the Acute Medicine Division, which involves stakeholders from Trust, Community, Primary and Social Care, to commence the work for admission avoidance and timely, efficient discharge of patients.

This group will focus on extending current initiatives to avoid admissions and will develop new joint initiatives to ensure that proactive discharge from day of admission is the priority and timely discharges occur at all times.

Objective 3: Ensure that ambulance and urgent patients are seen, assessed and treated in a timely manner

1.3.1 The redesign of the ED will incorporate the development of a Rapid Assessment and Treatment Unit [RATU] and Clinical Decision Unit [CDU], this will enable patients to be handed over safely from the ambulance staff to the department. This work has already commenced.

Objective 4: To ensure that we meet and exceed our mandated targets to achieve excellence in emergency care

1.4 To achieve London quality standards for emergency care.

To date the Trust has met nine of the fourteen Emergency Care Quality Standards, continued work with our local commissioning, Primary Care, Social Care colleagues, local Deaneries and Higher Education Institutes will assist in implementing our plans to achieve all the London Quality Standards.

Objective 5: Increase the number of senior ED medical staff through improved recruitment, training and job design

1.5 To deliver the workforce plan on improving recruitment and retention

Please see section on staffing

Objective 6: Ensure that all of our ED sites protect the security of our service users.

1.6.1 We will introduce swipe card access to QE ED

1.6.2 We will introduce swipe card access to QE ED ambulance bay doors

1.6.3 We will review entire department for vulnerability and security and take all of the necessary actions

Objective 7: We will ensure that our radiological services have the capacity for timely response to patients' needs

1.7.1 As part of the Trust's Five Year Strategy, we have committed to rolling our seven day working across a number of specialties.

We have looked at areas which have most impact on the ED department and patient flows and work to shift to seven day working will commence within radiology. This work is already underway and it is aimed to have seven day working within the core radiology services by April 2015.

1.7.2 We will make capital investments in imaging equipment and the supporting technologies.

Objective 8: Ensure that our processes and pathways are streamlined for all of our patients

1.8 Pathways

Acute and Emergency medicine:

1.8.1 A project already underway with the A & EM and McKinsey's is modelling capacity within A & EM, including the Emergency Department. The review has resulted in two business cases – one short term and due for implementation ready for the winter of 2014/2015, the second a long term plan which will be ready for implementation in June 2015.

The scoping of the medical models has commenced and is due for completion at the end of the July with a view to preparing for implementation from July onwards.

1.8.2 The development of specific standards and model pathways has already commenced. These plans include:

- Ensure the use of Urgent Care Triage system
- 100% of patients to have an estimated date of discharge (EDD) within 24 hours of admission
- Daily MDT patient flow board rounds
- Rapid extension of Ambulatory model
- Development of a standard pathway for specialist medicine patients
- Development of pathway for emergency care for gastroenterology patients
- Development of new model for Frail and Elderly
- Development of a Single stroke service post-acute care

1.8.3 Women's and Sexual Health

- Enhanced recovery pathway for elective lower segment caesarean section (LSCS) on the postnatal ward
- Streamlined discharge processes on the postnatal wards
- Outpatient management of hyperemesis and induction of labour in low risk women
- Review of prophylactic intravenous antibiotics given to new-borns on the postnatal wards
- Review of the pathway for women with complex social care needs and whose babies are at risk
- Review of postpartum women who are awaiting court dates as these women can remain on the ward for three weeks
- Safeguarding midwife to collate and share data at senior team meetings on all pregnant women with at risk babies which will include length of stay

1.8.3.1 Capacity will be reviewed three times daily, monitored through the manager on call, with an escalation policy to be applied in times of raised activity and acuity

1.8.3.2 The appropriate pathway will be identified for all women at the booking appointment

1.8.3.4 Discharge planning will begin antenatally

1.8.3.5 We will implement early reviews of women and their babies by the obstetric and neonatal teams

1.8.3.6 We will ensure that there is collaborative working with allied health professionals

1.8.3.7 Monthly meetings between midwives and health visitors to enhance community services

1.8.3.8 General Practitioner open evenings to encourage community access

1.8.3.9 The Multi Agency Risk Assessment Conference (MARAC) will meet quarterly as part of a co-ordinated community response to domestic violence. MARAC attendees include the police, social services, midwives, doctors (both community and hospital based) and other professionals

1.8.4 Surgery, Elective Surgery and Critical Care:

1.8.4.1 On-going 5 year plan with bed reconfiguration

1.8.5 Long Term Conditions and Cancer:

- We will review all of our space for required by our outpatients
- We will use advanced technology to review capacity in outpatients and endure the effective use of space
- We will complete a thorough review of capacity and demand within outpatients
- We will review our Did Not Attend (DNA) rates and establish if there are any Trust made barriers to patients attending
- We will ensure the safety of our most vulnerable patients

1.8.6 Medical Records:

- We will ensure that our staff have the most up-to-date information on patients as possible
- We will reduce the number of temporary patient notes in outpatients
- We will ensure that patients operations and outpatient appointments are not cancelled due to lack of notes

Objective 9: Ensure that our patients facing the end of their lives are cared for in the place they want and in a manner that improves the experience for them and their loved ones

1.9.1 The Trust has developed its approach to phasing out of the Liverpool Care Pathway and has approved the rolling out of the 'Principles of Care for the Dying Patient'.

100% Palliative care patients to have a plan of care following admission, 100% palliative care patients to have four-hourly reviews documented in their care plans. All staff dealing with End Of Life Care [EoLC] patients to have in-house informal training from the palliative care team.

Across the Trust we will:

- Roll-out of the principles of care for the dying patient
- Sage and Thyme communication training rolled out to all staff
- Our Nursing education team will work with Greenwich Hospice to implement EoLC training
- Ensure EOLC included is in the new Band 5 Preceptorship training
- Complete the DNAR policy review – led by the resus committee
- Develop new pathways for the Fast Tracking EOLC discharges – A & EM and LTC & C to discuss standardising and streamlining discharge process
- Ensure that there is robust Review of after death care – checklist to be created to prepare bodies for transfer to the mortuary, last offices box review
- Review the information available for patients and their families – including a review of the advertisements within the literature

Objective 10: Ensure that we are able to maintain line of site observation of our children and young person service users

1.10.1 This is a difficult issue as the PFI nature of the QE hospital contract will make it extremely difficult to make changes to the physical building specifications. We will ensure that all reconfiguration plans are discussed with are PFI partners.

1.10.2 An increase in staffing numbers will be agreed.

1.10.3 We will review the available technologies to enhance the nurse response to patient's needs

2 WORKFORCE

Improve the numbers and core skills of all of our staff

Why this is important?

While the CQC agreed that our care was safe, we were criticised for not having sufficient numbers of staff to provide effective care that was responsive to patient's needs. The trust was also reminded that for good quality care to be given, staff had to know was expected of them and we were also tasked to deal with the very few members of staff who let everybody else down. The Trust's values and behaviours will not be achievable without greater numbers of staff, all of whom have who have knowledge, training and confidence to care with compassion.

The CQC found that:

- On some wards, call bells were not answered as there were insufficient staff, particularly on medical wards
- Staff shortages were noted in many areas, and while recruitment plans were in place, these had not yet filled the vacancies
- QEH ED was singled out as there was a staffing review underway but heavy reliance on agency staff
- E-Rostering may be problematic in places and the CQC recommended a review of how E-rostering was being utilised
- Service users were at risk if there were insufficient numbers of suitably qualified skilled and experienced staff
- The trust needed to assure itself that staff with the required competencies were available within all clinical areas
- Insufficient numbers of staff on surgical wards meant that there were sometimes delays in patients receiving their meals
- A significant shortage of appropriately qualified staff was noted in children's services

Our assessment of the key issues:

- There is a national shortage of staff with specific experience and skills, especially in ED and C&YP
- Under the South London Health Trust, many posts, and accompanying expertise, were lost. It has taken some time to recruit back into these roles.
- The E-rostering system was implemented during 2013 and will be reviewed

Our objectives are:

1. Review the staffing needs of each clinical area and each division
2. All divisions have appropriately trained, skilled, experienced and competent staff in place
3. Ensure that clinical directorates and the Human Resource department have a shared objective to improve recruitment and retention
4. Strengthen and diversify the workforce
5. Improve the oversight and deployment of the workforce on a strategic and operational level
6. Increase the number of senior medical ED staff by improved recruitment, training and job design
7. Improve our recruitment and retention processes to reduce reliance on bank and agency staff
8. Ensure that all of our staff members are aware of the high standards that the Trust expects, that they work to exceed the 6C's and the Trust Values and Behaviours

Objective 1: Take time to review the staffing needs of each clinical area and each division

2.1.1 The clinical strategy is now being developed to include workforce requirements to reflect changes to service delivery

2.1.2 Development of the "Safer Staffing" review for nursing and midwifery in line with national guidance

2.1.3 Further specific reviews into job planning for consultants, nursing skill mix, A & EM workforce and EM staffing review. ED staffing review to follow change programme for pathway development by A & EM

2.1.4 Implementation of the safer nursing tool – facilitates the assessment of safe staffing by identifying acuity and dependence allowing real time planning of staffing levels.

2.1.5 Development and Implementation of the Nursing and Midwifery staffing escalation policy

2.1.6 Development and implementation of a Trust wide recruitment and retention plan

2.1.7 We will equip staff with the knowledge and expertise to support the recruitment process

Children's and Young People

2.1.8 The review and improvement plan has increased establishment to 1:4 (completed April 2014)

2.1.9 Escalation policy in place to ensure adequate staffing when staff members are ill – both within hours and out-of-hours

2.1.10 Safer staffing review to include specialist nursing review to care for children with oncological needs

Women's and Sexual Health

2.1.11 Use of the Birth Rate plus calculations and rota model to inform midwifery staffing levels

2.1.12 Minimum levels set at 1:29

2.1.13 Use of the Birth Rate plus calculations and rota model to inform skill mix, monitored daily and escalated appropriately

2.1.14 Shortfalls to be covered by re-deployment before use of Bank or Agency staff

Objective 2: All divisions have appropriately trained, skilled, experienced and competent staff in place

2.2.1 Newly qualified staff will mentored – new preceptorship programme in place – completed May 2014

2.2.2 Band 5 competencies reviewed and implemented with the preceptorship programme – completed May 2014

2.2.3 All other competencies per band are currently under review

2.2.4 Part of the OD strategy is a review of Leadership Development – group and individual development in clinical and non-clinical areas – includes Service Improvement, Transformation and management of change

2.2.5 Practice Development Nurses (PDN's) to be recruited to assist and support clinically based mentorship and learning following a review to ensure alignment with trust and local clinical priorities

2.2.6 The Trust to ensure that clinical staff have access to a wide range of clinical development opportunities via the HESL finding scheme.

2.2.7 Clinical link lecturer to support registered staff on the wards, supporting pre-registration students

2.2.8 All members of staff required to attend yearly mandatory training

2.2.9 Newly qualified midwives undertake a preceptorship programme and cannot progress to the next pay band until all competencies have been signed off.

2.2.10 All temporary staff are required to complete a local induction and self-declare competencies

Objective 3: Ensure that clinical directorates and the Human Resource department have a shared objective to improve recruitment and retention

2.3.1 Nursing documentation pack has been reviewed to ensure that all risks to patient welfare are assessed, reviewed and documented

2.3.2 The Trust Nursing and Midwifery strategy has been launched – highlighting trust values and 6C's.

2.3.3 Pilot schemes on selected wards to use Productive Ward principles with an aim to share learning across other areas

2.3.4 E-Rostering reviews across all areas

Objective 4: Strengthen and diversify the workforce

Objective 5: Improve the oversight and deployment of the workforce on a strategic and operational level

Objective 6: Increase the number of senior medical ED staff by improved recruitment, training and job design

Objective 7: Improve our recruitment and retention processes to reduce reliance on bank and agency staff

2.7.1 There are already active recruitment campaigns to secure skilled and experienced qualified staff from Europe

2.7.2 There are dedicated recruitment days for newly qualified nursing and midwifery staff

2.7.3 Return to Practice supported by the Higher Education Institute

2.7.4 Improvement of the Exit Interview so that we can actively reduce the number of people who want to leave the Trust

Objective 8: Ensure that all of our staff members are aware of the high standards that the Trust expects, that they work to exceed the 6C's and the Trust Values and Behaviours

2. 8.1 The Trust has developed a set of values and behaviours – staff are made aware on induction and the Welcome booklet, wallet cards for staff, open staff meetings and bespoke events

2.8.2 Staff members to review how they are already living the values at team meetings

2.8.3 Values are to be linked to appraisal, recruitment and workforce policies

2.8.4 Training is being commissioned to enable managers both to identify good practice and to give staff the confidence to challenge colleagues when Trust values are not being met

2.8.5 A Trust recognition scheme is being launched – the first ceremony is planned for November 2014

<u>We will know we have been successful if:</u>

- Our staffing establishments meet the capacity and demand of our activity on our wards
- Staff will be inducted and trained to deliver care according to their expertise
- Implementation of Safer Staffing Tool
- Implementation of Recruitment and Retention Plan
- Staff and patient satisfaction levels are improved due to enhanced levels of care and compassion
- Vacant posts are recruited to and staff remain in post until natural career progression
- Production of competencies for all banded staff
- All staff are up to date with their Mandatory Training
- All staff have appraisals once a year
- All staff leaving the Trust participate in exit interviews
- Less reliance on agency staff

3 SAFETY

3.1 Improve our management of clinical waste

Why is this important?

The danger to patients through poor adherence to Infection Control and Prevention policies cannot be overstated

The CQC found that:

- Our systems for managing clinical waste were poor.
- Many areas with clinical waste were accessible to members of the public

Our assessment of the key issues

During the CQC visit we were taken around the sites and shown the areas of non-compliance, these were immediately rectified and were subject to on-going audits

Our objectives are:

1 We will have robust policies in place for the management of clinical waste
2 We will ensure that all our staff and partners are complaint with our policies

Objective 1: We have robust policies in place for the management of clinical waste

3.1.1 We will review all of our waste management plans, and align across the sites

3.1.2 We will review our clinical waste storage site locations

3.1.3 We will fit digilocks as additional security as required

3.1.4 We will work with colleagues to enhance our Sharps policy

Objective 2: Our staff and partners are complaint with our policies

3. 1.5 We will communicate our plans to all staff groups

3.1.6 We will put in place enhanced training for all of our waste handlers

3.1.7 Training will enable staff to understand when they must use personal protective equipment

3.1.8 Personal protective equipment will be monitored on a monthly basis for compliance with its use

We will know we have been successful if:

- Our waste management plans have been successfully communicated to all staff groups and implemented
- Compliance with clinical waste storage sites is >85%
- Compliance with PPE usage is 100%

3.2 Improve our hand hygiene compliance

Why is this important?

The CQC found that although the Trust had comprehensive infection control and prevention policies in place, they had not been robust enough to ensure that all of our staff adhere to them. This leaves our patients vulnerable to the chance of acquiring a hospital related infection.

The CQC found that:

- In some areas compliance with being 'Bare below the Elbows' and hand hygiene was poor. This causes a risk of cross-infection for patients.

Our assessment of the key issues

- Compliance measured against some members of staff is better than others

Our objectives are:

1. To enhance training across all staff groups and ensure that all staff adhere to the guidelines
2. Assure compliance across all staff groups and complete on-going compliance audits across all staff groups
3. Ensure all staff understand importance of compliance to policy using examples of light box technology

Objective 1: Enhance training across all staff groups

3.2.1 Poster and information campaign to a public hand hygiene campaign, to include granting permission for patients to challenge staff to wash their hands

3.2.2 Develop and implement Trust wide Hand Hygiene roadshows

3.2.3 Training and updates during induction and mandatory training

3.2.4 Divisional purchase of training gel and light boxes for use when auditing and training

3.2.5 Aseptic Non Touch Technique and hand hygiene included in band 5 preceptorship training and all induction programmes

Objective 2: Assure compliance across all staff groups

3. 2.6 Review and update of policy to reflect new organisation and include a clear escalation process for non-complaint staff

3.2.7 All hand hygiene and infection control audits to be undertaken using online audit tool and presented at Divisional Performance Reviews

3.2.8 Purchase of lockable hand rub dispensers for outside clinical areas, with agreement with facilities for replenishing

3.2.9 Hand rub monitored at point of care – 95% compliance monitored by divisional performance report

We will know we have been successful if:

- Observational audits show increased compliance
- Formal monthly Hand hygiene audits show >85% compliance
- Patients and staff are able to challenge poor compliance
- Hospital acquired infection rates decrease

3.3 Improve the availability of our medical equipment and clinical devices and how we maintain them and check their suitability

Why is this important?

Every aspect of patient care revolves around technology, equipment and devices. It is important for patient and staff welfare that there is sufficient equipment to provide effective care; that staff are trained not only to use the devices, but to use them in such a way as to protect patient privacy, dignity and independence; that we know what equipment we have and that all of this is maintained to a high standard on schedules that are adhered to.

The CQC found that:

- Checks to medical equipment should be carried out regularly to ensure that when they are required, they will be working. These checks are recorded. In some areas, the checks were carried out regularly, but in other areas this was more sporadic and often missed.
- The hospital must ensure that there is appropriate clinical equipment available in all areas

Our assessment of the key issues

Our objectives are:

1. We will be able to say exactly what equipment we have within the Trust
2. We will ensure that our staff have appropriate equipment for the tasks they need to perform
3. We will ensure that all of our devices have appropriate maintenance schedules
4. We will make sure that our maintenance schedules are current
5. We will monitor the devices in their place of use, with regard to daily cleaning and availability
6. We will ensure that all of our staff have training to be able to use the available equipment in a manner that keeps them and their colleagues safe.
7. We will ensure that all of our staff training includes the use of equipment in protecting patient's dignity, privacy and independence, while respecting the patient's wishes.

Objective 1: We will be able to say exactly what equipment we have within the Trust

3.3.1 We will create a new single integrated policy for the management of medical devices

3.3.2 We will create a staffing structure to ensure that our policy is implemented effectively

3.3.3 We will create a robust ledger of all devices we currently have in stock

Objective 2: We will ensure that our staff have appropriate equipment for the tasks they need to perform

3.3.4 We will identify gaps in the provision of equipment at a divisional level

Objective 3: We will ensure that all of our devices have appropriate maintenance schedules

3.3.5 We will ensure that the Trust has a planned preventative maintenance schedule

Objective 4: We will monitor the devices in their place of use, with regard to daily cleaning and availability

3.3.6 We will create a robust system to manage medical devices at ward/department level

Objective 5: We will assure ourselves that the Trust has a robust system of effective device management to ensure staff and patient safety

3.3.7 We will monitor staff competencies with equipment and devices

3.3.8 We will establish committees to provide assurance that the medical device policy is adhered to.

4. ORGANISATIONAL LEARNING

4.1 Improve the knowledge we share with our staff about our learning from when and where things did not go well and from complaints made by patients

Why is this important?

Information gleaned from alerts, complaints and incidents allows us to analyse how we administer our policies and programs, deal with patients and their families and manage issues. It also helps us to identify areas that need work, leading to innovative solutions to problems, improvements in service delivery and better decision making. If we fail to share this information Trust-wide, we risk the same issues being repeated unnecessarily.

The CQC found that:

- The new governance structure was in place and worked well from the top to the Divisional level and that it had clear objectives but there was significant work needed to engage all staff from within all divisions and to improve complaints response times
- An underlying challenge is the need to ensure that staff learn from complaints and incidents and that information is shared widely
- Continued training in both complaints handling and investigation will ensure that processes are improved and consistent across the Trust

Our assessment of the key issues:

The new governance structure works well delivering information from many sources from alerts, complaints and incidents etc. from the board to the divisional governance level. Sharing this information with our staff who deal with patients on a day-to-day basis has been more challenging.

Our objectives are:

1 We will ensure that we continue to develop the culture of 'no blame' and encourage all staff to continue to report all incidents
2 We will use the After Action Review process to ensure that incidents can be reviewed and discuss without fear of blame culture
3 We will identify key learning from incidents, complaints, never events
4 We will share this information with staff at all grades and levels throughout the organisation
5 We will identify alternative sources, media and initiatives with which to disseminate information
6 We will not focus on negative attributes but share instances of good practice
7 We will embrace the Francis recommendation of the Duty of Candour

Objective 1: We will encourage the reporting of all incidents from all grades and levels of staff

4.1.1 Staff induction and mandatory training will include incident reporting

4.1.2 Trust wide Poster and "Staff Briefing" campaign to encourage the reporting of all incidents

4.1.3 We will develop our Workforce policies to include the requirement to report all incidents, accidents and near-misses as a professional duty

4.1.4 Serious incident training will be included in the band 5 preceptorship programme

Objective 2: We will identify key learning

4.2.1 Identification of lessons learned through the Outcomes with Learning (OWL) group which will then be shared across the organisation

4. 2.2 Identification of lessons learned through the Aspiring to Excellence (A2E) group which will then be shared across the organisation

4.2.3 Identification of lessons learned through the divisional governance meetings

4. 2.4 We will introduce a programme of After Action Reviews for staff

4. 2.5 Divisions will develop Patient Safety Improvement Plans (PSIPs) for their top three incidents (excluding pressure ulcers and falls)

4. 2.6 Patient safety and risk teams to develop PSIPs for the Trust top three incidents (excluding pressure ulcers and falls)

4. 2.7 The Patient Safety Team will organise PSIP staff events and road shows throughout the year

4. 2.8 Trends and themes arising from serious and red incidents will be analysed quarterly and provided to Divisional and Corporate Teams for dissemination at departmental meetings

4.2.9 All Divisions will be required to produce quarterly reports on patient safety and complaints

Objective 3: We will share this information with staff at all grades and levels

4. 3.1 The Trust will publish a newsletter with highlights and learning from the previous months' incidents

4. 3.2 Each division will publish a monthly newsletter with highlights and learning from the previous months' incidents

4. 3.3 Quarterly payslip messages delivered to all staff highlighting lessons learned

4. 3.4 Inter-divisional learning will be a standing agenda item on all Divisional Governance Agendas

4. 3.5 Each Divisional Governance meeting to start with a patient story

4. 3.6 Governance and Patient Experience Managers will meet with staff at ward/department meetings to discuss the lessons learned cross trust. This will include the Trust's partner organisations.

4.3.7 Trends and themes arising from quarterly analysis will be disseminated to all staff in leaflets, posters and on the intranet

Objective 4: We will identify alternative media with which to disseminate information

4. 4.1 All published newsletters will be available in paper copies and on-line of the staff accessible intranet

4.4.2 All areas of good practice and patient compliments will be shared on the intranet

4. 4.3 Key Messages and Key Facts will be printed for staff on payslips

Objective 5: We will not focus on negative attributes but share instances of good practice

4.5.1 Areas of good practice will be shared with the staff body as examples of good care

4. 5.2 Patient compliments will be widely shared and published

Objective 6: We will embrace the Francis recommendation of a Duty of Candour

4. 6.1 Our analysis of red and moderate incidents will include the duty of candour discussion and compliance to our Being Open Policy will be audited on a six monthly basis

4. 6.2 Nursing staff and clinicians will receive additional training on speaking to patients following an adverse incident

4. 6.3 We will monitor and report on how many of our red and serious incidents included a patient discussion of the incident

We will know we have been successful if:

- all staff are aware of how to recognise and report an incident and feel confident to do so
- staff feel comfortable participating in AAR sessions
- staff will be able to identify errors and complaints within their own area of practice, and the learning that came from this
- staff use initiation, creativity and innovative techniques to share best practice amongst other team members
- staff will be able to identify learning from other areas and how to incorporate that into their own practice
- staff will be aware of examples of good practice and how to replicate this
- staff will be aware of the impact that errors, accidents, mistakes and near misses can have on patients and their families.

