Healthier Communities Select Committee Agenda

Tuesday, 24 February 2015
7.00 pm,
Committee Room 2
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 except for the item numbered four on the Agenda. For legal reasons, that item will be considered in private with the press and public excluded.

Part 1

Item		Pages
1.	Minutes of the meeting held on 14 January 2015	1 - 10
2.	Declarations of interest	11 - 14
3.	Response from Mayor and Cabinet on matters raised by the Committee: to follow	
4.	Leisure centre contract	15 - 16
5.	Community Education Lewisham	17 - 30
6.	Implementation of the Care Act	31 - 48
7.	Adult safeguarding: to follow	
8.	Public health performance dashboard	49 - 74
9.	King's elective services changes: update	75 - 78
10.	Select Committee work programme	79 - 98
11.	Referrals to Mayor and Cabinet	

Members of the public are welcome to attend committee meetings. However, occasionally, committees may have to consider some business in private. Copies of agendas, minutes and reports are available on request in Braille, in large print, on audio tape, on computer disk or in other languages.

Healthier Communities Select Committee Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Tuesday, 24 February 2015.

Barry Quirk, Chief Executive
Thursday, 12 February 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)	

MINUTES OF THE HEALTHIER COMMUNITIES SELECT COMMITTEE

Wednesday, 14 January 2015 at 7.00 pm

PRESENT: Councillors John Muldoon (Chair), Stella Jeffrey (Vice-Chair), Paul Bell, Bill Brown, Ami Ibitson, Alicia Kennedy, Jacq Paschoud, Joan Reid and Alan Till and Alan Hall

APOLOGIES: Councillor Pat Raven

ALSO PRESENT: Val Fulcher (Lewisham Healthwatch), Councillor Chris Best (Cabinet Member Health-Wellbeing and Older People), Timothy Andrew (Scrutiny Manager), Diana Braithwaite (Commissioning Director) (Lewisham Clinical Commissioning Group), Aileen Buckton (Executive Director for Community Services), Dee Carlin (Head of Joint Commissioning) (LCCG/LBL), Jemma Gilbert (Programme Director, Primary Care) (NHS England), Heather Hughes (Joint Commissioner, Learning Disabilities), Joan Hutton (Interim Head of Adult Assessment & Care Management), Helen Kelsall (Service Manager, Inpatient Care) (South London and Maudsley NHS Foundation Trust), James Lee (Service Manager, Inclusion and Prevention), Jackie McLeod (Clinical Director and Primary Care Lead) (Lewisham Clinical Commissioning Group), David Norman (Service Director Older Adults) (SLaM), Georgina Nunney (Principal Lawyer), Lynn Saunders (Director of Strategy, Business Development and Planning) (Lewisham and Greenwich NHS Trust), Nick O'Shea (Lewisham Mencap), Belinda Regan (Deputy Director of Governance) (Lewisham and Greenwich NHS Trust), Simon Rowley (Assessments & Benefits Manager), Dr Danny Ruta (Director of Public Health), Geeta Subramaniam-Mooney (Head of Crime Reduction and Supporting People), Sarah Wainer (Head of Strategy, Partnerships and Improvement) and Martin Wilkinson (Chief Officer) (Lewisham Clinical Commissioning Group)

1. Minutes of the meeting held on 2 December 2014

Resolved: to agree the minutes of the meeting held on 2 December as an accurate record.

2. Declarations of interest

Councillor Muldoon – non-prejudicial – lead governor of SLaM NHS Foundation Trust.
Councillor Paschoud – non-prejudicial – family member in receipt of social care; Member of Lewisham and Greenwich NHS Trust.

3. Lewisham hospital update

3.1 Belinda Regan (Deputy Director of Governance, Lewisham and Greenwich NHS Trust) introduced the report; the following key points were noted:

- In February 2014, Lewisham and Greenwich NHS trust was inspected by the Care Quality Commission.
- The newly formed trust welcomed the inspection and the subsequent CQC report.
- An improvement plan had been developed to monitor progress against issues identified in the report.

DRAFT

- The plan was split into four themes: patient flow; workforce; safety and organisational learning.
- 140 actions were being monitored on an on-going basis and were due to be completed by 2015.
- There were some outstanding actions in the areas of patient flow. Some of the improvements identified required the redesign of patient pathways in order to ensure safe and timely discharge of all patients.
- Some of the improvements required the re-design of models of care, which in some instances, required the recruitment of specialist staff, which would be subject to its own timescales.
- Work was taking place on the development of the five year strategic plan
- Additional beds were being created from previously under-utilised space
- It was recognised that further work needed to take place to ensure that fit patients were able to move out of hospital quickly.

3.2 Lynn Saunders (Director of Strategy, Business Development and Planning) provided a verbal update about winter pressures; the following key points were noted:

- As reported, there had been significant increases in the demand for A&E services across the region and nationally.
- The Trust had seen 600 more A&E attendances in December 2014 – compared to December 2013.
- There had also been 200 more admissions that month.
- Meeting the four hour A&E target had been a challenge.
- The Trust was putting in places services and facilities to increase capacity.
- The Trust had been on alert for a number of weeks – this ensured that there was a robust set up of clinical and systems management to deal with problems as they arose.
- Crisis management teams met three times a day to review all of the Trust's patients.
- Work was also taking place with adult social care services and the CCG to ensure that there was sufficient step-down capacity for patients who were ready to leave hospital.
- Some new capacity had been opened at QEH – which had already delivered 36 extra beds.
- The Trust had also received some winter funding to help relive pressures; this had been used to facilitate additional weekend working by clinical staff and patient transport.
- Additional measures were being tested to reduce pressure on frontline services.
- The NHS national support team had been invited to the Trust in November and December to review implementation of improvements and comment on winter resilience plans.
- Quality of care to patients was the foremost consideration in all discussions about changes.

3.3 Belinda Regan (Deputy Director of Governance) and Lynn Saunders (Director of Strategy, Business Development and Planning) responded to questions from the Committee; the following key points were noted:

- Future reports would include additional information about the successful work being undertaken at the Trust as well as highlighting the improvements required.

- The Trust worked well with its PFI (Private Finance Initiative) partners and the PFI was supportive of the Trust's goals.
- The CQC inspection had highlighted a specific problem with waste management, which had been dealt with promptly.
- The report also underlined the importance of hand sanitising and of 'bare below the elbow' working.
- Observational audits were carried out in the Trust and managers at all levels were regularly challenged to ensure the Trust's procedures were being followed.
- Regular challenge of internal audits took place as well as independent inspections of services to support the Trust's improvement plans.
- The Trust was still working towards foundation status. The focus of work was on the development of the Trust's five year strategy.

Resolved: to note the update.

4. SLaM specialist care changes

4.1 David Norman (Service Director, Mental Health of Older Adults & Dementia Clinical Academic Group, SLaM) introduced the report; the following key points were noted:

- Demand for specialist dementia services was decreasing
- Some of SLaM's dementia services had been moved outside of the borough
- Work had taken place to re-assess provision for service users
- The availability of discharge and support services had improved in residential accommodation.
- The decline in numbers of patients in Lewisham provision raised concerns over continuing clinical safety in residential provision.
- Discussions would take place with commissioners over alternative provision for specialist care.
- Members were asked to determine whether this constituted a substantial change in services and to comment on the proposed consultation plan in advance of its consideration at the SLaM trust board.

4.2 David Norman (Service Director, Mental Health of Older Adults & Dementia Clinical Academic Group, SLaM) and Helen Kelsall (Service Manager, Inpatient Services, SLaM) responded to questions from the Committee; the following key points were noted:

- Numbers of patients from Lewisham requiring specialist care had declined more quickly than neighbouring boroughs because of Lewisham's early adoption of community model of care, to support people in care home settings.
- Specialist provision would always be available for those who required it.
- It was recognised that the decline in patients was in contrast to reports in the media about NHS services being overwhelmed. However, the provision of community services was now the preferred model of delivery.
- There had been changes in national policy, which had reduced numbers of patients requiring specialist care.
- National continuity of care criteria also changed in 2008 – which meant that the NHS no longer looked to provide patients with a home for life.

- There were regular clinical assessments of patients, which often indicated alternatives for patients with physical health problems that no longer required specialist mental health services.
- 9 individuals and their families would be affected by the proposed changes.
- Officers from SLaM had initial conversations with almost all family members of the patients affected by the changes.
- Each of the service users would have a clinical assessment and would remain in specialist care if there were clinical reasons for them to do so.
- Consultation would be open and honest. SLaM would genuinely listen to concerns of stakeholders; the proposals would not be considered a foregone conclusion.
- It was not anticipated that there would be redundancies – because there should be vacancies for those who required them.
- In 10 years' time there would be different services in the community and less reliance on acute services.
- Demographic projections and epidemiological work carried out in London, was well developed – and the projections for Lewisham were considered to be reliable.
- There were currently a lack of treatment options for the dementia – and work focused on early identification and support.
- Government had a special interest in the dementia care – early detection and primary care changes were being developed nationally to provide a coordinated response to dementia.

4.3 The Committee also discussed the proposal and noted their concerns about the impact on patients, particularly those who had already been moved from previous decommissioned provision. The Committee also highlighted its concerns about the future capacity of specialist services and requested an update on the 2007 projections provided in the report.

Resolved: that the changes proposed constitute a substantial variation in services; and to agree that the planned consultation takes place, with the findings reported back to the Committee.

5. Primary care strategy

5.1 Martin Wilkinson (Chief Officer, Lewisham CCG) and Gemma Gilbert (Programme Director, Primary Care, NHS England) introduced the report; the following key points were noted:

- The CCG was working to improve the delivery of primary care in the borough and had developed a Primary Care Strategy.
- NHS England, in partnership with patients and clinicians, had developed a framework for transforming GP services in London.
- The CCG along with SEL CCGs were submitting proposals for co-commissioning GP services, which would support the work happening in primary care.
- NHS England was currently the commissioner of GP services but the CCG was responsible for improving the quality of services.
- The national patient surveys on GP services were helping to highlight issues with access. There were still concerns from patients about getting through to GP practices over the phone- and awareness of who to contact out of hours.
- The CCG are developing communications for the public about out of hours services.

- CQC risk ratings for GP surgeries – had shown that few (3) were high risk.
- NHS England was working to develop a new vision for GP services over five years, building on the best practice in London.
- The local strategy would link with London strategy.

5.2 Martin Wilkinson (Chief Officer, Lewisham CCG); Gemma Gilbert (Programme Director, Primary Care, NHS England) and Jackie McLeod (Clinical Director and Primary Care Lead, Lewisham CCG) and Diana Braithwaite (Commissioning Director, Lewisham CCG) responded to questions from the Committee, the following key points were noted:

- The CCG Procurement Policy had been approved by the CCG Governing Body and each procurement activity would include public engagement activity.

Strategic Commissioning Framework for Primary Care Transformation in London

- A transformation framework has been developed deliver improvements to primary care, building on existing best practice and working to ensure consistency across providers.
- The model of general practice had not changed for a number of years
- NHS England intended to invest in the delivery of general practice including the development of systems; workforce development and facilities.
- In future, GP practices would likely work in groupings to share and deliver services and provide patients with choice as well as access to specialist services that could not be delivered by a single practice.
- Partners in London healthcare had been working closely together to determine what the future of healthcare in the city might look like.
- Increased population, demographic changes along with increasingly complex health problems and co-morbidities meant that more people were looking to see their GPs; however, GPs needed more time to deal with complex health problems not afforded in the current model.
- Practices in Lewisham recognised that the current service was unsustainable and different approaches would be required.
- There were examples of excellent practice in London. Where practices worked collaboratively, they were able to achieve a great deal.
- The changes being proposed would not just be about general practice – but would include all parts of primary care, preventative care and self-care.
- They would also have to build on existing services and provision to find new solutions for demand and capacity.
- There had to be consistency between local and regional strategies.
- There had previously been a focus on APMS (Alternative Provider Medial Services) through health centres – but this was no longer the case.
- Most GP services contracts in Lewisham were PMS (personal medical services) contracts.
- Providers might choose alternative contracting arrangements in order to develop new or innovative services.
- In order for a private provider to take over a GPs partnership – all of the partners would need to be in agreement.

Access

- GP practices were not able to close their lists to new patients
- It was recognised that further work needed to take place to ensure that the balance was right between pre-bookable appointments and those that were available on the same day.

- Current issues with access to A&E were a symptom of wider issues. A&E departments across the whole country were facing significant pressure.
- The development of new models of primary care could help avoid admissions to hospital through the provision of community services
- Prevention was a key focus of the CCG Primary Care Strategy.
- The CCG worked with NHS111 providers to ensure that the full range of treatment options was made available.
- Sicker people were going to A&E; work was also taking place to develop preventative activity and treatment options.
- Information was provided through surgeries about how to access out of hours services.
- SELDOC (South East London Doctors Cooperative), which provides the local GP out of hours service also provided services at Lewisham Hospital in the Urgent Care Centre; consideration would be given to promoting and advertising the out of hours service.
- Lewisham CCG and the Council were developing a coordinated structure of strong neighbourhood community teams; which would have the capacity to manage long term conditions in community settings.
- Community neighbourhood teams would also be able to identify and support people at risk of deterioration before they required admission to hospital.
- A ‘care navigation’ role was being developed as part of future proposals for multi-disciplinary community teams.
- Evidence from across London was that a named physician could help to ensure continuity of care and could work across a range of settings to advocate for patients. This person did not necessarily need to be a doctor – as long as they were able to coordinate care on behalf of their patients.
- In case conferences this person could act as a single point of contact.

Resolved: to note the update.

6. Lewisham Future Programme

6.1 The report provided additional information about savings proposals that had previously been brought to Committee.

6.2 Martin Wilkinson (Chief Officer, Lewisham CCG) provided an overview of the CCG response to the consultation the savings proposals for Public Health; the following key points were noted:

- The CCG had been given two weeks to respond to the consultation. The proposals had been reviewed against the CCG criteria for improving local health.
- The CCG wanted to emphasise the importance of health promotion and prevention – and would be interested to see the proposals being brought forward to distribute the reallocated funding.
- There were concerns about some of the prevention work that would no longer take place, including smoking cessation activities and work with schools.

6.3 Aileen Buckton (Executive Director for Community Services) and Danny Ruta (Director of Public Health) provided an update to the Committee; the following key points were noted:

- The proposals were designed to ensure that public health outcomes could be achieved more efficiently with the least impact on frontline service delivery.
- There had been a mixed pattern of take up of health initiatives from schools over a number of years. Further work would take place to encourage schools to take up health initiatives and to deal with potential obstacles.
- The proposals would deliver better health outcomes for less money.
- The proposals had also been considered by the Health and Wellbeing Board.

6.4 Aileen Buckton (Executive Director for Community Services) introduced the update on the day care services savings proposal; the following key points were noted:

- Fewer people were using day care centres; the Council supported the development of flexible service provision.
- Work was taking place to develop the role of local community based activities and voluntary provision in order to offer a wider range of services.
- A further set of proposals would be brought forward about the proposed changes.
- It was intended that day centres would remain open; the Council intended to work with community and voluntary sector providers to enable this to happen.
- The proposal would be to save £1.3m
- One centre would be allocated as a care centre for dealing with complex needs.
- Ladywell would provide a specialist dementia service.
- Some service users would move from Leemore to Ladywell and some would move from Ladywell to Calabash.
- Officers would consult with centre users to ensure that this was a smooth process.
- Other day centres would be redeveloped as community hubs with disability provision.
- In April, Care Act changes to eligibility criteria for services would come into place; the Council would work on market development with the community and voluntary sector to offer choice.

Door to door

- Provision was very costly in some instances so officers had been working to improve cost effectiveness and facilitate the use of personal independence, choice and the use of direct payments.
- The Council recognised the importance of clubs; as of yet details about the future operation of clubs had not been agreed.
- In order to be eligible for transport, service users needed to have an assessed care need.
- Where changes were carried out formal consultation would be carried out. Proposals were currently in a pre-consultation phase – and have been brought before the committee for comment before a decision my Mayor and Cabinet about whether or not to carry out further work on developing the scope of the consultation process.

6.5 Nick O’Shea (Volunteer, Lewisham Mencap) requested to address the Committee and was given five minutes to do so- the following key points were noted:

- The Lee Grove Disco was a popular evening club for a variety of people across a wide age range.
- The club enabled people to leave their homes and to meet other people; it had a range of social and community benefits.
- Mencap had serious concerns about removal of day service provision and the Council transport to evening clubs.
- A bureaucratic change meant that a personal budget could no longer be used to buy a club place. This would have a serious impact on future provision.
- 400 people using services would be subject to major changes
- The proposal for light touch and drop in services would be inadequate for some of the people currently in receipt of services.
- The changes being proposed would not save the Council money. A great deal of the cost of Mencap services was provided by the organisation itself; but it would struggle to survive if service users were no longer able to access transport or use their direct payments to buy club places.

6.6 In response to questions from the Committee Aileen Buckton (Executive Director for Community Services) and Heather Hughes (Joint Commissioner, Learning Disabilities) made the following key points:

- All provision was based on assessments of individual needs.
- The Council was working to provide choice of services.
- Light touch and moderate care services were proposed for people who would not be eligible for other services under the Care Act criteria.
- The Council had no interest in closing Mencap clubs.
- If the proposal to end door to door provision for clubs was ended, support would be provided for people to access alternative means of using transport
- Busses could no longer be provided for people who did not have an assessed need for transport.
- Detailed work was taking place with community and voluntary sector organisations to explore future options for the use of community spaces.
- For people who had an assessed need formal needs for transport.
- It was recognised that there were multiple demands on some carers and that some may not want direct payments.
- Current policy supported the greater use of direct payments and the Council was required to offer choice.
- Further information would be provided to services users about changes before any decision was taken.
- Officers would work with voluntary providers to support the transitions and to develop solutions.
- It would not be possible for another provider to take over the running of the door-to-door without it registering as a bus service.
- It was not a legitimate use of the adult social care budget to provide a blanket service, which was not based on identified need. Service users would be assessed for their transport needs on a case by case basis.

6.7 In response to a question from the Committee about the legality of the proposals – Georgina Nunney (Principal Lawyer) advised that the Council was required to review all of its budgets and provide statutory services in line with its published criteria. It would not be under any obligation to provide funding for other services.

6.8 Councillor Best (Cabinet Member for Community Services and Older People) noted that the Council was in an extremely challenging financial position and

committed to keeping the Committee updated about the options for the future development of services.

6.9 The Committee discussed the proposal and noted that people often found transport a concern. Members highlighted problems with other means of transport, noting that door to door is seen as a reliable service.

6.10 Sarah Wainer (Head of Strategy, Improvement and Partnerships) introduced the update to the adult social care charging and contributions consultation; the following key points were noted:

- The consultation was underway.
- Officers were seeking the Committee's formal response to the proposals.
- It was estimated that of 2500 service users half did not currently pay towards the services they received. It was anticipated that, should the proposals be implemented, 300 users would need to pay for the first time – depending on their circumstances.

6.11 The Committee discussed the proposals and commented on proposal number 6 – transport charges. The Committee highlighted the discrepancy between people with lower and higher level needs. Members felt that if most people with lower level needs would be entitled to free public transport it might be problematic to charge users for higher level services.

6.12 The Committee also noted its concern about the cumulative impacts of the proposals on service users – Members were concerned about any individual service user who might be subject to all of the new charges being proposed.

6.13 The updates on savings proposals B1; A1; A2; A3 and A9 were noted.

Resolved: to note the update reports; the Committee also noted its concerns about the combined impact of the proposals on service users and asked to be kept updated about the development of other options for funding provision of transport.

7. LSL sexual health strategy: action plan

Resolved: to note the information item.

8. Select Committee work programme

Resolved: to note the work programme report and to request further advice about the number of items scheduled for Committee meetings.

9. Referrals to Mayor and Cabinet

None

The meeting ended at 10.15 pm

Chair:

Date:

This page is intentionally left blank

Healthier Communities Select Committee				
Title	Declaration of interests			
Contributor	Chief Executive		Item	2
Class	Part 1 (Open)	24 February 2015		

Declaration of interests

Members are asked to declare any personal interest they have in any item on the agenda.

