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Healthier Communities Select Committee Agenda

Wednesday, 18 May 2016
7.00 pm,
Committee Room 3
Civic Suite
Lewisham Town Hall
London SE6 4RU

For more information contact: John Bardens (Tel: 02083149976)

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

Part 1

Healthier Communities Select Committee Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Wednesday, 18 May 2016.

Barry Quirk, Chief Executive
Tuesday, 10 May 2016

Councillor John Muldoon (Chair) Councillor Stella Jeffrey (Vice-Chair) Councillor Paul Bell Councillor Colin Elliott Councillor Ami Ibitson Councillor Jamie Milne Councillor Jacq Paschoud Councillor Joan Reid Councillor Alan Till Councillor Susan Wise Councillor Alan Hall (ex-Officio) Councillor Gareth Siddorn (ex-Officio)	

MINUTES OF THE HEALTHIER COMMUNITIES SELECT COMMITTEE

Tuesday 19 April 2016, 7pm

Present: Councillors John Muldoon (Chair), Stella Jeffrey (Vice Chair), Paul Bell, Jamie Milne, Jacq Paschoud, Joan Reid, Alan Till

Apologies: Councillors Colin Elliot, Ami Ibitson and Susan Wise

Also Present: Nigel Bowness (Healthwatch Bromley and Lewisham), Georgina Nunney (Principal Lawyer), Barry Quirk (Chief Executive), Charles Malcolm-Smith (Deputy Director, Strategy & Organisational Development, Lewisham CCG), John Bardens (Scrutiny Manager)

1. **Confirmation of the Chair and Vice Chair**

   Resolved: Chair and Vice Chair confirmed

2. **Minutes of the meeting held on 2 March 2016**

   Resolved: minutes of the meeting held on 2 March 2016 agreed as an accurate record

3. **Declarations of interest**

   The following non-prejudicial interests were declared:

   - Councillor Muldoon is a governor of the South London and Maudsley NHS Foundation Trust.
   - Councillor Paschoud has a family member in receipt of a package of adult social care.
   - Councillor Paul Bell is a member of King's College Hospital NHS Foundation Trust.

4. **Select Committee work programme**

   John Bardens introduced the item. The following key points were noted:

   - The Committee discussed Wigan Council's approach to adult social care, *The Deal for Adult Social Care and Wellbeing*, and how the council is moving from being a provider of services to helping people find the best services in the local community for them. The Committee also discussed a possible visit to Wigan Council to talk to service users and staff about how integration has worked.

- The Committee agreed to hold an in-depth review of health and adult social care integration.
- The Committee also discussed whether there would be time to look into place-based care as there is a lot of evidence available. The Committee agreed to include this in the meeting on 18 October.

Resolved: changes to the work programme were agreed.

5. Sustainability and Transformation Plans

Barry Quirk (Chief Executive) introduced the report. The following key points were noted:

- The NHS forecasts that without change there will be £30 billion shortfall in its budget by 2020-21 – mostly driven by the cost of caring for the country's increasing and ageing population. The Government has agreed to provide an extra £8 billion by 2020. But the NHS must make up the rest by improving efficiency.

- These savings can't be achieved by looking at individual hospitals. They have to be done by area, across a range of hospitals. As part of this, all NHS organisations have been asked to produce a local health and care system Sustainability and Transformation Plan (STP), covering 2016 to 2021. There are 44 'footprint' areas across England that will submit their own STPs.

- South East London's STP covers six boroughs in South East London: Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. The STP sets out how these boroughs will work together to re-organise and integrate the way health and social care services are provided across the area. The South East London STP is owned by all providers and commissioners of health and social care in these areas.

- Amanda Pritchard (Chief Executive, Guy's and St Thomas' NHS Foundation Trust) is leading the work on South East London's STP. Andrew Parson is the clinical lead, Andrew Bland is the Clinical Commissioning Group Lead and Barry Quirk is the lead for local government.

- South East London's initial STP was re-submitted today – after changes were made to bring it in line with NHS financial guidelines.

- In South East London, there is forecast to be a gap in NHS finances of over £670 million by 2021. Some savings have been identified from, among other things, changing services (£145 million) and increased collaboration (£250 million), but it is still estimated that there will be financial gap of over £280 million after 5 years. If nothing was to change at all, the gap would be over £1 billion.