TRUST QUALITY IMPROVEMENT PLAN (CQC ACTION PLAN)

CHRONOLOGICAL METRICS

V11.0 5 JANUARY 2015

April 2014 – Dec 2015

Overall Chronological Trust Improvement metrics										
RAG Rating Legend: N = 140	**Aug**		**Sept**		**Oct**		**Nov**		**Dec**	
Completed – with evidence and assurance	**63**	**45%**	**67**	**48%**	**73**	**51.7%**	**95**	**67%**	**101**	**72%**
Evidence and assurance in the planning stages	**73**	**52%**	**69**	**49%**	**64**	**45.4%**	**43**	**30.7%**	**37**	**26%**
No evidence submitted or delays in planning	**4**	**3%**	**4**	**3%**	**4**	**2.8%**	**2**	**1.4%**	**2**	**1.4%**

Lewisham and Greenwich NHS Trust									
#	*Metric*	*Definition*	*Workgroup/Lead*	*Threshold*	*Action plan target date*	*Current*	*Ideal Current Position*	*Est. date completion*	*RAG*
1	*Security*	*Ambulance bay door secure QE ED Sites Secure*	*John Ferguson*	*100%*	*April 2014*	*Complete*	*Complete*	*April 2014*	●
2	*Measured pathway improvement*	*ED board rounds to support flow*	*A & EM*	*3 x daily*	*Apr 2014*	*100%*	*100%*	*Apr 2014*	●
3	*Increased establishment*	*Review and improvement plan has increased establishment to 1:4 in Children's department*	*C & YP*	*100%*	*April 2014*	*Completed*	*Completed*	*April 2014*	●
4	*Measured pathway improvement, reduced LOS*	*Capacity reviewed three times daily, monitored through manager on call and escalated in times of increased acuity and activity*	*WASH*	*3 x per day*	*In planning*	*Complete*	*Complete and on-going*	*May 2014*	●
5	*Reduced LOS*	*Discharge planning to begin antenatally*	*WASH*	*100%*	*May 2014*	*100%*	*Complete and on-going*	*May 2014*	●
6	*C&YP*	*Observation of QEH child inpatients improved by increased staffing*	*Angie Jones C&YP*	*100%*	*May 2014*	*Complete*	*Complete*	*May 2014*	●
7	*Enhanced support for staff*	*Newly qualified staff to be mentored*	*Claire Champion*	*100%*	*June 2014*	*Completed*	*Completed*	*May 2014*	●
8	*Enhanced support for staff*	*Band 5 competencies reviewed and implemented with new preceptorship programme*	*Nursing Development Team*	*100%*	*May 2014*	*Completed*	*Completed*	*May 2014*	●
9	*100% hand rub availability*	*Hand rub will be available either in dispensers or in personal tottles at all times*	*Matron/ Facilities*	*100%*	*Immediate*	*100%*	*100%*	*May 2014*	●
10	*100% hand rub*	*Hand rub will be available either in locked*	*A & EM*	*100%*	*Immediate*	*100%*	*100%*	*May 2014*	●

	availability	*dispensers outside clinical areas at all times*	*Facilities*						
11	*Improved staffing establishment*	*Development of "Safer Staffing " review for nursing and midwifery in line with NICE guidance*	*Claire Champion*	*100%*	*June 2014*	*Completed*	*Completed*	*June 2014*	
12	*Caring and effective nursing is assured*	*Nurse staffing escalation policy*	*Claire Champion*	*100%*	*July 2014*	*Complete*	*Approved and updated policy*	*June 2014*	
13	*Specific establishment review*	*Birth Rate Plus calculations for midwifery staffing levels*	*WASH*	*100%*	*June 2014*	*Completed*	*Completed*	*June 2014*	
14	*Increased establishment*	*Review and improvement plan has increased establishment to 1:29*	*WASH*	*100%*	*June 2014*	*Completed*	*Completed*	*June 2014*	
15	*Measured pathway improvement*	*Shortfalls to be covered by re-deployment before use of bank or agency staff*	*WASH*	*100%*	*June 2014*	*Completed*	*Completed*	*June 2014*	
16	*Measurable improved safety*	*Safer nursing tool to identify acuity and dependence*	*Claire Champion*	*100%*	*June 2014*	*And Dependency Tool in place as pilot*	*Adult acuity and dependency tool in place*	*June 2014*	
17	*Enhanced support for staff*	*Newly qualified midwife preceptorship programme – midwives cannot progress until competencies tested*	*WASH*	*100%*	*June 2014*	*100%*	*Completed*	*June 2014*	
18	*Enhanced support for staff*	*Temporary staff have a local induction and must self-declare competencies*	*WASH*	*100%*	*June 2014*	*100%*	*Completed*	*June 2014*	
19	*Training*	*Improvement in the recruitment service*	*Janet Lynch*	*Sessions complete*	*June 2014*	*100%*	*Completed*	*June 2014*	
20	*Enhanced assurance*	*Complete review of all waste storage areas*	*Estates*	*100%*	*Aug 2014*	*Complete*	*100%*	*June 2014*	
21	*Training compliance and comprehension*	*All appropriate staff are aware of the need for PPE when appropriate*	*Estates, IGC, & IPC*	*100%*	*Dec 2014*	*100%*	*100%*	*June 2014*	
22	*Enhanced compliance*	*Creation of a robust ledger of the equipment the Trust possesses*	*Estates and Facilities*	*100%*	*Completed*	*Completed and audited for both sites*	*Completed*	*June 2014*	
23	*Measured pathway improvement*	*100% women are placed on the appropriate pathway at the time of booking*	*WASH*	*By audit, 100%*	*Jul 2014*	*100%*	*Complete and on-going*	*July 2014*	
24	*Reduced LOS*	*Early reviews by the obstetric and neonatal*	*WASH*	*100%*	*July 2014*	*Plans approved*	*Complete and on-*	*July 2014*	

		teams					*going*		
25	*Measured pathway improvement*	*Collaborative working with allied health professionals*	*WASH*	*100%*	*July 2014*	*Plans approved*	*Complete and on-going*	*July 2014*	
26	*EOLC*	*Roll out of Principles for the care of dying patients*	*LTC&C*	*100%*	*July 2014*	*On-going*	*On-going*	*July 2014*	
27	*EOLC*	*Greenwich Hospice and Nurse education working to deliver EOLC training to all appropriate staff*	*LTC&C*	*100%*	*July 2014*	*On-going*	*On-going*	*July 2014*	
28	*EOLC*	*EOLC training included in preceptorship training for new band 5 nurses*	*LTC&C*	*100%*	*July 2014*	*On-going*	*On-going*	*July 2014*	
29	*EOLC*	*Review of the information available to families following a death*	*LTC&C*	*100%*	*July 2014*	*Complete*	*Complete*	*July 2014*	
30	*C&YP*	*Review of available technology to maximise efficient nurse response for call bell systems in CYP*	*C&YP*	*100%*	*July 2014*	*Complete but system not appropriate*	*Complete*	*Jul 2014*	
31	*Outpatients*	*Review of supervision of vulnerable patients in clinics*	*LTC&C*	*100%*	*July 2014*	*Complete*	*Complete*	*Complete July 2014*	
32	*Enhanced support for staff*	*Practice development nurses to support clinical areas*	*Nursing Development Team*	*100%*	*July 2014*	*Completed*	*All PDNs in post and supporting clinical areas*	*July 2014*	
33	*Enhanced support for staff*	*Clinical staff have access to clinical development opportunities through HESL funding scheme*	*Nursing Development Team*	*100%*	*July 2014*	*Completed*	*Commissioning for student places completed*	*July 2014*	
34	*Enhanced support for staff*	*Clinical link lecturer to support all students*	*Nursing Development Team*	*100%*	*July 2014*	*Completed*	*Named Clinical Lecturer in place for all clinical areas*	*July 2014*	
35	*Update and ratification*	*All clinical waste policies*	*Estates*	*100%*	*Dec 2014*	*Unknown*	*100%*	*July 2014*	
36	*Digilock use audit*	*Appropriate use of locks on all of the necessary clinical waste areas*	*Estates*	*100%*	*Dec 2014*	*100%*	*100% completion*	*July 2014*	
37	*Enhanced public awareness*	*Poster and leaflet campaign on hand hygiene*	*IP Site Matron Comms*	*100%*	*End Jul 2014*	*100%*	*Posters printed*	*July 2014*	
38	*Enhanced public awareness*	*C & YP Poster design completion*	*DIPC C&YP*	*100%*	*Jul 2014*	*Winning designs chosen*	*Posters displayed*	*Jul 2014*	
39	*Enhanced awareness*	*Ad hoc asset and materials survey for QEH*	*DIPC*	*100%*	*July 2014*	*100%*	*100%*	*July 2014*	
40	*Enhanced compliance*	*Creation of a committee structure to provide assurance that medical devices are being managed appropriately at ward/department*	*Director of Nursing and Clinical Services*	*100%*	*June 2014*	*Committee Structure in place cross site*	*Completed*	*July 2014*	

		level							
41	*Enhanced compliance*	*Gap analysis of the equipment needed at a divisional level*	*Divisional leads*	*100%*	*Completed*	*Complete. Equipment ordered for some Divisions*	*July 2014*	*Completed July 2014*	
42	*Enhanced staff awareness*	*Serious incident investigation to be included in Band 5 preceptorship training*	*Janet Lynch*	*100%*	*July 2014*	*Completed*	*Completed*	*July 2014*	
43	*Identification of learning*	*Learning specifically discussed in OWL, A2E, divisional governance and AAR meetings*	*Divisional Governance leads/meeting chairs*	*100%*	*July 2014*	*Completed*	*Completed*	*July 2014*	
44	*Enhanced staff awareness*	*Divisional governance meetings to begin with patient impact story*	*Divisional Governance leads*	*100%*	*July 2014*	*Completed*	*Completed*	*July 2014*	
45	*Security*	*All vulnerable areas of QEH ED secured*	*John Ferguson*	*100%*	*Aug 2014*	*Parts on order (one lock to be done). Now part of the winter pressures plan and will be completed end Oct 14*	*Staff increased awareness*	*August 2014- delayed to Oct 14*	
46	*Measured pathway improvement, reduced admission days*	*Outpatient management of hyperemesis*	*WASH*	*100%*	*Oct 2014*	*Plans approved and now with the medicine management committee(sits on 28 August)*	*Plan implementation*	*End August 2014*	
47	*Outpatients*	*All patient notes will be available at outpatients*	*Medical Records*	*100%*	*August 2014*	*Review of OPD notes complete, standard to be agreed with medical record. Resources allocated to ICare= later implementation to MR SOP. Change now*	*Standard agreed and auditing in place. Already completed for UHL – compliance at QEH on target for Nov 14*	*Aug – slipped to Nov 2014*	

						begins Sept 1st with improvement expected – Nov 2014			
48	*EOLC*	*New DNAR policy under review – new policy to include changes in case law and ceilings of treatment*	*LTC&C Resus Committee*	*100%*	*August 2014*	*External policy review complete and now progressing through the committee stage. Revision requested by the Patient Safety Committee – next meeting – 5th September*	*Policy drafted and ready for approval and ratification – further changes requested – back out to consultation*	*August 2014 – slipped to end Oct 14*	
49	*Safe and effective care*	*Patient care escalation policy, in and out of hours*	*C & YP*	*100%*	*August 2014*	*In development*	*Escalation Policy in draft – 2nd draft has been approved – for ratification at next CYP divisional governance meeting*	*August 2014 – slip to end Oct 14*	
50	*Staff provided with aids to care*	*Reviewed nursing documentation pack to ensure that risks are assessed and documented*	*Claire Champion*	*100%*	*July 2014*	*100%*	*Packs approved – for ratification at Trust level- implementation roll out – 1st September*	*Aug 2014*	
51	*Measurable improved safety and patient experience*	*Trust Nursing and Midwifery strategy to highlight Trust values and 6 C's*	*Claire Champion*	*100%*	*May 2014*	*Completed, planning implementation – this was written in May 14*	*Implementation plan completed – roll out planned*	*Aug 2014*	
52	*Audit of staff*	*All staff trained in PPE use to appropriately*	*Estates, IGC, &*	*100%*	*Dec 2014*	*100%*	*100% of relevant*	*August 2014*	

	groups		*IPC*				*staff trained to use PPE*		
53	*Enhanced awareness*	*Ad hoc asset and materials survey for QEH*	*DIPC*	*100%*	*Aug 2014*	*100%*	*100%*	*Aug 2014*	
54	*Enhanced public awareness*	*Adult Strapline competition*	*DIPC C&YP*	*100%*	*Jul 2014*	*Competition closed*	*Posters printed and displayed during Hand Hygiene week – Oct 14*	*Aug 2014*	
55	*Enhanced compliance*	*Creation and ratification of an integrated Medical Devices policy*	*Medical Devices Manager*	*100%*	*August 2014*	*Drafted, awaiting approval – delayed- Nov 2014*	*Policy approved and ratified*	*August 2014 – slip to Dec 14*	
56	*Enhanced staff awareness*	*Inter-divisional learning to be a standing agenda item*	*OWL Group*	*100%*	*Aug 2014*	*TOR to be reviewed*	*Implementation plan on-going*	*Aug 2014*	
57	*Enhanced staff awareness*	*Trust publication of lessons learned*	*Divisional Governance leads/Comms*	*100%*	*Aug 2014*	*Partially complete*	*Newsletter, divisional training and drop-in sessions begun and on-going*	*Aug 2014*	
58	*Enhanced staff awareness*	*Divisional publication of lessons learned*	*Divisional Governance leads/Comms*	*100%*	*Aug 2014*	*Completed and on-going for surgery in divisional newsletter*	*Newsletter, divisional training and drop-in sessions begun and on-going*	*Aug 2014*	
59	*Measured pathway improvement, reduced admission days*	*Induction of labour in low risk women*	*WASH*	*100% patients*	*Nov 2014*	*Plans approved, finalised and sitting with the innovations committee for final approval*	*Implemented*	*Pilot began Sept 2014*	
60	*Measured pathway improvement*	*Midwife led discharge clinics so that discharge process is swifter*	*WASH*	*100%*	*Sept 2014*	*Plans approved*	*Training in place*	*Complete Sept 2014- pilot running*	
61	*Secure storage site locations*	*No clinical waste or cleaning products are accessible to the public*	*Estates*	*100%*	*Dec 2014*	*80%*	*80% compliance results from recent audit*	*September 2014*	
62	*Enhanced public awareness*	*Hand Hygiene roadshow*	*LTC&C*	*100%*	*Oct 2014*	*In planning*	*Self-sustaining programme.*	*Sept 2014*	

							Preparation complete and dates set for Infection Prevention Week in October		
63	*Enhanced staff awareness*	*Training and updates in induction/mandatory training*	*Deputy DIPC A & EM*	*>85%*	*On-going*	*Current 76%*	*>85%*	*Sept 2014*	
64	*Enhanced staff awareness*	*Divisional purchase of light boxes and training gel*	*All divisions*	*100%*	*Aug 2014*	*100%*	*100%*	*Sept 2014*	
65	*Enhanced staff awareness*	*ANTT and hand hygiene included in band 5 preceptorship training*	*Janet Lynch*	*>85%*	*Nov 2014*	*Ratified and included in the training package*	*Implemented*	*Sept 2014*	
66	*Enhanced compliance*	*Policy update to include escalation for non-compliant staff*	*DIPC with divisional leads*	*100%*	*Jul 2014*	*In the committee stage- awaiting Chair's action then to Patient Safety for ratification*	*Implemented*	*Sept 2014*	
67	*Audit*	*>95% compliance with hand hygiene audit, reported on Synbiotix*	*WASH A & EM*	*>95%*	*Sept 2014*	*91%*	*A & EM 96%* *WASH 94%*	*A & EM Sept 2014* *WASH*	
68	*Audit*	*>95% compliance with bare below the elbows initiative audit, reported on Synbiotix*	*WASH A & EM*	*>95%*	*Sept 2014*	*Aug results WASH - 100% A & EM – 99%*	*>95%*	*Sept 2014*	
69	*Measurable improved safety and patient experience*	*Pilot of Productive Ward principles to share learning across all areas*	*Claire Champion*	*100%*	*October 2014*	*Pilot has begun with 3 wards initially*	*In piloting stages*	*Oct 2014*	
70	*Measured pathway improvement*	*Surgical patient pathway review*	*S, ES & CC*	*100%*	*In planning*	*Review completed – business case being produced for SAU for both sites*	*In planning stages*	*October 2014*	
71	*Pathway streaming*	*Internal Short –term A & EM business case for winter funding allocation*	*A & EM*	*100%*	*October 2014*	*Approved*	*Implementation plans*	*Oct 2014*	

72	*100% within 24 hours*	*All patients to have EDD within 24 hours of admission*	*HON - UHL*	*100%*	*September 2014*	*Planning stage*	*Roll out stage*	*October 2014*	
73	*Patient board rounds*	*Daily MDT rounds*	*Divisional Director A&EM*	*100%*	*October 2014*	*Scoping and Planning Stage*	*Pilot in place and being expanded to A & EM wards*	*October 2014*	
74	*Measured pathway improvement*	*Streamlined discharge process*	*WASH*	*100%*	*Oct 2014*	*Plans approved*	*Implementation Plans*	*Oct 2014*	
75	*Outpatients*	*Review OPD DNA's and identify barriers to attendance*	*LTC&C*	*100%*	*October 2014*	*Review underway*	*Review underway*	*October 2014*	
76	*Specific establishment review*	*Clinician and nursing skill mix within Surgery UHL*	*S, ES & CC*	*100%*	*October 2014*	*Ahead of schedule*	*Review underway*	*October 2014*	
77	*Enhanced support for staff*	*Competencies for all other bands under review*	*Nursing Development Team*	*100%*	*October 2014*	*Band 6 currently under review, Band 7 plan to review by October 2014*	*All Competency reviews to be completed by October 2014*	*October 2014*	
78	*Staff provided with skills to care*	*Review of Ward nursing leadership development – includes pressure ulcers, ANTT, falls and dementia*	*Nursing Development Team*	*100%*	*October 2014*	*Leadership programme under review*	*Continual development of existing leadership programme*	*October 2014*	
79	*Measurable improved safety and patient experience*	*Values linked to appraisal, recruitment and workforce policies*	*Janet Lynch*	*100%*	*October 2014*	*In planning*	*Work currently being undertaken and action plan target date will be set*	*October 2014*	
80	*Enhanced assurance*	*Creation of a staffing structure to implement the medical devices policy*	*Estates and Facilities*	*100%*	*October 2014*	*Advert placed awaiting interviews*	*Staff recruited and in post*	*October 2014*	
81	*Enhanced staff awareness*	*Poster and leaflet campaign to make staff more confident to report incidents*	*Patient safety leads*	*100%*	*October 2014*	*Planning*	*Implemented*	*October 2014*	
82	*Enhanced compliance*	*Workforce policies requiring staff to report incidents*	*Janet Lynch*	*100%*	*October 2014*	*Review*	*Implemented*	*Oct 2014*	
83	*Enhanced staff awareness*	*The analysis of serious and red incidents to be published quarterly*	*Patient Safety leads*	*100%*	*Oct 2014*	*Partially complete*	*SI's completed July 2014. Red incidents extraction has begun*	*Oct 2014*	

84	*Safety Walk round*	*HON to assess compliance on the ground in safety walkrounds*	*A & EM*	*100 %*	*November 2014*	*In planning Stages*	*In planning stages*	*1 Nov 2014*	
85	*Pathway streaming*	*Ambulance holding bay and CDU operational by end October 2014, will remove the need for grey chairs*	*A & EM*	*100%*	*Nov 2014*	*12 bedded unit being designed with project managers in place. On target as of 20 Aug 14*	*Planning & execution*	*Nov 2014*	
86	*Radiology*	*Completion of 7-day working feasibility plan, including agreed funding for additional staff*	*Radiology*	*100%*	*Oct 2014*	*Winter funds available- staff consultation process now on-going*	*Plan approved*	*Nov 2014*	
87	*Pathway streaming*	*Development and implementation of a standard pathway for elderly frail patients*	*Divisional Director A&EM*	*100%*	*Dec 2014*	*Approved*	*Consultant Lead to scope pathway guidance*	*Nov 2014*	
88	*Measured pathway improvement*	*Enhanced programme for LSCS women*	*WASH*	*100%*	*Nov 2014*	*In planning*	*Programme implementation*	*Nov 2014*	
89	*Enhanced support for staff*	*Training for managers to identify good practice and are able to challenge when values not being met*	*Janet Lynch*	*100%*	*Nov 2014*	*Plans approved*	*Implementation commenced*	*Nov 2014*	
90	*Enhanced support for staff*	*Trust recognition scheme*	*Janet Lynch*	*100%*	*Nov 2014*	*Plans approved*	*Implementation commenced*	*Nov 2014*	
91	*Publication of PSIPs*	*Divisional PSIP publication*	*Divisional Governance leads*	*100%*	*Nov 2014*	*Planning. Completed and on-going in surgery*	*Planning Completed*	*Nov 2014*	
92	*Publication of PSIPs*	*Trust PSIP publication*	*Patient Safety leads*	*100%*	*Nov 2014*	*Partial plan competed*	*Planning Completed,*	*Nov 2014*	
93	*Enhanced staff awareness*	*Payslip messages – quarterly*	*Patient safety leads*	*100%*	*Nov 2014*	*Review*	*Planning*	*Nov 2014*	
94	*Enhanced staff awareness*	*Shop floor and handover meetings with patient safety leads*	*Patient Safety leads*	*100%*	*Nov 2014*	*Review of resources*	*Planning*	*Nov 2014*	
95	*Reduced ED attendance*	*Plan to reduce attendance by treating in the community*	*CCG's/TDA*	*100%*	*October 2014*	*Whole Systems Group established with ToRs*	*Planning stage*	*December 2014*	
96	*Update,*	*Sharps policy*	*Estates & IPC*	*100%*	*Dec 2014*	*50%*	*100% completion*	*Dec 2014*	

	ratification and audit								
97	*Audit of staff groups*	*Staff are aware of how to dispose of clinical, domestic and confidential waste*	*Estates, IGC, & IPC*	*100%*	*Dec 2014*	*50%*	*100% completion*	*Dec 2014*	
98	*Training compliance and comprehension*	*All appropriate staff are aware of enhanced disposal of clinical, domestic and confidential waste*	*Estates, IGC, & IPC*	*100%*	*Dec 2014*	*50%*	*100% completion*	*Dec 2014*	
99	*Enhanced compliance*	*Business case submission for E-Quip Asset Management system to manage planned maintenance schedules*	*Estates and Facilities*	*100%*	*December 2014*	*Business case in process of being written*	*Business case written and submitted*	*December 2014*	
100	*Outpatients*	*Enhanced use of Bookwise to provide real time data on capacity in OPD*	*LTC&C*	*100%*	*Demonstration of system 22 July 14*	*Review of systems underway*	*Review of systems to be completed*	*January 2015*	
101	*Enhanced patient awareness*	*Duty of candour discussions will be monitored and reported*	*Patient Safety leads/ Divisional Governance leads*	*100%*	*Nov 2014*	*Proposal to PSC July 2014, accepted.*	*Reports to divisions start Sept 2014. Report to the Trust Scorecard Nov 2014*	*Jan 2015*	
102	*Enhanced compliance*	*Development of individualised care plans which are age appropriate for children and young people*	*C & YP*	*100%*	*July 2014*	*Baseline audit complete*	*Development of a new set of core care plans*	*Jan 2015*	
103	*Pathway improvement*	*Extension of consultant hours – will reduce wait times & provide support for junior staff*	*A & EM*	*100%*	*Feb 2015*	*Funding agreed*	*Advert published in Nov 14*	*Feb 2015*	
104	*Specific establishment review*	*Clinician and nursing skill mix within Surgery QEH*	*S, ES & CC*	*100%*	*February 2015*	*In planning stage*	*Review on schedule*	*February 2015*	
105	*QEH ED repurpose*	*Agreed and funded plans for the rebuilding of QE ED, building work commences*	*Estates, A & EM*	*100%*	*Winter 2015*	*On-going*	*Planning Capacity requirement for relocation of services to create space*	*March 2015*	
106	*Measured pathway improvement*	*LAS RAT waiting time targets are met* *Extended hours* *Pilot to agree SOP* *Senior mid-grade funding to cover 1800 - 0000*	*A & EM*	*100%*	*Winter 2014/15*	*On-going*	*Planning and recruitment phase*	*March 2015*	
107	*Pathway improvement*	*Recruitment plan for senior medical staff within ED*	*A & EM*	*100%*	*December 2014*	*Scoping and mapping exercise for pathway model*	*Scoping complete and staffing requirement met*	*March 2015*	

						underway			
108	*Pathway streaming*	*Development and implementation of a standard pathway for specialist medicine patients including gastroenterology*	*Divisional Director A&EM*	*100%*	*October 2014*	*Planning*	*Consultant post being recruited to – interviews in September. There is adequate cover across both sites in the interim. Working group has been established*	*March 2015*	
109	*Measured pathway improvement*	*Development of surgical assessment unit at UHL for direct GP referrals*	*S, ES & CC*	*100%*	*In planning*	*In planning stages*	*In planning stages*	*March 2015*	
110	*EOLC*	*Ward and outpatient staff to receive Sage and Thyme communications training*	*S, ES & CC LTC&C*	*100%*	*July 2014*	*On-going*	*On-going*	*March 2015*	
111	*Improved staffing establishment*	*International recruitment campaigns*	*Claire Champion/ Janet Lynch*	*75%*	*March 2015*	*30%*	*Recruitment teams holding overseas sessions*	*March 2015*	
112	*Improved staffing establishment*	*Return to Nursing campaigns*	*Claire Champion/ Janet Lynch*	*100%*	*March 2015*	*Pilot programme completed and successful, roll out of new programme underway*	*Approval and roll out of new programme*	*March 2015*	
113	*Improved staffing establishment*	*Dedicated recruitment days for qualified staff and newly qualifying students*	*Claire Champion/ Janet Lynch*	*100%*	*On-going*	*Dedicated recruitment days underway*	*Designated recruitment days planned for the year*	*March 2015*	
114	*Pathway streaming*	*Completion of capacity modelling*	*A & EM McKinseys*	*100%*	*October 2014*	*Pathway modelling complete- development of implementation plan and staff recruitment plan*	*Completion and proposal agreed*	*June 2015*	
115	*Pathway streaming*	*Long –term A & EM business case – Redesign of A&E and Acute Medicine pathways*	*A & EM*	*100%*	*June 2015*	*Emergency pathways plan now*	*Implementation plans*	*June 2015*	

						commenced			
116	*Pathway streaming*	*Ambulatory AMU model To be fully implemented*	*Divisional Director A&EM*	*100%*	*June 2015*	*Planning*	*Implementation plans*	*June 2015*	
117	*Outpatients*	*Review of clinical space within outpatients*	*LTC&C Estates*	*100%*	*In planning stages July 2015*	*Under review at present within estates review plans*	*In planning*	*July 2015*	
118	*Mandated ED Targets*	*Meet and exceed all externally reported metrics*	*A & EM*	*95%*	*March 2015*	*Daily monitoring of thresholds and silver command in place*	*Increase in capacity to deal with demand*	*July 2015*	
119	*Measured pathway improvement*	*Trauma patients not kept fasting if unrealistic chance of theatre slot – involves anaesthetists and introduction of nutrition pre-operative pack*	*S, ES & CC*	*100%*	*In planning*	*In planning*	*September 2015*	*September 2015*	
120	*Pathway streaming*	*Implementation of the PULL model for inpatients*	*WSIG*	*100%*	*October 2014*	*On-going engagement with Adult Integrated Care Programme, especially local authority /UHL Work stream 2. Weekly monitoring of delayed discharges at Tracker meeting. Hospital at Home to come online*	*Development of models to be implemented*	*December 2015*	
121	*Radiology*	*Capital equipment refurbishment /replacement scheme UHL Digital x-ray rooms & ultrasound machines*	*Radiology*	*100%*	*TBC on business case submission*	*Business case developed*	*Business case completion and submission*	*Nov 14*	
122	*Measured pathway improvement*	*Review of prophylactic antibiotics given to newborns on neonatal wards*	*WASH*	*100% patients*	*In planning*	*In planning stage*	*Antibiotic review completed*	*Feb 2015*	
123	*Measured*	*Pathway review for women with complex*	*WASH*	*100%*	*March 2015*	*In planning*	*Pathway under*	*Joint working*	