1. Personal interests

There are three types of personal interest referred to in the Council's Member Code of Conduct:

(1) Disclosable pecuniary interests
(2) Other registerable interests
(3) Non-registerable interests

2. Disclosable pecuniary interests are defined by regulation as:-

(a) Employment, trade, profession or vocation of a relevant person* for profit or gain

(b) Sponsorship –payment or provision of any other financial benefit (other than by the Council) within the 12 months prior to giving notice for inclusion in the register in respect of expenses incurred by you in carrying out duties as a member or towards your election expenses (including payment or financial benefit from a Trade Union).

(c) Undischarged contracts between a relevant person* (or a firm in which they are a partner or a body corporate in which they are a director, or in the securities of which they have a beneficial interest) and the Council for goods, services or works.

(d) Beneficial interests in land in the borough.

(e) Licence to occupy land in the borough for one month or more.

(f) Corporate tenancies – any tenancy, where to the member's knowledge, the Council is landlord and the tenant is a firm in which the relevant person* is a partner, a body corporate in which they are a director, or in the securities of which they have a beneficial interest.

(g) Beneficial interest in securities of a body where:

(a) that body to the member's knowledge has a place of business or land in the borough;

(b) and either

(i) the total nominal value of the securities exceeds £25,000 or 1/100 of the total issued share capital of that body; or
(ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person* has a beneficial interest exceeds 1/100 of the total issued share capital of that class.

*A relevant person is the member, their spouse or civil partner, or a person with whom they live as spouse or civil partner.

3. Other registerable interests

The Lewisham Member Code of Conduct requires members also to register the following interests:-

(a) Membership or position of control or management in a body to which you were appointed or nominated by the Council
(b) Any body exercising functions of a public nature or directed to charitable purposes, or whose principal purposes include the influence of public opinion or policy, including any political party
(c) Any person from whom you have received a gift or hospitality with an estimated value of at least £25

4. Non registerable interests

Occasions may arise when a matter under consideration would or would be likely to affect the wellbeing of a member, their family, friend or close associate more than it would affect the wellbeing of those in the local area generally, but which is not required to be registered in the Register of Members' Interests (for example a matter concerning the closure of a school at which a Member's child attends).

5. Declaration and Impact of interest on members' participation

(a) Where a member has any registerable interest in a matter and they are present at a meeting at which that matter is to be discussed, they must declare the nature of the interest at the earliest opportunity and in any event before the matter is considered. The declaration will be recorded in the minutes of the meeting. If the matter is a disclosable pecuniary interest the member must take not part in consideration of the matter and withdraw from the room before it is considered. They must not seek improperly to influence the decision in any way. **Failure to declare such an interest which has not already been entered in the Register of Members' Interests, or participation where such an interest exists, is liable to prosecution and on conviction carries a fine of up to £5000**

(b) Where a member has a registerable interest which falls short of a disclosable pecuniary interest they must still declare the nature of the interest to the meeting at the earliest opportunity and in any event before the matter is considered, but they may stay in the room, participate in

consideration of the matter and vote on it unless paragraph (c) below applies.

(c) Where a member has a registerable interest which falls short of a disclosable pecuniary interest, the member must consider whether a reasonable member of the public in possession of the facts would think that their interest is so significant that it would be likely to impair the member's judgement of the public interest. If so, the member must withdraw and take no part in consideration of the matter nor seek to influence the outcome improperly.

(d) If a non-registerable interest arises which affects the wellbeing of a member, their, family, friend or close associate more than it would affect those in the local area generally, then the provisions relating to the declarations of interest and withdrawal apply as if it were a registerable interest.

(e) Decisions relating to declarations of interests are for the member's personal judgement, though in cases of doubt they may wish to seek the advice of the Monitoring Officer.

6. Sensitive information

There are special provisions relating to sensitive interests. These are interests the disclosure of which would be likely to expose the member to risk of violence or intimidation where the Monitoring Officer has agreed that such interest need not be registered. Members with such an interest are referred to the Code and advised to seek advice from the Monitoring Officer in advance.

7. Exempt categories

There are exemptions to these provisions allowing members to participate in decisions notwithstanding interests that would otherwise prevent them doing so. These include:-

(a) Housing – holding a tenancy or lease with the Council unless the matter relates to your particular tenancy or lease; (subject to arrears exception)
(b) School meals, school transport and travelling expenses; if you are a parent or guardian of a child in full time education, or a school governor unless the matter relates particularly to the school your child attends or of which you are a governor;
(c) Statutory sick pay; if you are in receipt
(d) Allowances, payment or indemnity for members
(e) Ceremonial honours for members
(f) Setting Council Tax or precept (subject to arrears exception)

This page is intentionally left blank

Healthier Communities Select Committee			
Title	Leisure Contracts KPI’s – Performance Monitoring		
Contributor	Executive Director for Community Services	Item	2
Class	Part 1	24 February 2015	

Exclusion of press and public

It is recommended that in accordance with Regulation 4(2)(b) of the Local Authorities (Executive Arrangements) (Meetings and Access to Information)(England) Regulations 2012 and under Section 100(A)(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in paragraphs 3 of Part 1 of Schedule 12(A) of the Act, and the public interest in maintaining the exemption outweighs the public interest in disclosing the information

This page is intentionally left blank

Healthier Communities Select Committee			
Title	Community Education Lewisham		
Contributor	Executive Director for Community Services	Item	5
Class	Part 1 (open)	24 February 2015	

1. Purpose of the report

1.1 To update the Healthier Communities Select Committee on the adult learning services offered by Community Education Lewisham (CEL) in 2014-15.

2. Recommendation

2.1 Members of the Healthier Communities Select Committee are asked to note the contents of this report.

3. Policy context

3.1 *Shaping our Future*, Lewisham's Sustainable Community Strategy, establishes the Council's and Lewisham Strategic Partnership's vision for Lewisham and its citizens, "Together, we will make Lewisham the best place in London to live, work and learn." Underpinning this vision are six priority outcomes that describe sustainable communities in Lewisham and provide a clear picture of what citizens and services can deliver together.

3.2 The work of CEL contributes to the delivery of these priority outcomes, primarily towards 'Ambitious and Achieving', in which residents are inspired and supported to fulfil their potential and which carries our commitment to encourage and facilitate access to education, training and employment opportunities for all citizens. In addition, the benefits of adult learning mean that CEL plays an important supporting role for other priority outcomes including 'Empowered and Responsible' – through which people can be actively involved in their local area and contribute to supportive communities; and 'Dynamic and Prosperous' – through which people are part of the vibrant localities and town centres in Lewisham and well-connected to London and beyond.

3.3 CEL also supports the Council's corporate priority to deliver services that support Active, healthy citizens and Strengthen the local economy.

4. **Background to CEL**

4.1 CEL is now an Ofsted-graded 'Good' provider, one of the few Grade 2 providers of adult skills in South London (see section 7. below). CEL offers a wide range of adult learning opportunities at three dedicated adult education centres across the borough. Services and centres are designed to welcome adults, many of whom may not otherwise take part in education or training. Courses provide accessible entry routes for new or returning learners and good progression routes to further training. As well as acquiring new knowledge and skills, learners develop confidence, motivation and raised aspirations, as well as gaining health and social benefits. CEL

also works across the borough to improve learners' progression into employment and provides courses for Jobcentre Plus.

4.2 CEL aims to be community-led and responsive to resident needs across the borough, and our overarching goal is 'to be an outstanding Learning Community' meaning a community that transforms, through education, the lives of our residents for the better. CEL's strategic objectives are derived from both the Sustainable Community Strategy and the Council's corporate priorities and can be summarised as follows:

- To provide adult learning opportunities, which promote access to skills and knowledge for continuing education and employment.
- To provide entry and first step qualifications into key economic growth areas raising educational attainment and skill levels.
- To improve residents' quality of lives through personal, social and recreational education.
- To widen access to education services through the development and monitoring of equality and diversity impact measures.

4.3 CEL monitors itself against six performance indicators:

(1) Providing teaching and learning that is outstanding or good in 90% of the provision, including the effective use of e-learning in delivery.
(2) Ensuring there are no significant areas of unaddressed underachievement across the service, leading to headline retention rates of 93%, achievement rates of 92%, and success rates of 85% within CEL.
(3) Ensuring CEL meets its safeguarding responsibilities, for the safety and wellbeing of all.
(4) Using the views of wider community and users to shape future developments and ensure that CEL responds to meet these needs
(5) Ensuring CEL buildings, services and resources enable learning to take place in a safe, secure and inspiring environment
(6) Embedding skills development for all CEL staff as a key quality function

4.4 CEL receives funding from the Department of Business Innovation and Skills (BIS) through the Department's Skills Funding Agency (SFA) to provide adult learning opportunities within Lewisham (see 5.1 below). The SFA are clear that their funding should be seen as a contribution to local authority adult learning, and providers like CEL bolster this contribution with fee income from learners, which for CEL is usually around £450k per annum.

4.5 CEL operates out of three sites: Brockley Rise, Granville Park and Grove Park, all of which are council owned and managed by Lewisham Property Services. CEL also delivers a range of provision in community settings across the borough by working in partnership with libraries, schools, children's centres and community groups.

5. CEL Funding

5.1 Funding for CEL is through two designated SFA streams: the Adult Skills Budget (for accredited courses) and the Community Learning Budget (broadly speaking for non-accredited courses). There remain substantial reductions across the sector in SFA funding, with BIS predicting year-on-year reductions for the forthcoming Parliament. Funding cuts have unfortunately impacted on the number of learners and the range of provision that is offered by CEL.

	2012-13	2013-14	2014-15
Adult Skills Budget	£1,675,676	£1,623,346	£1,416,810
Community Learning Budget	£1,880,426	£1,880,426	£1,881,080
Total CEL funding	**£3,556,102**	**£3,503,772**	**£3,297,890**

5.2 However, in 2014 CEL were successful in receiving two additional payment-by-results funding streams to support learners with ESOL needs. The first stream is the Job Centre Plus mandation scheme, which refers JCP claimants with ESOL needs to CEL to learn English (see Appendix). The second stream is through the European Social Fund, and supports ESOL learners into employment (see 6.11 below). We anticipate that these two additional streams will draw down a further £140K of income for CEL by the end of this academic year.

5.3 The Skills Funding Statement 2013-2016 was reissued in January 2014 and this provides a commitment to maintain the same level of Community Learning funding until 2015.

5.4 In December 2011 BIS published "*New challenges, New Chances: Further Education and Skills System Reform Plan*". The report provides a commitment to maintaining the funding for Community Learning with a clearer commitment to using the funding to support access and progression for people who are disadvantaged and who are furthest from learning and therefore least likely to participate.

5.5 Community Learning funding is attached to an increased emphasis on partnership working to ensure a learning offer which is underpinned by engagement and consultation with communities and is responsive to local need.

5.6 The Lewisham learning partnership which includes Lewisham College, Twin Group, Voluntary Action Lewisham, Economic Development, CEL and Lewisham Libraries actively engages in joint marketing activities to ensure that Lewisham residents are aware of the range of provision available across the borough.

5.7 Further cuts to the Adult Skills funding budget have been announced by BIS and confirmation to the final settlement is due in March 2015.

5.8 Learning Loans for learners over the age of 24 years are available for those who wish to study for a level 3 qualification. In 2014-15 there were 17 learners who took the opportunity to draw down a loan to support their study on the level 3 course in Childcare.

6. CEL Course Provision

6.1 CEL offers a wide range of adult learning across the borough, with over 1100 courses for residents to chose from, and offering both accredited and unaccredited learning opportunities to help LBL residents flourish and fulfil their potential.

CEL provision covers the following Sector Subject Areas (SSAs)	
SSA 1	Health and Childcare
SSA 2	Mathematics
SSA 6	Information and Communications Technology
SSA 9	Arts and Leisure; Textile and Floral Design; Design, Media and Food
SSA 12	Languages
SSA 13	Supporting Teaching & Learning (teaching assistants)
SSA 14	Supported Learning – Mindlift project; ESOL; English; Family Learning

6.2 Lewisham's learner profile varies considerably across the borough, from those looking to achieve a formal qualification to those who are re-engaging with learning after having had poor school experiences or interrupted learning.

6.3 An adult engaging with CEL for the first time is offered a wide range of opportunities and provided with help and support at a Pre-Course Assessment to enable them to make their own individual choices about their future progression. Learners value the opportunities and the social interaction that their classes provide and this is in itself a valuable outcome.

6.4 CEL aims to widen access to education services for residents across the borough. This is achieved in collaboration with other LBL services and partner organisations through a range of CEL programmes including: , the Mindlift programme; CEL projects in areas of multiple disadvantage; CEL's family learning programme; the 'Understanding the Language of Work' project. Ofsted confirmed as a strength that over 75% of learners now come from areas where deprivation is high.

6.5 CEL has a large and thriving provision of supported learning through its Mindlift programme. These are classes for learners with learning disabilities, physical disabilities, sensory impairments or mental health difficulties. Learners on the Mindlift programme can access a range of non-accredited learning opportunities including art, dance, keep fit, fashion, floristry and health. Progression for these students includes increased confidence, development of new skills and an increased independence to help in further education or towards employment. In January 2015 a CEL bid was submitted to the SFA for the Community Learning and Mental Health pilot which would create a 'Mindlift Plus' project, building on the success of the supported learning programme.

6.6 The supported learning provision for adults with learning difficulties and disabilities also works in partnership across the borough. The curriculum is delivered from CEL's sites as well as in outreach community centres, for the purposes of maximising accessibility for the wider local community, at Wesley Halls and the Leemore centre. CEL has continued to work in partnership with Lewisham Clinical Commissioning Group to deliver aspects of the Mindlift programmes.

6.7 CEL has continued to develop the course offer which takes place at Deptford Lounge, and this has had the effect of engaging new learners (60% of learners at the Deptford Lounge were new to CEL in 2014-15 to date). The employability and skills provision on offer here includes English, ESOL, Maths, the 'ICT- Get Into Work' programme for both beginners and Improvers, the NCFE 'Working With Children' qualification as well as the new 'understanding the language of work' project (see 6.11) which supports ESOL learners into employment.

6.8 CEL also delivers family learning with a range of other providers across the borough, including primary schools, libraries and children's centres . The family learning offer has increased the number of learners engaged in family learning from 659 enrolments (in 2012-13) to 843 enrolments (in 2013-14). The focus remains on improving the quality of provision and working with key partners who are successful in engaging the hardest to reach. Success rates remain high, with 94% of parents on Wider Family Learning courses achieving their goals, and 85% on accredited family learning courses achieving a qualification in English or Maths.

6.9 Within the vocational learning section learners studying to be child carers or teaching assistants use a variety of school and childcare placements across the borough, in partnership with LBL's schools team.

6.10 CEL supplements the courses outlined above, through offering courses for those residents most able to pay, which generates income for additional courses that CEL can in turn use to widen participation. Thus CEL delivers a range of informal learning opportunities through its Studio courses launched last year. These courses offer learners an opportunity to continue to update and develop their skills in these subject areas outside of Skills Funding Agency funding. These areas include Botanical illustration, Tailoring and Clothes making, Glasswork, Pottery, Printing and Upholstery. The Studio courses thus enable learners to continue their learning in areas where they have previously completed a range of SFA funded courses.

6.11 The 'Understanding the Language of Work' project is a new European Social Fund programme that provides a dedicated pathway to help secure employment for unemployed Lewisham residents with English is a second language. The programme has been highly successful and to date we have engaged 54 learners through the JCP where they have improved their language and ICT skills (to help in applying for Universal Credit), undertaken a work placement, and had dedicated 'Pathfinder' one to one support to improve their job-search skills. Currently 18 learners have secured sustainable employment, some the journeys that the learners have travelled on to reach that point are outlined in the Appendix.

6.12 As part of our contribution to Lewisham's *Shaping our Future* strategy, in particular to make our services more accessible electronically and online, CEL have developed a number of online initiatives to engage with learners. For example, outside of the classroom learners can access class materials, communicate with tutors and receive feedback through our iCEL virtual learning environment. Changes have also been made to CEL's online material, course descriptions and display of information on the website, so that in 2014 the website received 504,501 page views from 37,622 users, compared with the previous year when there were 288,132 page views from 26,646 users. Learners have access to technology outside of teaching times at all three sites in our centres cafes, and at Grove Park

we have also opened a community café with PCs available to both learners and non-learners who may wish to use these for job and training searches etc.

7. Ofsted Inspection of CEL

7.1 Ofsted inspectors visited CEL for a week in February 2014 as part of the formal inspection process undertaken through the Common Inspection Framework. CEL was awarded a Grade 2 (Good) in all areas, confirming it as one of the best providers of adult skills and community learning in South London.

7.2 The inspection report included the following significant strengths: "Teaching, learning and assessment are good, with a significant minority of lessons that are outstanding. Learners' success on their courses is high. Their standards of work and the skills the learners develop, including practical skills, are often good. Learners make good progress on their courses. They gain in confidence and are better able to contribute to their local communities. Learners enjoy their courses and work in a safe and friendly environment. CEL successfully encourages strong mutual support in very diverse groups of learners. Many courses help learners to gain employment or to progress within their current jobs. Tutors are skilled, knowledgeable and enthusiastic and use CEL's good resources well. Leaders' high expectations command wide acceptance across CEL and successfully drive improvement. Performance management is highly effective in improving teaching, learning and assessment. CEL successfully widens participation in learning. Over 75% of learners now come from areas where deprivation is high."

7.3 As noted in 4.2 it is the ambition of CEL to be an Outstanding (Grade 1) provider, and Ofsted recommended some steps that could be taken in order to reach this ambition. These included increasing the amount of outstanding teaching and learning; increasing success rates on higher level courses; providing even more effective target setting for learners; and evaluating and sharing classroom practice.

8. CEL learners

8.1 The tables below give details of the profile of learners who have enrolled on CEL courses over the past three years. These are in-year (rather than end-of-year) figures, with the 'census' point taken as February 2013, February 2014 and February 2015 respectively so that a fair comparison is possible between these years.

8.2 The headline enrolment figures show that, even though there have been significant reductions in funding over the last few years, CEL has maintained its learner numbers at 4,000 learners whilst continuing to increase its enrolment numbers across the service and is providing better value for money by operating with increased class sizes. Enrolments for the current year are 7768 (compared to 6561 for the equivalent period in 2012-13).

8.3 There has been only a slight increase in the proportion and number of male enrollers over the past three years (up by 300 enrolments and by 0.2%). The vast majority of CEL enrollers (76%) are female, which is in line with the country's adult learning sector as a whole.

8.4 Enrolments by learners aged 65 and over is up (by around 100 enrolments since 2012-13), though changes to accreditation processes (in Skills for Life courses not normally accessed by older learners) has caused a slight fall in the percentage of over 65s from the 2012-13 figure. Fee concessions remain for this group.

8.5 The percentage of learner enrolments who have declared a learning difficulty or disability remains high, with around a 33% of our learners declaring a disability (this compares with around 15% of Lewisham residents declaring a disability in both the Census and the 2007 Annual Residents' Survey).

8.6 The ethnicity of CEL enrollers broadly reflects that of the borough as a whole, with around 63% of our learners drawn from ethnic communities outside White British, which is a 1% increase from the figure in 2012-13.

8.7 The following tables provide details of the profile of people who enrol on CEL courses over a three year period from February 2012 through to February 2015.

	Enrolments by Gender		
	2012-13	**2013-14**	**2014-15**
Female	5005	5771	5913
Male	1556	1831	1855
Total	6561	7602	7768
% Male	23.7%	24.1%	23.9%
	Enrolments by Age		
	2012-13	**2013-14**	**2014-15**
Under 25	320	427	391
25-34	1091	1429	1550
35-44	1580	1900	1854
45-54	1408	1601	1699
55-64	1024	1054	1013
65-74	864	887	939
75+	274	304	322
Total	6561	7602	7768
% 65+ of known	17.3%	15.7%	16.2%
	Enrolments by declared disability		
	2012-13	**2013-14**	**2014-15**
Yes	2178	2638	2536
No	4258	4797	5067
Not provided	125	167	165
Total	6561	7602	7768
% Yes of known	33.8%	35.5%	33.4%
	Enrolments by Ethnicity		
	2012-13	**2013-14**	**2014-15**
31 White – British	2499	2714	2899
32 White – Irish	127	132	105
33 Gypsy or Irish Traveller		2	
34 White – any other White background	658	870	925
35 Mixed – White and Black Caribbean	113	176	135

36 Mixed – White and Black African	75	81	62
37 Mixed – White and Asian	31	48	37
38 Mixed – any other Mixed background	90	106	109
39 Asian or Asian British – Indian	84	109	117
40 Asian or Asian British – Pakistani	20	40	37
41 Asian or Asian British – Bangladeshi	29	38	58
42 Chinese	196	175	154
43 Asian or Asian British – any other Asian background	340	380	342
44 Black or Black British – African	775	977	1013
45 Black or Black British - Caribbean	1010	1125	1151
46 Black or Black British – any other Black background	184	250	281
47 Arab	36	56	41
98 Any other	226	268	257
99 Not known/not provided	68	55	45
Total	6561	7602	7768
% non-White British of known	61.5%	64.0%	62.5%

9. CEL developments and achievements

9.1 In addition to the successful Ofsted inspection, confirming CEL as grade 2 ‘Good’, CEL has met its headline performance indicators with outstanding achievement rates at 97%, retention rates at 91% and success rates at 88%.