- There are five key elements to South East London's STP: improving the health of people; improving care and quality of service; improving organisational effectiveness of primary care and social care; establishing priorities; leadership and governance.

- In terms of improving the health of people, Lewisham is doing well in some areas, like helping people who have recently come out of hospital, but not so well other, like access to GP services.

- The priorities of South East London's STP are: better contractual arrangements; establishing effective place-based governance; provider collaboration and accelerated delivery.

- All South East London Trusts are in financial deficit, so there is a need to look at how to speed up the process and shift the focus to community-based care. Re-designing and integrating adult social care is critical. The cost of social care is probably greater than cost of hospital care.

- Lewisham has discussed collaborative planning with several health partners across South East London, but local governments in the area are still a long way behind when it comes to collaborative working.

- Some local authorities in South East London have already done well establishing new ways to work more closely with local health partners. But most collaboration has been at individual local authority level. Local authorities are not yet looking at the overall costs across South East London in 5 years' time.

- Because of the work already done as part of Our Health South East London (OHSEL), South East London is considered to be one of the most advanced areas, with good conditions for further collaboration – and has been asked to be a national exemplar.

- Local government is generally under-represented at meetings about the STP and, without a South East London approach to social care, local government is in danger of being left behind.

Barry Quirk (Chief Executive) answered questions from the Committee. The following key points were noted:

- South East London's initial STP for 2018 to 2021 was submitted today – as well the individual local NHS organisations' plans for 2016/17.

- South East London's final STP will be submitted in June. This doesn't mean that any of the health devolution pilots are on hold, but they may have to be re-configured in the context of the STP.

- The directors of adult social care in the 6 boroughs are involved in the STP, but it is still felt that local government input is 'light' overall. There is a feeling that local government is being squeezed out and that health care will increasingly dominate as adult social care gets closer to health care. Local governments need to have a voice at the appropriate times.

- PFI deals will also be looked at as part of South East London's STP. Several PFI contracts in the area have previously been renegotiated.

- All meetings about South East London's STP have been open to public and have also involved patient groups from the area.

- There are some serious issues with patient safety across South East London. Clinical outcomes need to improve and South East London's STP is also about improving levels of service – as well as making efficiency savings.

- All the figures in the STP so far are *only* about the funding for NHS services. The financial gaps in social care funding have not yet been worked out. Local authorities need extra funding for programme management to do this effectively.

- There will be further discussions, with the programme director of South East London's STP, about how the public are being consulted.

The Committee made a number of comments. The following key points were noted:

- The Committee expressed some concern that South East London's STP was being described as a good thing when there were concerns that it would fragment health care, introduce further cuts and oversee the decline. Members expressed concerns about the burden of PFI deals on hospital finances.

- The Committee also expressed concern about the possibility of social care becoming merely an extension of medical care, with those who do not need medical care being side-lined.

- The Chair pointed out that the relevant scrutiny chairs across South East London have been working jointly through the South East London Stakeholder Reference Group.

- A copy of South East London's STP will be shared with the Committee and it may be added to the Committee's work programme again later in the year.

- Resolved: that the Committee would see a copy of the Plan and be sent information about the next meeting of the STP board.

6. **Information item: SLaM Place of Safety Joint Committee**

   Resolved: that the report be noted.

7. **Referrals to Mayor and Cabinet**

   There were none.

   The meeting ended at 8.25 pm

   Chair:

   Date:

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Committee	Healthier Communities Select Committee	**Item No.**	2
Title	Declarations of Interest		
Contributors	Chief Executive		
Class	Part 1	**Date**	18 May 2016

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; and

(b) 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 member's 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)

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Healthier Communities Select Committee		
Title	SLaM quality account	
Contributor	Scrutiny Manager	Item 3
Class	Part 1 (open)	18 May 2016

1. Purpose

As part of South London and Maudsley NHS Foundation Trust's plan to share and invite comments and contributions to its Quality Accounts, it has submitted the draft 2015-16 Account to the Committee (attached).

The Quality Account highlights performance in key areas, so partners and staff know how the Trust is performing and how it is working to improve quality.

3. Recommendations

The Select Committee is asked to:

- Review the draft Account and agree any comments it wishes to be included in the final submission.

For further information, please contact John Bardens, Scrutiny Manager, on 02083149976.