	pathway improvement	*social needs whose babies are at risk*					*review with Pan London Group and being audited*	*with Pan London Group. local authority and commissioners TBC*	
124	*Measured pathway improvement, reduced LOS*	*Review of postpartum women awaiting court date decisions re; babies at risk (length of stay sometime up to 6 weeks)*	*WASH*	*100%*	*March 2015*	*In planning with assistance of Pan London Group*	*Agreed social care pathway and process for all women awaiting court decisions*	*Needs external assistance*	
125	*Measured pathway improvement*	*Recruitment of 2 ortho-geriatricians on QEH site*	*S, ES & CC*	*100%*	*January 2015*	*In planning, vacancy authorisation in process*	*In planning*	*Apr 2015*	
126	*Patient Experience*	*Improved as measured by ED FFT*	*A & EM*	*100%*	*In place and on-going*	*In place and o-going*	*Improved response rates and scores*	*On-going*	
127	*Patient Experience*	*Improved as measured by Maternity FFT*	*WASH*	*100%*	*In place and on-going*	*In place and o-going*	*Improved response rates and scores*	*On-going*	
128	*Patient Experience*	*Improved as measured by inpatient FFT*	*Trust*	*100%*	*In place and on-going*	*In place and o-going*	*Improved response rates and scores*	*On-going*	
129	*EOLC*	*100% in 4 hours - Palliative care patients to have care plan in place following admission*	*A&EM*	*100%*	*August 2014*	*Staff training on EOLC in place*	*Patients have care plan in place 4 hours after admission*	*On-going*	
130	*EOLC*	*100% every 4 hours - Palliative care patients to have 4 hourly reviews documented in their records*	*A&EM*	*100%*	*August 2014*	*Staff training on EOLC in place*	*Patients have 4 hourly reviews undertaken*	*On-going*	
131	*EOLC*	*Review of after-death care*	*LTC&C*	*100%*	*July 2014*	*Complete*	*Checklist developed & subject to audit*	*On-going audit*	
132	*Recruitment and Retention plan*	*Recruitment plan to address vacancies*	*C & YP*	*100%*	*On-going*	*On-going*	*On-going recruitment campaign*	*On-going*	
133	*Specific establishment review*	*Increase nurses able to care for children with oncological needs*	*C & YP*	*100%*	*On-going*	*On-going*	*On-going recruitment campaign*	*On-going*	
134	*E-Rostering*	*Review of use of E-Rostering Tool*	*Nursing Development Team*	*100%*	*Aug 2014*	*Review complete*	*External reporting complete and accurate*	*On-going external reporting*	

								monitored	
135	*>85% compliance*	*Training on recognising and reporting incidents – induction and combi-day*	*Patient safety leads*	*>85%*	*Oct 2014*	*Implemented*	*Implemented*	*On-going*	
136	*External standard compliance*	*London Quality Standards for UHL ED*	*A & EM*	*100%*	*Winter 2015*	*13 met 1 not met*	*1 standard not met required recruitment of ED Consultants - on-going*	*October 2015*	
137	*External standard compliance*	*London Quality Standards for QEH ED*	*A & EM*	*100%*	*Winter 2015*	*9 met, 5 not met*	*Planning for recruitment of consultant cover*	*October 2015*	
138	*External standard compliance*	*London Quality Standards for UHL Paeds ED*	*A & EM*	*100%*	*Winter 2015*	*13 met 1 not met*	*1 standard not met required recruitment of ED Consultants - on-going*	*October 2015*	
139	*External standard compliance*	*London Quality Standards for QEH Paeds ED*	*A & EM*	*100%*	*Winter 2015*	*9 met, 5 not met*	*Planning for recruitment of consultant cover*	*October 2015*	
140	*Measurable improved safety*	*Safer nursing tool to identify acuity and dependence*	*GM CYP*	*100%*	*Oct 2015*	*Adult Acuity Tool being piloted & Business case to be written for purchase of tool*	*Adult Acuity Tool implemented & business case to fund paediatric tool submitted*	*Oct 2015*	

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Healthier Communities Select Committee			
Title	Lewisham Future Programme		
Contributor	Scrutiny Manager	Item	6
Class	Part 1 (open)	14 January 2015	

The following papers are included under this item:

- Adult Social Care Charging Consultation
- Public Health savings proposals – outcomes of consultation
- Future of Day Care Services
- Savings updates
    - Cost effective care packages
    - Reductions on costs of learning disability provision
    - Changes to sensory services provisions
    - Review of services to support people to live at home
    - Reduction and remodelling of Supporting People housing and floating support services

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Healthier Communities Select Committee			
Title	Consultation on changes to charges and contributions to adult social care services		
Contributor	Executive Director for Community Services	Item	6
Class	Part 1 (open)	14 January 2015	

1. Summary and purpose of report

1.1 This report invites comments from Members of the Healthier Communities Select Committee on the proposals to amend the Council's policy on charging for home care and non-residential care services and on extending charging to users with learning disabilities in supported accommodation.

1.2 On 12 November, the Mayor considered a number of proposals to address an anticipated General Fund revenue budget deficit of £85m over the next three years. At that meeting, the Mayor agreed that officers should consult on proposals to change the way people in Lewisham are charged for adult social care services.

1.3 At an earlier meeting on 21 October, Members of the Healthier Communities Select Committee approved the proposed consultation arrangements which set out how officers would seek the views from users, carers, providers and stakeholders on the proposed changes.

1.4 As part of the formal consultation, Members of the Healthier Communities Select Committee are now asked to comment on the proposals. The Committee's views will form part of the consultation outcome report.

2. Recommendation

2.1 Members of the Select Committee are invited to comment on the specific proposals set out in the consultation document which is attached at Annex 1.

3. Budget background

3.1 The detail of the budget situation was set out in the report: Lewisham Future Programme 2015/16 Revenue Budget Savings Report, which was presented to Scrutiny Committees throughout October and to the Mayor on 12 November.

3.2 That report set out the budget challenges faced by the Council and outlined a range of savings proposals to enable a balanced budget for 2015/16 to be put forward to Council in February 2015. The proposals presented to Healthier Communities Select Committee and to the Mayor included the proposals to amend the Council's policy on charging for home care and non-residential care services (A5) and on extending charging to those LD users in supported accommodation (A2).

4. Policy context

4.1 The focus for Adult Social Care services continues to be on the provision of safe and high quality care to those with eligible needs whilst achieving a reduction in

spend. The Council also needs to ensure that it makes the best use of limited resources whilst offering residents access to high quality services that meet their eligible care or support needs in a personalised way.

4.2 In allocating resources to adult social care services, the Council seeks to ensure that those with the greatest need receive the community care services they need to maximise their independence and to enable them to live in their own homes in their local communities wherever possible.

4.3 If a client is deemed eligible for statutory social care services under FACS, a package of care may be put in place. In accordance with the Council's policy on charging, an assessment is carried out to determine whether or not the client has the financial means to contribute to the cost of their care.

4.4 In providing services to adults with social care needs, the Council must comply with the current legislation and guidance issued by the Department of Health and other relevant bodies.

4.5 This includes Fair Access to Care Services (FACS); Fairer Charging Policies for Home Care and other non-residential Social Services – Guidance for Councils with social services responsibilities and Fairer Contributions Guidance – calculating an individual's contribution to their personal budget. In accordance with guidance issued by the Department of Health, before deciding whether or not to implement a change to the charging policy, a consultation must be carried out. The consultation paper, containing background information, details of the proposals and a questionnaire, is attached at Annex 1.

4.6 From April 2015, the Council must also meet the new obligations and provisions introduced by The Care Act. The recently published Care and Support Statutory Guidance published under the Act sets out a new framework for charging for care.

5. Consultation proposals

5.1 The attached consultation paper sets out ten proposed changes to the Council's policy on contributions and charging for adult social care. In proposing these changes the aims are:

- To increase total income as a contribution to the Council's overall savings target
- To remove anomalies in the charging policy where some services are charged for and some are not; and
- To bring charging for care at home more in line with charging for residential care.

5.2 The proposals include changes to: the income support buffer; the net disposable income; the maximum charge; charging for supported accommodation, respite care provided at home and transport; introducing charges for services provided to carers; charges for day centre attendance and meals. The consultation is also suggesting that charges for services are implemented from the first day services are provided.

5.3 Members are invited to comment on each of the ten proposed changes. A record of the comments made by Members will be included in the consultation outcome report.

6. Financial Implications

6.1 The Lewisham Future Programme 2015/16 Revenue Budget Savings Report sets out the financial issues that need to be taken into account in order for the Council to set a balanced budget in 2015/16.

6.2 The savings proposals attached to that report included a proposal to consult on changes to the Council's adult social care charging policy to achieve a saving of £275k and an additional saving of £50k in relation to charges for LD clients using supported living services.

6.3 All costs relating to the consultation have been met from the Strategy, Improvement and Partnership budget, Adult Social Care and Joint Commissioning budgets within Community Services. The funding set aside also included provision to respond to individual demands, for example for advocacy and translation.

7. Legal implications

7.1 Section 17 of the Health and Social Services and Social Security Adjudications Act 1983 (HASSASSA Act 1983) gives Local Authorities a discretionary power to charge adult recipients of non-residential services provided such charges are reasonable and they have regard to the Government's "Fair Access to Care Service" national guidance.

7.2 The Council must also comply with guidance issued by the Department of Health and other relevant bodies. This includes Fairer Charging Policies for Home Care and other non-residential Social Services – Guidance for Councils with social services responsibilities and Fairer Contributions Guidance – calculating an individual's contribution to their personal budget.

7.3 The guidance on Fairer Charging Policies recommends that consultation with users and carers about charging policies and increases or changes in charges should follow good practice advice. The advice set out in the Cabinet Office guidance states that timeframes for consultation should be proportionate and realistic to allow stakeholders sufficient time to provide a considered response and where the consultation spans all or part of a holiday period policy makers should consider what if any impact there may be and take appropriate mitigating action.

7.4 The guidance adds that the amount of time required will depend on the nature and impact of the proposal and might typically vary between two and 12 weeks.

7.5 The Care Act rewrites much of the existing adult social care legislation. The new requirements of the Care Act do not come into force until 2015. The consultation has followed current legislative requirements and all proposals are in line with the new requirements of the Care Act.

8. Equalities Implications

8.1 The consultation seeks to ensure that there is meaningful consultation with those who might be affected by any change. Where necessary, support is being provided to ensure access to the consultation. Support includes the provision of accessible venues, translation services where requested, advocacy services where required, and a BSL interpreter at the consultation meetings. The information pack is available in large print and made accessible to those with learning disabilities. An audio version is also be available on request.

9. Environmental Implications

9.1 Although the information pack has been printed and sent to current service users, the consultation documents are also available online to download. Where possible, officers and facilitators are travelling to meet users at suitable locations such as day centres to avoid unnecessary travel by users and their carers.

10. Conclusion

10.1 Consultation must take place on the proposals set out in the paper at Annex 1 before any changes can be implemented and any potential savings realised. Comments from Committee Members are invited on these proposals.

If there are any queries on this report please contact Sarah Wainer, Head of Strategy, Improvements and Partnerships on 020 8314 9611 or by email on sarah.wainer@lewisham.gov.uk.

Charges and contributions to adult social care services

Consultation

24 November 2014 to 25 January 2015

Information and questionnaire

Lewisham

If you are reading this on behalf of a service user and they need a more accessible version please fill in the sheet below or contact us by telephone.

You can ask for this information and questionnaire in:

- easy-to-read version
- another language
- audio
- Braille.

If you need any of these or if you would like help completing the questionnaire, please fill in the sheet below and send it to us using the pre-paid envelope provided.

Strategy and Policy Team
Community Services Directorate
Fifth Floor West
Laurence House, 1 Catford Road
Catford SE6 4RU

I require a large print version (size 16 font) ☐

I require a jumbo print version (size 18 font) ☐

I require a copy in Braille ☐

I require a copy translated into another language ☐

[please name language] .....

I require an easy-to-read version ☐

I require an audio version ☐

My name: .....

My address: .....

..... Postcode .....

My telephone number: .....

If you have any difficulty understanding the information in this pack please call 020 8314 8100 and leave a message with your contact details and we will get back to you.

Charges and contributions to adult social care services

24 November 2014 to 25 January 2015

Councils across the country have to make savings because of a reduction in funding from the Government. Lewisham Council has to make savings of £85 million over the next three years, which means reducing the budget by a third – or £1 in every £3. The amount of savings to be made means that we must consider many different options.

One of these options is to consider how and where we can make changes to the services we provide so that we save money while keeping the same level of quality. We are considering options for all council services, including adult social care.

This consultation is an opportunity for you to give your opinion on how a saving to adult social care services can be made. It offers the chance to consider a number of specific proposals that we have explored to help meet our savings targets. We welcome other points of view and different proposals or ideas.

In Lewisham, some people who get social care services pay for, or contribute to, the cost of their care and support. To make sure this is fair, we have rules on how we charge for services and how we calculate the contributions you make.

We are considering changing these rules and we would like to hear your views on the different proposals given in this paper. These changes could affect people who receive home care, day care, and those who choose to have a direct payment. Services such as residential care, equipment and adaptations to your home are not affected.

Where possible we have used plain and simple English. However, we have had to use some words and phrases that may be unfamiliar to you. You can find a glossary that explains these words and phrases on page 17.

It is very important that we hear from you and we welcome any comments you would like to make on this subject. We have written to all service users who may be affected by these changes asking them to complete this questionnaire.

We are inviting other local organisations, including voluntary and advocacy groups in Lewisham, to comment on these proposals.

How can I take part in the consultation?

Online – go to www.lewisham.gov.uk/asccharges

By post – please fill in the enclosed questionnaire and send it back to us in the pre-paid envelope provided.

By attending an event – you can hear about the proposed changes and discuss them with Council officers by attending one of the public events we are holding.

- 10am–12 noon, 18 December 2014, Mulberry Centre, 15 Amersham Vale, New Cross, SE14 6LE
- 7–9pm, 15 January 2015, Civic Suite, Catford Road, Catford SE6 4RU

Both of these are accessible buildings and have hearing loops and the events will be signed in British Sign Language. If you would like to attend please contact us to register by phone on 020 8314 8100 or by email to adultcare@lewisham.gov.uk

Lewisham Speaking Up, the independent advocacy group for people with learning disabilities living in Lewisham is also holding a special BIG self-advocacy group where people can attend to learn more and have their say at:

- 10.30am–12.30pm, 16th January 2015, Deptford Albany, Douglas Way, Deptford SE8 4AG

It would be helpful if you would register to attend to give us an idea of the number of people who want to attend. You can let us know by calling 020 8692 1862 or email: info@lsup.org.uk . If you can't tell us in advance, then just turn up on the day.

By email – you can send any views or any queries by email to adultcare@lewisham.gov.uk

By using an advocate – Lewisham is home to a wide range of community groups which can provide support and advice to those needing it, whether or not they receive social care services. The following section lists a number of these community organisations who have offered to provide additional support or advice to our service users or their families during this consultation. They have each provided an outline of the sort of support they offer.

- **Carers Lewisham** supports unpaid carers in the London borough of Lewisham aged 5 upwards. We provide a range of services including advice, information, emotional support, breaks, opportunities to meet other carers, time out from caring activities such as relaxation days and wellbeing sessions; coping strategies, specialist support for parent carers, carers of people with dementia or mental health problems, older carers and carers who are caring for someone who is nearing the end of their life. Our aim is to build healthy caring communities.

  Lewisham Carers Centre, Waldram Place, Forest Hill, SE23 2LB
  Telephone: 020 8699 8686
  Email: info@carerslewisham.org.uk
  Website: www.carerslewisham.org.uk

- **Victim Support** is here to help anyone affected by crime, not only victims and witnesses, but their friends, family and any other people involved. Because we're an independent charity, you can talk to us whether or not you reported the crime to the police. If you want, we can support you without the involvement of the criminal justice system, and we won't contact them about you unless we feel someone is at risk. We are here just to support you. - See more at: www.victimsupport.org

  Local contact number: 020 8854 1113 (Monday–Friday 9am–5pm)
  National Supportline: 0845 30 30 900

- **Lewisham Ethnic Minority Partnership (LEMP)** is a network of organisations and individuals that disseminates information, offers support, guidance and signposting, as well as provides opportunities for BME community groups to air their views, aspirations and opinions as well as to network with others.

  Elsa Pascal
  2nd Floor Showroom, H E Olby, 307-313 Lewisham High Street, Lewisham SE13 6NW
  Telephone: 020 8690 0013
  Email: lemp@btconnect.com

- **Centre for Vietnamese elders**, carers & people with health problems. Offers access to advice on benefits, language support, health care, and housing. Also health advice drop-in, health talks and mobile optician. Our carers support project provides advice, counselling, help with applications, training, social activities, outings, short breaks. Lunch club two days a week. Games, trips, cultural events, festivities.

  Federation of Refugees from Vietnam in Lewisham (FORVIL)
  Evelyn Community Centre, Wotton Road, Deptford, SE8 5TQ
  Telephone: 020 8694 0952, Fax: 020 8469 0364
  Email: forvilandproject@yahoo.co.uk
  Website: to www.forvil.org.uk

- **METRO** is a leading equality and diversity charity, providing health, community and youth services across London and the South East as well as national and international projects. METRO works with anyone experiencing issues related to gender, sexuality, diversity or identity and has five areas of work: METRO Youth; METRO Sexual and Reproductive Health; METRO HIV; METRO Mental Health and Wellbeing; METRO Community Services in Lewisham include: LGBT Equalities work; counselling and mental health crisis advice and support for LGBT people; LGBT mental health drop-in; youth group and service for LGBT 16-25 year olds; schools work; hate crime and domestic abuse service for LGBT people.

  Telephone: 020 8305 5000
  Email: info@metrocentreonline.org
  Website: www.metrocentreonline.org

- **170 Community Project's Advice Service** offers general advice and information, help with application forms, advice and casework in welfare benefits and assistance and representation at appeal hearings. We have a specialist housing caseworker and a Spanish speaking advice worker.

Appointments follow initial contact and home visits are offered to housebound residents. We also have access to computers and assistance with benefits claims online. Our service is free, confidential and independent.

170 Community Project, 170 New Cross Road, New Cross SE14 5AA.
Telephone: 020 7732 9716
Email: admin@170cp.org.uk

- **Lewisham Pensioners Forum**. Our main aim is to make sure that the views and thoughts of people 50+ are heard. We provide a means for individuals and groups to influence local and national government where decisions made impact on everyday life of ALL pensioners. Core office hours: 10am to 2pm Monday to Thursday.

  The Saville Centre, 436 Lewisham High Street, Lewisham SE13 6LJ
  Telephone: 020 8690 7869
  Email: kerrysmith2@btconnect.com lpforum@btconnect.com
  Website: www.lewishampensionersforum.org

- **Voluntary Services Lewisham** supports vulnerable isolated Lewisham residents by providing direct services delivered by volunteers. We run a befriending service at home and over the telephone. We operate Access Lewisham a community transport scheme for people unable to use public transport. We run happiness and wellness programs and operate seven mental health drop-ins and run seasonal projects such as gardening DIY and the Christmas project. All our projects and services aim to reduce isolation and stop Lewisham residents' health deterioration.

  300 Stanstead Road, Forest Hill SE23 1DE
  Website: www.vslonline.org.uk
  Email: info@vslonline.org.uk
  Telephone: 020 8291 1747

- **The 999 Club** runs a day centre in Deptford, an advice and advocacy service, and a winter night shelter. A variety of outside agencies, including NHS nurses, the Samaritans, CRI, Street Rescue, attend the day centre to meet clients. The centre is open 11am–4pm on Monday, 9.30am–4pm Tuesday–Friday.

  21 Deptford Broadway, Deptford SE8 4PA.
  Telephone: 020 8694 5797.
  Contact: Paul Hughes.
  Email: Paul@999club.org

- **Community Connections** supports vulnerable adults who are resident in Lewisham to improve their social integration and wellbeing by accessing local community resources. Facilitators will identify local services that meet the needs and interests of the individuals supported and help them to access these services such as clubs, lunch groups, activities or just a place to socialise. We can also provide support to local voluntary and charity sector organisations to develop services and cross-support activities.

  For more information on how you can refer, please contact us on:
  Email: communityconnections@ageuklands.org.uk
  Telephone: 020 8314 3244
  Website: http://cclewisham.wordpress.com/

- **Age UK** operates an information and advice service. We provide information, advice and support to people who are 60 and over on a wide range of topics such as:
  - welfare benefits (pension credit, housing benefit, council tax reduction, and attendance allowance)
  - help with applications and form filling.
  - benefit checks
  - housing issues
  - consumer issues
  - care in the Community
  - debt issues
  - tax issues

  We offer drop in sessions on Tuesdays and Fridays between 10am and 12 noon. We do home visits (through a referral process), and outreach sessions at the Deptford Library twice a month.

  10 Catford Broadway, Catford SE6 4SP
  Email: nathalie.riga@ageuklands.org.uk
  Website: www.ageuk.org.uk/lewishamandsouthwark
  Twitter: @AgeUKLS
  Dedicated advice line Monday to Friday 10am–1pm Telephone: 020 8690 9050.
  Our reception is open Monday to Friday 10am–1pm Telephone: 020 8690 9060.

- **Mencap** offers casework support for parent/carers and adults with a learning disability include: telephone advice, information, advice and advocacy focusing on direct payment, social welfare benefits (ESA, DLA, Income Support, IB, etc.), housing, respite care, day centre, reviews of services, community provision, appeals and complaints (covering education, community provision), health and support with NHS, fair access to services, charging etc. We provide evening clubs for adults with a learning disability age 18 and above.

  Lewisham Mencap, 72 Lee High Road, Lewisham SE13 5PT;
  Telephone: 020 8852 4100

- **Lewisham Bereavement Counselling** offers a professional counselling, advice and information service to any bereaved client living in the borough of Lewisham. Counselling sessions are held either in clients' own homes if they wish or if not suitable, venues outside the home usually a GP surgery though not necessarily their own. The sessions are weekly for up to a maximum of six months if needed and are free of charge to elderly people. Anyone can refer themselves or be referred by anyone else.

  Telephone: Pamela Austin on 020 8699 5080
  Email: lewishambereavement@btinternet.com
  Deptford based office hours are Tuesdays–Thursdays 10.30 am–6.30pm, but counselling can take place at any time.

- **Lewisham Speaking Up**, the independent advocacy group for people with learning disabilities living in Lewisham can be contacted by people looking for support to take part in the consultation.

  Telephone: 020 8692 1862
  Email: info@lsup.org.uk

Lewisham Speaking Up is also holding a special BIG self-advocacy group on 16 January from 10.30am till 12.30pm at the Deptford Albany where people can attend to learn more and have their say about the consultation. Register to attend please – 020 8692 1862 or email: info@lsup.org.uk

- **The DPC (Disabled People's Contact)** is a social contact day centre for disabled and/or vulnerable older people which meets on Tuesdays, Wednesdays and Thursdays. It facilitates friendships and provides support and a sense of community to those who otherwise would be isolated by their personal circumstances. Transport to and from the centre, a nutritious three course meal and various activities designed to promote and improve physical and mental health are provided.

  Deptford Methodist Mission – Disabled People's Contact
  1 Creek Road, Deptford SE8 3BT
  Telephone: 020 8692 5599
  Website: www.disabledpeoplescontact.org.uk

- **Lewisham Citizens Advice Bureau** is an independent registered charity and provide free, confidential and impartial advice to everyone, regardless of race, gender, disability or sexuality. We exist to serve the needs of people who live or work within or near the London borough of Lewisham. Our twin aims are:
  - to provide the advice people need for the problems they face

  and, equally:
  - to improve the policies and practices that affect people's lives, both locally and nationally.

  Lewisham CAB Service Ltd
  Correspondence address ONLY: Duke House, 3rd Floor, 84–86 Rushey Green,
  Catford SE6 4HW.
  Telephone: 020 8699 4360

What if I need more information on the consultation?

Please call **020 8314 8100** and leave a message or email us at **adultcare@lewisham.gov.uk**.

When does the consultation end?

The consultation will end on 25 January 2015 so please send us your views in time to reach us by then.

What happens next?

When the consultation has finished we will produce a report on the outcome of the consultation and make a decision on which of the changes, if any, should be made.

Seeing the results

You will be able to see the results:

- on our website at **www.lewisham.gov.uk**
- by emailing **adultcare@lewisham.gov.uk**

We expect to have the results available in February 2015.

Please note that the questionnaires are anonymous so we will not be able to identify you by your response.

Section 1 – Lewisham Council's current charging policy

How we currently charge you for the services you receive

All local councils follow the Department of Health's guidance on how we charge you for the services you receive. This guidance says that we must make sure that we have a reasonable and fair charging policy for the services we provide. This is known as "fairer charging" and, in the case of personal budgets, is known as "fairer contributions".