9.2 The success rate for qualification-based courses funded through the Adult Skills Budget has risen from 79% in 2010-11 and is now very good at 85% in 2013-14. Success rates for learners who receive additional support are outstanding at 95%. Headline success rates for English (83%) and Mathematics (82%) have improved significantly from 71% and 67% respectively in 2010-11.

9.3 Significant progress has been made in narrowing achievement gaps in key areas of gender, disability and widening participation.

9.4 Rigorous Pre-Course Assessments have improved the success of diagnosing and providing support for learners with a range of learning difficulties. This has in part led to the overall increase in success rates across the curriculum areas.

9.5 In September 2014 CEL successfully completed the relocation of its Grove Park centre to Baring Road, providing increased visibility and a more central location. An audit at the new site achieved ‘good’, ensuring compliance to the current BS 18001 H&S Management System.

9.6 As part of a rolling programme of improvement works to the centres, the roof and windows of the main building at Brockley Rise were replaced. We have also refreshed several areas including the Brockley Rise Café and teaching rooms at the Granville Park Centre as part of a rolling programme of improvement works.

9.7 There has been a significant increase in the training budget to ensure that all staff have access to priority training as identified across the service. There has been improved tutor awareness, use and understanding of ICT including iCEL (the virtual learning environment) to improve the learning experience.

9.8 Safeguarding for all learners is effective and meets statutory requirements as confirmed during the Ofsted inspection.

9.9 A new Head of Service is now in post, Gerald Jones, who has worked in adult education for 20 years and was previously head of adult learning at Ealing Council.

10. Financial implications

10.1 Grant funding for CEL has already reduced and is expected to reduce further in the Adult Skills budget. Despite this the CEL has managed to contain its expenditure within the reduced budgets.

10.2 The service will continue to adjust spend in the light of changes in funding, whilst minimising the impact on the number of learners it reaches.

11. Legal implications

11.1 It is one of the roles of the Select Committee to review policy within its terms of reference. It can make enquiries and investigate options for future direction in policy development. Additionally the Committee can require the Executive Members or Executive Directors to attend before it to explain amongst other things the extent to which actions taken implement Council policy and provide evidence of the same.

11.2 The power for local authorities to provide community education facilities for adults is a discretionary one. This discretion should be exercised reasonably in the sense that only relevant matters should be taken into account and irrelevant considerations ignored.

12. Crime and disorder implications

12.1 There are no crime and disorder implications arising from this report.

13. Equalities implications

13.1 CEL is the only Grade 2 ‘Good’ provider of adult skills in Lewisham. It offers accessible entry routes for new or returning learners as well as progression routes that are used by learners to further their skills and education. In addition, CEL provides a range of informal learning activities.

13.2 Low levels of basic skills is often a characteristic of deprived communities and can prevent people from finding employment and fulfilling their potential. 38% of Lewisham residents are educated to NVQ Level 4 and above, which means they have a higher national diploma or degree level qualifications. 48.8% have NVQ Level 3 and above which is equivalent to at least 2 A Levels or an advanced GNVQ. 62.7% have NVQ Level 2 and above (including apprenticeships) which is the equivalent of 5 or more GCSEs at grades A-C or an intermediate GNVQ. 73.8% have NVQ Level 1 and above, which equates to less than 5 GCSEs at grades A-C or a foundation GNVQ. The proportion of residents with no qualifications has decreased from 24.2% in 2001 to 17.7% in 2011. There has also been a notable rise in those with Level 4 or higher (degree or equivalent).

13.3 The profile of learners accessing CEL provision is predominantly female (76%). When analysed by age categories it is clear that provision is not disproportionately weighted to any particular age group. 84% of adult learners accessing CEL are of working age (16-65) with the remaining 16% aged over 65. The latter figure is higher than the borough profile for people aged 65 and over but reflects the number of older and retired people interested and with the time and capacity to develop new interests and skills. Half of CEL users are from a white ethnic background and half from a BME background. One quarter of CEL users identify themselves as having a disability or learning difficulty which is a higher proportion than the population average. Information on the other protected characteristics (sexual orientation, religion/belief, gender reassignment, pregnancy/maternity and marriage/civil partnership) is not currently collected by the service.

14. Environmental implications

15.1 As part of the councils sustainability initiative solar panels were fitted to the Granville Park Centre, these works took place over a 4 week period with the panels commissioned early April 2014.

16. Conclusion

16.1 The Ofsted inspection of February 2014 confirmed that CEL is now one of the best providers of community learning and adult skills in South East London. There has been a significant increase in enrolment numbers from 7214 (in 2011-12) to 8199 (in 2013-14) partly due to changes in curriculum design but also due to a continued increase in average class size. Despite funding cuts, CEL has maintained a wide range of learning opportunities for Lewisham residents and has increased partnership working across the borough. CEL continues to meet all SFA targets for learner numbers and funding allocation.

For further information, please contact Gerald Jones, CEL Service Manager
0208 314 6189

Glossary

BIS – Department of Business, Innovation and Skills
CEL – Community Education Lewisham
ESF – European Social Fund
ESOL – English for Speakers of Other Languages
GNVQ – General National Vocational Qualification
iCEL – the online ‘virtual’ learning environment used by CEL staff and students
ICT – Information and Communications Technology
JCP – Job Centre Plus
LBL – London Borough of Lewisham
LDD – adults with a learning difficulty or disability
Mindlift – CEL’s supported learning programme for adults with a learning difficulty or disability
NCFE – the Northern Council for Further Education exam board
NVQ – National Vocation Qualification
SFA – Skills Funding Agency
SSA – Sector Subject Area

APPENDIX – Learner Case Studies		
Report Title	Community Education Lewisham	Date: 9 February 2015

DZ - Case Study 1

DZ came to the UK from Côte d'Ivoire in 2008. She was eager to progress in the UK and felt passionate about fulfilling a caring role in society. Before joining the Understanding the Language of Work programme DZ had volunteered at her 6 year old's primary school and had completed qualifications in caring for children and adults at CEL and Lewisham and Southwark College. However, despite her experience and qualifications, DZ found it very difficult to find a job because of her poor English and her childcare responsibilities.

After completing the language classes the pathfinder helped DZ find an appropriate child minder for her son which overcame her major barrier to employment. The pathfinder then encouraged DZ to try a wider range of voluntary roles where she could get practical experience of using her qualifications in a more varied setting than a primary school. DZ completed voluntary placements at the British Heart Foundation and in a Nursery. DZ was also supported through the process of becoming DBS checked which is required for most care work.

The pathfinder worked with DZ to apply for care roles, and after mock interview practice and application guidance, DZ was successful and secured two roles. One as a care worker for TIG Heavens and a second organising children's parties for Party Cakes. She hopes to do both part-time.

.EK - Case Study 2

EK came to the UK from Greece in 2013. Since then he has been regularly attending Job Centre Plus to sign on for his JSA. EK was getting frustrated that he couldn't find work because he had lots of experience and qualifications in Electrical Engineering and Computer repair. However his low level of English and lack of work experience in the UK was stopping him getting a job. When EK was referred to Understanding the Languages of Work, he was enthusiastic about the opportunity to improve his English and gain relevant work experience. EK was eager to learn, on top of the ESOL course, EK improved his English by using books and websites suggested by the pathfinder. During the one to one sessions with the pathfinder EK focused on building his confidence and learning the technical words for computing in English. The pathfinder arranged for EK to do a work placement at Eco Communities repairing computers so that he could gain experience as well as improve his English computer vocabulary.
The pathfinder supported him to make job applications and ran practice interview sessions for EK. This gave him the confidence he previously lacked and he was successful in securing a job as a shop assistant at Lidl. The pathfinder encouraged EK to promote his technical abilities during the interview so that he can transition to a role within Lidl where he can use his skills. The pathfinder is continuing to support EK as he progresses.
Now EK has, he is a lot more confidence, he knows he has a future and is capable of learning and developing other skills to progress. He feels positive about reaching his goals.

MS - Case Study 3

MS came to the UK as a refugee from Iran 8 years ago, but he only received definite leave to remain a year ago. MS speaks Farsi and Arabic, but speaks little English and has very poor written English. For the previous 7 years MS was sleeping rough and developed alcohol dependency. His status change has meant that he has recently been placed in Temporary Accommodation and has been claiming JSA for the last year. Since then JCP have sent him on two courses; one ESOL course and a CCTV monitoring course. However the ESOL course did not improve his English skills enough to get a job and MS discovered he was unable to use his CCTV qualifications because he did not have a SIA License, which is required for security work, and could not get onto a course to receive it.

Although MS attended all of the language classes it was clear when he met with the pathfinder that his alcoholism was the primary barrier to employment. The pathfinder referred him on to New Direction Lewisham which provides an integrated treatment system for adults who have problems with drugs and alcohol. MS embraced the opportunity and his situation improved considerably, and the pathfinder reports that he no longer smells of alcohol when they meet. The pathfinder also helped MS navigate the housing system to solve problems with his accommodation. MS has said that before he was given support from the pathfinder he saw no positive way out of his situation, but the pathfinder helped him to put things into perspective by showing MS options that he could take with definite outcomes.

The pathfinder was able to arrange for MS to attend targeted training courses to provide the skills he was lacking in general IT, Excel and Health and Safety. The pathfinder also supported MS to apply for various roles and gave CV and interview advice. With this support MS was offered a part time role as an invigilator at the International House Language School. However as soon as MS started this job his employer noticed his enthusiasm and appointed him to be a full time Facilities Manager for the school. MS is now earning enough to fully support himself and he is hoping to move out of TA soon.

MS said *"If I had this course when I first came to the UK, I would be flying by now!"*

VBV - Case Study 4

VBV moved to the UK 2 years ago from Portugal with her 5 year old daughter. During the last 2 years VBV had been balancing childcare with low paid 5-10 hour a week cleaning job, but was struggling to make ends meet. This job ended and VBV has had to claim JSA for the last 3 months, she is also in receipt of Housing Benefit.
When VBV began the Understanding the Language of Work course there was confusion at JCP and she was signed off from JSA. This meant sorting out childcare became a major difficulty for VBV. The pathfinder quickly identified this issue and helped VBV arrange local childcare through contacts at her child's primary school. The pathfinder also helped navigate VBV through the JCP processes so that the error could be corrected and she could receive JSA again.
Once these immediate problems were resolved the pathfinder was able to focus on VBV's employability skills and gave her help with writing covering letters and developing her CV. The pathfinder identified that VBV would be interested in working as a carer so they supported her to apply for those roles and helped her tailor her CV to be appropriate for these jobs.
VBV secured a role as a Care Assistant where she travels to people's home to provide care. She is also receiving training to become a qualified Care Worker and is hoping to eventually work at a care home. At their last meeting the pathfinder reported that VBV seemed a lot happier having found work and now being on a path that leads to job progression.

RM - Case Study 5

RM came to the UK in 2009 from Poland with her youngest son. RM is 52 and has qualifications in Dentistry from Poland. Since she arrived RM has been on JSA. She has completed the Work Programme without securing employment, but when she moved down to London from Manchester her records were lost so she was referred to the Work Programme a second time. Her limited English language was a major barrier to finding work and also made communication with SEETEC, the work programme provider difficult. When RM, was referred to Understanding the Language of Work, she was surprised but comforted that the course provided one to one support.

The pathfinder helped RM to sort out her records with SEETEC, so that she could get her travel expenses paid and stop receiving communications from the Work Programme in Manchester. The pathfinder worked closely with the Lewisham JCP to get this issue resolved.

RM attended the ESOL classes and developed her language skills. During one to one sessions the pathfinder helped RM to learn the dental vocabulary and enabled RM to navigate the General Dental Council process of transferring her qualifications from Poland. Together with RM the pathfinder investigated opportunities at King's College Hospital, and supported her through the application process for a Dental Nursing Conversion Course, where she has been accepted to start in March 2015. The course involves on the job training so she will be paid a salary for her work.

RM was keen to find work before starting the Dental course. RM expressed interest in social care so the pathfinder arranged for her to be DBS checked and set up training opportunities where her skills could be developed. She also completed relevant courses: First aid, paediatric first aid and health and safety. To gain some work experience, the pathfinder arranged for RM to do a work placement at Pre-school Learning Alliance.

The pathfinder helped RM to apply for social care jobs and the pathfinder did mock interviews with RM. RM English was developed at this point but she lacked interview skills. The pathfinder encouraged RM to demonstrate her skills through examples when in an interview. The hard work paid off and now RM is working for Beverly Martins Limited as a Home Carer, while she waits to start her conversion course in March 2015.

LCP - Case Study 6

LCP came over from France, where he had worked as an auto-mechanic. When he came to the UK in 2011, he wanted to pursue his interest in Graphics design. Although, LCP initially found work, his English was a barrier to progression and when the job ended he was left unemployed and then he signed onto JSA. When LCP was referred to Understanding the Languages of Work, he was enthusiastic and thought it was *'a good opportunity for many people like me to improve English, CV and interview skills'.*

LCP was a keen student and worked hard in the ESOL classes. During the one to one sessions, the pathfinder helped JCP to set goals for the future and suggested different avenues for reaching his goals. LCP started a work placement in the voluntary sector doing graphics design work. He was unable to complete the work placement as his partner fell ill. The pathfinder helped LCP to find a training course to help him and his family better cope with his partners illness. LCP is very grateful for the support of the pathfinder, and says she is *'always available to help and support the students'.*

The pathfinder worked with LCP to assist him with his job search and develop his interview skills. The pathfinder asked for feedback after LCP had unsuccessful interviews so they were able to work on his weaknesses. Group interviews were still to difficult for LCP because he felt he was being held back by his English abilities. The pathfinder and JCP, started to target the job search to exclude those with group interviews. After all the practice and hard work LCP was successful and found a job as a cleaner.

The pathfinder is still supporting LCP to progress into a job in the graphic design industry. LCP is happy that he is in work and is confident that he can reach his goals. LCP plan is to save money to buy a graphics design software and to start a higher education graphics design course in September 2015. The pathfinder *'gave me some way (direction)'.*

This page is intentionally left blank

Healthier Communities Select Committee			
Title	Implementation of the Care Act		
Contributor	Joan Hutton (Head of Assessment and Care Management)	Item	6
Class	Part 1 (open)	24 February 2015	

1. Summary

Lewisham is making good progress in implementing the Care Act, though the scale of change is significant. Understanding the new approach to social care is important for delivering the changes and for communicating them to residents in a constructive, sensitive way.

2. Purpose

To update the Committee on progress in implementing the Care Act and seek the agreement of key documents.

3. Recommendations

Members of the Healthier Communities Select Committee are asked to:

a. **Note the progress towards implementing Care Act and information about the changes which it introduces**
b. **Note and comment on Lewisham's 'Approach to Adult Social Care', in Appendix A**
c. **Note and comment on Lewisham's draft Strategic Plan for Information and Advice about Care and Support, in Appendix B**

4. **Policy context**

4.1. The priority area in Lewisham's Sustainable Community Strategy which the Care Act most aligns with is "Support people with long term conditions to live in their communities and maintain their independence". There is also a clear opportunity to support further progress with the priorities "Improve health outcomes and tackle the specific conditions that affect our citizens" and "Empower citizens to be involved in their local area and responsive to the needs of those who live there".

4.2. With reference to the Health and Wellbeing Strategy, the Care Act supports the integration of health and social care, use of preventative and enablement services, and the harnessing of stronger communities in meeting care and support needs.

5. Key Elements of the Care Act

5.1. The Care Act 2014 was passed in April. It is the most substantial rewrite of legislation on adult social care since 1948.

5.2. The Act can be seen in many areas as taking good practice in the sector, and setting it down as legislation or statutory guidance. The Department of Health's vision is that it will ensure that "*people's well-being, and the outcomes which matter to them, will be at the heart of every decision that is made*".

5.3. The Act: -

- provides for a single national threshold for eligibility to care and support;
- puts carers on the same footing as those they care for (including a brand new statutory eligibility framework);
- focuses on assisting people to use their personal, social and community resources;
- emphasises preventing and delaying needs for care and support, rather than only intervening at crisis point;
- has new provisions to ensure that young adults are not left without care and support during their transition to the adult care and support system;
- sets down the approaches required for commissioning and management of the social care marketplace;
- reforms the funding system for care and support, by introducing a cap on the care costs that people will incur in their lifetime (*from April 2016);*
- includes new protections to ensure that no one goes without care if their provider fails, regardless of who pays for their care

6. Highlights of Progress on Implementation

6.1. A Task and Finish group with core representation from Adult Services, Joint Commissioning, Workforce Development and Legal services has met monthly to oversee progress.

6.2. Highlights of work in Lewisham to date include: -

- Workforce Development programme for Council and related NHS staff
- Commissioning and service design plans in development
- Communications and engagement work with key partners and local leaders
- Protocols for Council services, including links made to London Probation, Children and Young People's services and other partners
- Processes and tools created so staff can deliver the functions required

6.3. Lewisham has also been an active part of the work across London, co-ordinated through London Councils.

7. Assessment and Eligibility

7.1. A personalised approach to the assessment of someone's needs and the development of a support plan to meet those needs are now legal duties.

7.2. The Act creates new national eligibility frameworks for both people with care needs, and their unpaid carers.

7.3. Eligibility for people with care and support needs is based on determining that

a. Needs arise from a physical or mental health condition, which

b. Affects someone in 2 or more of 10 prescribed outcome areas, and

c. This has a significant detrimental impact on their wellbeing (as defined in the Act)

7.4. For carers, a similar process of eligibly applies, where

a. Needs arise from the caring role and the care provided is necessary, which

b. Affects someone in 1 or more of 8 prescribed outcome areas **or** has a detrimental effect on their health, and

c. This has a significant detrimental impact on their wellbeing (as defined in the Act)

7.5. For both groups, assessments of eligibility will:

- Focus on wellbeing and promoting people living independently
- Focus on needs, not on the services that might meet those needs
- Harness personal, family, social and community resources before funding services

7.6. By April 2015, Lewisham will have: -

- Introduced new Resource Allocation Systems (RAS) for all clients and carers
- Updated our case management IT systems to account for initial Care Act changes
- Agreed mitigations with SLAM for changes in integrated mental health services whilst longer term solutions are developed
- Rolled out new support planning processes and tools
- Finalised plans for on-line / self-service options to be introduced for residents
- Retrained all assessment staff on the new assessment practices and eligibility definitions
- Trained all our Support Planners on best practice in support planning

8. Impact of Assessment Changes

8.1. These changes shift focus from peoples 'deficits and risks' to their 'assets and strengths'. This strongly links to the self-care approach in Health. Achieving this will mean using the skills of professionals and local support services to help people do more for themselves and each other.

8.2. Evidence shows that this will lead to better outcomes for people, but many will find the change difficult. People may have expectations of adult social care which are no longer based on good practice, our legal framework or our financial position as a local authority.

8.3. Building capacity and resilience means that people who are eligible under the national eligibility framework may not always get services from the Council, as their needs can be met by themselves or others.

8.4. For those who do get ongoing services, a personal budget must be in place, giving them choices about how their needs are met. They may not choose to use typical care and support services, or to go with providers – including the Council – which we might prefer they use.

8.5. However we will always have a decision about whether to agree a support plan and will always strive to make sure that support and care services are safe and effective.

8.6. These new ways of working and wider principles for the delivery of social care and support for adults are set out in Appendix A, presented for here for comment and agreement of the Committee. This has been written as a touch-stone document we can use to explain adult social care in Lewisham to both professionals and residents.

8.7. The consequences for our market development of care and support services will be set out in more detail in a subsequent report.