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South London and Maudsley NHS
NHS Foundation Trust

Quality Account for 2015/2016

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CONTENTS PAGE

Part 1:

1.1 Statement on quality from the Chief Executive of the NHS Foundation Trust

The annual quality account report is an important way for the Trust to report on quality and show improvements in the services we deliver to local communities and stakeholders.

This year saw a comprehensive inspection across 11 service areas which included 71 wards, teams and clinics across all the trust's sites by the Care Quality Commission (CQC). The inspection involved more than 100 inspectors which judged services to be "safe, effective, caring, responsive and well led. The trust has much to be proud of and to receive an overall rating of 'good' reflects the commitment, talent and compassion demonstrated by our staff day in, day out.

Out of 11 services, inspectors rated those for people with a learning disability or autism as 'outstanding'; six as 'good', including specialist community and inpatient services for children and adolescents; and three services as 'requires improvement'. Delivering mental health services within large, complex and often deprived inner city communities is challenging. All trusts in this position are committed to addressing these challenges and improving their services, especially for patients in crisis.

We are working constantly to improve our care and there are still some significant areas that we need to improve. The CQC's report has provided us with an agenda and action plan for making these necessary improvements. It has also helped in forming the basis of discussions with our local commissioners, service users and other key stakeholders when agreeing our priorities for this year.

The CQC's publication of its rating and full report can be found at the following website: http://www.cqc.org.uk/provider/RV5

To our best knowledge the information presented in this report is accurate and I hope you will find it informative and stimulating.

Dr Matthew Patrick
Chief Executive Officer

1.2 A summary of successes and developments in 2015/2016

AREA	SUCCESS/DEVELOPMENTS
Care Quality Commission (CQC)	➢ Achieved an overall Inspection rating of 'Good'. ➢ In June 2015 praised Lambeth's mental health services as an example of how to support people experiencing a mental health crisis.
ICT/Technology	➢ SlaM is working with technology partners to develop an in-house virtual reality environment where service users can challenge their OCD. ➢ We are the number one NHS Trust to adopt cloud services with over 3500 staff migrated to Microsoft Office 365 with a further 1400 on line shortly. ➢ SLaM is developing with partners, MioCare, open source eOBs technology to enable paper free patient observations. Following a pilot at Bethlem Royal Hospital SLaM made a successful bid to fund this project across inpatient areas. ➢ We can now share both physical and mental health records with our Academic Health Sciences Centre partners; Guy's and St Thomas', King's College Hospital.
Service Development	➢ The opening of a 24/7 Crisis line which is operated 24/7 by mental health professionals was launched in December 2015. ➢ Opening of the Bethlem Hospital's new Gallery and Museum space in the original hospital administration building.
Research	➢ Born out of the Maudsley's Biomedical Research Centre (BRC) the Centre for Translational Informatics provides a research and clinical informatics environment delivering real-world improvements to patients and clinicians in partnership with King's College London. The CTI provides a functional interface between analytics, software development and implementation to promote digital innovation in mental health.
Awards/Creditations	➢ Two adult mental health wards at Bethlem Royal Hospital, won the quality of care category a top HSJ patient safety award, for their work

	with carers this year. ➢ The Centre for Interventional Paediatric Psychopharmacology & Rare Diseases within SlaM won an RCPsych Award in the category Psychiatric Team of the Year: children and adolescents. ➢ The mental health street triage service was set up to help thousands of people with mental health problems who come into contact with the capital's front line police officers every year. On 16 September it won an NHS Lambeth Clinical Commissioning Group Lammy award in the 'working together' category. ➢ SLaM has been rated as the best hospital trust in the country for dementia care. An in-depth report, released in August 2015 by the Health and Social Care Information Centre (HSCIC), showed SLaM scored an impressive 98.4 points out of 100 in terms of how well we are established to deal with people with dementia and is top of a league table for all trusts in the country. ➢ Healthwatch England recognised SlaM's Channi Kumar Unit as being an example of 'where the NHS gets it right'. The 'Safely Home' report explains how at our unit 'mothers with complex mental health conditions work with staff to establish a relationship with their child and enable them to have a graduated discharge, ensuring they are prepared for a lasting return into the community'. ➢ In July 2015 the Trust was chosen as one of the best 100 places to work by the Health Service Journal (HSJ), recognising how we are working hard to create and maintain an environment where people can enjoy their work.