How we currently work out your charges

A social care assessment is completed to decide what your needs are, and a means test (also called a financial assessment) is carried out to determine how much, if anything, you should pay towards the services identified to meet your needs. This financial assessment looks at your income, savings and expenses, and the cost of the services you receive.

Currently we aim to protect people on low incomes and have introduced a level of financial protection. If your income is lower than the basic rate of income support levels plus 35% (the 'Income Support Buffer') you are exempt from charging, unless you have savings over a certain limit. This is more generous than the buffer used by most other councils.

When calculating what you should pay, our current approach is to take into account 90% of your "net disposable income" (income less expenses and allowances).

When working out whether or not to charge for a service, we take into account any expenses you have because of a disability or frailty. This is known as disability related expenditure (DRE).

Our current rules mean that nobody is charged more than £500 each week, excluding meals on wheels which are charged for separately. If you have more than £23,250 in savings or if you choose not to declare your finances to us, then you will be charged the full cost of your services up to a maximum of £500 each week plus the cost of any meals you receive from us.

Under our current rules, carers are not charged for any services provided to them. We also do not currently charge for transport we provide or for services provided in supported accommodation.

There are shortly to be changes in the law affecting the way that services are charged for. The recently published Care and Support Statutory Guidance published under the Care Act 2014 sets out a new framework for charging for care. The principles are that the approach to charging for care and support needs should:

- ensure that people are not charged more than it is reasonably practicable for them to pay;
- be comprehensive, to reduce variation in the way people are assessed and charged;
- be clear and transparent, so people know what they will be charged;
- promote wellbeing, social inclusion, and support the vision of personalisation, independence, choice and control;
- support carers to look after their own health and wellbeing and to care effectively and safely;
- be person-focused, reflecting the variety of care and caring journeys and the variety of options available to meet their needs;
- apply the charging rules equally so those with similar needs or services are treated the same and minimise anomalies between different care settings;
- encourage and enable those who wish to stay in or take up employment, education or training or plan for the future costs of meeting their needs to do so; and
- be sustainable for local authorities in the long-term.

The Care and Support Statutory Guidance published under the Care Act 2014 states that local authorities cannot charge for the following services:

- Intermediate care, including reablement, which must be provided free of charge for up to six weeks.
- Community equipment (aids and minor adaptions).
- Care and support provided to people with Creutzfeldt-Jacob Disease.
- After-care services/support provided under section 117 of the Mental Health Act 1983.
- Any service or part of service which the NHS is under a duty to provide.
- More broadly, any services which a local authority is under a duty to provide through other legislation may not be charged for under the Care Act 2014.
- Assessment of needs and care planning to meet these may also not be charged for, since these processes do not constitute "meeting needs".

These are the same exclusions as under existing guidance.

Additionally, we do not currently charge for the following services:

- supported accommodation
- respite provided at home
- transport we provide
- carers' services.

Section 2 – Proposed changes

As a Council we have looked at all of our services including adult social care to consider where savings could be made. This section is about the proposals for changing the way people in Lewisham are charged for services. Please note that the terms 'charges' and 'contributions' are both used to mean the amount of money that you might have to pay towards the cost of the services you receive.

If we do not make any of the proposed changes set out in this consultation and instead continue only to increase charges by the rate of inflation, it would mean that greater savings would need to be made in other areas of the Council's services.

Our three aims in proposing these changes have been

- to increase total income as a contribution to our overall savings target
- to remove anomalies in our charging policy where some services are charged for and some are not
- to bring charging for care at home more in line with charging for residential care.

Proposed change 1:

This proposes a reduction in the income support buffer (from 35% to 25%) to bring Lewisham in line with most other councils. This will mean that some service users who currently are not charged for their services will be charged in future. The proposed change will also increase charges for some service users who are currently charged.

Proposed change 2:

In working out how much to charge you or how much contribution you should make, the Council must make sure that you are left with enough money for everyday things. This is called 'protected income' and it aims to provide you with a reasonable standard of living. Anything above this amount is called 'net disposable income'. Lewisham currently takes 90% of your net disposable income into account when calculating your charge. This proposal would take 100% of your net disposable income into account when calculating how much you should contribute to the costs of your care, bringing us into line with most other councils.

Proposed change 3:

Currently if you live at home and receive a social care service, the most you could be asked to contribute (excluding meals) is £500 each week. This is currently Lewisham's maximum charge. At the moment, only a very few people are charged this amount and most pay a lot less. This proposed change would remove this maximum charge so that service users with high levels of capital would pay the full cost of their services (as they would if they were in residential care).

Proposed change 4:

There are some social care services that are currently provided free of charge. This proposed change would introduce charging for supported accommodation. This would remove the anomaly in the current policy where home care and residential care are chargeable but supported accommodation is not.

Proposed change 5:

This proposal would introduce charges for respite care provided at home. Department of Health guidance states that these services are provided to the service user not their carer. This proposed change removes the anomaly in the current policy where some forms of respite are chargeable and some are not.

Proposed change 6:

This proposal would introduce charges for transport that we provide.

Proposed change 7:

This proposal would introduce charges for services provided to carers with a charge based on household income above a minimum level together with the value of the services given.

Proposed change 8:

This proposal would increase charges for day centre attendance by the rate of inflation. Charges for this service are currently lower than the full cost of the service. We propose to increase these by 2.5% from 1 April 2015.

Proposed change 9:

This proposal would increase charges for meals we provide by the rate of inflation. Charges for this service are currently lower than the full cost of the service. We propose to increase these by 2.5% from 1 April 2015.

Proposed change 10:

As from 1 April 2015, we propose to start charging you for services you receive from the first day you receive them. In the past we have not backdated any charges.

Section 3 – The impact of proposed changes

In the following section we first describe some typical service users, then show how some of the proposed changes would impact on their charges.

Case study 1 – Sanjay
Sanjay is a single person aged 35 living with his parents. He goes to a day centre twice a week which costs £80. His income is £174.25 each week. This income is made up of Income Support (with disability premium and enhanced disability premium) and disability living allowance (care component middle rate).

He spends £9.00 a week on transport fares for his carer, which is a disability related expense (DRE).

His income support buffer (at 35%) is currently £161.73. If proposed change 1 was introduced to reduce the buffer to 25%, it would be £149.75.

To work out how much Sanjay should pay towards the cost of attending the day centre we subtract the income support buffer and the disability telated expenditure from his total income. Currently we only take 90% of the balance, which is called net disposable income.

How the proposed changes would affect Sanjay

Detail	Current (£)	Proposed (£)
His income each week	174.25	174.25
Less: income support buffer each week	-161.73	-149.75
Less: disability related expenditure each week	-9.00	-9.00
Net disposable income (NDI) each week	**3.52**	**15.50**

Currently, Sanjay pays 90% of his net disposable income of £3.52 which is **£3.16** a week, towards the cost of his day centre attendance.

If all of the proposed changes are considered, Sanjay would have a new charge of **£15.50** each week. If not all of the proposals are introduced Sanjay may pay less than £15.50.

Case study 2 – Ethel
Ethel, aged 80, lives alone and receives one hour of domestic care a week which costs £15.30 and 7 hours of personal care a week which costs £107.10.

Her income is £263.90 a week made up of state retirement pension, pension credit (including the disability premium) and the lower rate of attendance allowance. She owns her own home and has full help with her council tax. Her buildings insurance and maintenance charges are £17.60 a week. She spends £14.50 a week on a gardener and the purchase of a stair lift (disability related expenditure).

Her pension credit buffer (at 35%) is currently £200.27. If proposed change 1 was introduced to reduce the buffer to 25% it would be £185.44.

To work out how much Ethel should pay towards the cost of her home care, we subtract the pension credit buffer, household expenditure and disability related expenditure (DRE) from her total income. Currently we only take 90% of the balance, which is called net disposable income.

How the proposed changes would affect Ethel

Detail	Current (£)	Proposed (£)
Her income each week	263.90	263.90
Less: pension credit buffer each week	-200.27	-185.44
Less: household expenses each week	-17.60	-17.60
Less: disability related expenditure each week	-14.50	-14.50
Net disposable income (NDI) each week	**31.53**	**46.36**

Currently, Ethel pays 90% of £31.53 which is **£28.37** a week.

If all of the proposed changes were introduced, Ethel would have a new charge of **£46.36** each week. If not all of the proposals are introduced Ethel may pay less than £46.36.

Case study 3 – Melvin

Melvin has savings of £30,000 so is assessed to pay the maximum charge for his services. Under our current rules the maximum charge is £500 a week. He receives services costing £200 a week. Because of the level of his savings, he is charged the full charge of his services and pays £200 each week because this is below the maximum charge of £500 each week. None of the proposals would affect Melvin if the level of his services remain as they are.

Case study 4 – Roberta

Roberta has savings of £35,000 so is also assessed to pay the maximum charge for her services. She attends a day centre and receives home care. The full charge for services would be £550 each week but she is currently only charged £500 each week which is the maximum charge we apply. If proposed change 3 is adopted, Roberta would be asked to pay £550 each week.

Case study 5 – Ade

Ade is in supported accommodation costing £1,500 each week. His income is £174.25 a week. This income is made up of income support (with disability premium and enhanced disability premium) and disability living allowance (care component middle rate).

He spends £8.00 a week on disability related expenditure (DRE).

His income support buffer (at 35%) is £161.73. If proposed change 1 was introduced to reduce the buffer to 25% it would be £149.75.

Currently, the Council does not charge for services provided in supported accommodation. Ade is therefore not currently charged.

How the proposed changes would affect Ade

Detail	Current (£)	Proposed (£)
His income each week	Not currently charged	174.25
Less: income support buffer each week		-149.75
Less: disability related expenditure each week		-8.00
Net disposable income (NDI) each week		**16.50**

Currently, the Council does not charge for services provided in supported accommodation. Ade is therefore not currently charged.

If all of the proposed changes are introduced, Ade would now be charged £16.50 each week. If not all of the proposals are introduced Ade may pay less than £16.50 each week.

Case study 6 – Susan

Susan is looked after by her daughter but receives respite care at home costing £100 each week. Currently we charge for residential respite care but not respite care provided in a service user's home, so we do not charge Susan for this care.

Proposed change 6 proposes including respite at home as a chargeable service, which is in line with recent advice from the Department of Health that respite at home is not to be treated as a Carer's Service. This means that we propose financially assessing Susan to see how much, if anything, she should pay towards her respite.

Susan currently receives income of £239.25, which is made up of employment support allowance and DLA care. Out of this she spends £37.66 per week on council tax and rent. Her fuel bills are also higher than average so we have allowed her £21.63 a week as a disability related expense.

Her income support buffer (at 35%) is £161.73. If proposed change 1 was introduced to reduce the buffer to 25% it would be £149.75.

Currently, the Council does not charge for respite services provided at home. Susan is therefore not currently charged.

How the proposed changes would affect Susan

Detail	Current (£)	Proposed (£)
Her income each week	Not currently charged	239.25
Less: income support buffer each week		-149.75
Less: household expenses		-37.66
Less: disability related expenditure each week		-21.63
Net disposable income (NDI) each week		**30.21**

If all of the proposed changes are introduced, Susan would be charged **£30.21** each week. If not all of the proposals are introduced Susan may pay less than £30.21 each week.

Proposed change	Sanjay	Ethel	Melvin	Roberta	Ade	Susan
Proposed change 1 – to reduce income support buffer from 35% to 25%	Sanjay's charge will increase by £12.34 each week if we also take proposed change 2 or £10.19 if not.	Ethel's charge will increase by £17.99 each week if we take proposed change 2 or £13.35 if not.	No change	No change	See proposed change 4 below	See proposed change 5 below
Proposed change 2 – increase net disposable income charged to 100%	If we do not take proposed change 1, Sanjay's charge will increase by 36p each week.	If we do not take proposed change 1, Ethel's charge will increase by £3.16 each week.	No change	No change	See proposed change 4 below	See proposed change 5 below
Proposed change 3 – remove maximum weekly charge	No change	No change	No change	Roberta's charge will increase by £50 each week (or £155 if she has not yet had 2014/15 annual review)	No change	No change
Proposed change 4 – charge for supported accommodation	No change	No change	No change	No change	Ade will start to pay £16.50 each week if we also take proposed changes 1 and 2.	No change
Proposed change 5 – charge for respite care provided at home	No change	No change	No change	No change	No change	Susan will start to pay £30.21 each week if we also take proposed changes 1 and 2. She will pay £27.18 if we only take proposed change 1 or £18.23 if we only take proposed change 2.

Section 4 – glossary of unfamiliar words and phrases

Adult social care services	Some examples of adult social care services are day care, home care, meals on wheels, transport and respite care. These are services that are commissioned or provided by the Council that are available to help and support vulnerable adults.
Assessment	Two different types of assessment can take place: **1.** when you, your family and a social worker looks in detail at your social needs and decides how best your needs can be met **2.** when a council officer looks at your finances and works out what you should be charged or what contribution you should make to the services you receive.
Direct payments	A direct payment is where we give you money to pay directly for your own care, instead of making the arrangements ourselves.
Disability related expenditure	These are specific expenses that service users have as a result of an illness, disability or frailty.
Fairer charging	This is a term used to describe the way in which a council can set its charges for social care services and the way in which it can assess how much a person should pay towards the cost of those services. In making any changes to charges, councils must follow the fairer charging guidance that has been issued by the Government.
Fairer contributions	This is a term used to describe the way in which a council can set its charges for social care services and the way in which it can assess how much a person should pay towards the cost of those services. In making any changes to charges, councils must follow the fairer charging guidance that has been issued by the Government.
Income support buffer	Government guidance says that after your contribution has been calculated, the amount you should be left with should always be at least 25% more than the basic level of income support or 25% more than the basic level of pension credit if you are over 60.
Net disposable income	This term refers to the amount of your income that we can take into account when working out what charges or contribution you should make. It takes into account your income, less your income support buffer, less your disability related expenditure, less your household expenditure. Any remaining amount is called your net disposable income.
Personal budget	If you are eligible for social care support following an assessment of need, you will be told the amount of money we think is required to meet your needs. This is called a personal budget. You may decide to use this money to arrange or manage your own services.
Reablement (also called enablement)	Reablement (also called enablement) services are services offered to adults who need short-term intensive help to regain the skills they need to live more independently.

Section 5 – the questionnaire

If you have access to the internet you can complete this questionnaire online by going to www.lewisham.gov.uk/asccharges Alternatively, you can return it by post by detaching this section and sending it to us in the pre-paid envelope provided.

This section asks you how you feel about the ten proposed changes we are considering. You can tell us how you feel about each change by placing a tick in the box next to the statement that best reflects your views.

As well as the ten proposed changes, there are open questions which ask you for your suggestions for other ways make savings.

Are you: (please tick all that apply)

- ☐ a service user
- ☐ a friend or family member of a service user
- ☐ a carer of a service user
- ☐ a voluntary organisation or advocate group.
- ☐ a Lewisham resident
- ☐ Other (please specify) _____

An explanation of each proposal is given in sections 2 and 3.
You may want to read the explanation again before ticking a box.

If we do not make changes to charges and contributions to adult social care are there any other changes the Council can make to meet our saving requirements?
Please write your response below.

Proposed change 1 – the income support buffer should be changed from 35% to 25%.

☐ Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree

Proposed change 2 – 100% of your net disposable income should be taken into account when calculating how much you should be charged

☐ Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree

Proposed change 3 – the limit on the maximum amount you could be asked to contribute should be removed

☐ Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree

Proposed change 4 – charges should be introduced for supported accommodation

☐ Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree

Proposed change 5 – charges should be introduced for respite care provided at home

☐ Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree

Proposed change 6 – charges should be introduced for transport we provide

☐ Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree

Proposed change 7 – charges should be introduced for services provided to carers with a charge based on household income above a minimum level and the value of the services given

☐ Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree

Proposed change 7 – charges should be introduced for services provided to carers with a charge based on household income above a minimum level and the value of the services given

☐ Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree

Proposed change 8 – charges for day centre attendance should be increased by 2.5% from 1 April 2015 so that they reflect inflation and the real cost of delivering these services

☐ Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree

Proposed change 9 – charges for meals we provide should be increased by 2.5% from 1 April 2015 so that they reflect inflation and the real cost of delivering these services.

☐ Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree

Proposed Change 10 – As from 1 April 2015, we propose to start charging you for services you receive from the first day you receive them. In the past we have not backdated any charges.

☐ Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree

Are there any other ways we could change the adult social care charging policy to contribute to our saving requirements?

Please write your response in the box below.

Will any of these changes affect you or your family?

☐ Yes ☐ No

If so, please tell us how. Please write your comments in the box below.

If you have any other comments or suggestions about the proposed changes, please write them in the box below.

About you

We would like to ask a few questions about you so that we can evaluate the responses to this survey in greater detail. We want to do this so we can better understand what residents say to us, and so we can use that understanding when we make decisions.

However, you do not need to answer any of these questions.
Any information that you do provide will remain strictly confidential in accordance with the Data Protection Act.

Gender

☐ Male ☐ Female ☐ Rather not say Other (please specify) _____

Age

Please select your age group

☐ Under 18 ☐ 18–24 ☐ 25–29 ☐ 30–34 ☐ 35–39 ☐ 40–44 ☐ 45–49
☐ 50–54 ☐ 55–59 ☐ 60–64 ☐ 65–74 ☐ 75+ ☐ Rather not say

Ethnicity

What is your ethnic group?

White

☐ English/Welsh/Scottish/Northern Irish/British
☐ Irish ☐ Gypsy or Irish Traveller
☐ Any other White background (please specify)

.....

Mixed/multiple ethnic groups

☐ White and Black Caribbean ☐ White and Black African
☐ White and Asian
☐ Any other mixed/multiple ethnic background (please specify)

.....

Asian/Asian British

☐ Indian ☐ Pakistani
☐ Bangladeshi ☐ Chinese
☐ Any other Asian background (please specify)

.....

Black/African/Caribbean/Black British

☐ Caribbean ☐ African
☐ Any other Black/African/Caribbean background (please specify)

.....

Other ethnic group

☐ Arab
☐ Any other ethnic group (please specify)

.....

Rather not say ☐

Disability

Under the Equality Act 2010, a person is considered to have a disability if they have a physical or mental impairment which has a sustained and long-term adverse effect on their ability to carry out normal day-to-day activities. People with HIV, cancer and multiple sclerosis (MS) are also included.

Do you consider yourself to be a disabled person?

☐ Yes ☐ No ☐ Rather not say

Please state the type of impairment that applies to you.

People may experience more than one type of impairment, in which case you may indicate more than one. If none of the categories apply, please mark 'Other' and specify the type of impairment.

☐ Physical impairment, such as difficulty using your arms or mobility issues which mean using a wheelchair or crutches

☐ Sensory impairment, such as being blind/having a serious visual impairment or being deaf/having a serious hearing impairment

☐ Mental health condition, such as depression or schizophrenia

☐ Learning disability/difficulty, such as Down's syndrome or dyslexia or cognitive impairment, such as autistic spectrum disorder

☐ Long-standing illness or health condition such as cancer, HIV, diabetes, chronic heart disease or epilepsy

☐ Other (please specify)

Sexual orientation

How would you define your sexual orientation?

☐ Straight/heterosexual

☐ Gay/lesbian

☐ Bisexual

☐ Other (please specify)

☐ Rather not say .....

Religion/belief

What is your religious belief?

☐ None

☐ Christian (all denominations)

☐ Buddhist

☐ Hindu

☐ Jewish

☐ Muslim

☐ Sikh

☐ Any other religion/belief (please specify) .....

☐ Rather not say

Please put your finished questionnaire in the pre-paid envelope and post it to us in time for it to arrive by **25 January 2015**.

Thank you for giving us your views. The results of this public consultation are expected in February 2015 and will be available on our website or by emailing a request to **adultcare@lewisham.gov.uk**.

Healthier Communities Select Committee			
Title	Public Health Savings Response to Consultation with Lewisham CCG, with commentary by the Director of Public Health		
Contributor	Executive Director for Community Services, Director of Public Health	Item	6
Class	Part 1 (Open)	14 January 2015	

Reason for urgency

The report has not been available for 5 clear working days before the meeting and the Chair is asked to accept it as an urgent item. The report was not available for despatch on Tuesday 6 January due to it requiring additional input prior to publication. The report cannot wait until the next meeting due to the Council's savings programme timeframes.

1. Purpose

1.1 The purpose of this report is to update the Healthier Communities Select Committee on the response to the consultation with key partners on the public health savings proposals that will need to be agreed by the Mayor and Cabinet in order to set the budget in February 2015 for the 2015/2016 financial year.

2. Recommendation/s

Members of the Healthier Communities Select Committee are recommended to:

2.1 Note and comment on the response to the consultation process by Lewisham CCG, and on the commentary by the Director of Public Health;

3. Policy context

3.1 Under the Health and Social Care Act, the majority of public health responsibilities and functions transferred to the Council on 1 April 2013. This included all public health staff and most contracts for commissioned public health functions.

4. Background

4.1 Lewisham Council has to make savings of £85m over the next 3 years. Following a review of all transferred public health staff and all contracts for commissioned functions, £1.5M of initial savings were identified which could be made with minimal impact through more efficient use of resources and an uplift to the public health grant. A further £1.15M has been identified which will require a more substantial reconfiguration of public health services. This consultation relates to both of these savings proposals.

4.2 The public health budget is ring fenced in 2015/16. Where savings have been identified from the current public health budget these will be used to support public health outcomes in other areas of the council. The guiding principle for the re-investment will be to support areas where reductions in council spend will have an adverse public health outcome.

5. Consultation Process

5.1 This consultation was with Lewisham CCG and was not a public consultation.

5.2 The savings proposals have been considered by: The Children & Young People's Select Committee, The Healthier Communities Select Committee, and the Public Accounts Committee during a pre-consultation phase in autumn 2014.

5.3 The savings proposals have also been discussed at partnership meetings with the CCG and Lewisham and Greenwich Trust.

5.4 The CCG received the consultation document by email and was given 2 weeks to respond on the Public Health savings proposals.

5.5 The responses to the consultation are being reported here to the Healthier Communities Select Committee which will oversee the consultation process, and to the Health & Wellbeing Board. Both the response to the consultation and subsequent responses by the Healthier Communities Select Committee and the Health & Wellbeing Board will then be considered by Mayor & Cabinet in February 2015.

6. Lewisham CCG Response with Commentary by the Director of Public Health

6.1 Lewisham CCG responded to the consultation on the Public Health savings proposals on 29th December 2014 (see Appendix 1). In doing so, the CCG considered the impact of the proposals on its own plans and against a number of overarching criteria:

- Commissioning that is population-based
- Equitable access
- Tackling health inequalities
- The aims or goals of our joint commissioning intentions
- Stronger communities for adult integrated care and for children and young people

6.2 The CCG highlighted a number of general issues and then commented specifically on each public health programme in relation to the savings proposals. Both the general and specific responses are reported below, with a commentary by the Director of Public Health on each response.

6.3 Highlighted Issues

6.3.1 The CCG responded - "Given the importance of health improvement and prevention, and its prominence in our local Health and Wellbeing Strategy and nationally in the NHS 'Five Year Forward View', we are concerned that money is being taken away from the current public health budget priorities without a

comprehensive assessment of the implications on health outcomes and inequalities."

6.3.2 DPH commentary – the proposed disinvestments in current public health initiatives were prioritised for disinvestment on the basis that these initiatives would result in the least loss of public health benefit per pound spent when compared across all current public health investments. In this way the likelihood that re-investment in other areas of current council spend will result in equal or greater public health outcome and reduction in inequalities is maximised; however, it is acknowledged that a full and comprehensive assessment of the implications of this re-allocation of funds cannot be undertaken until the areas for investment have been identified.

6.3.3 The CCG responded – "In reviewing the proposals our response on their impact is necessarily restricted by the absence of details from the council of how monies will be reinvested."

6.3.4 DPH commentary – this is covered in the above DPH response.

6.3.5 The CCG responded – "Overall we would expect that the savings proposals are accompanied by redesign of services so that they will achieve positive health impacts, and that any changes are monitored accordingly to ensure that the expected benefits are realised. "

6.3.6 DPH commentary – Much of the mitigation of potential negative impacts on public health outcomes arising from the proposed savings is predicated on successful re-design and re-configuration of commissioned services. The council public health department intends to monitor closely the changes and fully expects to be asked to provide regular update reports to the relevant scrutiny committees and the Health & Wellbeing Board.

6.3.7 The CCG responded – "The need for voluntary organisations that previously accessed public health grants to be supported to access the council's mainstream grant programme."

6.3.8 DPH commentary – the council has already ensured that those voluntary organisations that previously accessed public health grants can now access the council's mainstream grant programme.

6.3.9 The CCG responded – "The criteria that you will use to identify substantial development or variation in service should be made available as soon as possible."

6.3.10 DPH commentary – the council agrees with this response.

6.3.11 The CCG responded – "Assessments of equalities implications should be carried out and made available at the outset of the savings programme."

6.3.12 DPH commentary – the council has already undertaken an initial equalities assessment and these are described in the savings proposal; however, as has been acknowledged above a comprehensive assessment can only be carried out once the re-investment plans and the impact of service re-configurations are known.

6.3.13 The CCG responded – “The areas of greatest concern are proposals that have negative impacts on smoking reduction and health inequalities.”

6.3.14 DPH commentary – the DPH shares these concerns. Smoking is still the single largest cause of health inequalities within Lewisham and between Lewisham and the England average for premature mortality.The proposals as they stand look to re-configure how smoking services are organised. They will essentially be integrated into the neighbourhood model of working which should give a more comprehensive use of staff resources and reduce the current level of overhead costs. If however, these proposals were not successfully implemented then consideration would need to be given to re-instating this level of funding. The DPH will be monitoring the progress of these proposals and will be able to provide a further progress report. The illegal tobacco sales work has been supported by public health funding and consideration will need to be given by the new enforcement service as to how this work should be continued. Smoking cessation will continue to be a priority for public health and new funding sources will be pursued to test new initiatives.