9. Advice and Information

9.1. A key plank of compliance with the new Act is reforming our planning and provision of information and advice.

9.2. A workstream has been led by the Director of Public Health to lead this work as part of the Adult Integrated Care Programme. A strategic plan has been prepared which sets out this work and how it will be taken forwards across the health and care system partners in Lewisham, and it is appended for agreement of the Committee in Appendix B.

9.3. The website, which is the core element of the new offer, will be continuously updated and developed, with the initial phase of updates in place for April 2015.

10. Financial implications

10.1 Funding for new Care Act responsibilities will come from two sources in 2015/16. Lewisham's share of the DH new burdens grant is £1,056,355. Additionally, the Better Care Fund contains £800k for Care Act implementation.

10.2 The DH have recently published proposals for the changes to funding of social care (including a cap on care costs) that will be introduced in April 2016. Funding for these changes will be announced later in 2016.

11. Legal implications

11.1. There are no particular additional legal implications arising from the work being undertaken to implement the Care Act, save to remind members that the duty to promote an adult’s well-being introduced by the Act affects all services, and may well have far-reaching effects on wider services as the effect of the new legislation becomes established.

12. Crime and disorder implications

12.1. There are no crime and disorder implications arising from this report.

13. Equalities implications

13.1. The Department of Health undertook an Impact Assessment of the Act prior to publishing the draft guidance. Equalities were considered under a previous Equalities Impact Assessment of the 'Caring for our Future' White Paper, which found that in all protected characteristics there were positive or no negative effects. Much of this stemmed from three factors: -

- the improved availability and quality of information and advice;
- involvement of local people in the design and delivery of services (co-production);
- personalisation of services meaning that people have care and support individually tailored by them.

13.2. The Council will undertake additional local Equality Analysis Assessments on specific areas if appropriate to do so, such as for the changes to the Fairer Contributions Policy.

14. Environmental implications

14.1. There are no environmental implications arising from this report.

15. Conclusion

15.1. Implementation of the Act is a complex and difficult task at a time of significant strategic change, demand increases and financial pressure. However, it is on track and Lewisham benefits from the Act being in-line with the strategic approach already set out in the borough

15.2. Agreement to an over-arching Approach document for Lewisham's adult social care and to a strategic plan for Information and Advice help us take this work forward and ensure we are not only compliant with the law, but achieving a high standard in supporting residents with care and support needs.

Background documents and originator

- Previous Care Act implementation report at October 2014 meeting
- The Care Act
- Statutory guidance
- Lewisham Health and Wellbeing Strategy
- Lewisham Sustainable Community Strategy

If you have any queries on this report or difficulty in opening the links above, please contact Joan Hutton, at joan.hutton@lewisham.gov.uk

Appendix A:

Lewisham's Approach to Adult Social Care

This document sets out how Lewisham Council will work with people who may need social care and support, and their carers, as well as joint working with health partners and service providers. It also describes the outcomes we seek to achieve from these partnerships and services.

Social Care for Adults in Lewisham

Lewisham is committed to having a structured and fair system of social care, which makes the best use of limited resources to offer residents access to high quality services to meet their care or support needs in a personalised way.

Some of the priorities in achieving this are to:

- **Ensure value for money** for all services, while maintaining service quality and a focus on achieving defined outcomes for the service user;
- Ensuring fairness and equity across the range of needs or conditions.
- Ensure everyone with ongoing use of social care services has a **personal budgets** and promote the use of **direct payments** to maximise the choice and control people have over managing their own care and support;
- Consider the **wider networks of support** or universal services which people access and optimise the use of these within the more formal support packages of care, e.g. the use of community groups, library services, adult education.
- Continue to **develop a range of housing options** together with partners which offer care and support in the community and reduce the need for long-term residential care;
- Make effective use of **technological solutions**, including Telecare, to maintain safe independent living, and assist with the care-giving process
- Support younger adults into **work or employment;**
- Develop **commissioning plans** based on robust analysis of local need and understanding of our provider markets
- Apply a **means tested approach**, implementing eligibility and charging policies which reflect Central Government guidance.

Services in the community

We know that people want to remain in their own homes and neighbourhoods if they develop health or social care needs. We will endeavour to support people in these settings and, wherever safe or feasible, will seek to assist them to avoid admissions to hospital or residential care settings.

We will ensure that assessments include health, housing and other support, including those personal to the individual, alongside social care.

Upon discharge from hospital, we will provide interim services to help people recapture the highest level of independence possible at home.

Resources Spent Wisely

We are acutely aware of the need to balance meeting the growing need for services, with reduced resources available to the Council and its partners.

We expect our staff and partners to always encourage people to maximise the use of their own resources - personal, social, familial or financial – to support them in their own surroundings.

We need to ensure resources are spent in a fair way, which gives value for money to the public, who fund these essential services.

This means that we normally we will

- not pay more for a community package of care than we would pay for a residential or nursing package of care (though we will assist people to "top-up" their care safely if they wish to do so from their own resources)
- undertake a continuing healthcare check if we think someone might be eligible for free NHS care
- include all ongoing care services in someone's financial assessment
- not admit someone to residential care from a hospital bed
- thoroughly review a care service put in place to resolve a crisis to inform what may be needed on an ongoing basis
- give someone in supported housing or residential care the option of living in their own home if we think they could

Wherever possible, we will put short-term services in place that will aid recovery or recuperation and a return to independence, before considering long-term care or support. We will encourage creativity and innovation to meet identified outcomes, and encourage everyone involved to look for solutions that offer the best quality and value for money.

Many people pay for their own care and if they want it, the Council and its partners will offer advice, guidance and other support.

Assessments will ensure that the right level of support is identified according to a person's needs and choices.

This will enable people to make wider choices than may be currently available to them. Should, for example, someone wish to remain at home, when the assessed service provision is a residential placement, we will provide a risk assessment to help them decide how they should enhance the community package of care from their own resources to ensure their needs are met in that setting.

We recognise the value of wider support networks that many people have within their own families and communities and will look at all available resources when considering how to meet needs. Where family or other support networks do not exist, we will help link people to build them including through appropriate community networks.

Supporting and valuing carers

We recognise that most care and support is provided by family or friends.

Carers will be supported to recognise their own needs and through this, ensure a longer and more manageable caring role for their family or support network. Carers will have the right to

an assessment of their needs, separate to those of the cared for person, and regardless of eligibility for formal social care input.

Managing risks

Our aim is to balance risk management alongside delivery of services that promote independence and empower people to take control of their health and social care needs. We will ensure that we talk openly about possible risks in relation to decisions that service users may make, and that there is an understanding of these risks. Ultimately, decisions will be made by the service user and this may mean that some people make decisions we would not have made.

We will never take responsibility away from someone unless we have a court order which determines that the person does not have capacity to manage their own affairs.

Focusing on Prevention

People are living longer with more complex health conditions, so there will be increasing need to spend the resources available to social care services, in a fair and equitable way.

We will focus resources across the system to reduce the overall need for services later in life. This 'preventative' activity will be undertaken jointly with partners in health services and through early intervention, help people to live their lives in a healthier way and reduce the need for intensive social care services later in life.

Inevitably though, there will always be those who suffer illness or accidents which cannot be avoided. However, we will always look for ways to support people to delay onset of further needs and make the most of the assets they have.

Integration of social care and health

Looking ahead to 2018, The NHS and Lewisham Council will continue to work together to transform health and social care in the borough for all adults. Lewisham's ambition is to make joined up and co-ordinated health and social care the norm by 2018 achieving our vision of: 'Better health, better care and stronger communities'. This means where possible, and with increasing regularity, we will have shared health and social care assessments and a single plan that will help people retain independence in the community.

The key principle to care and support in Lewisham is to ensure that there is an early or targeted intervention to reduce the necessity for more invasive long-term care. This will be particularly relevant to people at risk of hospital admission.

Social care providers

We will work with social care and support providers, including in-house services, to ensure service focus on outcomes and meeting needs in a way which maximises independence.

We will develop and commission community-based services which meet needs flexibly and address issues relating to social isolation. We will always ensure that services deliver value for money and will develop appropriate performance measures, focussed on outcomes.

With personal budgets for all in place from April 2015 onwards, and direct payments used where possible, we will shape the provider market to ensure that providers offer their service users choice and flexibility.

We will encourage providers to offer creative, innovative services, focussed on meeting needs with the least amount of formal care and support, while delivering identified outcomes, whether this is a user-led organisation, social enterprise or private business.

A Valued Workforce

All staff working directly for the London Borough of Lewisham and those within provider agencies will understand our vision and commitment to maximise independence and quality of life.

We will work with staff and partners to develop methods of sharing good practice, ensuring seamless, joined up services which empower service users and challenge staff and providers to meet needs in increasingly person-centred and creative ways.

Measuring success

We will know we are successful in delivering the commitments we have detailed in this statement, through the following measures:

- **A reduction in the number of people we are directly supporting** through formal social care services and an increase in the numbers of people being helped in their communities;
- **An increase in the number of people living in their own homes for longer**,
- **An increased number of people recovering from an episode of poor health or illness** through the use of intensive 'enablement' or recovery programmes;
- **An increase in independence,** with people taking increasing control of managing their own health and care needs, through the use of direct payments

Appendix B:

Strategic Plan for Information and Advice

Lewisham Council

Strategy for Information and Advice for people with Care and Support Needs

1. Strategic Context and Scope

1.1. The guidance for the Care Act 2014 asks local authorities to develop strategies for information and advice, and to report publicly on the improvements they are achieving.

1.2. Good public information and advice are priorities for Lewisham Council and CCG, as a key building block of the local care system.

1.3. Information and advice are now legal duties with guidance on how they should be delivered.

1.4. This gives Lewisham an opportunity to improve the quality, accessibility and coherence of information and advice as well as make the best use of available resources.

1.5. It is important to distinguish between

- **Information –** the communication of knowledge and facts regarding care and support, and
- **Advice** – helping a person identify choices, and/or providing an opinion or recommendation regarding a course of action.

1.6. The purpose of this strategy is to:

- Ensure that good information and advice contribute to improvements in health and wellbeing
- Ensure that the local authority and its partners achieve compliance with the relevant aspects of the Care Act 2014 and associated Guidance.
- Take stock of current information and advice provision across the whole system
- Set out an action plan that will improve people's experience through a better co-ordinated approach

1.7. This strategy is sponsored by the Adult Integrated Care Programme and led by the Director of Public Health.

1.8. We are co-producing the strategy with colleagues in the Council, including adult social care, public health and children's services; colleagues in the voluntary and provider sectors; service users and family carers.

1.9. The timetable is:

- February 2015: Sign off strategy
- April 2015: Begin roll out of new website
- Autumn 2015: Plan commissioning and service redesign proposals
- April 2016: All improvements are in place

2. Related strategies

2.1. This Information and Advice strategy will be relevant to the joint strategies and plans between the Council and CCG including the Adult Integrated Care Programme, Joint Commissioning Intentions and the Better Care Fund.

2.2. It also links to other local plans like the Council's Housing Strategy and the Special Education Needs and Disabilities plans.

2.3. These strategies can be supported by:

- Joining up activity between partners to make the most effective use of our limited capacity and resources
- Filling gaps and removing duplications in the provision of advice and information
- Helping people support themselves and others more effectively
- Working together to intervene earlier

2.4. We have also taken into account developments that are already under way or planned:

- A merged 'first contact' service for the Council's Adult social care and Lewisham and Greenwich NHS Trust's District Nursing service
- The 'neighbourhood model' of adult social care connected to health services, such as clusters of GP practice
- Reductions in public funding, particularly in local government

3. Where are we now?

3.1. Sources of information

- Residents or professionals can currently go to a number of local and national online platforms in order to access information on services and keeping well (e.g. www.nhs.uk).
- The Council website has basic information about Adult Social Care services, alongside standard information about accessing benefits plus targeted campaigns, such as 'Be Active'(www.lewisham.gov.uk)
- In addition to this, the Lewisham 'My Life My Choice' website (www.lewishammylifemychoice.org.uk) has a range of detailed sections where residents and professionals can access information about social care services.
- The Social Care Advice and Information Team (SCAIT) are currently the main point of contact for residents and professionals that have queries about social care needs.

- SCAIT provide general advice and signposting whilst also undertaking initial assessments of clients.
- In addition, residents can get information from a range of face to face provision (e.g. at the Council's Lifestyle Hubs).
- Lewisham also has a large and diverse voluntary sector, with lots of sources of advice and information, some of which relate to adult social care and support, such as Age UK Lewisham and Southwark, Community Connections or Carers Lewisham.

3.2. Local people's experience

- From what we have found out about local people's experience of getting information and advice, we know:
    - People seek advice and information from a wide range of sources – which creates a risk that people will get different advice depending on where they go
    - People with care and support needs may have very different requirements and use different methods from each other, and from their carers
    - Many older or disabled people do not use computers or the internet; though many do
    - NHS services are a key place where people pick up information
- The My Life My Choice site is not well known, and information has not been kept up to date, but it is quite well used. The most popular pages relate to getting information, rather than accessing specific services.
- Lewisham Healthwatch gathered the views of local people in 2013/14, which included requests for more information on
    - how to access services and activities, including how to access them out of hours or at weekends;
    - how services are performing against standards
    - how to do more self-care and manage their own care
    - their medication and discharge information
    - how to get involved in community activities
- Lewisham residents strongly supported joined up health and social care, specifically improving the coordination between district nurses, care workers and other agencies

3.3. From our analysis of population needs (including self-funders), our key target groups are:

- Family carers, including those living out of borough
- People with long term or other health conditions and at risk of needing care in future

- Differentiated approaches for women and men – in services, women are over-represented; men under-represented
- People with ongoing health and social care packages
- NHS professionals
- Professionals in the third or private sectors

3.4. Quality

- The Care Act 2014 gives us a responsibility to ensure that local information and advice is high quality. (For example, it should be clear, comprehensive, consistent, accurate and up-to-date).
- From our assessment, we believe that much good quality information is available to local people, but we have the following challenges:
  - Information has slipped out of date quickly in the past – we will need to identify long term ownership in order to keep the information accurate and up to date.
  - The expertise of our partners and residents has not always been used to keep the information current and comprehensive [we could "crowd-source" content from our local system]
  - Advice services are often grant funded, meaning that the Council has less direction over their quality and performance.

3.5. Integration

- The Care Act 2014 gives us a responsibility to help join up information and advice so that it forms a coherent 'service'.
- We have already established some good links between agencies, and introduced better ways of working including:
  - Joining together the contact centres for district nursing and adult social care
  - Interface meetings between GP surgeries and neighbourhood social care teams
  - Community Connections bringing voluntary sector advice and outreach alongside Council and NHS services
- There is still scope to create stronger links between services and to improve signposting and information sharing between organisations.

3.6. Efficiency

- In the current climate, public services have a responsibility to be as efficient as we can and get value for money.
- Using the existing Council website as the main platform not only rationalises the number of places information is held, but reduces costs of sever hosting, web design and web content management.

- There is short term funding to set up the new website arrangements and there will need to be long term funding for ongoing management and ownership of its content.
- This could lead to disinvestment in other areas, creating a net saving, if there are ways to reduce duplication or improve productivity through this role.
- Reviewing external commissioned / funded services in Lewisham may identify other ways of reducing duplication, for example making more use of online resources, combining back-office processes or making better use of people's skills.

4. Where do we need to get to?

4.1. Our Vision

- Lewisham's vision as set out in the Better Care Fund is to deliver joined up and co-ordinated health and social care to all adults in the borough and so to achieve
    - **Better Health** – to make choosing healthy living easier - providing people with the right advice, support and care, in the right place, at the right time to improve their health and wellbeing.
    - **Better Care** - to provide the most effective personalised care and support where and when it is most needed - giving all adults control of their own care and supporting them to meet their individual needs.
    - **Stronger Communities** – to build engaged, resilient and self-directing communities, enabling and assisting local people and neighbourhoods to do more for themselves and one another.
- The vision for this strategy is that Information and Advice for people in Lewisham is arranged and provided in a way that helps to achieve these objectives as much as possible.
- The Joint Commissioning Intentions set out information and advice priorities to do this: -
    - Better information to support people to have greater confidence to make choices and take control of the management of their own care.
    - Better information and advice which is personalised to enable individuals to look after themselves more and be willing to self-manage their health and wellbeing.
    - Better co-ordination and joined up health and care services which includes the voluntary sector.
- The action plan in the next section sets the actions needed for these priorities and the benefits we expect to see.

5. Action Plan

Priority Commissioning Intention	Key Actions	Benefits and Outcomes
1. Better information to support people to have greater confidence to make choices and take control of the management of their own care	Develop the Council's website into an online resource for staff, partners and the public with significantly better content, design and functionality Ensure that the content can be easily accessed, downloaded, printed or shared with people so that everyone is accessing the same resources Provide effective and up to date resources for staff in all organisations so they can convey accurate information and give quality advice Improve the 'first point of contact' centre for health and social care queries so people get quality information quickly Achieve call centre standard performance in terms of call waiting times and call pick up rates.	Information and advice resolves issues at an early stage and helps people to plan ahead I find it easy to understand how the social care system works It is easy to understand how social care is funded and what my contribution will be Information is accessible, comprehensive and of good quality
2. Better information and advice which is personalised to enable individuals to look after themselves more and be willing to self-manage their health and wellbeing	Explain how the health and social care systems work and give people self-service tools or self-care guides wherever possible Improve access to the internet in our community, and develop citizens' skills in this area Make information accessible, usable and useful enough that a typical resident could read it and explain it to someone else	Have a range of queries addressed without being passed from pillar to post Residents, the public and other residents can navigate care and support issues on their terms with the minimum of intervention and steps Local people and communities have control over their health and wellbeing

Priority Commissioning Intention	Key Actions	Benefits and Outcomes
	Test on-line access to case records and 'self service' options to learn what works and how to increase uptake Tailor the search results for each individual searching on the Council's website	The person is at the heart of their care
3. Better co-ordination and joined up health and care services which includes the voluntary sector.	Work with partners like SLAM and LGTT to link high quality information and advice across health and social care locally. Review information and advice provision in the independent sectors (and develop commissioning plans if required) to test if they are, or can be, • Part of an integrated system of working together • Fair, accurate, independent and impartial • Personalised • Efficient • Clear and accessible to the public Continue to harness the Community Connections model Improve interfaces between organisations, e.g. • telephone transfer arrangements between agencies • on-line referrals and on-line purchasing • shared assessment/referral tools	Supportive environments that help people to make positive changes We recognise the health implications in everything we do Promoting integration and community based care I tell my story once

This page is intentionally left blank

Healthier Communities Select Committee			
Title	Health and Wellbeing Board Performance Dashboard		
Contributor	Executive Director for Community Services, Director of Public Health	Item	8
Class	Part 1 (open)	24 February 2015	

1. Purpose

1.1. The purpose of this report is to present the Health and Well Being Board Performance Dashboard to the Healthier Communities Select Committee.

2. Recommendation

2.1 Members of the Healthier Communities Select Committee are recommended to note performance as measured by the health and care indicators set out in the attached dashboard Annex A, and by progress in delivering the actions within the Health & Wellbeing Strategy Delivery Plan.

3. Policy Context

3.1 The Health and Social care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. The activity of the Health and Wellbeing Board is focused on delivering the strategic vision for Lewisham as established in Shaping our Future – Lewisham's Sustainable Community Strategy, and in Lewisham's Health and Wellbeing Strategy.

3.2 The Health and Social Care Act 2012 placed a duty on local authorities and their partner clinical commissioning groups to prepare and publish joint health and wellbeing strategies to meet needs identified in their joint strategic needs assessments (JSNAs). Lewisham's Health and Wellbeing Strategy was published in 2013.

3.3 The Health and Social Care Act also required health and wellbeing boards to encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area.

3.4 The Better Care Fund (BCF) sits as part of a wider strategic approach and the focus of this work is to establish better co-ordinated and planned care closer to home, thus reducing demand for emergency/crisis care in acute settings and preventing people from requiring mental health and social care services.

4. **Background**

4.1 In response to the request from members of the Board, the Director of Public Health has worked alongside colleagues within Adult Social Care and the Clinical Commissioning Group (CCG) to produce a dashboard of indicators which would

assist members in monitoring health and wellbeing improvements across Lewisham and the effectiveness of the integrated adult care programme.

4.2 The dashboard also includes a number of indicators (including those on birth weight, immunisation and excess weight) that are also included in the Be Healthy priority of the Children and Young People's Partnership.