6.3.15 Lewisham’s Community Outreach NHS Checks team, commissioned from the Lewisham & Greenwich Trust Community Health Improvement Service, won the Heart UK Team of the Year award in 2014. It is envisaged that these services will be reconfigured with less overheads as part of the neighbourhood working but again this needs to be monitored.

6.3.16 Area based health improvement programmes have been shown locally to improve health outcomes and have been identified as an example of best practice by the GLA Well London Programme. The council has successfully leveraged extra resources, including from the GLA, to extend the work that has been shown to be effective in Bellingham and North Lewisham to Lewisham Central and Downham.

6.4 Service specific responses

6.4.1 Sexual Health: the CCG responded – “As the lead commissioner the CCG will advise the council as its agent in the proposed contract renegotiation with LGT. Public Health will be fully involved in the appropriate contracting forum. Further detail is required about how sexual health services will be delivered through a neighbourhood model. The CCG would seek assurance that the health improvement package will be taken up by schools if the SRE funding is reduced. Where some services have been provided on a limited pilot basis we support the move to enable a wider population coverage. Where incentive funding is withdrawn from GP practices we need to take into account the total impact from all the proposed changes. The CCG Medicines Management team can provide professional advice in the further development of pharmacy needs assessment .”

6.4.2 DPH commentary – the council acknowledges and appreciates the CCG’s role as lead commissioner with LGT, and its desire to involve public health fully in the contracting process. The CCG will be kept fully appraised of sexual health service re-configuration within the neighbourhood model as plans emerge. The council would welcome the CCG’s help and support to influence and persuade schools of the benefits of taking up the health improvement packages, in particular SRE. The council would also welcome the CCG’s support in jointly assessing the impact of any funding withdrawal from GP practices, and the continued support of the Medicines Management Team in the pharmacy needs assessment.

6.4.3 NHS Health Checks: the CCG responded – "We agree with the highlighted risks concerning the pre-diabetes intervention. This may have an impact on the CCG's plans for long-term conditions, for risk stratification and around variation in primary care. The removal of the Health Checks facilitator post and reduction of GP advisor time may mean that the focus is on maintenance rather than the continuing development of the programme We support the continuing integration of the pharmacy into the neighbourhood resources to deliver the health checks programme. Further detail is required about how health checks will be delivered through a neighbourhood model to achieve efficiency and effectiveness."

6.4.4 DPH commentary – the council would welcome the CCG's financial support to invest in diabetes prevention alongside public health investment in the NHS Health Checks programme in line with NHS England's recently published five year forward view operational plan for 2015-16. The CCG will be kept fully appraised of the NHS Health Checks service re-configuration within the neighbourhood model as plans emerge.

6.4.5 Health Protection: the CCG responded – "We acknowledge that this service has not been proven to be a cost effective intervention. "

6.4.6 DPH commentary – the council welcomes the CCG's acknowledgement.

6.4.7 Public Health Advice to CCG: the CCG responded – "We will adopt responsibility for the Diabetes and cancer GP champion posts from April 2015."

6.4.8 DPH commentary – the council welcomes the CCG's adoption of this responsibility.

6.4.9 Obesity / Physical Activity: the CCG responded – "This area is a Health & Wellbeing Board priority. As with the reduced SRE funding, we would seek assurance that the health improvement package will be taken up by schools, and where some services have been provided on a limited pilot basis we support the move to enable a wider population coverage. The reduction in funding for the community nutritionist and withdrawal of clinical support may mean that the focus is on maintenance rather than the continuing development of the programme. This is an area that should be part of a whole programme approach to neighbourhood development. "

6.4.10 DPH commentary – please see 6.3.6 and 6.4.2 above.

6.4.11 Dental Public Health: the CCG responded – "This may represent a missed developmental opportunity to improve dental health particularly for children and young people."

6.4.12 DPH commentary – the DPH shares this concern, but the reality is that this budget has not been spent for several years prior to the transfer of public health to the local authority, and there has been no expenditure in 2013-14 or 2014-15. The number of decayed, missing and filled teeth at the age of five is one of the few measures of children's health on which Lewisham has done consistently well. The council will continue to monitor this performance indicator which is based on a national survey.

6.4.13 Mental Health: the CCG responded – "We recognise the potential benefits of pooling resources with other neighbourhoods but need to highlight the potential

difficulties inherent in working across multiple organisations and sectors that may make this difficult to achieve."

6.4.14 DPH commentary – the council also recognises the potential difficulties and challenges of working with other boroughs and organisations but also recognises the need to overcome these challenges.

6.4.15 Health Improvement Training: the CCG responded – "This area has a potential impact on achievement of the 'Every Contact Counts' strategy. This will need to be mitigated further through additional development via HESL resourcing, development of neighbourhood teams, and SEL Workforce Supporting Strategy."

6.4.16 DPH commentary – the council welcomes these suggestions for further mitigation of potential impact on achieving 'Every Contact Counts' and would welcome the CCG's support in leveraging resources from HESL and from the SEL workforce supporting strategy.

6.4.17 Health Inequalities: the CCG responded – "We support the neighbourhood model as an integral part of the integration programme. But investment and implementation requirements should be defined that support the development of the four hub approach, in particular how they will address health inequalities where services are decommissioned, such as the money advice service which can be an important enabling factor in supporting health improvement. We support changes to a whole neighbourhood approach away from specific groups, and building community capacity to tackle inequalities; again, this may require further resources to ensure continuing support to vulnerable population groups. Where there are proposed changes to the LGT contract these must be assessed for their impact and likely success for linking to the neighbourhood model. We recognise the mitigation in respect of the 'warm homes' funding but seek assurance that this will be strong enough."

6.4.18 DPH commentary – please see 6.3.6, 6.3.8, 6.3.15, and 6.3.16 above.

6.4.19 Smoking & Tobacco Control: the CCG responded – "Both the local and SEL JSNAs identify the impact of smoking on mortality rates, inequalities and QALYs. The CCG has identified smoking quitters as one of its local quality premium outcomes. This is therefore an area of considerable importance for local population health and the CCG. As with other aspects of the LGT contract, the CCG will advise the council as its lead commissioner in the proposed contract renegotiation. Public Health will be fully involved in the appropriate contracting forum. Further detail is required about how efficiencies in the stop smoking service will be achieved without reducing its effectiveness."

6.4.20 DPH commentary – please see 6.3.14 above.

6.4.21 Maternal & Child Health: the CCG responded – "Recognising that change to the sessional commitments of the child death liaison nurse will not prevent its delivery of the main purpose of the role, there may be an impact on support for bereaved families which may need to be provided or commissioned differently. We have significant concerns about the reduction in support to breastfeeding cafés and peer support and the possible impact on our UNICEF status. This is an identified priority for the CCG and for SEL. While the peer support proposal is actually a reduction in

the supporting infrastructure so should not have an impact, the support for the cafés could. But if this can be maintained for a further 6 months and alternative can be put in place this may avoid a negative impact."

6.4.22 DPH commentary – the council welcomes the CCG's view that support for bereaved families may need to be provided or commissioned differently. The DPH also shares the CCG's concerns that disinvestment in breastfeeding peer support and breast feeding cafes may jeopardise Lewisham's final stage submission to achieve the highly prestigious UNICEF baby friendly status, after successfully completing stages one and two. The council may wish to consider extending funding for these initiatives for at least 6 months, but this would mean that the level of anticipated savings would not be achieved in 2015-16.

6.4.23 Department Efficiencies: the CCG responded – "We would seek assurance that any revised structures or functions can deliver our agreed memorandum of understanding (MOU) of PH support to the CCG, for instance by freeing up time for PH consultants and intelligence support, and working with us around the commissioning cycle. A clear, agreed work plan will be essential to realise delivery of this service. "

6.4.24 DPH commentary – the council can provide reassurance that any revised structures or functions will be designed to deliver the council's mandatory responsibilities to provide public health support to CCG commissioning. The council has already advertised for a public health intelligence officer at a higher grade and salary than the equivalent NHS grade and salary of the previous post holder. A clear work plan will be agreed with the CCG for 2015-16.

7. Financial implications

7.1 Failure to meet the health and wellbeing strategic objectives, particularly in relation to child health and wellbeing, obesity in adults and children, and maintaining the health and independence of older people, could result in additional financial burdens being placed upon health and social care services in the short, medium and long term.

8. Legal implications

8.1 There are no legal implications arising from this report.

9. Crime and Disorder Implications

9.1 It is not possible to fully assess the Crime and Disorder Implications without knowing how the proposed savings will be re-invested in public health.

10. Equalities Implications

10.1 It is not possible to fully assess the Equalities Implications without knowing how the proposed savings will be re-invested in public health.

11. Environmental Implications

11.1 It is not possible to fully assess the Environmental Implications without knowing how the proposed savings will be re-invested in public health.

12. Conclusion

12.1 This report describes the response of the CCG to the consultation on the public health savings proposals for the 2015/2016 financial year, together with a commentary on the general and service specific issues identified by the CCG in its response, and sets out the Committee's role in the next stage in the consultation process.

If there are any queries on this report please contact **Dr Danny Ruta**, **Director of Public Health**, 020 8314 ext 49094**.**

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Clinical Commissioning Group

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Dr Danny Ruta
Director of Public Health
London Borough of Lewisham
By e-mail

Dear Danny

Lewisham CCG Response to Lewisham Public Health Savings Proposals 2015/16

Thank you for providing us with the opportunity and supporting information on which to comment on your proposed savings to public health programmes.
In reviewing the savings proposals we have considered their impact on our plans and against a number of overarching criteria:

- Commissioning that is population-based
- Equitable access
- Tackling health inequalities
- The aims or goals of our joint commissioning intentions
- Stronger communities for adult integrated care and for children and young people

Each of the proposals is considered in the pages that follow. Additionally we would like to highlight the following

- Given the importance of health improvement and prevention, and its prominence in our local Health and Wellbeing Strategy and nationally in the NHS 'Five Year Forward View', we are concerned that money is being taken away from the current public health budget priorities without a comprehensive assessment of the implications on health outcomes and inequalities.

- In reviewing the proposals our response on their impact is necessarily restricted by the absence of details from the council of how monies will be reinvested.

- Overall we would expect that the savings proposals are accompanied by redesign of services so that they will achieve positive health impacts, and that any changes are monitored accordingly to ensure that the expected benefits are realised.

- The need for voluntary organisations that previously accessed public health grants to be supported to access the council's mainstream grant programme

- The criteria that you will use to identify substantial development or variation in service should be made available as soon as possible

- Assessments of equalities implications should be carried out and made available at the outset of the savings programme

- The areas of greatest concern are proposals that have negative impacts on smoking reduction and health inequalities.

We recognise the need to achieve greater efficiencies and budget savings in order to make the best use of limited public funding and that this requires difficult choices and decisions. We look forward to receiving further details on your impact assessments of your proposals, the new alternative spending priorities and also how your plans will be implemented so that they support the improvement in health outcomes for our local population.

Yours sincerely

Martin Wilkinson
Chief Officer

cc
Dr Marc Rowland, Chair, Lewisham CCG
Tony Read, Chief Finance Officer, Lewisham CCG

Public Health Savings Proposals

Public Health Programme Area	Total Budget	Total Saving	Proposals	Service re-design where applicable	Risk & Mitigation	CCG Response
Sexual Health	£7,158,727	£321,600	1. Re-negotiation of costs for sexually transmitted infection testing with LGT in 2015/16, including application of a standard 1.5% deflator to the contract value as an efficiency saving, and inclusion of laboratory costs in the overall contract (£275.6k). 2. Reduce sex and relationships (SRE) funding and develop a health improvement package that schools can purchase that includes SRE co-ordinated and supported by school nursing (£20k) 3. Remove incentive funding for chlamydia and gonorrhoea screening in GP practices (£26k)	These proposals do not rely on any major service re-design but in the medium term the development of a neighbourhood model of sexual health will lead to improved services. In the short to medium term the development of a neighbourhood model of sexual health provision will lead to improved services. This will be considered as part of a sub-regional review of provision in 15/16. A London-wide sexual health etc In the longer term a London wide sexual health transformation programme is being developed in partnership with 20 boroughs, which is expected to deliver greater benefit at reduced costs.	The risk would be that LGT cannot deliver the same level of service within reduced funding, and GPs disengage with sexual health. Mitigation includes work with primary care to deliver sexual health services in pharmacy to provide free training to GPs and practice nurses to maintain the current level of provision The second risk is that SRE is not delivered in schools. Mitigation includes developing a health improvement package that schools can purchase that includes SRE, and work with school nursing to support schools to provide quality SRE	As the lead commissioner the CCG will advise the council as its agent in the proposed contract renegotiation with LGT. Public Health will be fully involved in the appropriate contracting forum. Further detail is required about how sexual health services will be delivered through a neighbourhood model. The CCG woud seek assurance that the health improvement package will be taken up by schools if the SRE funding id reduced. Where some services have been provided on

						a limited pilot basis we support the move to enable a wider population coverage Where incentive funding is withdrawn from GP practices we need to take into account the total impact from all the proposed changes The CCG Medicines Management team can provide professional advice in the further development of pharmacy needs assessment
NHS Health checks	£551,300	£157,800	1. Removing Health checks facilitator post 2. Pre- diabetes intervention will not be rolled out 3. Reduced budget for blood tests due to lower take up for health checks than previously assumed 4. Reducing GP advisor time to the programme 5. Reduction in funding available to support IT infrastructure for NHS	An essential component of the NHS Healthchecks programme is delivered through the Community Health Improvement Service. See proposed re-commissioning and service re-design under 'health inequalities' below.	Missed opportunity to prevent diabetes and for early diagnosis of diabetes IT system not able to deliver requirements of the programme Future plans to align commissioning of NHS Health Checks with Neighbourhoods will help to optimise the efficiency and	We agree with the highlighted risks concerning the pre-diabetes intervention. This may have an impact on the CCG's plans for long-term conditions, for risk stratification and around variation in primary care. The removal of the

			health checks		effectiveness of resources and may identify more people at risk earlier	Health Checks facilitator post and reduction of GP advisor time may mean that the focus is on maintenance rather than the continuing development of the programme We support the continuing integration of the pharmacy into the neighbourhood resources to deliver the health checks programme. Further detail is required about how health checks will be delivered through a neighbourhood model to achieve efficiency and effectiveness.
Health Protection	£35,300	£12,500	Stop sending the recall letter for childhood immunisations (as this is already done via GPs)		Minimal as impact of letter on uptake appears to be low. Uptake of childhood immunisations continues to be monitored.	We acknowledge that this service has not been proven to be a cost effective intervention.
Public Health	£79,200	£19,200	Decommissioning diabetes and cancer GP champion		These posts will be commissioned by the CCG in	We will adopt responsibility for the

Advice to CCG			posts.		future	Diabetes and cancer GP champion posts from April 2015
Obesity/ physical activity	£650,000	£173,400	1. Decommission Hoops4health (£27,400) 2. Changing delivery of Let's Get Moving GP & Community physical activity training (£5,000) 3. Decommissioning Physical Activity in Primary Schools (£50,000) 4. Reduce funding for community development nutritionist (£30k) 5. Remove funding for obesity/ healthy eating resources (£10K) 6. Withdraw of funding for clinical support to Downham Nutritional Project (£9k) 7. Efficiency savings from child weight management programmes. (£12k) 8. Reduce physical activity for health checks programme (£20k)		There is a risk of reduction of physical activity in schools. Mitigation includes Schools being encouraged to use their physical activity premium to continue programmes selected from a recommended menu of evidence based activities. The risk is a reduction in support to voluntary sector healthy eating and nutrition programmes. Mitigation includes organisations being encouraged to build delivery into their mainstream funding programme.	This area is a Health & Wellbeing Board priority. As with the reduced SRE funding, we would seek assurance that the health improvement package will be taken up by schools, and where some services have been provided on a limited pilot basis we support the move to enable a wider population coverage. The reduction in funding for the community nutritionist and withdrawal of clinical support may mean that the focus is on maintenance rather than the continuing development of the programme. This is an area that should be part of a

						whole programme approach to neighbourhood development.
Dental public health	£64,500	£44,500	Release funding from dental public health programmes	Dental public health services commissioned by NHS England	Sufficient resource retained to assure dental infection control function.	This may represent a missed developmental opportunity to improve dental health particularly for children and young people
Mental Health	£93,400	£59,200	1. Withdraw funding for clinical input to Sydenham Gardens 2. Reduce funding available for mental health promotion and wellbeing initiatives (including training)		The risk is that Sydenham Gardens is unable to sustain clinical input from grant funding, but it is agreed to direct them to alternative funding sources. The risk is a reduction in mental health awareness training across the borough. Mitigation includes pooling resources with neighbouring boroughs for delivery of training and work closely with voluntary sector and SLAM to deliver mental health awareness training and campaigns.	We recognise the potential benefits of pooling resources with other neighbourhoods but need to highlight the potential difficulties inherent in working across multiple organisations and sectors that may make this difficult to achieve
Health Improvement Training	£88,000	£58,000	1. Decommission Health Promotion library service		The risk is reduced capacity to develop a workforce	This area has a potential impact on achievement of the 'Every Contact

			2. Limit health improvement training offer to those areas which support mandatory public health services.		across partner organisations which contributes to public health outcomes. Mitigation includes working with CEL to develop new models of delivery for essential public health training.	Counts' strategy. This will need to be mitigated further through additional development via HESL resourcing, development of neighbourhood teams, and SEL Workforce Supporting Strategy
Health inequalities	£1,460,019	£581,500	1. Reconfiguring LRMN Health Access services to deliver efficiencies (£21,500) 2. Remove separate public health funding stream to VAL (£28,000) 3. Decommissioning FORVIL Vietnamese Health Project (£29,000) 4. Reducing funding for Area Based Programmes (£40,000) 5. Decommissioning CAB Money Advice in 12 GP surgeries (£148,000) 6. Reduce the contract value for community health improvement service with LGT and working with the Trust to reorganise how that services can be delivered more cost	It is proposed to integrate a number of community based health improvement programmes, including those funded by the GLA (e.g. Bellingham Well London) with the health and social care activities currently being developed in these neighbourhoods by the Community Connections team, District Nurses, Community Health Improvement Service, Social Workers and GPs. There is also a plan to develop a stronger partnership working with Registered Social Landlords as well as any local regeneration projects in each of these	The risk is reduced capacity across the system to tackle health inequalities, and a reduction in service for the most vulnerable., Mitigation includes working with the Adult integrated Care Programme to deliver a neighbourhood model for health inequalities work, and develop local capacity. It is anticipated that basing these services directly in the community and with greater integration will accommodate the funding reduction. Voluntary organisations will have an opportunity to continue some of this work	We support the neighbourhood model as an integral part of the integration programme. But investment and implementation requirements should be defined that support the development of the four hub approach, in particular how they will address health inequalities where services are decommissioned, such as the money advice service which can be an important enabling factor in supporting health improvement. We support changes to

			effectively by linking the delivery of the programme into community based neighbourhood model (£270k) 7. Further reduce funding for area based public health initiatives which are focused on geographical areas of poor health with in the borough. (£20k) 8. Reduce funding for 'warm homes' (£25K) 9. Grant money was given to 'Warm Homes' for year 2013/14. This was extended for a further year to enable more homes to be insulated. It is proposed that the grant be downsized.	neighbourhoods.	in a different way through the grant aid programme.	a whole neighbourhood approach away from specific groups, and building community capacity to tackle inequalities; again, this may require further resources to ensure continuing support to vulnerable population groups Where there are proposed changes to the LGT contract these must be assessed for their impact and likely success for linking to the neighbourhood model We recognise the mitigation in respect of the 'warm homes' funding but seek assurance that this will be strong enough.
smoking and tobacco control	£860,300	£348,500	1. Reduce contract value for stop smoking service at LGT by £250k (30%) 2. Stop most schools and young people's tobacco awareness programmes	There are proposals to re-configure the stop smoking service as part of the neighbourhood developments described under 'health inequalities'	There is a risk of a reduction in number of people able to access stop smoking support and an increase in young people starting smoking if services are not –	Both the local and SEL JSNAs identify the impact of smoking on mortality rates, inequalities and QALYs. The CCG has identified

			3. Decommission work to stop illegal sales	above.	reconfigured appropriately. Mitigation includes optimising efficiencies in the delivery of the SSS and reducing the length of time smokers are supported from 12 to 6 weeks to release capacity. Schools will be able to fund some of the peer education non-smoking programmes as part of the menu of programmes. The restructuring of enforcement services is likely to allow tackling illegal sales of tobacco in a more integrated way with the same outcomes and prevent young people having access to illegal tobacco.	smoking quitters as of one its local quality premium outcomes. This is therefore an area of considerable importance for local population health and the CCG. As with other aspects of the LGT contract, the CCG will advise the council as its lead commissioner in the proposed contract renegotiation. Public Health will be fully involved in the appropriate contracting forum. Further detail is required about how efficiencies in the stop smoking service will be achieved without reducing its effectiveness
Maternal and child health	£187,677	£68,400	1. Reducing sessional funding commitment for Designated Consultant for Child Death Review		There may be less opportunity to learn from	Recognising that change to the sessional commitments of the

			2. Reduce capacity for child death review process by reducing sessional commitment of child death liaison nurse. 3. Removal of budget for school nursing input into TNG 4. Reduce capacity/funding for breast feeding peer support programme & breast feeding cafes.		and improve services for families which have been bereaved, but this is not the purpose of the panel and there will be no impact on prevention of child deaths. The school nursing service received grant funding of £250k in 2014/15 which has not been reduced, and the service will be able to accommodate input into TNG. There is a risk that women will be less well supported to breast feed and Lewisham may not achieve UNICEF/WHO Baby Friendly status in 2015. Mitigation will include re-negotiating support through the maternity services contract, although this may not be achievable in time for 2015 contracts. Baby café licences may be re-negotiated.	child death liaison nurse will not prevent its delivery of the main purpose of the role, there may be an impact on support for bereaved families which may need to be provided or commissioned differently. We have significant concerns about the reduction in support to breastfeeding cafés and peer support and the possible impact on our UNICEF status. This is an identified priority for the CCG and for SEL. While the peer support proposal is actually a reduction in the supporting infrastructure so should not have an impact, the support for the cafés could. But if this can be maintained for a further 6 months and alternative can be put in place this may avoid a negative impact.

Department efficiencies		£262,200	To be identified through a staff restructure in 2015. At this point public health staff terms and conditions and pay scales are to be harmonised with council staff terms and conditions and pay scales.			We would seek assurance that any revised structures or functions can deliver our agreed memorandum of understanding (MOU) of PH support to the CCG, for instance by freeing up time for PH consultants and intelligence support, and working with us around the commissioning cycle. A clear, agreed workplan will be essential to realise delivery of this services.
2014/2015 Uplift (uncommitted)		£547,000				
TOTAL	**£14,995,000**	**£2,653,800**				

Healthier Communities Select Committee			
Title	Remodelling Lewisham Council's Day Service Offer and Associated Transport including Evening Club Provision		
Contributor	Executive Director for Community Services	Item	6
Class	Part 1 (Open)	14 January 2015	

Reason for Urgency

The report has not been available for 5 clear working days before the meeting and the Chair is asked to accept it as an urgent item. The report was not available for despatch on Tuesday 6 January due to finalising the implications of paper. The report cannot wait until the next meeting due to the Council's savings programme timeframes.

1. Summary

1.1. This report sets out proposals as to how day services and related transport could be remodelled to deliver the £1.3m of savings that was previously considered by Mayor and Cabinet on 12th November 2014. It includes a number of options and associated recommendations which will be presented to Mayor and Cabinet on February 11th 2015 for agreement to consult. The recommendations reflect the current focus of Adult Social Care services on delivering the national and local strategic agendas of personalisation and community inclusion.

1.2. The recommendations include a change to the configuration of the in-house day service provision, the consolidation of the directly managed transport offer, the consolidation of the older adults day service offer and a wide spread application of personal budgets through direct payments. The paper also includes a recommendation to reduce the Council's financial support for transport to evening clubs.

1.3. As part of the reconfiguration of the Council's directly managed service, the report recommends that of all of the four existing day centres (Ladywell, Leemore, Naborhood and Mulberry) be retained and their function expanded for use as community hubs. This option is to be considered in parallel with set of proposals being managed by the Culture and Community Development Team's review of its grant aided organisations and its assets.

1.4. The recommended options have implications both for service users and their families; and for staff employed by the Council. There will be a requirement for formal consultation with both clients and staff on a number of recommendations. The report also sets out an outline

consultation timeline which reflects this. Part year savings will be made in 2015/16 with the remainder being realised for by the beginning of 2016/17.

2. Recommendations

2.1. The Healthier Communities Select Committee are requested to note and invited to comment on the proposals for the future modelling for day services and transport, and their associated savings, which will be recommended to Mayor & Cabinet in February 2015 as follows:

2.2. To agree that officers can commence a formal 3 month consultation with service users and their families for the following proposals. The results of that consultation will reported back to Mayor and Cabinet

2.3. That the Ladywell Centre be identified as the core complex needs centre for adults with disabilities and be the recognised as the main office base for the in-house provision. Mulberry, Naborhood and Leemore are retained as community hubs but with a specific day service presence.

2.4. That the Intensive Support (ISR) service for people with profound learning disabilities and complex needs currently at Leemore to move to Ladywell.