4.3 The Health & Wellbeing Strategy Implementation Group has recently received an update on delivery progress based on actions in the Health & Wellbeing Strategy Delivery Plan. The Group uses RAG ratings to assess progress, where Green is good, Amber is fair, and Red is poor.

4.4 The Implementation Group provides an assurance mechanism for the Board that enables discussion with leads for underperforming areas and for plans to be put in place to address this, and where appropriate escalate to Board. The update shows the majority of actions rated as green. All other actions that were rated amber or red were judged by the Implementation Group to have plans to address them. The Implementation Group will monitor the action plans closely to ensure that effective progress is being made. It is anticipated that the progress being made in delivery of the Strategy will translate into improvement in Health & Wellbeing Board Dashboard Indicators in 2015.

4.5 This Health & Well Being Board Performance Dashboard report was presented to the Health and Well Being Board by Dr Danny Ruta (Director of Public Health, LBL) in November 2014. he highlighted the following points:

- A review of Lewisham's Health and Wellbeing Strategy Delivery Plan shows that good progress is being made in implementing the strategy, with the majority of actions rated as green. Plans are in place to address actions rated amber or red.
- Potential years of life lost (PYLL) from causes considered amenable to healthcare has significantly reduced in Lewisham.
- Human Papilloma Virus has decreased significantly.
- The alcohol related admission rate is increasing.
- The smoking quit rate is decreasing, although Lewisham is still performing better than the London average.
- The rate of new admissions to long-term care is decreasing, but the percentage of older people (65+) still at home 91 days after discharge from hospital has not changed significantly.
- The avoidable emergency admission rate is reducing and the emergency admission rate for acute conditions that should not usually require hospital admission is decreasing.

The following issues were raised or highlighted in the discussion:

- Future reports need only focus on exceptions.
- The time-lag between flagging actions and the recording of the outcomes of those actions can sometimes be as long as ten (10) years. A more refined monitoring schedule is needed to explain the overall direction of travel.

5. Health and Wellbeing Board Performance Dashboard

5.1 The Performance Dashboard is based on 26 national metrics drawn from the Quality and Outcomes (Primary Care), Public Health, NHS and Adult Social Care Outcomes Frameworks. These metrics have been selected to assist members in their assessment of the impact and success of the plans and activities in relation to the Health and Wellbeing Strategy and Lewisham's adult integrated care programme.

5.2 The indicators are used to monitor the health outcomes and the integration of health and social care services on an annual or quarterly basis.

5.3 Overarching Indicators of Health & Wellbeing
Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare has significantly reduced in Lewisham and we are now very similar to England.

5.4 Delayed Transfer of Care rate and average days of delays has not significantly changed.

5.5 Priority Objective 1: Achieving a Healthy Weight
There has been no updated data since the last report.

5.6 Priority Objective 2: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years
There has been no update since the last report.

5.7 Priority Objective 3: Improving Immunisation Uptake
No Significant change in uptake ofD4 at 5 years, D3 at 1 year, MMR at 2 years and MMR2 at 5 years. Uptake of HPV has decreased significantly during 2013/14.

5.8 Priority Objective 4: Reducing Alcohol Harm
Alcohol related admission rate is increasing and is statistically similar to England, but higher than London.

5.9 Priority Objective 5: Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking
Smoking quit rate is decreasing but is higher than London and England. Smoking status at time of delivery is slightly increasing but the percentage is still less than half that of London and England (SATOD)

5.10 Priority Objective 6: Improving mental health and wellbeing
There has been no update since the last report.

5.11 Priority Objective 7: Improving sexual health
Chlamydia Diagnosis rate is improving and we are significantly higher than England. Legal abortion rate is going down but the rate is significantly higher than London and England.

5.12 Priority Objective 8: Delaying and reducing the need for long term care and support
Rate of new admissions to long term care is decreasing, but is higher than London and below England. The percentage of older people (65+) still at home 91 days after discharge from hospital into rehabilitation and reablement services has not changed significantly. It is still lower than London but higher than England.

5.13 Priority Objective 9: Reducing the number of emergency admissions for people with long term conditions

Avoidable emergency admission rate is reducing but still significantly higher than England and London. Emergency admission rate for acute conditions that should not usually require hospital admission is decreasing but is still significantly higher than London and England. Emergency readmission rate within 30 days of discharge seems to be increasing and it is significantly higher than England. Reviews of Adult Social Care clients is decreasing but is still higher than England and London.

6. Financial implications

6.1 There are no specific financial implications arising from this report.

7. Legal implications

7.1 There are no specific financial implications arising from this report.

8. Crime and Disorder Implications

8.1 There are no specific crime and disorder implications arising from this report or its recommendations.

9. Equalities Implications

9.1 There are no specific equalities implications arising from this report or its recommendations, but the dashboard highlights those areas where health inequalities in Lewisham can be monitored.

10. Environmental Implications

10.1 There are no specific environmental implications arising from this report or its recommendations.

11. Conclusion

11.1 Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare has significantly reduced in Lewisham. Delayed Transfer of Care rate and average days of delays has not significantly changed. There has been no change in uptake of childhood immunisations, but HPV has decreased significantly. The alcohol related admission rate is increasing and smoking quit rate is decreasing (although still performing better than London). Rate of new admissions to long term care is decreasing, but the percentage of older people (65+) still at home 91 days after discharge from hospital has not changed significantly. The avoidable emergency admission rate is reducing and the emergency admission rate for acute conditions that should not usually require hospital admission is decreasing. The emergency readmission rate seems to be increasing and reviews of Adult Social Care clients is decreasing. No updates are available for other indicators.

11.2 A review of Lewisham's Health & Wellbeing Strategy Delivery Plan shows that good progress is being made in implementing the strategy, with the majority of actions rated as green, and all other actions that were rated amber or red judged to have plans to address them. It is anticipated that this will translate into improvement in Health & Wellbeing Board Dashboard Indicators in 2015.

If there are any queries on this report please contact Dr Danny Ruta, Director of Public Health, Community Services Directorate, Lewisham Council, on 020 8314 8637 or by email danny.ruta@lewisham.gov.uk

Annex B: Definitions and Data sources

Please note that some of the definitions may have PCTs instead of CCGs for organisation. This is due to the national definitions in the technical specification document which can be obtained by clicking on the link in the data source section.

Overarching Indicators

1a/1b. Life Expectancy at Birth (Male/Female)	
Definition	The average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years a newborn baby would survive if he or she experienced the age-specific mortality rates for that area and time period throughout his or her life. Figures are calculated from deaths from all causes and mid-year population estimates, based on data aggregated over a three year period. Figures reflect mortality among those living in an area in each time period, rather than what will be experienced throughout life among those born in the area. The figures are not therefore the number of years a baby born in the area could actually expect to live, both because the mortality rates of the area are likely to change in the future and because many of those born in the area will live elsewhere for at least some part of their lives.
Numerator	Number of deaths registered in the respective calendar years
Denominator	ONS mid-year population estimates for the respective calendar years
Data source	PHOF 0.1ii http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/6/par/E12000007/are/E09000023

2. Children in Poverty (Under 16s)	
Definition	Percentage of children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income) for under 16s only.
Numerator	Number of children aged under 16 living in families in receipt of CTC whose reported income is less than 60 per cent of the median income or in receipt of IS or (Income-Based) JSA.
Denominator	Number of children aged under 16 for whom Child Benefit was received in each local authority.
Data source	PHOF 1.01ii http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/6/par/E12000007/are/E09000023

3. Under 75 Mortality Rates from CVD	
Definition	Mortality from all circulatory diseases (ICD-10 I00-I99 equivalent to ICD-9 390-459).
Numerator	Deaths from all circulatory diseases, classified by underlying cause of death (ICD-10 I00-I99, ICD-9 390-459 adjusted), registered in the respective calendar year(s).
Denominator	2001 Census based mid-year pop estimates for the calendar years 1993-2001. 2011 Census rebased mid-year pop estimates for the calendar years 2002-2010 2011 Census based mid-year pop estimates for the calendar year 2011 onwards
Data source	NHSIC - P00400 Data https://www.indicators.ic.nhs.uk/download/NCHOD/Data/06A_076DRT0074_12_V1_D.csv Specification https://www.indicators.ic.nhs.uk/download/NCHOD/Specification/Spec_06A_076DRT0074_V1.pdf

4. Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (DSR)	
Definition	Directly age and sex standardised potential years of life lost to conditions amenable to healthcare in the respective calendar year per 100,000 CCG population.
Numerator	Death registrations in the calendar year for all England deaths based on GP of registration from the Primary Care Mortality Database (PCMD).
Denominator	Unconstrained GP registered population counts by single year of age and sex from the HSCIC (Exeter) Systems; supplied annually on 1 January for the forthcoming calendar year.
Data source	NHOF 1a (NHSIC P01559 – CCGOI 1.1) Data https://www.indicators.ic.nhs.uk/download/Clinical%20Commissioning%20Group%20Indicators/Data/CCG_1.1_I00767_D_V5.xls Specification https://www.indicators.ic.nhs.uk/download/Clinical%20Commissioning%20Group%20Indicators/Specification/CCG_1.1_I00767_S_V4.pdf

5a/5b. Slope index of inequality in life expectancy at birth (Males/Females)	
Definition	This indicator measures inequalities in life expectancy. Life expectancy at birth is calculated for each local deprivation decile based on Lower Super Output Areas (LSOAs). The slope index of inequality (SII) is then calculated based on these figures. The SII is a measure of the social gradient in life expectancy, i.e. how much life expectancy varies with deprivation. It takes account of health inequalities across the whole range of deprivation factors within each local authority and summarises this as a single number, which represents the range in years of life expectancy across the social gradient from most to least deprived, based on a statistical analysis of the relationship between life expectancy and deprivation across all deprivation deciles. Life expectancy at birth is a measure of the average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years a newborn baby would survive if he or she experienced the age-specific mortality rates for that area and time period throughout his or her life.
Data source	PHOF 0.2iii http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/6/par/E12000007/are/E09000023

6. Infant Mortality	
Definition	Mortality rate per 1,000 live births (age under 1 year)
Numerator	The number of infant deaths aged less than 1 year that occurred in the relevant period.
Denominator	Number of all births.
Data source	CHIMAT Child health Profiles for Lewisham http://www.chimat.org.uk/resource/view.aspx?RID=101746®ION=101634 Original source is from ONS.

7. Low birth weight of all babies	
Definition	Percentage of live and stillbirths weighing less than 2,500 grams
Numerator	Number of new born babies weighing less than 2500gms
Denominator	Number of all births
Data source	CHIMAT Child health Profiles for Lewisham http://www.chimat.org.uk/resource/view.aspx?RID=101746®ION=101634 Original source is from ONS

8. Proportion of people using social care who receive self-directed support, and those receiving direct payments	
Definition	This is a two-part measure which reflects both the proportion of people using services who receive self-directed support (part 1), and the proportion who receive a direct payment either through a personal budget or other means (part 2).
Numerator	Number of clients and carers receiving self-directed support (part 1) or direct payments (part 2) in the year to 31 March
Denominator	Number of clients receiving community-based services and carers receiving carer specific services in the year to 31 March (aged 18 and over)
Data source	ASCOF 1C – NHSIC https://indicators.ic.nhs.uk/download/Social Care/Data/1C - Dec.xls

9. Delayed transfers of care from hospital	
Definition	This measures the impact of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from hospital. This indicates the ability of the whole system to ensure appropriate transfer from hospital for the entire adult population, and is an indicator of the effectiveness of the interface within the NHS, and between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care. This is a two-part measure that reflects both the overall number of delayed transfers of care (part 1) and, as a subset, the number of these delays which are attributable to social care services (part 2). A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.
Numerator	Average number of delayed transfers of care on a particular day taken over the year (aged 18 and over) - this is the average of the 12 monthly snapshots collected in the monthly Situation Report (SitRep) (part 1) and of those the delays that are attributable to social care or jointly to social care and the NHS (part 2)
Denominator	Size of the adult population in area (aged 18 and over)
Data source	ASCOF 2C http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

10. Days of Delay due to delayed transfers of care from hospital	
Definition	This measure is similar to ASCOF 2C in that it measures the impact of hospital services and community based care in facilitating timely and appropriate transfer from hospital. However the measure looks at the average number of days of delay, rather than the number of patients that were delayed.
Numerator	Average number of days of delay patients experienced on a particular day taken over the year (aged 18 and over) - this is the average of the 12 monthly snapshots collected in the monthly Situation Report (SitRep)
Denominator	Size of the adult population in area (aged 18 and over)
Data source	NHS England http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/ Up to date Local data obtained from PPLUS(LPI264)

*(*** Indicators below to be appear under Priority 8: Delaying and reducing the need for long term care and support)*

43. Social care related quality of life (to be replaced by a national metric in due course)	
Definition	How do people receiving adult social care services rate their quality of life? This measure is calculated using a combination of responses to the Adult Social Care Survey, which asks how satisfied or dissatisfied users are with indicators of quality of life, such as personal cleanliness and safety. A higher score is better, with a theoretical maximum of 32, and a minimum of 8. Any score better than 16 suggests a positive result.
Numerator	The sum of the scores for all respondents who answered all eight questions.
Denominator	Number of respondents who answered questions 3a to 9a and 11 in the annual Adult Social Care Survey
Data source	ASCOF 1A https://indicators.ic.nhs.uk/download/Social Care/Data/1A - Dec.xls

44. Rate of new admissions to long term care

Definition	This is a two part-measure reflecting the number of admissions of younger adults (part 1) and older people (part 2) to residential and nursing care homes relative to the population size of each group. The measure compares council records with ONS population estimates.
Numerator	Number of council-supported permanent admissions of older adults to residential and nursing care, excluding transfers between residential and nursing care (aged 18-64 – part 1 and aged 65 and over - part 2)
Denominator	Size of older adult population in area (aged 65 and over)
Data source	ASCOF 2A https://indicators.ic.nhs.uk/download/Social Care/Data/2A - Dec.xls

45. Percentage of older people (65+) still at home 91 days after discharge from hospital into rehabilitation/reablement services	
Definition	This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – a key outcome for people receiving reablement. It captures the joint work of social services and health staff and services commissioned by joint teams, as well as adult social care reablement.
Numerator	Number of older people (aged 65 and over) discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator.
Denominator	Number of older people (aged 65 and over) discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with the clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting).
Data source	ASCOF 2B https://indicators.ic.nhs.uk/download/Social Care/Data/2B - Dec.xls

*(*** Indicators below to be appear under Priority 9: Reducing the number of emergency admissions for people with long term conditions)*

46. Rate of avoidable emergency admissions	
Definition	Composite measure of: • unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages); • unplanned hospitalisation for asthma, diabetes and epilepsy in children; • emergency admissions for acute conditions that should not usually require hospital admission (all ages); and • emergency admissions for children with lower respiratory tract infection.
Numerator	Total avoidable emergency admissions for primary diagnoses covering those in all four metrics above, by local authority of residence (NB. This is not the same as adding admissions from the separate metrics as the four separate metrics overlap to some degree and this will therefore lead to 'double counting')
Denominator	Mid-year ONS population estimates
Data source	Data: HSCIC HES/ONS Mid-year population estimates Specification: NHS Quality Premium Estimate http://www.england.nhs.uk/ccg-ois/qual-prem/ Latest update from CCGOF 2.6 https://www.indicators.ic.nhs.uk/webview/velocity?v=2&mode=documentation&submode=ddi&study=http%3A%2F%2F172.16.9.26%3A80%2Fobj%2FfStudy%2FP01563

47. Percentage of patients with Long-Term conditions actively engaged in self-care	
Definition	This indicator measures the degree to which people with health conditions that are expected to last for a significant period of time feel they have had sufficient support from relevant services and organisations to manage their condition. Patients are encouraged to consider all services and organisations that support them in managing their condition, and not just health services. It is based on responses to the GP Patient Survey q30 (about whether a patient has a long-term condition) and q31 (asking about type of condition, which can reset q30 if they said no/don't know).
Numerator	Total of respondents who said 'yes definitely' and half the total respondents who said 'yes, to some extent' for q32 (which asks whether in the last six months they have had enough support to help manage their condition).
Denominator	As the numerator, but adds in those that responded 'no'.
Data source	NHSOF 2.1 https://indicators.ic.nhs.uk/download/Outcomes Framework/Data/NHSOF_2.1_I00706_D_V3.xls

Priority Objective 1: Achieving a Healthy Weight

11. Excess weight in Adults	
Definition	Percentage of adults classified as overweight or obese
Numerator	Number of adults with a BMI classified as overweight (including obese), calculated from the adjusted height and weight variables. Data are from APS6 quarters 2-4 and APS7 quarter 1 (mid-Jan 2012 to mid-Jan 2013). Adults are defined as overweight (including obese) if their body mass index (BMI) is greater than or equal to 25kg/m2
Denominator	Number of adults with valid height and weight recorded. Data are from APS6 quarters 2-4 and APS7 quarter 1 (mid-Jan 2012 to mid-Jan 2013).
Data source	PHOF 2.12 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: Active People Survey (APS), England

12a/12b. Excess weight in Children - Reception Year/ Year 6 Children	
Definition	Proportion of children aged 4-5 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.
Numerator	Number of children in Reception (aged 4-5 years) or Year 6 (aged 10-11) and classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex
Denominator	Number of children in Reception (aged 4-5 years) or Year 6 (aged 10-11) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England
Data source	PHOF 2.06 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: HSCIC National Childhood Measurement Programme (NCMP)

13. Breastfeeding Prevalence 6-8 weeks	
Definition	This is the percentage of infants that are totally or partially breastfed at age 6-8 weeks. Totally breastfed is defined as infants who are exclusively receiving breast milk at 6-8 weeks of age - that is, they are not receiving formula milk, any other liquids or food. Partially breastfed is defined as infants who are currently receiving breast milk at 6-8 weeks of age and who are also receiving formula milk or any other liquids or food. Not at all breastfed is defined as infants who are not currently receiving any breast milk at 6-8 weeks of age.
Numerator	Number of infants at the 6-8 week check who are totally or partially breastfeeding.
Denominator	Number of infants due for 6-8 week checks.
Data source	PHOF 2.02ii http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: Department of Health Integrated Performance Monitoring Return

14a/14b. % of physically active and inactive adults	
Definition	The number of respondents aged 16 and over, with valid responses to questions on physical activity, doing at least 150 “equivalent” minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 16.
Numerator	Number of respondents aged 16 and over, with valid responses to questions on physical activity, doing at least 150 “equivalent” minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the last 28 days
Denominator	Number of respondents aged 16 and over, with valid responses to questions on physical activity.
Data source	PHOF 2.13i http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: Active People Survey, England

Priority Objective 2: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years

15a. Cancer screening coverage - breast cancer	
Definition	The percentage of women in the resident population eligible for breast screening who were screened adequately within the previous three years on 31 March
Numerator	Number of women aged 53–70 resident in the area (determined by postcode of residence) with a screening test result recorded in the previous three years
Denominator	Number of women aged 53–70 resident in the area (determined by postcode of residence) who are eligible for breast screening at a given point in time.
Data source	PHOF 2.20i http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: Health and Social Care Information Centre (Open Exeter) Up to date available from HSCIC – http://www.hscic.gov.uk/article/2021/Website-Search?productid=14224&q=Breast++screening&sort=Relevance&size=10&page=1&area=both#top

15b. Cancer screening coverage - cervical cancer	
Definition	The percentage of women in the resident population eligible for cervical screening who were screened adequately within the previous 3.5 years or 5.5 years, according to age (3.5 years for women aged 25-49 and 5.5 years for women aged 50-64) on 31 March
Numerator	The number of women aged 25-49 resident in the area (determined by postcode of residence) with an adequate screening test in the previous 3.5 years plus the number of women aged 50-64 resident in the area with an adequate screening test in the previous 5.5 years
Denominator	Number of women aged 25–64 resident in the area (determined by postcode of residence) who are eligible for cervical screening at a given point in time.
Data source	PHOF 2.20ii http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: Health and Social Care Information Centre (Open Exeter)

15c. Cancer screening coverage - bowel cancer	
Definition	The number of persons registered to the practice aged 60-69 invited for screening in the previous 12 months who were screened adequately following an initial response within 6 months of invitation.
Rate of Proportion	Screening uptake %: the number of persons aged 60-69 invited for screening in the previous 12 months who were screened adequately following an initial response within 6 months of invitation divided by the total number of persons aged 60-69 invited for screening in the previous 12 months.
Data source	Cancer Commissioning Toolkit GP Profiles Data https://www.cancertoolkit.co.uk/Profiles/PracticePublic/Filters Specification https://www.cancertoolkit.co.uk/Profiles/PracticePublic/Documents NB: Data in the performance indicator portal is local data from London Bowel Screening hub

	obtained via Open Exeter. Up to date data available from HSCIC – http://www.hscic.gov.uk/article/2021/Website-Search?productid=12601&q=Cervical+cancer+screening&sort=Relevance&size=10&page=1&area=both#top

16. Early diagnosis of cancer	
Definition	New cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed (specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin). This indicator is labelled as experimental because of the variation in data quality: the indicator values primarily represent variation in completeness of staging information.
Numerator	Cases of cancer diagnosed at stage 1 or 2, for the specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin
Denominator	All new cases of cancer diagnosed at any stage or unknown stage, for the specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin
Data source	PHOF 2.19 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: National cancer registry

17. Two week wait referrals	
Definition	The number of Two Week Wait (GP urgent) referrals where cancer is suspected for patients registered at the practice in question
Rate or proportion	The crude rate of referral: the number of Two Week Wait referrals where cancer is suspected multiplied by 100,000 divided by the list size of the practice in question.
Data source	Cancer Commissioning Toolkit GP Profiles Data https://www.cancertoolkit.co.uk/Profiles/PracticePublic/Filters Specification https://www.cancertoolkit.co.uk/Profiles/PracticePublic/Documents

18. Under 75 mortality from all cancers	
Definition	Mortality from all malignant neoplasms (ICD-10 C00-C97 equiv to ICD-9 140-208).
Numerator	Deaths from all malignant neoplasms, classified by underlying cause of death (ICD-10 C00-C97, ICD-9 140-208 adjstd), registered in the respective calendar year(s).
Denominator	2001 Census based mid-year pop estimates for the calendar years 1993 - 2001. 2011 Census rebased mid-year pop estimates for the calendar years 2002-2010 2011 Census based mid-year pop estimates for the calendar year 2011 onwards
Data source	PHOF 4.05i - NHSIC P00381 Data https://www.indicators.ic.nhs.uk/download/NCHOD/Data/11B_075DRT0074_12_V1_D.xls Specification https://www.indicators.ic.nhs.uk/download/NCHOD/Specification/Spec_11B_075DRT0074_V1.pdf

Priority Objective 3: Improving Immunisation Uptake

19. Uptake of the first dose of Measles Mumps and Rubella vaccine (MMR1) at two years of age	
Definition	All children for whom the CCG is responsible who received one dose of MMR vaccine on or after their 1st birthday and at any time up to their 2nd birthday as a percentage of all children whose 2nd birthday falls within the time period. Estimates for local authorities are based on CCGs, which include all people registered with

	practices accountable to the CCG.
Numerator	Total number of children who received one dose of MMR vaccine on or after their 1st birthday and at any time up to their 2nd birthday.
Denominator	The responsible population. The CCG is responsible for all children registered with a GP whose practice forms part of the CCG, regardless of residency, plus any children not registered with a GP who are resident within the CCG's statutory geographical boundary.
Data source	PHOF 3.03vii http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by PHE. Available from HSCIC. ****Up to date Immunisation COVER data is provided by the Local Immunisation Team on a quarterly basis which has been updated in the dashboard.*

20. Uptake of the second dose of Measles Mumps and Rubella Vaccine (MMR2) at five years of age	
Definition	All children for whom the CCG is responsible who received two doses of MMR on or after their 1st birthday and at any time up to their 5th birthday as a percentage of all children whose 5th birthday falls within the time period. Estimates for local authorities are based on CCGs, which include all people registered with practices accountable to the CCG.
Numerator	Total number of children who received two doses of MMR on or after their 1st birthday and at any time up to their 5th birthday.
Denominator	All children in the responsible population whose 5th birthday falls within the time period. The CCG is responsible for all children registered with a GP whose practice forms part of the CCG, regardless of residency, plus any children not registered with a GP who are resident within the CCG's statutory geographical boundary.
Data source	PHOF 3.03 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by PHE. Available from HSCIC. ****Up to date Immunisation COVER data is provided by the Local Immunisation Team on a quarterly basis which has been updated in the dashboard.*

21. Uptake of the third dose of Diphtheria vaccine (D3) at one year of age	
Definition	The percentage of children for whom the CCG is responsible who received 3 doses of DTP, polio, Hib) at any time up to their 1st birthday. Estimates for local authorities are based on CCGs, which include all people registered with practices accountable to the CCG.
Numerator	Total number who received 3 doses of DTP, polio, Hib at any time up to their 1st birthday.
Denominator	The responsible population. The CCG is responsible for all children registered with a GP whose practice forms part of the CCG, regardless of residency, plus any children not registered with a GP who are resident within the CCG's statutory geographical boundary.
Data source	Local Immunisation Cover Data ****Up to date Immunisation COVER data is provided by the Local Immunisation Team on a quarterly basis which has been updated in the dashboard.*

22. Uptake of the fourth dose of Diphtheria vaccine (D4) at five years of age	
Definition	The percentage of children for whom the CCG is responsible who received 3 doses of DTP, polio, Hib as well as the DTP, polio booster at any time up to their 5th birthday. Estimates for local authorities are based on CCGs, which include all people registered with practices accountable to the CCG.
Numerator	The number of children for whom the CCG is responsible who received 3 doses of DTP, polio, Hib as well as the DTP, polio booster at any time up to their 5th birthday.

Denominator	The responsible population. The CCG is responsible for all children registered with a GP whose practice forms part of the CCG, regardless of residency, plus any children not registered with a GP who are resident within the CCG's statutory geographical boundary.
Data source	Local Immunisation Cover Data ****Up to date Immunisation COVER data is provided by the Local Immunisation Team on a quarterly basis which has been updated in the dashboard.*

23. Uptake of Human Papilloma Virus (HPV) vaccine in girls in Year 8 in Lewisham Schools	
Definition	The percentage of girls aged 12 to 13 years for whom the CCG is responsible who have received all three doses of the HPV vaccine. Estimates for local authorities are based on CCGs, which include all people registered with practices accountable to the CCG.
Numerator	Number of Year 8 schoolgirls (aged 12 to 13 years) who have received all three doses of the HPV vaccine.
Denominator	Number of Year 8 schoolgirls (aged 12-13). The CCG is responsible for all children registered with a GP whose practice forms part of the CCG, regardless of residency, plus any children not registered with a GP who are resident within the CCG's statutory geographical boundary.
Data source	PHOF 3.03xii http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 NB: Data in the performance indicator portal is local data from GP systems obtained via EMIS Web. Original source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by PHE. Available from HSCIC. ****Up to date Immunisation COVER data is provided by the Local Immunisation Team on a quarterly basis which has been updated in the dashboard.*

24. Uptake of Influenza vaccine in those over 65 years of age	
Definition	Flu vaccine uptake (%) in adults aged 65 and over, who received the flu vaccination between 1st September and 31st January each financial year.
Numerator	Number of adults aged 65 years and over vaccinated between 1st September and 31st January of the financial year.
Denominator	Adults aged 65 years and over. The CCG is responsible for all adults registered with a GP whose practice forms part of the CCG, regardless of residency.
Data source	PHOF 3.03 xiv http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original source: PHE https://www.gov.uk/government/organisations/public-health-england/series/vaccine-uptake ****Up to date Immunisation COVER data is provided by the Local Immunisation Team on a quarterly basis which has been updated in the dashboard.*

Priority Objective 4: Reducing Alcohol Harm

25. Alcohol related admissions	
Definition	The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause per 100,000 population (age standardised).
Numerator	The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause. See LAPE user guide for further details - http://www.lape.org.uk/downloads/Lape_guidance_and_methods.pdf
Denominator	ONS mid year population estimates
Data source	PHOF 2.18 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: PHE Knowledge and Intelligence Team (North West) using data from HSCIC HES and ONS Mid Year Population Estimates. http://www.lape.org.uk/

26. Number of practitioners skilled in identifying those at risk from alcohol harm and delivering brief interventions	
Definition	TBC
Numerator	TBC
Denominator	TBC
Data source	Data available from Lewisham Public Health Team. The Scheme started in November 2013.

Priority Objective 5: Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking

27. Under 75 Mortality from Respiratory	
Definition	Age-standardised rate of mortality from respiratory disease in persons less than 75 years per 100,000 population
Numerator	Number of deaths from respiratory diseases (classified by underlying cause of death recorded as ICD codes J00-J99) registered in the respective calendar years, in people aged under 75, aggregated into quinary age bands (0-4, 5-9,…, 70-74). Counts of deaths for years up to and including 2010 have been adjusted where needed to take account of the ICD-10 coding change introduced in 2011. The detailed guidance on the implementation is available at http://www.apho.org.uk/resource/item.aspx?RID=126245
Denominator	ONS 2011 Census based mid-year population estimates; Population-years (aggregated populations for the three years) for people of all ages, aggregated into quinary age bands (0-4, 5-9, …, 70-74).
Data source	PHOF 4.07i http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023

28. Under 75 Mortality from Lung Cancer	
Definition	Mortality from lung cancer (ICD-10 C33-C34 equivalent to ICD-9 162).
Numerator	Deaths from lung cancer, classified by underlying cause of death (ICD-10 C33-C34, ICD-9 162 adjusted), registered in the respective calendar year(s).
Denominator	2001 Census based mid-year pop estimates for the calendar years 1993-2001. 2011 Census rebased mid-year pop estimates for the calendar years 2002-2010 2011 Census based mid-year pop estimates for the calendar year 2011 onwards
Data source	NHSIC – P00512 Data https://www.indicators.ic.nhs.uk/download/NCHOD/Data/14B_105DRT0074_12_V1_D.xls Specification https://www.indicators.ic.nhs.uk/download/NCHOD/Specification/Spec_14B_105DRT0074_V1.pdf

29. Smoking Prevalence (18+) - routine and manual	
Definition	Prevalence of smoking among persons aged 18 years and over.
Numerator	The number of persons aged 18+ who are self-reported smokers in the Integrated Household Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.
Denominator	Total number of respondents (with valid recorded smoking status) aged 18+ in the Integrated Household Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.
Data source	PHOF 2.14 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: ONS Integrated Household Survey

30. 4 week smoking quitters	
Definition	This indicator relates to clients receiving support through the NHS Stop Smoking Services. A client is counted as a self-reported 4-week quitter if they have been assessed 4 weeks after the designated quit date and declares that he/she has not smoked even a single puff on a cigarette in the past two weeks. The indicator is a count of treatment episodes rather than people, so an individual who undergoes two treatment episodes and has quit at four weeks in both cases are counted twice.
Numerator	Number of self-reported 4-week smoking quitters.
Denominator	Population aged 16 or over.
Data source	Data – Local NHS Stop Smoking Service database. Specification https://nascis.hscic.gov.uk/download.ashx?src=MetaDataPdf&file=JSNA_Metadata_NI+123.pdf

31. Number of 11-15 year-olds who take up smoking	
Definition	Data is obtained from survey of Yr8 and Yr 10 secondary schoolchildren. Survey happens every 2 years (2008, 2010 – No survey in 2012 but one expected in 2014) Percentage of pupils in each group responding to: 'Which statement describes you best?' Responses taken into account to calculate the percentage are below. • I smoke occasionally (< 1 / week) • Smoke regularly, like to give up • Smoke, don't want to give it up
Data source	SHEU Survey 2010 – Lewisham Public Health Team N:\lew ph team\Health Intelligence\Archive\Health Intelligence\SHEU reports

32. Number of children in smoke free homes	
Definition	Data is obtained from survey of Yr8 and Yr 10 secondary schoolchildren. Survey happens every 2 years (2008, 2010 – No survey in 2012 but one expected in 2014) Percentage of pupils in each group responding to: How many people smoke, including yourself and regular visitors, on most days indoors in your home? Responses taken into account to calculate the percentage are below. • None (as Proxy)
Data source	SHEU Survey 2010 – Lewisham Public Health Team N:\lew ph team\Health Intelligence\Archive\Health Intelligence\SHEU reports

33. Prevalence of Smoking in 15 year olds	
Definition	Data is obtained from survey of Yr8 and Yr 10 secondary schoolchildren. Survey happens every 2 years (2008, 2010 – No survey in 2012 but one expected in 2014) Percentage of pupils in each group responding to: 24: Which statement describes you best? Responses taken into account to calculate the percentage are below. • I have never smoked at all
Data source	SHEU Survey 2010 – Lewisham Public Health Team N:\lew ph team\Health Intelligence\Archive\Health Intelligence\SHEU reports

34. Smoking at time of delivery	
Definition	Number of women who currently smoke at time of delivery per 100 maternities. Data includes all women resident within the CCG's boundary, and no data are available to break down the CCG denominators for different areas within the CCG.
Numerator	Number of women known to smoke at time of delivery.
Denominator	Number of maternities.
Data source	PHOF 2.03 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 NB: Latest available quarter data from NHS Stop smoking service database.

Priority Objective 6: Improving mental health and wellbeing

35. Under 75 mortality rates for those with serious mental illness

Definition	Rate of mortality in people aged 18 to 74 suffering from serious mental illness standardised and compared to the general population.
Numerator	Deaths from any cause in age range 18-74 at death. MH-NMDS linked over three years and to the Primary Care Mortality Database (PCMD).
Denominator	The mental health population is defined as anyone who has been in contact with the secondary mental care services in the current financial year or in either of the two previous financial years who is alive at the beginning of the current financial year. MH-NMDS linked over three years and to PCMD, in age range 18-74.
Data source	NHSOF 1.5 Data https://www.indicators.ic.nhs.uk/download/Outcomes%20Framework/Data/NHSOF_1.5_I00665_D_V7.xls Specification https://www.indicators.ic.nhs.uk/download/Outcomes%20Framework/Specification/NHSOF_Domain_1_S_V2.pdf

36a. Prevalence of SMI	
Definition	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers.
Numerator	Patients with schizophrenia, bipolar affective disorder and other psychoses
Denominator	CCG responsible population
Data source	National GP Practice Profiles http://fingertips.phe.org.uk/profile/general-practice/data#mod,3,pyr,2013,pat,19,par,E38000098,are,-,sid1,2000003,ind1,-,sid2,-,ind2,- Original Source: HSCIC QOF http://www.hscic.gov.uk/catalogue/PUB12262

36b. Prevalence of Dementia	
Definition	The percentage of patients with dementia as recorded on practice disease registers.
Numerator	Patients with dementia
Denominator	CCG responsible population
Data source	Original Source: HSCIC QOF http://www.hscic.gov.uk/catalogue/PUB12262.

36c. Prevalence of Depression	
Definition	The percentage of patients aged 18 and over with depression, as recorded on practice disease registers.
Numerator	Patients aged 18 and over with depression, as recorded on practice disease registers.
Denominator	CCG responsible population
Data source	Original Source: HSCIC QOF http://www.hscic.gov.uk/catalogue/PUB12262

37. Suicide rates	
Definition	Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population
Numerator	Number of deaths from suicide and injury of undetermined intent classified by underlying cause of death recorded as ICD10 codes X60-X84 (all ages), Y10-Y34 (ages 15+ only) registered in the respective calendar years, aggregated into quinary age bands (0-4, 5-9,…, 85-89, 90+). Counts of deaths for years up to and including 2010 have been adjusted where needed to take account of the ICD-10 coding change introduced in 2011. The detailed guidance on the implementation is available at http://www.apho.org.uk/resource/item.aspx?RID=126245.
Denominator	Population-years (aggregated populations for the three years) for people of all ages, aggregated into quinary age bands (0-4, 5-9, …, 85-89, 90+). ONS 2011 Mid year estimates.
Data source	PHOF 4.10 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/pat/6/ati/102/page/6/par/E12000007/are/E09000023

	Original Source: ONS Mortality data extracted by Public Health England

38. Self-reported well-being - people with a low happiness score	
Definition	The percentage of respondents who answered 0-4 to the question "Overall, how happy did you feel yesterday?" ONS are currently measuring individual/subjective well-being based on four questions included on the Integrated Household Survey: "Overall, how satisfied are you with your life nowadays?" "Overall, how happy did you feel yesterday?" "Overall, how anxious did you feel yesterday?" "Overall, to what extent do you feel the things you do in your life are worthwhile?" Responses are given on a scale of 0-10 (where 0 is "not at all satisfied/happy/anxious/worthwhile"; and 10 is "completely satisfied/happy/anxious/worthwhile") In the ONS report, the percentage of people scoring 0-4, 5-6, 7-8 and 9-10 have been calculated for this indicator. The percentage of those scoring 0-4 (respondents in that area that scored themselves the lowest marks) in the question: 'Overall, how happy did you feel yesterday?' will be presented in this indicator.
Numerator	Weighted count of respondents in the APS who rated their answer to the question: "Overall, how happy did you feel yesterday?" as 0, 1, 2, 3 or 4 on a scale between 0-10, where 0 is not at all and 10 is completely. These respondents are described as having the lowest levels of happiness. Respondents in the APS are aged 16 and over who live in residential households in the UK
Denominator	Weighted count of all respondents to the question "Overall, how happy did you feel yesterday?"
Data source	PHOF 2.23ii http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: Annual Population Survey (APS); ONS

Priority Objective 7: Improving sexual health

39. Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24	
Definition	Crude rate of chlamydia diagnoses per 100,000 young adults aged 15-24 based on their area of residence
Numerator	The number of people aged 15-24 diagnosed with chlamydia
Denominator	Resident population aged 15-24
Data source	PHOF 3.02i http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000043/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source http://www.chlamydiascreening.nhs.uk/ps/data.asp

40a. People presenting with HIV at a late stage of infection(%) or	
Definition	Number of adults (aged 15 years or more) newly diagnosed with HIV infection with CD4 counts available within 91 days and indicating a count of less than 350 cells per mm^3 as a percentage of number of adults (aged 15 years or more) newly diagnosed with HIV infection with CD4 counts available within 91 days.
Numerator	Number of adults (aged 15 years or more) newly diagnosed with HIV infection with CD4 counts available within 91 days and indicating a count of less than 350 cells per mm^3
Denominator	Number of adults (aged 15 years or more) newly diagnosed with HIV infection with CD4 counts available within 91 days.
Data source	PHOF 3.04 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023

40b. Prevalence of diagnosed HIV infection per 1,000 among persons aged 15 to 59 years	
Definition	People aged 15 to 59 years who were seen at HIV care services.

Numerator	The number of people living with a diagnosed HIV infection resident in a given local health service who were aged 15 to 59 years and who were seen for HIV care at a NHS site in the UK.
Denominator	Estimated total population aged 15 to 59 years resident in a given local health service area (ONS mid-year population estimates)
Data source	Public health England Sexual and Reproductive Health Profiles http://www.phoutcomes.info/profile/sexualhealth/data#gid/8000057/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source - HPA for HIV stats/ ONS for Population http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListDate/Page/1201094588844?p=1201094588844

41. Legal Abortion rate for all ages	
Definition	Legal Abortions: Age Standardised Rate per 1000 resident women aged 15-44
Numerator	Number of all Legal Abortions
Denominator	Number of resident women aged 15-44
Data source	ONS via DH. Detailed data obtained through Local commissioners. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307650/Abortion_statistics__England_and_Wales.pdf Latest Data: Total abortion rate per 1,000 resident women 15-44. PHE Sexual Health Profile http://fingertips.phe.org.uk/profile/sexualhealth/data#gid/8000059/pat/6/ati/102/page/3/par/E12000007/are/E09000023

42. Teenage conceptions	
Definition	Conceptions in women aged under 18 per 1,000 females aged 15-17
Numerator	Number of pregnancies that occur to women aged under 18, that result in either one or more live or still births or a legal abortion under the Abortion Act 1967.
Denominator	Number of women aged 15-17 living in the area.
Data source	Public health outcomes framework 2.04 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original source: ONS

Priority Objective 8 – Delaying and reducing the need for long term care and support.