2.5. That a review of service provision for those adults needing only 'light touch' support be undertaken to provide for their needs to be met by more effective means that directly commissioned services. A drop in service would be suitable for those existing service users who may only need 'light touch' support.

2.6. That the Council's directly provided day service offer for those people with complex needs will be consolidated. This means the specialist Dementia Service, Challenging Needs Service (CNS) and the Intensive Support Service (ISR) and the sheltered employment schemes.

2.7. That the older adults' service users (non-Dementia service) offer be consolidated with the existing providers of older adult day services in the borough; Cinnamon Court, Cedar Court and the Calabash Centre.

2.8. That all other service users to be allocated a personal budget/ direct payment and supported to plan their own service using those budgets individually or through pooling them with others.

2.9. That Mulberry, Leemore and Naborhood are developed as community hubs, rather than day centres, in partnership with the Culture and Community Development Team's review of grant aided organisations and assets.

2.10. That these buildings become multi use centres for service delivery with an established presence for disability services but will also be used by

third sector providers who help deliver the Council's community inclusion and neighbourhood agendas.

2.11. That the buildings are considered as part of the Community Services Asset portfolio and thus rental and running costs are not recovered as income but agreed to be offset by savings or capital receipts that are currently related to other assets which can be rationalised.

2.12. That in-house Door2Door transport will be reviewed, with some routes for the most complex service users being retained, but otherwise, where an individual meets the eligibility threshold for Council funded transport, they are offered a direct payment to arrange their own transport separately or with others.

2.13. That the discretionary transport service to the evening clubs be withdrawn, with some discretionary transitional support put in place where there may be significant detriment for current passengers who live on their own or at home with their families.

2.14. To note that should these proposals be agreed by a future Mayor and Cabinet a further formal 28 day consultation with staff in both the in-house day service and in-house transport service will be required.

2.15. The change to transport arrangements for the evening clubs does not require formal consultation as these are not commissioned services and people are not referred to them as part of their care plan. However, there will be discussion with service users and their families which will be managed as a separate process within the same timescale.

3. Policy context

3.1. The function of Adult Social Care is to ensure that vulnerable adults receive services appropriate to their needs within the framework of statutory duties and agreed policies. For adults, this is determined through the completion of an assessment in accordance with section 47, of the NHS and Community Care Act (1990), soon to be replaced by the Care Act 2014, followed by the application of the appropriate eligibility criteria and service decisions.

3.2. There have been a number of government documents which set out the pathway of 'Personalisation' as a way of meeting those needs so that eligible service users have both greater flexibility about the service they receive and greater control over how they are delivered (for example: 'Putting People First' (2007); 'Transforming Social Care' [LAC (DH) 2008]; 'Caring for Our Future: reforming care and support' (2012)). These policy and guidance documents have promoted the provision of Direct Payments whereby eligible adults are given an assessed sum as cash to purchase their own service, and the local authority's role rather than being one of a direct provider of services, becomes one more focused on market development and shaping.

3.3. The Care Act 2014 (The Act) is the most substantial piece of legislation relating to adult social care to be implemented since 1948. It has taken previous legislation, common law decisions and other good practice guidance and consolidated them. The Care Act places a wide emphasis on prevention, the provision of advice and information, changes to eligibility, funding reform and market shaping and commissioning. This final aspect of The Act also emphasises the use of personal budgets and direct payments and requires the Council to promote appropriate service supply across the provider market and assure quality and diversity to support the welfare of adults in the community. It also requires the Council to engage with providers and local communities when redesigning service and planning for the future.

3.4. The final report of the Local Government Association's Adult Social Care Efficiency (ASCE) Programme published in July 2014, sets out a number of initiatives that Councils across the country have put in place to deliver services that will meet the requirements of the Care Act in the current financial climate. It sets out advice on how to agree a new contract with citizens and communities, managing demand, transforming services, improving commissioning and developing more integrated services.

3.5. The Programme report's 'big lessons' mirror what Lewisham is already undertaking in order to develop services which consider workforce optimisation, cultural change and creative approaches to delivering care and support while managing demand. The report offers specific focus on managing demand and utilising community offers to help deliver personalisation, prevention and early intervention; improving commissioning using outcome-based approaches which maximise independence and integrating services putting people at the centre of care and support.

3.6. The recommendations set out in this report seek to make further progress in the delivery of the Council's Sustainable Communities Strategy priorities of 'empowered and responsible' and 'healthy, active and enjoyable'.

4. Background

Social Care modernisation

4.1. Adult Social Care has been delivering a programme of modernising its local day service offer to deliver the principles of choice and control by promoting the use of personalised Budgets and Direct Payments. This programme has included looking at ways of supporting Third Sector partners in developing alternative day service offers; and how they will promote the delivery of day services in a general community setting. The principles of day service modernisation promote people as valued and active citizens, encouraging independence and particularly for working aged adults, employment.

4.2. As the social care Resource Allocation System (RAS) is rolled out, there is increasing scope for more personalised service responses. There has been an increase in the number of Direct Payments and Personal Budgets in Lewisham, reflected in an uptake in the use of personal assistants who support the person to directly choose their own activities and create their own timetable.

4.3. This work has already identified a clear reduction in the demand for services directly managed by the Council. The roll out of the social care RAS will reduce this demand still further and it is therefore timely for the Council to review its role in direct provision of day care for adults. The day service modernisation programme has also included efficiency on its list of outcomes and has looked to support the savings programme.

4.4. The Council has been working with partners to develop more local, and sometimes neighbourhood specific, opportunities in anticipation of legislative requirements, in particular the Care Act, which has begun the process of reshaping what is available to people as day activities. This has been achieved particularly through the 'Communities that Care' and Faith Grants programme, which are now providing a wide range of alternatives. These developments are also helping people to remain actively known within their community. Along with direct procurement activity, there is now a much wider range of choice than there was four years ago. These developments are discussed in more detail below.

4.5. In recognition of this shift the Community Services Division has been repositioning itself into a role more focussed on quality assurance so that provision for its most vulnerable citizens continues to meet their needs in a way that is both competent and skilled, such as developing a 'quick to view' quality assurance dash board.

4.6. The next step in the day service delivery programme is to strategically support the pooling of Direct Payments which will require the Council to take a more active role in supporting people to design and commission their own service provision. To help deliver this Social Care has developed the new role of Support Planners who will work with individuals and small groups to creatively think about how they want to spend their allocated financial resource.

Current service provision

4.7. The Council directly funds and/ or manages building based day services for 199 older adults (for 438 days) and 160 younger adults (for 584 days). 128 of the younger adults have a learning disability and 32 are adults with a complex physical disability and/ or other long term conditions. These services are delivered in seven day centres across borough, four of which are directly managed by the Council and three by the Third Sector. A breakdown of attendance at each is set out in tables 1 and 2 below.

4.8. In addition to these 359 Lewisham clients, the in-house service also supports 4 people with learning disability who are funded by neighbouring boroughs. All but one of these people were originally Lewisham residents whose families then moved to neighbouring boroughs.

4.9. Three of the Council managed centres are currently nominated as learning disability specific day centres: the Mulberry Centre in New Cross, the Leemore Centre in Lewisham and the Naborhood Centre in Sydenham. There are specific bespoke services for people whose behaviour is challenging at the Mulberry Centre (the CNS Service), and for people with a profound learning disability and complex physical support needs (the ISR service) at the Leemore Centre. The fourth centre, the Ladywell Centre, is currently nominated as a centre for older adults and people with physical disabilities. The specialist Dementia day service which was recently extended is located there.

4.10. The Council also purchases building based day services for older adults at Cedar Court and Cinnamon Court managed by Housing 21. In addition building based day services for older adults are also funded at the Calabash day centre managed by Hestia Support and Care.

Centre	5 days	4 days	3 days	2 days	1 day	Total days	Total users
Ladywell long term conditions	6	2	6	9	4	78	27
Mulberry General	8	9	7	5	5	112	34
Mulberry CNS	15	0	1	2	0	82	18
Naborhood	16	1	5	2	1	105	25
Leemore General	16	6	8	6	1	141	37
Leemore ISR	6	3	2	0	0	48	11
Cinnamon Court	0	0	2	0	0	6	2
Cedar Court	0	0	0	2	1	5	3
Calabash	0	0	1	2	0	7	3

Table 1 – Day Services Usage - Under 65

Centre	5 days	4 days	3 days	2 days	1 day	Total days	Total users
Ladywell dementia	5	0	13	12	8	96	38
Ladywell Older adults	0	0	6	18	9	63	33
Mulberry General	0	0	1	0	0	3	1
Naborhood	0	1	0	0	0	1	4
Leemore General	1	0	0	0	0	5	1
Cinnamon Court	2	0	6	14	10	66	32
Cedar Court	2	0	3	22	14	92	46
Calabash	5	3	8	19	6	112	44

Table 2 – Day Services Usage - over 65

4.11. The current cost of the service totals £4,954,100 with an associated transport cost of £2,443,268. A breakdown of the Day Service figures is given in table 3 below.

Day Centre	Budget
Ladywell Day Centre	£510,500.00
Ladywell Dementia Services	£234,900.00
Leemore Day Centre	£453,700.00
Mulberry Day Centre	£414,000.00
Naborhood Day Centre	£355,700.00
Day Opportunities Business Support	£198,800.00
Lifestyles Admin	£46,600.00
Lifestyle Intensive Support Resource	£402,000.00
Lifestyles Challenging Needs Service	£790,100.00
All Change Project	£15,100.00
Calabash Day Centre	£309,400.00
Cedar Court	£304,300.00
Cinnamon Court	£189,300.00
Mental Health COS Teams	£729,700.00
Total	**£4,954,100.00**

Table 3 – Day service cost breakdown

4.12. There is also an associated income from charges for individual service users or the payment made by other boroughs for clients placed in the in-house service.

4.13. The staffing structure across the Day Service is detailed in table 4 below.

Post Title	Number Posts	FTE
Service Manager	1	1
Day Service Managers	4	4
Team Leader	1	1
Business Support Team Leader	1	1
Business Support	5	4.6
Day Service Coordinators	7	7
Day Services Officer	37	34.1
Day Service Support Worker	42	38.9
Activity Specialist	1	1
Caretaker	2	2
Kitchen Assistant	1	1
Total	**102**	**95.6**

Table 4 – Day Services staffing

4.14. There have been changes in referral patterns to all centres over the past 5 years, with a noticeable downward trend in numbers due to an increase in people using Direct Payments and Personal Budgets to purchase their own support. Analysis of how Direct Payments and Personal Budgets are used is challenging due to their flexible nature. People can buy services and change them as they want in order to meet their identified needs. Evidence from Public Health and Joint Commissioning audits suggest that there are increases in the numbers of people accessing health and leisure centres; and increased enrolment in community education.

4.15. There is clearly a much reduced referral rate for people with a physical disability/ long term conditions and the numbers using the Ladywell centre have reduced significantly. This reflects societal shifts in expectations and assumptions about people with physical disability, expectations regarding independence, competence and employability. Additionally, developments in IT and assistive technology have supported people with a disability to be more self-determining.

4.16. A community focussed approach, and the development of alternative opportunities has also reduced the number of older adults requiring building based day services generally. This has impacted on both the Council's provision as well as that of other commissioned services.

4.17. The Council also funds 24 hour supported living and residential care services. Currently there are 231 people who live in Supported Living, 184 in 24 hour supported accommodation, 23 in residential care and 34 who receive non-24 hour supported living. In 2011 the Council worked in partnership with those providers to develop alternative ways of meeting the need for structured day activities for those people. This has resulted in a significant decrease in the use of day centres.

4.18. In addition many young people with learning disabilities who attend out of borough schools tend to receive support out of the borough once their education is completed, meaning that fewer young people are transitioning to Social Care from Children's services. Since then the buildings have been significantly underused and numbers have not been inflated by Transition clients from Children's Services. This reflects in the main the development of alternative options and the reality that many young people attending out of borough schools and colleges tend to stay out of borough once their education is completed.

4.19. The Council's grants programme particularly the 'communities that care' category has provided seed corn funding for specific community based offers such as:

- 'Meet me at the Albany' for older adults,
- Time Banking which has significantly promoted volunteering among adults with a learning disability who use or who might otherwise have used day services,
- 'Community Connections' which among other developments, has supported 413 people, 55% of them referred from adult social care, to get connected to their local communities,
- 'Allsorts' programme which around 50 Lewisham Citizens with a learning disability attend every week.

4.20. Procurement of learning disability day services has particularly focussed on providing employment as an outcome (for example Nexus 'The M'Eating Place' cafe and 'Clickstart' projects, PLUS's 'Cup Cakes' café, and Aurora's office cleaning social enterprise). Additionally a wide range of other employment and leisure opportunities including horticulture, service industries, arts and crafts, and IT related skills have been developed by providers as part of their 24 hour services.

4.21. Procurement for older adults day services has also reflected a reduction in demand for building based services for this group. The contract with Housing 21 for day services in its provision at Cedar Court and Cinnamon Court was reduced by 10 places a day 3 years ago, and is reflecting a further under delivery on the contract number of approximately 10 places a day on a contract of 50 places a day.

4.22. The day service for Older Adults from Black and Ethnic Minority backgrounds at the Calabash Centre has recently been recommissioned. The new contract was agreed by Mayor and Cabinet on 16th July 2014 and reflected a reduction in funded places from 51 places a day to 25. It was also a key outcome of that process that the Calabash Centre should continue to be available to the self-managed 'Active Elders Groups' who had historically used it. It was also extended to other client and wider citizen groups during the day and at evenings and weekends. Since the Centre reopened in October 2014, a small group of people with learning disability have begun to have their day service delivered there and the successful providers (Nexus and Hestia) have also developed

opportunities for supported employment, volunteering and apprenticeships.

The Council's directly provided transport

4.23. The Council's Door2Door transport service has been until now organisationally linked with specific day centre locations: the Council's own provision (Ladywell, Leemore, Naborhood and Mulberry), the Calabash Centre and with Cinnamon and Cedar Courts. A number of buses are shared with education and a number are used solely by adult social care. Changes as to how people want their service to be delivered, plus the impact of the adult social care transport policy, is highlighting the inherent inflexibility of this arrangement in delivering the personalisation agenda, as well as inefficiencies in the use of Council assets. In 2014, two routes to the Naborhood Centre were merged into one, and a reconfiguration of the service offer the year before resulted in the Wesley Halls route becoming redundant.

4.24. Table 5 below illustrates the clear reduction in number of people using Door2Door transport between 2011 and 2014.

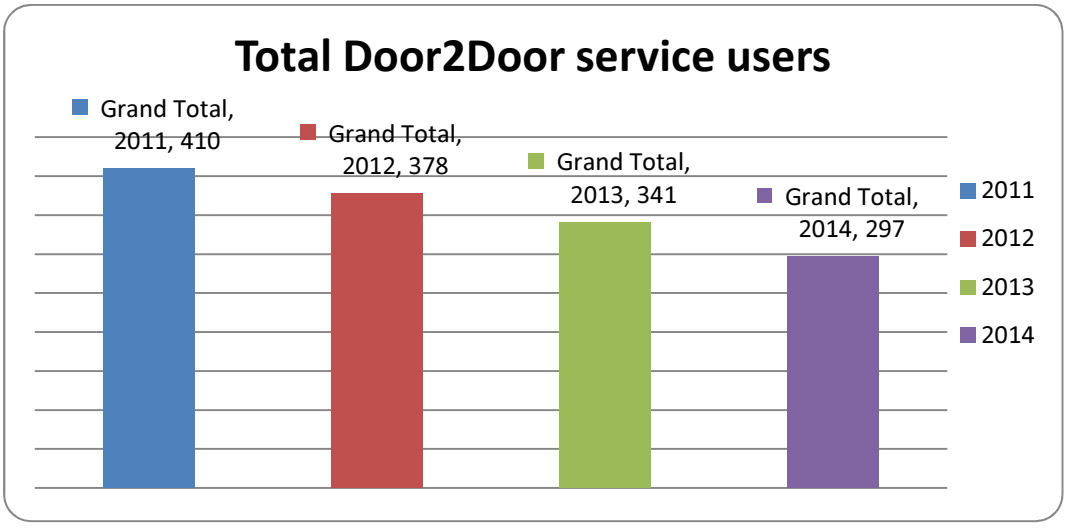

Table 5 – total number of day care service users needing Door2Door Transport

4.25. As personalised supports become the norm, it is increasingly clear that the Door-2-Door service will not be able to meet the transport needs of people choosing day services away from historical and traditional building bases. It cannot offer cost effective flexible transport at times or days outside of the core hours of 9-5, Monday to Friday. In addition, due to the need to manage the risks associated with transporting people with sever and complex physical disabilities, it has become increasingly challenging for Door2Door to provide a service for these service users, who are increasingly the people who meet the eligibility threshold for Council funded transport.

4.26. Door2Door has evidenced flexibility in supporting new routes for new clients as part of the Calabash Centre re-commissioning and, while the routes shared with education will need to be subject to a wider and more long-term projection of need and demand, it is probable that there is potential for some further flexibilities around 'collapsing' routes, particularly as the number of people on some Door2Door routes can on average be less than five people.

4.27. Door2Door historically also supports some discretionary transport (i.e. transport to people who do not meet eligibility criteria) to out of hours clubs. This is met through an additional overtime payment to drivers and escorts funded by adult social care; and are not a statutory service.

5. Proposals for remodelling direct service delivery

5.1. Officers have considered a number of proposals relating the directly managed day services, and related transport, to examine reshaping them to support a cost effective modernised day service. Some of the proposals detail internal reconfiguration of the services, which will require a consultation with service users and their families. However, there are also options which require formal consideration by Mayor and Cabinet. These proposals and options are set out below with officer recommendations.

5.2. Some of the recommendations will require formal statutory consultation with service users and their families. The option regarding transport to evening clubs does not require formal consultation as the clubs are voluntary sector offers which people are not referred to as part of their care plans. However, good practice suggests that the impact of withdrawal on existing users and families be considered and mitigated for if necessary.

5.3. Should the recommended options for the directly managed services, both the in-house day services and Door2Door, be agreed following the formal consultation, there may also be a requirement for a further formal consultation with affected staff.

5.4. The Council is currently the major provider of day care in the borough. However, the local service market has been growing and is now sufficiently well developed to support the general population of people meeting eligibility criteria for day care. There are a small number of people with complex care needs where the market remains relatively immature. It is timely, therefore, for the Council to consider its role as a continuing direct provider of day services. The following section sets out five options for the future management of the service.

5.5. Consultation which officers undertook in 2013/14 with service users, their families and staff from the learning disability day centres have shaped some of these proposals. There were reference group meetings every six weeks for a year with representatives of family carers and with people

with learning disabilities and staff, as well as three quarterly meetings to which all service users, carer and staff were invited.

5.6. The consultation specifically considered the issues of the future of the buildings. While there was discussion about rationalising the buildings from three to one single learning disability day centre, a 'supercentre' the strongly expressed preference was to retain all the existing centres. While the 'supercentre' option had the advantage of remaining client group specific and families felt that users would be safer, the disadvantage would be loss of choice of location and geographical spread across the borough and a continued inward focus which would not deliver the strategic outcome of being a citizen in a wider community. There was no similar in depth consultation with users and carers at the Ladywell centre, though it is worth noting that the Dementia unit is now a self-contained unit within the Ladywell Centre which would allow the remaining areas to be used differently.

5.7. Knowing the preference of the learning disability service users and their families, officers are mindful of the need to make best use of Council assets. The Community and Cultural Development team are consulting on a number of proposals which may have synergy with the reconfiguration of day services as set out in proposal two, which would support the maintenance of a specific disability service and a presence in the other centres. Officers consider that the Ladywell Centre best lends itself as a disability specific day centre because of its accessibility on the ground floor, its specialist facilities and the fact that the newly expanded Dementia Service is already located there by definition. Leemore, Naborhood and Mulberry would be best placed to develop a service presence.

5.8. The challenging needs service (CNS) is to remain at Mulberry as part of a wider community hub, with some specific agreements in place to support the needs of this client group.

5.9. The following paragraphs set out options to consider for the future management of the service. All of the above service redesigns can still apply independently of decisions on the following options by Mayor and Cabinet. The importance that service users and carers place on their friendships and relationships is recognised and whichever option is agreed officers will be mindful through the consultation process how these relationships are maintained.

Options

5.10. **Option 1** – That the management of the in-house provision continues as is. The advantages are that users and carers would be supportive as the service and its staff are well known and well regarded. Some savings may be made. However, the disadvantages are that opportunities for further market developments are potentially stifled, making it difficult for the Council to fulfil its new duty to promote market development under the

Care Act. Furthermore a rigid service does not provide the flexibility and individual focus required to enable adults to fully realise the potential of their Direct Payments and with the Council as a provider, users may find the range of choice and flexibility of services on offer to them decrease on the long term at a higher cost overall. The anticipated level of savings will not be achieved by this option.

5.11. **Option 2** – That the Council closes its directly managed service to new referrals who are referred instead to other providers. The advantage of this option is that existing users and families are very likely to support the proposal. There is also potential to tailor the staffing levels to client usage in a planned manner. The disadvantages are that there may be a perception of a two-tier service with continuing service users receiving a declining service while new service users feel aggrieved that they cannot access the in-house service. Potentially it will fragment the service making it difficult to pool budgets and design new service offers 'which again frustrates the full potential of the use of Direct Payments and Personal Budgets. The staff: client ratio within the in-house service may not be adequate to ensure client safety and also be efficient, thereby preventing potential for efficiency savings on staffing costs and possibly representing a cost pressure. Additionally the buildings will become increasingly empty and represent a poor use of assets.

5.12. **Option 3** – That the in-house service continues to support service users but its location is rationalised to a single centre. The advantages of this are that there is potential saving in management costs and some rationalisation in front line staff through increased staff: client ratios. There would be a rationalisation of capital assets, and the use of transport to a single location. The disadvantages are the risk of continued institutional service delivery and 'warehousing', with more 'engaging' clients drawing disproportionate staff attention. This option also fails to promote market development. Families are more likely to view this option as not meeting individual client needs and minimising choice, which again may be contrary to the Councils overall duties to promote market diversity and personalisation, There are potential risks associated with client mix (e.g. people with complex care needs sharing space with people with challenging behaviour), and the possibility of fewer activities delivered to larger groups.

5.13. **Option 4** – Full outsourcing of the in-house service development through formal procurement or as a 'mutual'. The advantages are continuity for service users and their families, the identification, or development of new, third sector partner(s) who could deliver the modernisation agenda for the Council, a high degree of control by existing staff over service design, delivery and efficiencies in staff costs over time. The disadvantages are the potential impact of TUPE and the time it would take to manage and deliver the programme will represent a significant delay in delivering efficiency savings. In the consultation with staff in 13/14 the idea of a staff mutual was discussed and there was little

enthusiasm from the staff team for the idea. There has been no approach from the staff team subsequent to that. There are likely to be general concerns from service users and families over the withdrawal of direct involvement by the Council and concern that complex clients might not have their needs fully met.

5.14. There are additional commissioning challenges around developing a procurement exercise, including soft market testing, which may add additional delay in achieving efficiency savings, regardless of outsourcing to a partner or mutual. There is a mix of in-house, outsourced and mutual led organisations that provide day services for other councils in the South East. It is notable that Councils which have previously outsourced to a single provider are refining their second round of procurement to include more providers.

5.15. **Option 5** - That the Council consolidates its directly delivered services to people with complex needs, ISR, Dementia and CNS and sheltered employment services in-house; with the ISR service currently located at the Leemore Centre transferring to Ladywell. The specialist dementia is already located there, so there is no change to that service. Both services will occupy different areas within the building. The move of the ISR will require formal consultation with service users and their families, who could also be offered a personal budget to purchase a service from elsewhere such as the complex needs learning disability service at Calabash managed by Lewisham Nexus.

5.16. Users of other services will be supported to plan alternatives, including referral to other service providers. The Council would thereby retain management responsibility for its most complex clients, whilst promoting the potential for market development for the wider group of adults. Flexibility would be available through the choice and shape of offers by individuals and groups and savings can potentially be achieved through rationalisation of management costs.

5.17. For some of the current day centre users where a ‘light touch’ support is sufficient to meet needs, a specific ‘drop in’ type service will be commissioned. This service will also operate out of Ladywell, which would enhance the use of the building as a service base, capitalising on its central Lewisham location with all of its easily accessible transport and leisure opportunities. This would not preclude an option of people choosing to meet up at the communal areas in community hubs.

5.18. There are likely to be concerns raised by service users and families where services are not retained as direct provision and concerns about the potential negative impact on friendship groups. There would be challenges in managing the logistics of the service change for individual clients and the need to develop of shared space protocols with a potentially large variety of providers.

6. Details of the recommended option

6.1. Officers recommend option five to the Council as it meets a number of strategic outcomes. Particularly, this option allows the council to retain its management responsibility for complex clients where the market is underdeveloped and the existing successful employment projects. These services are:

- Support for people with complex physical and learning disabilities (the Intensive Support Resource or ISR)
- Support for people whose behaviour presents significant challenges (the Challenging Needs Service or CNS).
- The specialist Dementia Service.
- The 'Tuck Stop' café at the Waldron Clinic.
- The 'Grow' project.

6.2. It supports an increased use of personal budgets and direct payments to use on other market offers within the third sector. This in turn will help develop the market in a sustainable way. It will also allow service users to have the flexibility to change the services they purchase over time and it delivers the best value for money for individual services as they can purchase more from the Third Sector within their budget.

6.3. The development of a 'light-touch drop-in' will be specified in such a way that the service will be flexible to allow it to be purchased over time by others. For example people who have greater support needs can choose to use their personal budget to purchase an enhanced service from the 'drop-in'. Other people who may not meet eligibility for funded services could opt to pay for the service from their own resources. This will also help people to maintain existing relationships or friendship groups.