****NB: Indicators 43, 44 and 45 are already presented in page 8 & 7 under Integration of Health and Social care – Better care Funding section of the Overarching Indicators ****

Priority Objective 9: Reducing the number of emergency admissions for people with long term conditions

****NB: Indicators 46 and 47 are already presented in page 7 & 8 under Integration of Health and Social care – Better care Funding section of the Overarching Indicators ****

48. Adult Social Care Reviews	
Definition	Number of current adult social care service users that have been receiving services for at least twelve months that were reviewed in the last twelve months.
Numerator	Number of reviews undertaken in the last twelve months of long term service users still receiving a service.
Denominator	Number of service users receiving services for at least twelve months currently receiving long term services as at the end of the twelve months.
Data source	HSCIC – subset of old RAP A1 and new SALT Return LTS Table 2b https://nascis.hscic.gov.uk/Portal/Tools.aspx Cumulative % since April (Year To Date) is available on Performance Plus (Local Performance Management System) –AO/D40

49. Health-related quality of life for people with long-term conditions	
Definition	Average adjusted health status (EQ-5D™) score for individuals reporting that they have a long-term condition, measured based on responses to a question from the GP Patient Survey.
Numerator	The numerator is the sum of the weighted EQ-5D™ values for all responses from people who identify themselves as having a long-term condition with a valid age and sex.
Denominator	The denominator is the weighted sum of responses from people who identify themselves as having a long-term condition with a valid age and sex.
Data source	CCG Outcomes Framework 2.1 https://www.indicators.ic.nhs.uk/webview/velocity?v=2&mode=documentation&submode=ddi&study=http%3A%2F%2F172.16.9.26%3A80%2Fobj%2FfStudy%2FP01663

50. Emergency admissions for acute conditions that should not usually require hospital admission	
Definition	Directly age and sex standardised rate of emergency admissions for acute conditions for persons of all ages.
Numerator	Hospital Episode Statistics (HES) Admitted Patient Care (APC), provided by the Health and Social Care Information Centre (HSCIC).
Denominator	Unconstrained GP registered patient counts by single year of age and sex from the NHAIS (Exeter) Systems; extracted annually on 1 April for the forthcoming financial year.
Data source	CCG Outcomes Framework 3.1 https://www.indicators.ic.nhs.uk/webview/velocity?v=2&mode=documentation&submode=ddi&study=http%3A%2F%2F172.16.9.26%3A80%2Fobj%2FfStudy%2FP01566

51. Emergency readmissions within 30 days of discharge from hospital	
Definition	Percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge after admission. Admissions for cancer and obstetrics are excluded.
Numerator	Hospital Episode Statistics (HES) finished and unfinished admission episodes. Provided by HSCIC. Final annual and quarterly confirmed HES data are released in the November following the financial year-end.
Denominator	ONS mid-year population estimates for England – used to calculate the rate of admissions per 100,000 populations.
Data source	NHSOF 3b - NHS Indicator Portal – P01445 Data https://indicators.ic.nhs.uk/download/Outcomes%20Framework/Data/NHSOF_3b_I00712_D_V4.xls Specification https://indicators.ic.nhs.uk/download/Outcomes%20Framework/Specification/NHSOF_Domain_3_S_V2.pdf

Annex C: Glossary

APS – Active People Survey

ASCOF -Adult and Social Care Outcomes Framework

BCBV - NHS Better Care Better Value Indicators

BMI – Body Mass Index

CCG - Clinical Commissioning Group

CCGOI - Clinical Commissioning Group Outcome Indicator

CTC – Child Tax Credit

D3 – Third dose of Diphtheria vaccine

D4 – Fourth dose of Diphtheria vaccine

HES – Hospital Episode Statistics

HSCIC - Health and Social Care Information Centre

ICD – International Classification of Diseases

IS – Income Support

JSA – Job-Seekers Allowance

MH-NMDS – Mental Health National Minimum Dataset

MMR- Measles, Mumps, Rubella dose 1

MMR2 - Measles, Mumps, Rubella dose 2

NHSIC - NHS Indicator Portal

NHSOF – National Health Service Outcome Framework

ONS – Office for National Statistics

PCMD - Primary Care Mortality Database

PCT – Primary Care Trust

PHOF - Public Health Outcomes Framework

PHE - Public Health England

QOF - Quality and Outcomes Framework

This page is intentionally left blank

Health and Wellbeing Performance Metrics 2014/15

		Frequency	Latest Period of Availability	Previous Available Period (Lewisham)	Latest Available Period (Lewisham)	Lon	Eng	England Benchmark	Direction from Previous Period	Data Source
	Overarching Indicators									
1a	Life Expectancy at Birth (Male)(yrs)	Annual	2010-12	77.6	78.2	79.7	79.2	sig high	↑	PHOF 0.1i
1b	Life Expectancy at Birth (Female)(yrs)	Annual	2010-12	82.3	82.6	83.8	83	sig high	↑	PHOF 0.1ii
2	Children in poverty (%)	Annual	2011	31.7	30.5	26.5	20.6	sig high	↓	PHOF 1.01
3	Under 75 from CVD mortality (DSR)	Annual	2010-12	96.7	91.0	83.1	81.1	sig high	↓	NHSIC - P00400/ PHOF 4.04i
4	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (DSR)	Annual	2011-13	2102	2027	1890.2	2023.5	similar	↓	NHSOF 1A - ONS (CCG 1.1 DSR)- P01559
5a	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Male)	Annual	2010-12	6	6.6				↑	PHOF 0.2iii
5b	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Female)	Annual	2010-12	6.3	6.6				↑	PHOF0.2iii
6	Infant Mortality (%)	Annual	2010-12	4.8	4.9	4.2	4.3	similar	↑	P00723/CHIMAT Profile 2014
7	Low Birth Weight of all babies (%)	Annual	2012	8.3	8.4	7.9	7.3	sig high	↑	P00455/CHIMAT Profle 2014
8	Proportion of people using social care who receive self-directed support, and those receiving direct payments (Crude rate per 100,000)	Annual/Qtr**	2013/14	55.5	69.4	67.5	62.1	-	↑	ASCOF(1C)- NHSIC -P01509
9	Delayed transfers of care from hospital (crude rate per 100,000)	Annual/Qtr**	2013/14	4.9	4.7	6.9	9.7	-	↓	ASCOF 2C- NHSIC - P01516
10	Average Days of Delay (crude rate per 100,000)	Annual/Qtr**	2012/13	103.7	105.5				↑	BCF - Local Data - LPI264 (PPLUS)
	Priority Objective 1: Achieving a Healthy Weight									
11	Excess weight in Adults (%)	Annual	2012/13	-	61.2	57.3	63.8	similar	N/A	PHOF 2.12
12a	Excess weight in Children - Reception Year (%)	Annual	2012/13	24.8	25.0	23.0	22.2	sig high	↑	PHOF 2.06
12b	Excess Weight in Children- Year 6 (%)	Annual	2012/13	40.4	38.3	37.4	33.3	sig high	↓	PH NCMP Profiles
13	Breastfeeding Prevalence 6-8 weeks(%)	Annual/Qtr	2014/15 Q1 (Prov)	70.8	74.8			sig high	↑	PHOF 2.06; 2014/15 Q1 Local data - validation criteria not met
14a	% of physically active and inactive adults - Active adults	Annual	2012	57.8	54.3	57.2	56.0	similar		PHOF 2.13i
14b	% of physically active and inactive adults - Inactive adults	Annual	2012	25	29.2	27.5	28.5	similar		PHOF 2.13ii
	Priority Objective 2: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years									
15a	Cancer screening coverage - breast cancer (%)	Annual/Qtr	2013	65.1	66	68.6	76.3	sig low	↑	PHOF 2.20i
15b	Cancer screening coverage - cervical cancer(%)	Annual/Qtr	2013	75.6	77.5	74.1	78.3	sig low	↑	HSCIC
15c	Cancer screening coverage - bowel cancer (%) - 60% Target	Monthly/Qtr	May-14	45.6	43.5	45.8		-	↓	S.E London Bowel Cancer Screening centre (Available in Local Cancer Dashboard)
16	Early diagnosis of cancer (%)	Annual	2012	-	39.9	-	41.6		N/A	PHOF 2.19 – experimental statistics
17	Two week wait referrals (number per 100,000 population)	Annual	2013		2273		2166			Cancer Toolkit GP Profiles
18	Under 75 mortality from all cancers (DSR)	Annual	2010-12	169.4	159.9	139.1	146.5			NHSIC - P00381/ PHOF 4.05i
	Priority Objective 3: Improving Immunisation Uptake									
19	Uptake of the first dose of Measles Mumps and Rubella vaccine (MMR1) at two years of age	Qtr	2014/15 Q1	88.3	85.5	86.8	92.4	low	↓	PHOF 3.03viii/ Local Imms Cover Data
20	Uptake of the second dose of Measles Mumps and Rubella Vaccine (MMR2) at five years of age	Qtr	2014/15 Q1	69.5	70.8	79.9	88.5	low	↑	Local Immunisation cover data
21	Uptake of the third dose of Diptheria vaccine (D3) at one year of age	Qtr	2014/15 Q1	88.9	90	88.6	93.9	low	↑	Local Immunisation cover data
22	Uptake of the fourth dose of Diphtheria vaccine (D4) at five years of age	Qtr	2014/15 Q1	76.2	76.2	77.3	88.6	low	→	Local Immunisation cover data
23	Uptake of Human Papilloma Virus (HPV) vaccine in girls in Year 8 in Lewisham Schools	Annual/Qtr	2013/14	84.8	78.2				↓	Local Immunisation cover data
24	Uptake of Influenza vaccine in those over 65 years of age	Annual/Qtr	2013/14	68.2	70.2	62.8			↑	Local Immunisation cover data
	Priority Objective 4: Reducing Alcohol Harm									
25	Alcohol related admissions (ASR per 100,000 pop)	Annual*	2012/13	588	614	554	637	similar	↑	PHOF 2.18
26	Number of practitioners skilled in identifying those at risk from alcohol harm and delivering brief interventions (Local source)	Annual Local*	Nov-13 to Aug-14		384					LBL

Health and Wellbeing Performance Metrics 2014/15

		Frequency	Latest Period of Availability	Previous Available Period (Lewisham)	Latest Available Period (Lewisham)	Lon	Eng	England Benchmark	Direction from Previous Period	Data Source
	Priority Objective 5 : Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking									
27	Under 75 Mortality from Respiratory (DSR per 100,000 pop)	Annual	2010-12	40.9	38.6	32.6	33.5		↓	PHOF 4.07i
28	Under 75 Mortality from Lung Cancer (DSR per 100,000 pop)	Annual	2012	23.57	23.04	24.06	24.2		↓	NHS Indicator Portal - P00512
29	Smoking Prevalence(%)	Annual	2012	22.6	21.4	18	19.5			PHOf 2.14
30	4 week smoking quitter (crude rate per 100,000)	Annual/Qtr	2013/14	821	751.0	656.0	688.0		↓	HSCIC
31	Number of 11-15 year-olds who take up smoking (%)	Every 2-3 years	2010		9%					SHEU Survey (to be completed)
32	Number of children in smoke free homes (%)	Every 2-3 years	2010		57%					SHEU Survey (to be completed)
33	Prevalence of Smoking in 15 year olds (proxy: % Never smoked at all - Yr8 and Yr10 children)	Every 2-3 years	2010		74%					SHEU Survey (to be completed)
34	Smoking at time of delivery (%)	Annual/Qtr	2014/15 Q1	5.2	5.4	11.9	11.8		↑	HSCIC
	Priority Objective 6: Improving mental health and wellbeing									
35	Under 75 mortality rates for those with serious mental illness (DSR per 100,000 pop)	Annual	2011/12	845.7	839.8	-	1,274.8	sig low	↓	NHSOF 1.5
36a	Prevalence of SMI (%)	Annual	2012/13	1.2	1.2	1.0	0.8	-	→	QOF
36b	Prevalence of Dementia (%)	Annual	2012/13	0.3	0.3	0.4	0.6	-	→	QOF
36c	Prevalence of Depression (%)	Annual	2012/13	10.4	5.3	4.4	5.8	-	↓	QOF
37	Suicide rates (DSR per 100,000 pop)	Annual	2010-12	7.1	7.5	7.5	8.5	similar	↑	PHOF 4.10
38	Self-reported well-being - people with a low happiness score	Annual	2012/13	15.0	10.2	10.3	10.4	similar	↓	PHOF 2.23iii
	Priority Objective 7: Improving sexual health									
39	Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24 (crude rate)	Annual	2013	4186	3480	2179	2016	sig high	↓	PHOF 3.02i/3.02ii (NCSP & CTAD)
40a	People presenting with HIV at a late stage of infection(%) or	Annual	2011-13	50.9	46.1	40.5	45	similar	↓	PHOF 3.04
40b	Prevalence of diagnosed HIV infection per 1,000 among persons aged 15 to 59 years (crude rate)	Annual	2012	7.94	8.18	5.69	2.14	sig high	↑	PHE SH Profile
41	Legal Abortion rate for all ages (crude rate per 1000 women)	Annual	2013	27.4	27.6	22.8	16.6	sig high	↑	ONS Abortion Stats
42	Teenage conceptions (Rate per 1,000 15-17 Yr olds)	Annual	2012	39.9	42.0	25.9	27.7	sig high	↑	PHE Sexual Health Profile
	Priority Objective 8 – Delaying and reducing the need for long term care and support.									
43	social care related quality of life (%)	Annual	2013/14	18.3	18.6	18.4	19	-	↑	ASCOF 1A (P01507)
44	Rate of new admissions by older adults to long term care (crude rate per 100,000)	Annual/Qtr	2013/14	612.9	527	509.4	668.4	-	↓	ASCOF2A (P01514) (BCF)
45	% older people (65+) still at home 91 days after discharge from hospital into rehabilitation/reablement services	Annual/Qtr***	2013/14	86.5	86.9	88.9	81.9		↑	ASCOF 2B
`	**Priority Objective 9: Reducing the number of emergency admissions for people with long term conditions**									
46	Rate of avoidable emergency admissions (Std rate per 100,000 pop)	Annual/Qtr***	2013/14(Prov)	1027.6	940.9	734.6	780.9	sig high	↓	BCBV / NHS Comparators/CCGOF 2.6
47	% people able to manage effectively their own long term condition at home	Annual	2013/14(Prov)	62.3	61.1	59.7	65.1		↓	NHSOF 2.1 (BCF)
48	Reviews of Adult Social Care Clients (cumulative % since Apr)	Annual/Qtr	2014/15 Q1	77.9	70.7	69.8	66.6		↓	BCF/Local Data - AO/D40 PPLUS
49	Health-related quality of life for people with long-term conditions	Annual	Jul 12 - Mar 13	0.7	0.7	0.7	0.7		↑	CCGOF 2.1
50	Emergency admissions for acute conditions that should not usually require hospital admission (DSR rate per 100,00 Pop)	Annual	2013/14(Prov)	1324.8	1279.4	991.0	1164.7	sig high	↓	CCGOF3.1
51	Emergency Readmissions within 30 days of discharge (ISR rate per 100,000 pop)	Annual	2013/14	11.96	12.73		11.78	sig high	↑	NHSOF3b

Health and Wellbeing Performance Metrics 2014/15

		Frequency	Latest Period of Availability	Previous Available Period (Lewisham)	Latest Available Period (Lewisham)	Lon	Eng	England Benchmark	Direction from Previous Period	Data Source

Key

sig high -signficantly higher than England; sig low - significantly lower than England
similar - statistically similar to England
DSR - Directly Standardised Rates
ASR - Age Standardised Rates
ISR - Indirectly standardised Rates
Lew - Lewisham; Lon - London; Eng - England

Statistically Better than England
Statistically Similar to England
Statistically Worse than England
blank where no statistical comparison could be made

Arrows Indicate up or down performance of current year /qtr from previous yr/qtr

Links to Source with their abbreviations

http://www.phoutcomes.info/	Public Health Outcomes Framework (PHOF)
http://www.phoutcomes.info/profile/sexualhealth	Public Health England Sexual Health Profiles
https://www.indicators.ic.nhs.uk/webview/	NHS Indicator Portal (NHSIC) by Health and Social Care Information Centre (HSCIC)
http://www.hscic.gov.uk/qof	Quality and Outcomes Framework(QOF) by HSCIC
http://ascof.hscic.gov.uk/	Adult and Social Care Outcomes Framework (ASCOF)
http://www.productivity.nhs.uk/	NHS Better Care Better Value Indicators
https://www.nhscomparators.nhs.uk/NHSComparators/HomePage.aspx	NHS Comparators by HSCIC

Note:
Annual/Qtr* - National Data available both quarterly and annually
Annual* - Indicators not updated due to NO HES updates
Qtr - Financial Quarters

Boroughs (Bromley, Bexley, Lambeth, Southwark , Greenwich and Lewisham) from London Bowel Screening Hub
Annual/Qtr** - Only Local Data available both quarterly and annually
Annual /Qtr*** - 2013/14 Q3 emergency admission rates are available on BCBV metrics for each Ambulator Care Sensitive (ACS) condition.
Local Ad-hoc - Bowel Screening data only available for all 6 South East London

This page is intentionally left blank

<table>
<tr><th colspan="4">Healthier Communities Select Committee</th></tr>
<tr><td>Title</td><td colspan="3">King's elective services changes: update</td></tr>
<tr><td>Contributor</td><td>Scrutiny Manager</td><td>Item</td><td>9</td></tr>
<tr><td>Class</td><td>Part 1 (open) - for information</td><td colspan="2">24 February 2015</td></tr>
</table>

1. Purpose

1.1 An item on elective service changes at King's College Hospital NHS Foundation Trust was considered at the Committee's meeting on 16 July 2014.

1.2 The Committee resolved to note the presentation from Roland Sinker (Chief Operating Officer, King's College Hospital NHS Foundation Trust) as well as the report on the changes and a response to the proposals from Lewisham Clinical Commissioning Group.

1.3 The Committee agreed that the changes should not be considered as a substantial variation in services; and that it would receive a further update on the implementation of the changes in early 2015.

1.4 The attached briefing from King's provides an update on the changes.

2. Recommendation

2.1 The Select Committee is asked to:

- review the briefing provided by King's about the elective service changes;
- give consideration to any issues for further scrutiny- when proposing items for the Committee's 2015-16 work programme.

Background documents

Minutes of the meeting held on 16 July 2014: http://tinyurl.com/lv59v3z

HCSC 160714:
- King's changes paper: http://tinyurl.com/p4guh3n
- Letter from Roland Sinker to OSC Chairs: http://tinyurl.com/pxysr5w
- King's OSC trigger template: http://tinyurl.com/obf774z
- King's changes CCG review: http://tinyurl.com/pgtja2h

King's College Hospital NHS
NHS Foundation Trust

Briefing: Trust update

Briefing for: Lewisham Healthier Communities Select Committee

Date February 2015

Subject Update on elective inpatient orthopaedic and gynaecology services at the Orpington Hospital and Princess Royal University Hospital

Contents

1. Introduction
2. Patient choice and numbers
3. Waiting times and cancellations at KCH, Denmark Hill
4. Patient transport
5. Patient feedback

1. Introduction

It has now been some time since elective inpatient orthopaedic and gynaecology services began to be provided at Orpington Hospital and the Princess Royal University Hospital (PRUH) respectively.

The rationale for relocation of these services is still very relevant as demand for our services continues on an upward trajectory. Impact on the availability of beds in the key areas of general medicine and critical care remains impacted by emergency admissions levels. In putting our patients first it is important that we take measures to manage this pressure. We have already done this in a number of areas with these elective changes being a specific example.

An update on the move was last provided in July 2014. This report provides a further update on the current status.

Overall the services are attracting a growing number of patients and patient satisfaction scores remain high. Patients using the service at Orpington Hospital, for example, have not experienced any cancellations due to bed pressures and the site has recently been given a five star rating on NHS Choices.

2. Patient choice and numbers

The choice of using these services is discussed with patients during consultations including patient transport arrangements. We have now formalised these discussions with all our consultants now using a bespoke pro forma. We do not currently hold data on patients who have chosen to remain at Denmark Hill but this is something we will work towards capturing for future reporting.

Numbers of patients choosing to use the services in 2014 are as follows:

Elective inpatient orthopaedic

By the end of December 2014 we had seen 3,160 patients since the opening of the service at Orpington Hospital. Length of stay continues to be low with the maximum stay at 4 days. The service has grown steadily and we are now operating at full capacity with 3 operating theatres, 23 inpatient beds and around 12 procedures every day with plans to increase this to 14.

Lewisham

A total of 69 Lewisham elective, inpatient orthopaedic patients had their procedures at Orpington hospital.