6.4. This option retains a specialist disability centre while at the same time developing integrated community offers at the other three centres.

6.5. It will deliver the highest level of efficiency savings as it minimises the additional cost that may relate to any TUPE liability. Whilst some of the savings identified below could be delivered by other options, only the full level of savings will be more likely to be delivered with this option. This proposal will deliver savings totalling £570K (plus reduction in 1:1 staffing) in the following areas:

- £130K will be saved through a management restructure of the in-house service reflecting the reduced size of the directly managed provision.
- £40K will be saved through the consolidation of building based day care for older adults from the Ladywell Centre.
- £60K will be saved by consolidating users currently funded in other building based day services to the newly redesigned Dementia Unit which has allowed five additional places a day within the existing budget plus the cost of what were additional 1:1 staffing which is also no longer required.

- £65K will be saved through the development of a 'drop-in' facility will deliver a reduction in current cost of package reflecting the more independent needs of a group of current users.
- £275K will be delivered through top slicing the Personal Budget rate for people who plan for their services to be delivered in the centres.

7. Proposal to reduce the usage of Door2Door

Transport to day services

7.1. The past year has seen a more independence focussed approach to transport. In previous years, through the targeting of grant funding, the Council has increased volunteer driver schemes and grown the Community Transport service. The social care assessment process has taken more account of what transport assets people already have available to them (e.g. mobility allowance, taxi cards, bus passes) and has also been more focussed on opportunities for travel training adults with a learning disability. These developments, alongside the reduction in day centre attendance, has resulted in a falling away in the use of Door2Door, the Council's in-house transport provider, which cannot meet the transport needs of assessed eligible adults in terms of flexibility and availability.

7.2. However, the biggest challenge to rationalising transport routes relates to the fact that approximately two thirds of the busses social care use are shared with, and priority is given to, Education. Currently eleven routes out of 34 provided by Door2Door are dedicated to supporting Day Care service users and not shared with education. Specifically routes servicing Leemore, Mulberry, and the Naborhood are not shared with Education equating to a combined cost to Social Care of £675K annually. Table 6 below details the number of service users using the bus at the three centres, the buses being used and the approximate cost of the service.

Establishment	Number of buses	Service Users	Days Attending	Cost
Leemore	4	35	146	£355K
Mulberry	2	26	101	£178K
Naborhood	1	24	24	£142K

Table 6 – Dedicated ASC Door2Door routes

7.3. It is these routes which can be most easily consolidated as the busses are not shared with education and are used entirely for transport for people with a learning disability. The use of Door2Door for transport for shared routes is unlikely to be affected by this proposal.

7.4. It is proposed that social care retain specific routes for three client groups (i) people with challenging behaviour (CNS) and specifically the Mulberry mini bus, (ii) people with complex physical support needs (ISR) and (iii) people with dementia using the specialist dementia service. All other

users with eligible needs for transport will be offered a budget allocation to maximise other ways to support arrival at day activities or shared taxis be commissioned using the Council's Transport Framework Agreement. This Framework lists a number of transport companies and ensures important standards such as DBS checks are in place. This Framework list can be shared with individual people and their families as well as be used for commissioning purposes.

7.5. While some of the busses are leased on a short term basis, there are a number of busses that are owned by the Council. To fully realise the potential saving, the Council will need to sell the lease on to other organisations pending the end of the lease period. There will also be implications for redundancy of drivers and escorts.

Transport to Evening Clubs

7.6. The Council has historically funded transport to evening clubs, primarily the Lewisham Mencap Monday, Tuesday and Thursday clubs and also to SEALS, a swim club for people with a physical disability. These are not services commissioned to meet eligible social care needs and funding such transport is discretionary. This paper therefore proposes that direct funding of this transport now ends.

7.7. That is not to say that the Council does not recognise their value to the people who attend them for their social value and their respite value to families. However, 32 out of 82 named individuals who use this transport to travel to and from the Lewisham Mencap clubs live in 24 hour supported services and could make alternative arrangements for transport. Some providers already assist service users in pooling their money for other reasons. 30 of 82 use the bus more than once a week. Take up of the SEALS transport is a maximum of three people and sometimes none although the Council still has to meet the overtime costs.

7.8. **Option 1** – Stop funding transport entirely. The advantage is a direct saving for the Council. The disadvantage is that this may have a more disproportionate effect on some people and their families than others

7.9. **Option 2** – Attendees can pay Door2Door directly for the cost of this service. The advantages are that 'specialist' transport with escort would continue to be available and that the Council has the appropriate Public Carriage Vehicle (PCV) licences, which allows the vehicles to be available for hire. However, it is unlikely that individuals would be able to afford the related costs or commit consistently to meeting the cost of transport.

7.10. **Option 3** – Stop the provision of transport for people living in 24 hour funded services and liaise with providers to develop an alternative offer. Officers will work with attendees either living at home with their families or living independently on a transitional basis depending on their circumstance. The advantages of this approach are that people who may otherwise be isolated can continue to attend at least one club, its

preventive role is maintained and people are not caused significant detriment to their health and well-being. The disadvantages are that it will take time to transition from Door2Door to alternative services, and that the full saving will not be made in year.

7.11. **Option 4** – that Door2Door offer transport during the winter, but not summer, months. The advantage is that people would not have to travel in the dark. The disadvantage is that the Council will continue to provide a non-statutory service for the foreseeable future and people with greater vulnerability than others may not attend during the summer months.

Details of the recommended option

7.12. Officer recommend option 3 as it recognises that thought this is not a statutory service and is not reflected in people's care plan as meeting an eligible need, there may be some families for whom it is indirectly serving as a break from providing care and support. Also, there may be some individuals who do not generally meet the Council's eligibility criteria for any service, but for whom the clubs offer the opportunity for social engagement. While it does not deliver the maximum saving which could be achieved as some form of support may be available to help during transition, it supports people's general health and wellbeing, and therefore may help prevent pressure on other budgets in the future.

7.13. Savings will be achieved by changing how Door2Door is used. This is estimated to save a total of £300K in two ways:

1 - Assessing service users attending Mulberry Lifestyles, Leemore Lifestyles and the Naborhood with a view to offering them a direct payment to organise their own transport £260K.

2 – Evening Clubs £60K (though there is opportunity for up to a further £24K of saving dependent on the review of individual clients living independently or at home).

7.14. Officers will continue to work with colleagues in the Children and Young People Directorate to assess wider opportunities for further transport savings.

8. Community Hubs, not Day Centres

8.1. Paragraphs 4.1 – 4.3 reported that the current day centres, particularly the three learning disability centres, are underutilised. Should Proposal 1, Option 5, be agreed consolidating the older adult offer along with the falling demand for funded day service for people with physical disabilities/ long term conditions will also result in an underutilisation of Ladywell. This presents an opportunity to consider how the buildings can be best used to deliver wider strategic outcomes.

8.2. The Culture and Community Development Team's review of grant aided organisations and their assets, has allowed consideration of an Option 3, representing an amalgamation of options 1 and 2. There is potential for

synergy between the day service / centres and the wider third sector which would allow a main centre to be identified for people with disabilities while also maintaining a presence in the other three centres. These could be re-designated as community hubs managed by a consortium of voluntary organisations for use by organisations, thereby delivering the Council's vision for inclusive citizenship and the development of social capital.

8.3. The Mayor and Cabinet (12 November 2014) have been previously advised of the development and savings proposals relating to the Culture and Community Development Team's process of rationalising its public buildings and proposing to develop the assets as Community Centres. There are currently 41 council assets within the community premises portfolio including 23 community centres, 3 sports grounds and 15 buildings housing Voluntary and Community Sector (VCS) organisations. In addition there are other properties used by VCS organisations that are not part of the community premises portfolio. These neighbourhood based facilities will be predominantly geared to providing services at a neighbourhood level with equitable support arrangements across the portfolio.

8.4. It is recommended that three of the four day centres, Leemore, Naborhood and Mulberry be included as part of these wider considerations to support the best possible outcomes for the Community Services grant and asset programme. Along with the Calabash Centre, these three centres would be considered part of the Community Services Assets portfolio and thus no charges/ rental would be required from those third sector organisations to offset the savings in the Main Grants Programme or delivery of capital receipts as a result of the grants and asset review. The Culture and Community Development Team will be consulting with organisations on their proposals in January 2015.

8.5. A defined presence for use for social care will be established as part of this wider offer. This will facilitate the pooling of personal budgets. This would be in addition to the use of general public spaces by service users e.g. as a meeting place before going onto other activities.

8.6. The Mulberry, Leemore and Naborhood centres all have 'Changing Place' standard personal care facilities. Their development as community hubs would also include those facilities being made available to all people with disabilities who need access to specialist personal care facilities, using a radar key or similar. This will have many benefits to people eligible for social care services, but also support the prevention agenda. The absence of such facilities are a limiting factor to any wider access to everyday opportunities such as shops, libraries, restaurants and leisure facilities. Additionally, facilities would be available to disabled adults and children.

8.7. Savings and efficiencies that may be delivered by the Culture and Community Development Team proposals are not included here

9.1. The proposals outlined in this paper will affect a number of Council employees who work in the Council's directly managed day services and the Door2Door transport service.

9.2. Should these proposals be agreed there is potential for redundancy at both management and front line level. The day service currently operates using a high number of agency staff, therefore it is expected that redundancy of any front line staff is likely to be relatively minimal as substantive staff are deployed into those posts. The transport service also uses some agency drivers and escorts which will also minimise redundancies.

9.3. Appropriate consultation with staff and their trade unions will take place in accordance with the Council's Management of Change policy.

9.4. The proposals do not recommend a total outsourcing of the service and much of the reconfiguration is unlikely to reflect a continuation of the same service. However, there is always a possibility that TUPE may apply to relevant Council employees therefore appropriate consultation with staff and their trades unions will take place in line with the Council's TUPE transfer guidance and statutory requirements.,

10. Other related savings

10.1. The Care Act requires the Council's assessment of need to be focused on a person's identified outcomes across a wide range of functions rather than on providing a traditional service delivery model. There is also an emphasis on prevention and early intervention and helping people to remain within their communities; and be actively supported by them.

10.2. The Council envisions a key role for prevention and early intervention across all client groups is best played by Community Connections.

10.3. The Community Opportunity Services (COS) delivered by SLaM to support people with mental health issues has been reconfigured in order to provide better value for money and work in conjunction with Community Connections. It now focuses on prevention and recovery, and in particular the impact of the Improving Access to Psychological Therapies (IAPT) services on helping people remain in work and maintaining recovery through structured lives and routines. This budget is delivering £200K of savings towards the overall day care savings target.

10.4. Access to support is through professional assessment of need, guided by nationally set eligibility criteria. Local Authorities can take their own resources into account when determining how those assessed needs should be met and may use the most cost effective solutions available. In some situations the assessment will be the only service that is provided directly by the Council, particularly when care and support needs do not

reach the eligibility criteria or when needs can be met by opportunities available from within the community or from the person's network of support and their own resources. The new social care support planning service will be well placed to help people to define the outcomes which will meet their needs, and how their personal assets and available social capital can be combined to deliver them.

10.5. This approach is expected to reduce the overall number of days support and activity that the Council will need to fund directly. Care will be taken to ensure that these different ways of meeting need do not destabilise any individual's ability to manage at home, and that families are not overwhelmed by their caring duties, thus escalating need from day services into residential care. Attention will be given in particular to ensuring that no one person loses all of their existing service offer thus maintaining some consistency for them and their family. The "community based" approach to meeting needs is not about cutting services from a specific group of people, but redefining how those needs are met without necessarily requiring specific funding from the Council, and viewing an individual as part of the community first.

10.6. This approach is estimated to deliver £200K in savings representing an equivalent reduction in existing Council funded or directly delivered day services of between 77 and 96 days a week dependent on the cost of the current service.

11. Other potential opportunities

11.1. This paper makes a series of recommendations for the redesign of directly managed day services and transport which also deliver savings and efficiencies to the Council. The recommendations reflect a number of key outcomes in the ongoing programme of day service developments to promote personalisation and the take up of direct payments/ individual budgets, while also identifying an effective role for the Council as a direct service provider and making best use of the existing day centres in partnership with other parts of the Community Services Directorate. However, the specific recommendations in this paper are not exhaustive and there are a number of other options and opportunities that officers will continue to explore in line with the strategic direction of travel and with potential to deliver further savings or income for the Council.

11.2. Public health – There are a number of public health programmes, such as 'Healthy Eating' where identification of venue e.g. a kitchen in one of the day centres, may deliver a saving to the public health budget or represent potential income.

11.3. The Ladywell, Leemore, Mulberry and Naborhood Centre Kitchens – The way that meals are provided has already changed at the Learning disability day centres. The kitchens at the Leemore, Mulberry and Naborhood centres are surplus to requirements. There is a remaining requirement for a meal service for the Dementia unit in Ladywell. However

all kitchens could be made available to colleges or other training or supported employment providers to generate income or avoid cost. The service priority to identify an operating partner would be the Ladywell Kitchen.

11.4. The Ladywell Gym – Savings in the youth service will potentially result in reduced use of the gym located at the Ladywell Centre. The Culture and Community Development Team will explore the potential to identify a sports organisation who can run the gym as a social enterprise or community interest company. This will ensure its ongoing availability for use by local people. This could represent a potential income source and/ or could support public health or other wellbeing agendas for both children and adults.

11.5. Extra Care Services –The Council is developing a number of Extra Care services as part of its "Housing Matters" programme and the older person's housing strategy. The developments are explicitly addressing an avoidance and prevention agenda as part of which service specifications require the development of inclusive day time offers in the schemes public spaces, including the meals offer. The first of three new schemes at Conrad Court in Deptford has recently opened and will be shortly offering access for exercise classes and 'spa' type activities, as well as the restaurant facilities to the wider older adult population. The contracts for the second of these schemes, Campshill in Lewisham, has been awarded for delivery in late 2016 and a third service is in development in partnership with Phoenix Housing in Bellingham for delivery in early 2016. These schemes collectively will give scope for managing cost pressures on day service budgets for older adults.

12. Timescales and next steps

12.1. The proposals outlined in this paper represent in some parts a significant variation to how the Council delivers its day care and associated transport services. Should Mayor and Cabinet agree that officers may proceed to consult on the proposals, some will require a formal 3 months formal consultation process. Others will not, as they do not represent change to statutory services. However, officers will engage in discussions with affected users and families as best practice.

12.2. While there will also be informal staff briefings regarding the proposals in this paper, formal staff consultation will not take place until any decision that Mayor and Cabinet may take following the statutory consultation. Staff consultation will requirement a further 28 days.

12.3. The changes to the evening club transport will be consulted on separately from the consultation regarding change to the day service and associated transport.

12.4. Officers will work closely with third sector partners in this work, such as Community Connections, Voluntary Action Lewisham, the Lewisham

Disability Coalition and Lewisham Speaking Up, as well as recognised service providers such as Headway, Hestia, Housing 21, PLUS, Nexus, Aurora Options, Three Cs, Entelechy, Heart'n'Soul and others .

12.5. The following is an outline timetable for the main consultation and decision making process:

Mayor and Cabinet	11 February 2015
Consultation start	18 February 2015
Consultation end	18 May 2015
Mayor & Cabinet	June 2015
Business Scrutiny	June 2015
Staff Consultation start	June 2015
Staff Consultation ends	July 2015
Full implementation of changes	1 October 2015

13. Financial implications

13.1. The 2015/16 savings proposals considered by Mayor and Cabinet on 12th November 2014 included £1.3m from day care and associated transport. This report describes how this saving will be delivered in a full year.

13.2. The current budget for the day care service is summarised in table 7 below.

Day Care Type	**Budget**
In-house budgets for care	£3,421,400
Purchased day care	£803,000
Mental health (COS)	£729.700
Sub total	**£4,954,100**
Transport budgets	£2,443,268
Total budget	**£7,397,368**

Table 7 – Overall cost of day service and transport

13.3. The savings proposals described in the body of the report are summarised in table 8 below. Savings from 1:1 arrangements have not yet been quantified but are expected to exceed the £30K required to fully achieve the £1.3m savings sought.

Proposal	Saving £K
Reconfiguration of in house provision	230 + 1:1s
Improving access and service redesign	340
Adult Mental Health day service	200
Reduction in days of service delivered	200
Reduction in use of Door2Door	300
Total	1,270 + 1:1 costs

Table 8 – Day service savings proposals summary

13.4. These costs exclude capital costs for redesign of the building for communal use (e.g. IT costs, key coded doors).

13.5. The paper highlights that there may be costs relating to redundancy or potential for TUPE of existing members of staff. However, the full implication of this will not be known until the conclusion of the formal staff consultation period and the Council's DR/VR process. No estimate is included in the costs in table 2 above.

13.6. The needs for service user consultation followed by staff consultation means that implementation by April 2015 will not be possible and therefore a full year saving will not be achieved in 2015/16. Current estimates are that a part year saving of £953K will be delivered in 2015/16 and the residual £317K of saving relating to this programme being delivered into 2016/17.

13.7. A separate report considers options for alternative uses of the four buildings currently used by the in-house day care service.

14. Legal implications

14.1. The main legal implications are contained in the body of the report.

14.2. The National Assistance Act 1948 places both duties and powers upon local authorities to assess the needs of, and provide services to support such needs including residential accommodation, to people aged 18 years and over who because of their disability are in need of care and attention not otherwise available to them. In changing or altering services provided under Social Care legislation each individual's needs for services must be individually reassessed before changing the service or manner of delivery. In addition, in making proposals for service changes overall, there must be proper and meaningful consultation with service users, their families and any stakeholders, to enable and facilitate clear understanding of the proposals and enable stakeholders to express their views effectively.

14.3. In the event that Mayor and Cabinet agree the proposals relating to day services and transport changes, there is the possibility of redundancies and the application of TUPE for relevant council employees. Appropriate

consultation with staff and their trade unions will take place in line with the Council's TUPE guidance, redundancy policy and statutory requirements.

14.4. The Equalities Act 2010 (the Act) introduced a new public sector equality duty (the equality duty or the duty). It covers the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. In summary the Council must, in the exercise of its functions, have due regards to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited under the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

14.5. The duty continues to be a "has regard" duty, and the weight to be attached to it is a matter for the Mayor to decide, bearing in mind the issues of relevance and proportionality. It is not an absolute requirement to eliminate unlawful discrimination, advance equality of opportunity or foster good relations.

14.6. The Equality and Human Rights Commission (EHRC) has issued "Technical Guidance on the Public Sector Equality Duty" and statutory guidance the "Equality Act 2010: Services and Public Functions & Associations Statutory Code of Practice". The Council must have regard to the statutory code in so far as it relates to the duty and attention is drawn to chapter 11 which deals in particular with the equality duty. The Technical Guidance also covers what public authorities should do to meet the duty. This includes steps that are legally required, as well as recommended actions. The guidance does not have statutory force but nonetheless regard should be had to it, as failure to do so without compelling reason would be of evidential value. The Statutory Code and the Technical Guidance can be found at www.equalityhumanrights.com/legal_and_policy/equality-act-codes-of-practice-and-technical-guidance/

14.7. The EHRC has previously issued five guides for public authorities in England giving advice on the duty:

1. The essential guide to the public sector equality duty
2. Meeting the equality duty in policy and decision making
3. Engagement and the equality duty
4. Equality objectives and the equality duty
5. Equality information and the equality duty

14.8. The essential guide provides an overview of the equality duty requirements including the general equality duty, the specific duty and who they apply to. It covers what public authorities should do to meet the duty, including steps that are legally required, as well as recommended actions. The other four documents provide more detailed guidance on key

areas and advice on good practice. Further information and resources are available at:
www.equalityhumanrights.com//advice_and_guidance/public_sector-equality-duty/guidance-on-the-equality-duty

15. Equalities implications

15.1. An Equalities Analysis Assessment (EAA) has been completed for these proposals.

15.2. It suggests that:

- Across all services included in this paper and given the nature of the services being delivered, people with learning and physical disabilities as well as people with mental health issues will be negatively impacted by the specific nature of the services subject to these proposals.
- Broadly, no ethnic group will be disproportionately affected by the proposals, though some specific services have slightly more impact than others.
- In terms of age the majority of services are for younger adults under 65, which will mean they will be disproportionately affected by the proposals compared to other social care services.
- There are proportionately more males in day care settings which will affected by these proposals than women when compared to the population of day services users across Social Care.
- There is only a limited amount of data available for carers. Across Day Services only a small percentage carers have a long term health condition or disability; thought at the Naborhood 35% of family or carers have a health condition. Approximately a third of parents or carers are working and a third is over the age of 65.

15.3. The impact across all protected characteristics affected by these proposals will be low as the services being provided will be delivered differently rather than being removed. Additional services will be developed in conjunction with the Voluntary and Community Sector in order to provide a broader range of services than that currently available.

15.4. The EAA for Transport suggests that:

- Service users of the age of 65 are more likely to be affected by the proposals than younger adults attending Day Services.
- Women will be disproportionately affected, but the numbers are broadly similar to the percentage of women receiving support from social care.
- Though there are more white people receiving transport to Day Services the numbers are comparable to those in Social Care.

15.5. All services users will be negatively impacted by the proposed changes to transport to Day Services, though alternative arrangements have been developed in partnership with Voluntary and Community Sector organisations which will mitigate this impact. In addition service users will be provided the opportunity to organise their own transport as part of the

Personal Budget/Direct Payment, meaning that transport will still be provided for.

16. Environmental implications

16.1. There are no specific environmental implications arising from this report.

Background Documents
Adult Social Care Efficiency Programme
http://www.local.gov.uk/documents/10180/11779/LGA+Adult+Social+Care+Efficiency+Programme+-+the+final+report/8e042c7f-7de4-4e42-8824-f7dc88ade15d

Putting People First
Transforming Social Care
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/SocialCare/Socialcarereform/Personalisation/index.htm

The Care Act
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Caring for our future
https://www.gov.uk/government/publications/caring-for-our-future-reforming-care-and-support

For further information on this report please contact Heather Hughes on 020 86988133

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Healthier Communities Select Committee			
Title	Lewisham Future Programme 2015/16 Revenue Savings		
Contributor	Executive Directors for Community Services	Item	6
Class	Part 1 (open)	14 January 2015	

Reason for Urgency

The report has not been available for 5 clear working days before the meeting and the Chair is asked to accept it as an urgent item. The report was not available for despatch on Tuesday 6 January due to it requiring additional input and clearances prior to publication. The report cannot wait until the next meeting due to the Council's savings programme timeframes.

1. Purpose of Report

1.1 The attached appendices provide updates on the readiness to implement changes and the results of consultations in relation to the savings proposals due to return to Mayor and Cabinet on 11 February 2015.

2. Recommendations

2.1 Members of the Healthier Communities Select Committee are asked to note and comment on the updates for the following savings proposals, prior to their presentation to the Mayor on 11 February 2015:

- A1 – Cost effective care packages
- A2 – Reductions on costs of learning disability provision
- A3 – Changes to sensory services provisions
- A9 - Review of services to support people to live at home
- B1 – Reduction and remodelling of Supporting People housing and floating support services

3. Background

3.1 Following the 2015/16 savings proposals being considered by Select Committees and the Mayor during October and November 2014, updates on a number of proposals are now returning to Select Committees prior to their consideration by the Mayor in February 2015.

3.2 The following savings are dealt with through individual reports on the Committee agenda:

- A4 – Remodelling building based services
- A6 and A8 – Public Health programme review

For further information please contact Geeta Subramaniam-Mooney, Joan Hutton or Dee Carlin on 020 8314 8675 or Danny Ruta on 020 8134 8637.

Update on Budget Savings Proposals for Adult Social Care

- A1 – Cost effective care packages
- A2 – Reductions on costs of learning disability provision
- A3 – Changes to sensory services provisions
- A9 – Review of services to support people to live at home

Purpose of Update

To enable Members of the Healthier Communities Select Committees to scrutinise the budget savings proposals for adult social care for 2015/16, some of which are currently the subject of consultation with staff, partners, carers and people with care and support needs. These proposals are due to return to Mayor and Cabinet on 11 February 2015.

This report briefly provides an update on the adult social care budget proposals. Some of the proposed efficiencies will be realised as a consequence of the redesign of the assessment process which aims to embed best practice, the requirements of the Care Act that promotes well being and improved outcomes so that people can remain independent for longer and therefore delay access to long term care.

The Joint Commissioning Team is working to improve outcomes and reduce costs through re-tendering and reviewing placements and care contracts.

1. A1: Cost effective care packages - £2.680M

1.1 The adult social care service's vision is to support and promote strong communities so that people live their lives as successfully, independently and safely as possible. We believe that people themselves, regardless of age or ability, are best placed to determine what help they need.

1.2 Access to support is through a professional assessment of need, guided by nationally set eligibility criteria. Local authorities can take resources into account when determining how those assessed needs should be met and may use the most cost effective solution. In some situations the assessment will be the only service that is provided directly by the Council, particularly when care and support needs do not reach the eligibility criteria or when needs can be met by opportunities available from within the community or from the persons network of support and own resources.

1.3 The Care management and assessment teams have been aligned to GP practices within the borough. There are four neighbourhood multi disciplinary teams that are developing an approach to multi disciplinary work and support planning that will ensure people remain living at home as independently as possible by providing low level support to keep people well and prevent them from needing more intensive (and expensive) care.

1.4 These services include information ,advice and sign posting, Enablement (to aid recovery after illness), falls prevention, support to family carers, employment, assistive technology, equipment and by making use of existing universal services within the community and the development of targeted and a range of support developed from the community connections work aimed to tackle social isolation.