Elective inpatient gynaecology

By the end of December 2014 a total of 126 gynaecology patients from Denmark Hill have received their inpatient surgery at the Princess Royal University Hospital

Lewisham

A total of 11 Lewisham elective inpatient gynaecology patients have had their procedures at the Princess Royal University Hospital.

3. Waiting times and cancellations at KCH, Denmark Hill

We have made progress in cutting waiting times for orthopaedic surgery at Denmark Hill, making more beds available on the site. When comparing 2014 with the previous year, there is a significant reduction. The average waiting time in 2014 was 68 days compared to 103 days in 2013. This equates to a reduction of around four weeks. Additionally we have reduced the number of patients waiting over 18 weeks by more than half.

There has also been some reduction in cancelled procedures due to the availability of beds, down by 28 in 2014 compared to 2013.

4. Patient transport

King's provides free transportation to Lewisham patients who choose to attend Orpington Hospital and the PRUH. To date we have not received any formal complaints or had any issues raised with us regarding the free service provided to patients.

5. Patient feedback

Orpington Hospital – Boddington, orthopaedic ward

Friends and Family Test

The most recent Friends and Family test scores for the orthopaedic (Boddington) ward at Orpington Hospital are:

November:
97% would recommend their friends or family to have treatment on Boddington Ward
0% would not recommend their friends or family to have treatment on Boddington Ward

Owing to administrative error we are unable to provide data for December 2014. The issues have been resolved and standard reporting has resumed for the following months.

Princess Royal University Hospital - Surgical 8, Gynaecology ward

Friends and Family Test

The most recent Friends and Family test scores for the Gynaecology (Surgical 8) ward at PRUH are:

December:
100% would recommend their Friends and Family to have treatment
0% would not recommend their Friends and Family to have treatment

November:
96% would recommend their friends or family to have treatment on Surgical 8
4% would not recommend their friends or family to have treatment on Surgical 8

Healthier Communities Select Committee		
Title	Select Committee work programme	
Contributor	Scrutiny Manager	Item 10
Class	Part 1 (open)	24 February 2015

1. Purpose

1.1 To provide Members of the Select Committee with an overview of the work programme for 2014-15 and to advise the Committee about the process for agreeing the 2015-16 work programme.

2. Summary

2.1 At the beginning of the municipal year each select committee is required to draw up a work programme for submission to the Overview and Scrutiny Business Panel. The Panel considers the suggested work programmes and coordinates activities between select committees in order to maximise the use of scrutiny resources and avoid duplication.

2.2 The meeting on 24 February is the last scheduled meeting of the Healthier Communities Select Committee in the 2014-15 municipal year. This report provides a list off the issues considered in 2014-15 and asks the Committee to put forward suggestions for the 2015-16 work programme.

3. Recommendations

3.1 The Select Committee is asked to:

- note the completed work programme attached at **appendix B**;
- review the issues covered in 2014-15 municipal year;
- take note of the notice of key decisions attached at **appendix C**;
- consider any matters arising that it may wish to suggest for future scrutiny.

4. Healthier Communities Select Committee 2014-2015

4.1 The Healthier Communities Select Committee had six meetings in the 2014-15 year:

- 16 July
- 3 September
- 21 October
- 2 December
- 14 January
- 24 February

4.2 Along with all other select committees, the Healthier Communities Select Committee has devoted considerable attention to the proposals put forward as part of the development and delivery of the Lewisham Future Programme. It is anticipated that all overview and scrutiny committees will be tasked with reviewing further Lewisham Future Programme proposals in the 2015-16 municipal year.

4.3 The Committee's completed work programme is attached at **appendix B**.

5. Planning for 2015-16

5.1 Eight meetings will be scheduled for 2015-16 municipal year. A work programme report will be put forward at the first Healthier Communities Select Committee meeting of the 2015-16 year for members to review, revise and agree. The report will take account of the Committee's previous work and may incorporate:

- issues arising as a result of previous scrutiny;
- issues that the Committee is required to consider by virtue of its terms of reference;
- items requiring follow up from Committee reviews and recommendations;
- issues suggested by members of the public;
- petitions;
- standard reviews of policy implementation or performance, which is based on a regular schedule;
- suggestions from officers;
- decisions due to be made by Mayor and Cabinet.

Issues arising from the 2014/15 work programme

5.2 The Committee has already indicated that there are matters it feels should be considered for further scrutiny, these are:

- outcome of the SLaM older adults specialist care consultation;
- the implementation of the Care Act;
- health and social care integration;
- transition from children's to adult social care;
- update from the Care Quality Commission.

5.3 The Public Health working group also made the following proposals:

- The Working Group notes that the staffing arrangements in Public Health are due to be reviewed with a restructure effective from April 2015. The Working Group would like the Healthier Communities Select Committee to be updated on the new staffing structure once this is in place.
- The integration of services via the neighbourhood model is crucial to achieving the required savings and further integration is clearly required. The Healthier Communities Select Committee should continue to receive updates on the integration programme including information on the savings being achieved via the programme.
- The Healthier Communities Select Committee should have the opportunity to comment on and scrutinise the proposed use of the savings resulting from the

implementation of the 2015/16 public health savings proposals. A full breakdown of the use of the savings resulting from the proposals should be provided to the Healthier Communities Select Committee once this has been agreed.

Healthier Communities Select Committee terms of reference

5.4 The Committee's terms of reference are included at **appendix A**.

5.5 The Council's constitution sets out the Committee's powers, based on the legal underpinning of the Council's Overview and Scrutiny Committee by legislation: in particular the NHS Act 2006 as amended, the Health and Social Care Act 2012, the Care Act 2014. The Committee has the ability to call decision makers to account for a decision or any series of decisions made. The Committee may also decide to call officers from partner organisations to answer questions about the delivery of health care services in the borough.

5.6 The Committee's areas of responsibility, include, but are not limited to:

- Public health
- Adult social care
- Services for disabled people
- Day care provision
- Delivery of healthcare by partners

5.7 The Committee is also required to review proposals for substantial changes in services and decide whether or not consultation is required in the instance that those changes will have a significant impact on local people.

6. Financial implications

There are no financial implications arising from the implementation of the recommendations in this report. There will be financial implications arising from items on the agenda; these will need to be considered, as necessary.

7. Legal implications

In accordance with the Council's Constitution, all scrutiny select committees must devise and submit a work programme to the Business Panel at the start of each municipal year.

8. Equalities implications

8.1 The Equality Act 2010 brought together all previous equality legislation in England, Scotland and Wales. The Act included a new public sector equality duty, replacing the separate duties relating to race, disability and gender equality. The duty came into force on 6 April 2011. 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.

8.2 The Council must, in the exercise of its functions, have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by 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.

8.3 There may be equalities implications arising from items on the work programme and all activities undertaken by the Select Committee will need to give due consideration to this.

Background documents

Lewisham Council's Constitution

Centre for Public Scrutiny: the Good Scrutiny Guide

Appendix A

Healthier Communities Select Committee terms of reference

(a) To fulfil all of the Overview and Scrutiny functions in relation to the provision of service by and performance of health bodies providing services for local people. These functions shall include all powers in relation to health matters given to the Council's Overview and Scrutiny Committee by any legislation but in particular the NHS Act 2006 as amended, the Health and Social Care Act 2012, the Care Act 2014 and regulations made under that legislation, and any other legislation in force from time to time. For the avoidance of doubt, however, decisions to refer matters to the Secretary of State in circumstances where a health body proposes significant development or significant variation of service may only be made by full Council.

(b) To review and scrutinise the decisions and actions of the Health and Wellbeing Board and to make reports and recommendations to the Council and/or Mayor and Cabinet.

(c) To review and scrutinise in accordance with regulations made under Section 244 NHS Act 2006 matters relating to the health service in the area and to make reports and recommendations on such matters in accordance with those regulations

(d) Require the attendance of representatives of relevant health bodies at meetings of the select committee to address it, answer questions and listen to the comments of local people on matters of local concern.

(e) With the exception of matters pertaining to the Council's duty in relation to special educational needs, to fulfil all of the Council's Overview and Scrutiny functions in relation to social services provided for those 19 years old or older including but not limited to services provided under the Local Authority Social Services Act 1970, Children Act 2004, National Assistance Act 1948, Mental Health Act 1983, NHS and Community Care Act 1990, NHS Act 2006, Health and Social Care Act 2012 and any other relevant legislation in place from time to time.

(f) To fulfil all of the Council's Overview and Scrutiny functions in relation to the lifelong learning of those 19 years or over (excluding schools and school related services).

(g) To receive referrals from the Healthwatch and consider whether to make any report/recommendation in relation to such referral (unless the referral relates solely to health services for those aged under 19 years of age, in which case the referral from the Healthwatch should be referred to the Children and Young People Select Committee.

(h) To review and scrutinise the Council's public health functions.

(i) Without limiting the remit of this Select Committee, its terms of reference shall include Overview and Scrutiny functions in relation to:

- people with learning difficulties
- people with physical disabilities
- mental health services

- the provision of health services by those other than the Council
- provision for elderly people
- the use of Section 75 NHS Act 2006 flexibilities to provide
- services in partnership with health organisations
- lifelong learning of those aged 19 years or more (excluding
- schools and school related services)
- Community Education Lewisham
- other matters relating to Health and Adult Care and Lifelong
- Learning for those aged 19 years or over38

(j) Without limiting the remit of the Select Committee, to hold the Executive to account for its performance in relation to the delivery of Council objectives in the provision of adult services and health and lifelong learning.

NB In the event of there being overlap between the terms of reference of this select committee and those of the Children and Young People Select Committee, the Business Panel shall determine the Select Committee which shall deal with the matter in question.

Healthier Communities Select Committee work programme 2014/15

Programme of work

Work item	Type of item	Priority	Strategic priority	Delivery deadline	16-Jul	03-Sep	21-Oct	02-Dec	14-Jan	24-Feb
Lewisham future programme (LFP)	Standard item	High	CP9	On-going						
Confirmation of Chair and Vice Chair	Constitutional req	High	CP9	Jul						
Select Committee work programme	Constitutional req	High	CP9	Jul						
Healthwatch annual report	Standard item	Medium	CP9	Jul						
Sexual health strategy and action plan	Information item	Medium	CP9	Jan					Information	
Better care fund update	Standard item	Medium	CP9	Jul						
Community mental health review: update	Standard item	High	CP9	Dec						
King's: elective services proposals	Consultation	High	CP9	Feb						Information
Sustainability of community health initiatives	Standard item	Medium	CP9	Dec						
South East London five year commissioning strategy	Standard item	Medium	CP9	Sep						
Lewisham hospital update	Standard item	Medium	CP9	On-going		Nursing	Resilience		Improvement plan	
Emergency services review	Standard item	High	CP9	Dec			Resilience	LAS		
Delivery of the Lewisham Health & Wellbeing priorities	Performance monitoring	High	CP9	Oct						
Health and social care integration	Standard item	High	CP10	On-going						
Autism strategy and Campaign in Lewisham for Autism Spectrum Housing	Standard item	Medium	CP10	Dec						
Leisure centre contract	Performance monitoring	Medium	CP9	Dec						
Primary care strategy	Standard item	Medium	CP10	Jan						
LFP: Outcome of the public health proposals consultation	Consultation	High	CP9	Jan						
LFP: adult social care consultation	Consultation	High	CP9	Jan						
Future of day care services	Consultation	High	CP9	Jan						
SLaM specialist care changes	Consultation	High	CP9	Feb						
Public Health performance dashboard	Standard item	Medium	CP9	Feb						
Community education Lewisham annual report	Performance monitoring	Medium	CP9	Feb						
Leisure contract KPIs	Performance monitoring	Medium	CP9	Feb						
Adult safeguarding	Standard item	High	CP9	Feb						
Implmentation of the Care Act	Standard item	Medium	CP9	Feb						
Development of the local market for adult social care services	Standard item	Medium	CP9	Feb						
SLaM specialist care changes consultation	Consultation	High	CP9	2015/16						
CQC update	Standard review	Medium	CP9	2015/16						
Transition from children's to adult social care	Standard review	Medium	CP9	2015/16						

Key
Item completed
Item on-going
Item outstanding
Proposed timeframe
Item added

Meetings					
1)	Wed	16 July	4)	Tue	02 December
2)	Wed	03 September	5)	Wed	14 January
3)	Tue	21 October	6)	Tue	24 February

Shaping Our Future: Lewisham's Sustainable Community Strategy 2008-2020		
	Priority	
1	Ambitious and achieving	SCS 1
2	Safer	SCS 2
3	Empowered and responsible	SCS 3
4	Clean, green and liveable	SCS 4
5	Healthy, active and enjoyable	SCS 5
6	Dynamic and prosperous	SCS 6

Corporate Priorities		
	Priority	
1	Community Leadership	CP 1
2	Young people's achievement and involvement	CP 2
3	Clean, green and liveable	CP 3
4	Safety, security and a visible presence	CP 4
5	Strengthening the local economy	CP 5
6	Decent homes for all	CP 6
7	Protection of children	CP 7
8	Caring for adults and older people	CP 8
9	Active, healthy citizens	CP 9
10	Inspiring efficiency, effectiveness and equity	CP 10

FORWARD PLAN OF KEY DECISIONS

Forward Plan February 2015 - June 2015

This Forward Plan sets out the key decisions the Council expects to take during the next four months.

Anyone wishing to make representations on a decision should submit them in writing as soon as possible to the relevant contact officer (shown as number (7) in the key overleaf). Any representations made less than 3 days before the meeting should be sent to Kevin, the Local Democracy Officer, at the Council Offices or kevin.flaherty@lewisham.gov.uk. However the deadline will be 4pm on the working day prior to the meeting.

A "key decision"* means an executive decision which is likely to:

(a) result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates;

(b) be significant in terms of its effects on communities living or working in an area comprising two or more wards.

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
December 2014	**Acquisition of Property Lee Green**	Wednesday, 11/02/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
November 2014	**Budget 2015-16**	Wednesday, 11/02/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
December 2014	**Day Care Services**	Wednesday, 11/02/15 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
January 2015	**Local Government Association Peer Challenge**	Wednesday, 11/02/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Joe Dromey, Cabinet Member Policy & Performance		
December 2014	**Phoenix Community Housing Board**	Wednesday, 11/02/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
December 2014	**Re-configuring Community Based Healthy Eating**	Wednesday, 11/02/15	Aileen Buckton, Executive Director for		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
	Initiatives	Mayor and Cabinet	Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
March 2014	**Review of Blackheath Events Policy 2011**	Wednesday, 11/02/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Rachel Onikosi, Cabinet Member Public Realm		
November 2014	**Prevention and Inclusion Team Contract**	Wednesday, 11/02/15 Mayor and Cabinet (Contracts)	Frankie Sulke, Executive Director for Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
November 2014	**Procurement of the School Catering Contract service**	Wednesday, 11/02/15 Mayor and Cabinet (Contracts)	Frankie Sulke, Executive Director for Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
December 2014	**Savings Proposals Delegated to Executive Directors for Community Services, Customer Services and Resources and Regeneration**	Tuesday, 17/02/15 Overview and Scrutiny Business Panel	Janet Senior, Executive Director for Resources & Regeneration, Aileen Buckton, Executive Director for Community Services, Kevin Sheehan, Executive Director for Customer Services and		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
			Councillor Kevin Bonavia, Cabinet Member Resources		
February 2015	**Adult Social Care - Independent Mental Capacity Advocacy Service**	Tuesday, 17/02/15 Overview and Scrutiny Business Panel	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
January 2015	**Healthwatch Contract Tender Award**	Not before 17/02/15 Overview and Scrutiny Business Panel	and		
February 2015	**Contract Award for Works at Beecroft Primary School**	Tuesday, 17/02/15 Overview and Scrutiny Education Business Panel	Frankie Sulke, Executive Director for Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
December 2014	**Award of contract for works at Kender Primary School**	Tuesday, 17/02/15 Overview and Scrutiny Education Business Panel	Janet Senior, Executive Director for Resources & Regeneration and Councillor Paul Maslin, Cabinet Member for Children and Young People		
December 2014	**Savings Proposals Delegated to Executive Director CYP**	Tuesday, 17/02/15 Overview and Scrutiny Education	Frankie Sulke, Executive Director for Children and Young People and		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
		Business Panel	Councillor Paul Maslin, Cabinet Member for Children and Young People		
November 2014	**Budget Update 2015-16**	Wednesday, 18/02/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
January 2015	**Community Infrastructure Levy Adoption version**	Wednesday, 25/02/15 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
January 2015	**Planning Obligations SPD**	Wednesday, 25/02/15 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
November 2014	**2015/16 Budget Report**	Wednesday, 25/02/15 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
January 2015	**Lewisham River Corridors Improvement Plan SPD**	Wednesday, 25/02/15 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
December 2014	**Asset Management Strategy (Highways)**	Wednesday, 04/03/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
December 2014	**Catford Town Centre CRPL Business Plan 2015/16**	Wednesday, 04/03/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
September 2014	**Church Grove Custom Build**	Wednesday, 04/03/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
June 2014	**Housing Strategy 2015 - 2020**	Wednesday, 04/03/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
February 2015	**Local Development Framework Revised Local Development Scheme**	Wednesday, 04/03/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
November 2014	**Pay Policy Statement**	Wednesday, 04/03/15 Mayor and Cabinet	Andreas Ghosh, Head of Personnel & Development and Councillor Kevin Bonavia, Cabinet Member		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
			Resources		
February 2015	**Phase 1 & Phase 2 Excalibur Estate**	Wednesday, 04/03/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
September 2014	**Strategic Asset Management Plan 2015-2020**	Wednesday, 04/03/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
January 2015	**London Councils and POPLA Contract**	Wednesday, 04/03/15 Mayor and Cabinet	and		
September 2014	**Award of Street Advertising and Bus Shelter Contract**	Wednesday, 04/03/15 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
September 2014	**Prevention and Inclusion Contract Extension and Commissioning Recommendation**	Wednesday, 04/03/15 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
September 2014	**Prevention and Inclusion Framework Contract Award**	Wednesday, 04/03/15 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best,		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
			Cabinet Member for Health, Wellbeing and Older People		
February 2015	**Re-procurement of Adult Social Care System**	Tuesday, 17/03/15 Overview and Scrutiny Business Panel	Aileen Buckton, Executive Director for Community Services and		
February 2015	**Re-procurement of Children's Social Care System**	Tuesday, 17/03/15 Overview and Scrutiny Business Panel	Frankie Sulke, Executive Director for Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
December 2014	**Annual Lettings Plan**	Wednesday, 25/03/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
September 2014	**Deptford Southern Sites Regeneration Project**	Wednesday, 25/03/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
February 2015	**Local Support Scheme Update**	Wednesday, 25/03/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Joan Millbank, Cabinet Member Third Sector & Community		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
November 2014	**School Admissions 2015-16**	Wednesday, 25/03/15 Mayor and Cabinet	Frankie Sulke, Executive Director for Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
January 2015	**Waste Strategy Consultation**	Wednesday, 25/03/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Rachel Onikosi, Cabinet Member Public Realm		
June 2014	**Surrey Canal Triangle - Compulsory Purchase Order Resolution**	Wednesday, 25/03/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
November 2014	**Award of Highways Public Realm Contract Coulgate Street**	Wednesday, 25/03/15 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
November 2014	**Award of Design and Build Contract Phase 1 Grove Park Public Realm Project**	Wednesday, 25/03/15 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
November 2014	**Procurement of the School Kitchen Maintenance Contract**	Wednesday, 25/03/15 Mayor and Cabinet	Frankie Sulke, Executive Director for Children and Young People and		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
		(Contracts)	Councillor Paul Maslin, Cabinet Member for Children and Young People		
December 2014	**Catford Town Centre CRPL Business Plan 2015/16**	Thursday, 26/03/15 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
December 2014	**Pay Policy**	Thursday, 26/03/15 Council	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		
December 2014	**Contract Award Launcelot Primary school**	Wednesday, 08/04/15 Overview and Scrutiny Education Business Panel	Frankie Sulke, Executive Director for Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
February 2015	**Voluntary Sector Accommodation**	Wednesday, 22/04/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Joan Millbank, Cabinet Member Third Sector & Community		
February 2015	**Award of Design and Build Contract Phase 1 Grove Park Public Realm Project**	Wednesday, 22/04/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
		(Contracts)	Councillor Rachel Onikosi, Cabinet Member Public Realm		
February 2015	**Local Development Framework: Revised Local Development Scheme (version 7)**	Wednesday, 24/06/15 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		

This page is intentionally left blank