How we work to deliver these savings

1.5 There are currently 6,000 people in receipt of a community care package, this includes people who are placed in Residential or Nursing care homes.

1.6 A cultural shift in practice is required to move from an approach that is predominantly service led, to an approach that considers the strengths and resources an individual can contribute to meet their needs. In order to achieve this, a programme of training and development is in place, due to be completed by March. The training focuses on the assessment of need and how to support plan within a budget allocated that is determined by the assessment process.

1.7 An extended and more comprehensive resource allocation formula (RAS) will be introduced at the end of January to calculate how much money (personal budget) should be allocated to a person who is eligible for support from adult social care following their assessment. The size of the budget will reflect the scale and complexity of their care needs but also the availability of informal care from their families and friends. Opportunities for support from universal services and from within the community will also be considered. The work that has taken place to date to develop the market with opportunities for activities and alternatives to traditional care services has provided wider and more personalised options for people.

1.8 Alternative ways of providing meals are being explored as part of the review/ assessment process. The alternatives that are being offered and accepted are Wiltshire Farm Foods or supermarket ready meals. For those people who receive other care calls assistance can be given to heat up a ready meal. Alternatively, MOW (hot meal plus pudding) can be purchased direct from Apetito for £ 6.50 per day. Support planners can assist with the information and getting the person set up.

1.9 We are anticipating that by adopting this approach we will have fewer people accessing care and that we will be able to reduce the costs of some existing packages of care to achieve the above mentioned savings target. Monthly reports will be provided to the Departmental management team to ensure that the savings target is monitored. Attached to this report (appendix 2) are pen pictures of community care reviews that have taken place so far demonstrating how needs can be met in a more cost effective way.

2. A2: Reduction in the cost of Learning Disability provision 1.5M

2.1 These saving proposals are based on national best practice, areas where the Council does not benchmark well against other similar authorities in terms of spend. They relate to the reduction of costs associated with residential care, supported living and Income generation.

2.2 Supported Living (target £900K) – Provider costs that relate to overheads and also the level of 1:1 support provided in placements are being re-assessed and re-negotiated with the providers following an assessment of need. This work has achieved £100K and is on target to achieve the full amount. A programme of Community care reviews is in place as part of the process to look at needs and how outcomes can be met in the most cost effective way.

2.3 Residential care (target £500K) – Significant progress has been made towards delivering this target with some transfer of funding to out of borough CCGs as part of the national guidance for Ordinary residence. In addition, some older adults with a learning disability are in the process of moving to

more appropriate placements within extra care housing and residential services. £200K has been achieved to date in relation to this element of the savings proposal.

2.4 Income (target £100K) – This proposal relates to changes in the Council's charging policy for people with a learning disability in supported accommodation which is charging proposal 4 in the charging document currently out to consultation.

3. A3: Changes to Sensory service provision - £150K

3.1 Consultation with staff affected by the re-structure of sensory services is taking place throughout January. The proposed delivery model aims to provide continued access to information and advice in a range of communication formats that meet the needs of people who are Deaf, users of British sign language, Hard of hearing, Visually impaired or who have a dual sensory impairment and use hands on or visual frame communication.

3.2 There will continue to be specialist Social work support for those people who meet the eligibility criteria requiring this level of support, such as young people with sensory impairment who transfer to adult services. Rehabilitation intervention and support for sight guidance and communication / guidance will continue to be available from existing therapists resources to people so they remain as independent as possible. There will be a greater emphasis placed on personalisation and the use of Direct payments for those people that have on-going needs that meet the criteria for support. Practitioners from the Care management and assessment teams will also work with people who have a sensory impairment.

4. A9: Review of services to support people to remain at home - 250K

4.1 The review of services to support people at home includes Linkline, Enablement, Special Duty and Sheltered Floating Support Services. The proposal seeks to make better use of existing staffing resources whilst supporting the further integration of services. These services focus on keeping people independent and in their own homes, minimising hospital stays, wrapping services around the person and employing the right skills, in the right place at the right time. Detailed proposals are being worked on as part of the Better Care Fund plan and will be ready in March.

4.2 Sheltered Floating Support Service – Sheltered Housing and Extra Care Housing provision has been reviewed in recent years, site appraisals were carried out in 2010, a stock condition survey in 2012 and the draft Older People's Housing Strategy in 2014.

4.3 The approach to the review of housing and care for older people has focussed on:

- The quality and appropriateness of sheltered accommodation
- Exploring different models of revenue funding for sheltered accommodation
- Quality of specialist housing for those older people who require it
- Investment in the Council's Sheltered Housing accommodation.

4.4 The focus of this saving proposal is to establish a new way of funding sheltered accommodation that will also ensure consistency in the delivery of support to older people in different housing settings. Adult Social Care is working closely with Housing to achieve this savings target.

Update on Budget Savings Proposals

B1 - Reduction & remodelling of supporting people services

Total Savings 2015/16 and 2016-17 - £2,523,000

1. Overview

1.1 In Lewisham, housing-related support is delivered by a number of service providers to clients with a range of needs. Support takes place across different accommodation settings: high-support hostels, shared supported housing and in the community via floating support. As well as funding a number of schemes providing generic support for vulnerable adults such as sheltered housing Lewisham runs specialist projects for individual client groups, such as older people, people with mental health problems, drug and alcohol users, women experiencing violence and exploitation, offenders and rough sleepers.

1.2 The savings proposals are to reduce funding to these services by a further £2,523,000 (20% of the budget) over the next two years through a combination of:

- Efficiency savings through reduced contract values while maintaining capacity[1]
- Reductions in service capacity
- Service closures

1.3 The majority of the savings will be taken from 'floating support' services that visit people in their own homes. Currently these services support over 800 people at any one time with up to 1600 supported each year.

1.4 The savings will be delivered through a reduction in individual contract values in the first instance but ultimately through a major reconfiguration exercise to create one large service across the borough rather than the current arrangement of several services each supporting a particular client group.

1.5 It is inevitable that funding reductions of this level will lead to reduced service provision and some people who currently receive support will no longer be supported.

1.6 However, officers believe that through effective consultation and planning with providers, service users and other stakeholders the impact can be keep to a minimum and given the overall financial pressure on the council these are achievable savings.

1.7 The original funding proposals highlighted a series of risks relating to these reductions.

1.8 However, officers are working hard across departments to ensure that the impacts of these reductions are kept to a minimum. Due to these actions officers are confident that the savings can be delivered with the minimum of disruption to services and service users.

1.9 This papers sets out the mitigating actions for these risks (Table 1) as well as for each of the individual reductions (Table 2). Equalities Implications and

[1] It is important to note that all staff engaged in service delivery will be paid the London living Wage as a absolute minimum

Impacts are considered individually for each of the planned reductions in Table 2.

Table 1 – Overarching mitigating actions and principles applied across this area of funding reductions

Risk	Mitigation actions
1. People becoming homeless *Any losses to the floating support service will carry increased risk of more individuals becoming homeless*	The impact of this will be mitigated by targeting the remaining services at those most in need. The majority of the reductions to floating support services will be from 1 April 2016. During 2015/16 officers will undertake a full review of the provision and consult on the most appropriate access and referral criteria. This is will be undertaken in partnership with colleagues in housing and other frontline services to identify need. The new floating support service (s) to run from 1 April 2016 will have a contract value (s) of c£750,000 per annum which is considered sufficient to provide a service to prevent single people in the borough experiencing homelessness. There is also an opportunity to integrate this funding with other areas of council spend to create more efficient and joined up services e.g. within sheltered housing. This will also be explored during 2015/16.
2. Impact on statutory services/temporary accommodation/residential care *Loss of hostel bed spaces will inevitably lead to pressure elsewhere within council resources.*	Officers considered this risk carefully when drafting proposals and the saving are designed to ensure that there are very few hostel or supported housing spaces closed due to the funding reductions. The vulnerable adults' pathway will provide step down accommodation from front line hostels allowing enough throughput for those with the most complex needs to continue to access high level support for longer periods in order to stabilise their physical health and chaotic behaviour preparing them for a more independent lifestyle. In addition to this officers are undertaking a full review of the accommodation support provided to people with Mental Health problems to ensure that this resource is effectively targeted and the most vulnerable individual in the borough have easy and rapid access to in to prevent admissions to hospital or residential care.
3. Increased risk of safeguarding cases and services failure *Further reductions in funding my impact on staff quality and morale to such an extent that service users are put at risk*	In order to protect against reduction in the quality of the workforce, decreased morale and increased staff turn-over officers have rejected wholesale 'salami-slicing' contracts and looking for continued savings while delivering similar services. Instead a range of services which are considered low risk will simply be ended and fundamental reviews of

	floating support and MH services will be undertaken to redesign services and procure new contracts against revised outcomes.
4. Increased use of existing hostels by high needs out of borough clients *The loss of buildings currently used as hostel accommodation is in itself a significant one.*	As highlighted above the savings proposals have been designed to ensure that very few units of accommodation are lost to the borough. This also ensures that other boroughs do not begin to place high need clients within Lewisham.
5. A rise in rough sleeping *Numbers of people living on the streets in Lewisham will rise significantly*	All services are being remodelled to target those most likely to end up sleeping rough or requiring high support services. This includes ensuring that floating support services have effective referrals mechanisms to get to those in need before they lose their accommodation, protecting high support hostels for those that needs them and ensuring there is a 'Pathway' of support so services work more effectively and efficiently to move people into independent accommodation. Officers also continue to work closely with a range of service in the borough funded through other sources including the 'No Second Night Out' Hub and the Bench and Deptford Reach outreach services to ensure that all rough sleepers are housing in accommodation as soon as possible.
6. A rise in Anti Social Behaviour on the streets *Anti social behaviour on the streets in Lewisham may rise significantly*	Again, the reduction of high support services that often contribute to this type of behaviour have been protected.
7. Financial Viability *Remaining services become financially unsustainable for providers and they withdraw from provision*.	Officers are working closely with all providers to ensure that they are financially viable. There are currently a number of mergers taking place across the sector that will mitigate risk for individual providers and officers will continue to undertake market management activity to ensure that individual cuts do not have a cumulative impact on providers.

Table 2 – Individual consultation/mitigating actions to each individual reduction in this area

Provider	Service	2015/16 Reduction	2016/17 Reduction	Consultation/Mitigating Actions
One Support	*Older Person's Floating Support* This service is delivered to Older People in their own homes to provide support in a range of areas including rent arrears, budgeting, social isolation, housing issues etc	£50,000	See table on page 9	This is a 14% reduction in the current contract value and officers are confident that the provider will be able to limit the impact on existing service users through efficiency savings. Officers have spoken to senior management at One Support who have indicated that the vast majority of this reduction can be absorbed through efficiency savings. However the reduction may mean that the threshold for the service increases slightly and officers will be undertaking a consultation with stakeholders and affected service users to ensue that any ongoing and future needs are met and the impact of this change is minimised. Further reductions in 2016/17 will be part of a major reconfiguration exercise for floating support services across the borough. There are a number of options for these services which will be subject to a wide ranging consultation with stakeholders and service users during 2015/16. Full details are of contracts covered under this reconfiguration are listed at table 3 below.
One Support	*Mental Health Floating Support* This service is delivered to people with mental ill health in their own homes to provide support in a range of areas including rent arrears, budgeting, social isolation,	£117,000	£0	This saving involves the merging of this contract with a larger MH accommodation based contract. This makes sense as the majority (60 out of 85) of the current clients live within designated housing units which are essentially longer term supported housing. The merger of these contracts will allow the provider to make significant savings in management and accommodation costs with only a smaller reduction in overall service.

	housing issues, anti-social behaviour, medicine compliance etc			Officers have spoken to senior management at One Support who have indicated that they feel these reductions are achievable with only minimal disruption to the current service provision. Will we consult with the provider and colleagues within the council to ensure that the impact of this change is minimised. All current service users will have their needs assessed and those who are able to move on from the service will be supported to do so. Those with continuing needs will be referred to other services for ongoing support.
Lookahead	*Adults with Learning Disabilities Floating Support* This service is delivered to adults with learning disabilities in their own homes to provide support in a range of areas including rent arrears, budgeting, social isolation, housing issues, independent living skills, accessing other services etc	£80,000	See table on page 9	This is a 28% reduction in the current contract value. Officers have spoken to the provider of this service and while a degree of the saving will be absorbed through efficiency savings it will inevitably lead to an overall loss of capacity. This means that the current service users will receive fewer direct support hours than they currently do but officers will consult with the provider, service users and colleagues within the council to ensure that the impact of this change is minimised. All current service users will have their needs assessed and those who are able to move on from the service will be supported to do so. Those with on going needs will be referred to other services but the overall threshold for services will increase and some may not receive ongoing support. Further reductions in 2016/17 will be part of a major reconfiguration exercise for floating support services across the borough. There are a number of options for these services which will be subject to a wide ranging consultation with stakeholders and service users during 2015/16.

				Full details are of contracts covered under this reconfiguration are listed at table 3 below.
Thames Reach	*Vulnerable Adults Floating Support* This service is open to all adults across borough in their own homes to provide support in a range of areas including rent arrears, budgeting, social isolation, drug and alcohol misuse, housing issues, independent living skills, accessing other services etc	£100,000	See table on page 9	This is a 14% reduction in the current contract value but the provider has indicated that the vast majority of this saving can be delivered without impact on service capacity due to a recent organisational restructure designed to reduce the costs of their services across London. Officers are conscious that restructures of this type have the potential to impact on service quality due to reduced investment in front line staff, training etc. As such will we consult with the provider and colleagues within the council to ensure that the impact of this change is minimised. Further reductions in 2016/17 will be part of a major reconfiguration exercise for floating support services across the borough. There are a number of options for these services which will be subject to a wide ranging consultation with stakeholders and service users during 2015/16. Full details are of contracts covered under this reconfiguration are listed at table 3 below.
Thames Reach	*Generic Supported Housing* This service is delivered to	£150,000	£0	As above the provider has indicated that the vast majority of this saving can be delivered without impact on service capacity due to a recent organisational restructure designed to reduce the costs of their services across London.

	individuals living within supported housing units across the borough. The service prepares individuals for independent living by addressing their individual support needs which may relate to a range of issues including drug and/or alcohol misuse, lack of budgeting skills, history of mental health problems etc			Officers are conscious that restructures of this type have the potential to impact on service quality due to reduced investment in front line staff, training etc. As such will we consult with the provider and colleagues within the council to ensure that the impact of this change is minimised.
Thames Reach	*Hostel Diversion Pilot*	£37,000	NA	The ending of this pilot may lead to people having to enter hostels or supporting housing while they wait for independent accommodation. However, the introduction of the Pathway approach means that any time spent in such accommodation will be kept to a minimum and officers are working with a range of stakeholders to ensure that there is an effective supply of independent 'move-on' accommodation available.
Hestia	*Multi Agency Public Protection Arrangements (MAPPA) Floating Support* This service is delivered to adults who are subject to MAPPA in their own homes to provide support to enable them to engage with the requirements of their probation or other statutory orders and therefore reduce harm to the public.	£0	£82,300	This reduction will lead to the closure of the MAPPA floating - clients are low need but high risk and we will need to undertake a full consultation with Police and Probation colleagues to fully understand the impact of this and confirm the proposal for 2016/17.

Centrepoint	*Young People's Assessment Centre* An accommodation based service that assesses the housing and support needs of vulnerable young people who have recently approached the council as homeless.	£50,000	£0	This reduction will end a 'payment by results' element to the service designed to support more individuals into independent living. While the saving may reduce the capacity within the service it is expected that the overall impact will be limited. Will we consult with the provider and colleagues within the council to ensure that the impact of this change is minimised.
Single Homeless Project (SHP)	*Young People's Floating Support* This service is open to all adults across borough in their own homes to provide support in a range of areas including rent arrears, budgeting, social isolation, drug and alcohol misuse, housing issues, independent living skills, accessing other services etc	£0	See table on page 9	This reduction will be part of a major reconfiguration exercise for floating support services across the borough. There are a number of options for these services which will be subject to a wide ranging consultation with stakeholders and service users during 2015/16. Full details are of contracts covered under this reconfiguration are listed at table 3 below.
LB Lewisham	*Very Sheltered Accommodation) - Extra Care*	£0	£100,000	This 2016/17 proposal will be subject to wide consultation. A number of Extra care are planned for closure but this reduction will limit the funds available for re-provision and the impact of this needs to be considered carefully.
Range of providers	*Mental Health Supported Housing* This service is delivered to individuals living within	£0	£270,814	This is a 12% reduction in the overall contract value and officers are confident that the provider could absorb this cost through limited reductions in service. However, this saving is not scheduled until 2016/17 and remains indicative at this stage as officers are currently undertaking a full review of all housing provision for

	supported housing units across the borough. The service prepares individuals for independent living by addressing their individual support needs which may relate to a range of issues including drug and/or alcohol misuse, lack of budgeting skills, history of non compliance with medication etc			people with MH problems and all final proposals will be subject to consultation.
LB Lewisham	*Sheltered Housing* This funding is for a Floating Support service which provides support for people living in the boroughs Sheltered schemes (managed by Lewisham Homes) Support includes help with rent arrears, budgeting, social isolation, housing issues etc	£100,000	£0	An element of the current service covers basic cleaning and maintenance tasks which are eligible for funding through housing benefit. As such it is proposed that costs of the service are met by Lewisham Homes through its rental income. This proposal will be subject to a full consultation as part of the rent setting exercise. The overall approach to support for Older People in the borough will be examined in detail as part of the review of floating support in 2015/16.
Greenwich Telecare	*Alarm system* This funding is for an alarm service for a Peabody Sheltered scheme. When the One Support Older Persons Floating Support service was	£5,757	£0	Peabody, as a large registered landlord, have agreed to absorb this cost into its wider housing management provision. We will consult with Peabody regarding the overall approach to support for Older People in the borough as part of the review of floating support in 2015/16.

	commissioned Peabody requested that they were able to continue with their existing alarm service. The service provides out of office cover through use of alarms and pendants etc.			
Abbeyfield Deptford	*Older Persons support service* This service is a small shared house supported by a local organisation affiliated to the National umbrella organisation Abbeyfield. Support provided is at a very low level	£1,085	£0	The impact of this small funding withdrawal will be minimal. Officers have spoken to Abbeyfield and they have agreed to absorb the cost of this reduction. We will consult with Abbeyfield regarding the overall approach to support for Older People in the borough as part of the review of floating support in 2015/16.
Anchor Trust	*Tony Law House - Alarm system* Alarm only service	£2,486	£0	Anchor, as a large registered landlord, have agreed to absorb this cost into its wider housing management provision. We will consult with Anchor regarding the overall approach to support for Older People in the borough as part of the review of floating support in 2015/16.
Anchor Trust	*Knights Court - Alarm system* Service includes contribution towards Alarm system and office based support (9am to 4pm weekdays)	£9,674	£0	Anchor, as a large registered landlord, have agreed to absorb this cost into its wider housing management provision. We will consult with Anchor regarding the overall approach to support for Older People in the borough as part of the review of floating support in 2015/16.

Various Providers	*Various service for Adults with Learning Disabilities*	£430,000	£104,000	The Year 1 savings have been achieved through a range of actions undertaken by colleagues in Adult Social Care. Further savings from 2016/17 will be subject to wide consultation.
Dinardos	Fairway Lodge	£271,000		This reduction has previous been agreed and took effect from October 2014. So far there has been no impact from this reduction as the provider has continued to deliver the service.

During 2015/16 there will be a major reconfiguration of floating support services in the borough to move from a client group based approach to an outcomes based approach i.e. the provider will be required to work with a range of different people to achieve the same outcomes such as reduced rent arrears, reduced drug and alcohol use, increasing independent living skills etc.

Table 3 – Services in scope for the review of Floating Support

Provider	Services included	Contract values (2015/16)	Overall saving across the 4 contracts	Impact/Process
One Support	*Older Persons Floating Support*	£305,210	£525,000	This proposal will lead to one overall service with a contract value of approximately £730,000 per annum. This will be subject to full consultation with providers, service users and stakeholders.
Lookahead	*Adults with Learning Disabilities Floating Support*	£200,000		
Thames Reach	*Vulnerable Adults Floating Support*	£485,040		
SHP	*Young Person Floating Support*	£268,000		

For further information on this briefing please contact James Lee, Prevention and Inclusion Manager
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Adult Social Care –
Assessment and Support Planning Services – Outcomes

JON

Adult with a learning disability, male age 24, high functioning, in care since a child, went into residential care placement on the South Coast as an adult, funded by Lewisham.

The 2011 review of care whilst in residential placement found that he was unhappy with his life in that environment.

After much work to remedy this situation by the team it was found JON wanted to live a more independent life. Over a period of 18 months of working with the team JON secured a home in the private rented sector on the South Coast, he used housing benefit and his other state benefits to contribute toward setting up a new home and he had a small care package of carer visits daily.

After a further review at 2 years he decided that he wanted to live permanently in that South Coast borough, which has happened.

Care Package and Changes:-
2011 Residential weekly cost- £1200 per week
2013 Reduced to care package cost of 14 hours per week- £220
2014 Now nil cost as JON is now a resident of this South Coast borough

Outcomes for JON:-
Lives independently now with help from staff, alone in his own home, attends college, is volunteering in the Gaming shop his passion, and mixing on an everyday basis in his community.

Adult Social Care –
Assessment and Support Planning Services - Outcomes

JM

JM, female aged 76, lives north of borough, with son as main carer, has significant cognitive impairment. Her son called the duty desk 6 months ago to say JM was getting fed up and becoming tearful, and that he as the carer was struggling to cope as it was getting him down. The team assessed both the client, and the son as carer and identified that some sort of day activity, and memory service help would be beneficial to give her a change, assess her mental health and to give the son a break.

At assessment it emerged that she was resistant to outside help but was able to self care with prompting from her son, had friends locally who she had not seen for a long time, and that she knew the Deptford area well. However she could not be left alone at all night or day as her dementia had deteriorated and her short term memory was poor. She was encouraged to consider going once a week to a free lunch club for 3 hours every week in the local community centre. To do this she needed help, both to get there, remain there and be safe, and to get back home. In consideration of this fact she was awarded a direct payment for 3 hours per week and would use her own resources to pay for lunch there. She was supported to identify a carer from the personal assistant bank and this is now working well.

Assistive technology was installed to keep her safe and monitor her movements if the carer popped out.

Care Package and Changes:-
2012 no services
2013 £35 per week for a personal assistant to support to attend lunch club locally- this was where her old friends were meeting too!

This care package avoids the need to attend a traditional day centre attendance, at a unit cost in the region of £100 per day.

Outcomes for JM:
Supported to remain in the community living with her son in a familiar environment and to pick up on her old friendship networks. Carer gets a regular weekly break. JN becomes familiar with accepting outside help in case her care needs increase in the future.

Adult Social Care –
Assessment and Support Planning Services- Outcomes

AN

Female aged 40, living with partner and autistic son in a Lewisham Home's property. She had a road traffic accident about 3 years ago and was in hospital for a while. Although she could stand up and mobilise short distances, she needed help with all her activities of daily living because of significant nerve and muscle damage. She, and her family had significant support from occupational therapy services with moving to an adapted property, where there was a good range of aids and adaptations made available. On leaving hospital she had a care package of 21 hours a week of personal care, with some domestic support of 1 hour per week to help keep the home tidy and was supported to apply for additional disability related benefits to help the household finances now she could not work. Her partner carried out all other tasks. During this time she had a number of other therapeutic interventions to help increase her independence.

Through the ongoing process of annual review the care package continued to be reduced to remain relevant and appropriate to meet her needs. Today she has difficulties with some of her activities of daily living but she has recovered some of her former strength and ability.

Care Package and Changes
3 years ago on discharge from hospital 21 hours of personal care plus 1 hour domestic help, at a cost of £350 pw
2 years ago- reduced to 14 hours plus 1 hour domestic help at a cost of £200 pw
Now – reduced to 6 hours with domestic help of .5 hour at a cost of £100 pw

Outcomes for AN:-
Tailored package of care to suit improving ability to self care, increased confidence due to improved independence , greater ability to participate in family and community life. Now volunteering as a way to get back into the workplace.

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Appendix 2

Adult Social Care –
Assessment and Support Planning Services - Outcomes

Mrs BW

Mrs BW, age 82 lives at home with her daughter, who is also her informal carer. Her daughter works full time and prepares/ cooks main meal in the evening. Daughter also carries out all day to day activities like housework.

Mrs BW was admitted to University Hospital Lewisham (UHL) 2 years ago following a major stroke (left lacunar infarct), which resulted in cognitive impairment, confusion, reduced mobility, left sided weakness, left sided inattention, visual impairment, reduced self-help skills and double incontinence. Mrs BW had difficulty with swallowing and was at risk of choking so all her food needed to be soft.

Mrs BW was discharged home with a care package of 2 carers per visit – 4 calls a day 7 days a week. She was unable to weight bear or mobilise and needed assistance of two with all aspects of personal care and mobility.

Action Plan identified at review to assist Mrs BW regain some of her former abilities-
Referral to LATT (Lewisham's physiotherapy team) for mobility programme.
Encourage enablement self help outcomes within the care package i.e. Mrs BW to wash and cream top half of her body herself, for her to help with moving on the bed and for her to mobilise with walking frame over short distances

Care Package and Changes
Two years ago care package 4 visits daily and 2 carers each visit costing £500 per week
Today reduced to single person care visits at £250 per week

Outcomes for Mrs BW
Mrs BW completed a mobility programme with physiotherapist and her mobility has improved. She is able to transfer assisted by one person and is able to walk a few paces with her walking frame and with supervision. Mrs BW is independent to wash her face and hands now. Continues to live with her daughter in their home in the community.

Slide 4

c1 craneka, 09/10/14

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