Table one: A summary of successes and developments in 2015/2016

1.3 …..and what we can do better.

- We need to improve in the three service areas that the CQC inspectors judged to require further improvement, the main issues for improvement highlighted were: staff recruitment and retention; improving the recording of risk for individual patients; the need to improve practices relating to restraint and seclusion; maintaining emergency medical equipment; and improving some environments to make them safer for patients.

- Where we did not achieve the quality priority target or indeed did not do as well as we had hoped, the priority has been rolled over to this year or are being monitored via other assurance processes such as Commissioning for Quality and Innovation (CQUINS).

- The effective documentation and use of Risk assessments needs improving and was highlighted as an issue with the CQC.

- We need to reduce the incidence of restraint, particularly prone, and improve recording. We hope to do this by continuing to roll out the four steps to safety and Implementation of the Safe and Therapeutic Services strategy.

- The role of the Carer is important and as such we need to improve the number of identified carers who are offered a carers assessment and associated care plan. We hope to do this by further Implementation of Carers strategy and a review of carer assessment documentation across 4 boroughs

All these have been translated into quality priorities for 2015/16.

Part 2: Priorities for Improvement and statements of assurance from the Board

2.1.1 Our priorities for improvement for 2016/2017

Over the last year we have listened to feedback from service users, their families, carers and our staff, as well as commissioners and regulators. This feedback alongside the CQC visit in September 2015 has helped us to identify our future priorities. This process of gathering feedback has included:

- Trust Quality Summit held on the 20th January 2016 with CQC, Commissioners and Stakeholders outlining CQC final feedback and results.
- Improving Quality and the CQC event for all Trustwide staff on the 2nd November 2015.
- Listening to questions, concerns and complaints from patients and their families and carers. A special thanks to the Dragon Café.
- Asking for feedback from service users from clinical areas on various sites.
- Listening to staff at Trust-wide events including the Trust-wide Annual conference and the Team Leader day.
- Receiving reports on our services from the Care Quality Commission, following inspections of our services.
- Listening to the views of commissioners at contract, quality and serious incident monitoring meetings.
- Listening to the views of the Health Overview and Scrutiny Committees of Lambeth, Southwark, Lewisham and Croydon.
- Listening to the views of Healthwatch in each of our four main boroughs.
- Reviewing audit results, research findings, service reviews and assessments and service user surveys.
- Continuing discussions with a quality working group of the Council of Governors which has looked at quality issues over the year.
- We have also reviewed national guidance and service quality themes and issues which are emerging nationally.

2.2.2 Care Quality Commission (CQC); Inspection September 2015 Results and Actions

SLaM is required to be registered with the CQC and its current registration status is registered, without condition. The CQC has not taken enforcement action against SLaM during the period 2015/16.

The grid below outlines the results of the comprehensive inspection of some our services by the CQC on 21-25 September 2015.

	Safe	Effective	Caring	Responsive	Well led	Overall
Community mental health services for people with learning disabilities or autism	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
Mental health crisis services and health-based places of safety	Requires improvement	Good	Good	Good	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
Forensic inpatient/secure wards	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Specialist community mental health services for children and young people	Good	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement
Wards for older people with mental health problems	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Good	Good	Good

Whilst the inspection highlighted much to be proud of there were also areas that both the CQC and the Trust recognised needed improvement and following the visit Action plans have been drafted and currently being implemented within the timeframes submitted. Below is a summary of the quality improvement work currently being undertaken.

Area of Improvement	Issues	Actions
Risk Assessments	Consistent completion, sufficiently detailed, responsively up dated, recorded in right place, linked to actions	•Redesign of ePJS •EObs project •Revising and strengthening training •Ongoing audit
Food	Responding better to individual and cultural need (Particularly Forensic and Older Adult Wards)	•New menu developed •Improve menu booking •Retendering of catering contract •Tighter monitoring and feedback •Regular patient feedback, centrally collated
Reducing Restraint	Reducing incidence of restraint, particularly prone, and improving recording	•Improve detail/process of reporting (complete) •Complete Trust Violence Reduction Strategy (including NICE guidance) •Roll out 4 Steps to Safety on all inpatient wards •Review training to ensure best practice and emphasis on accurate recording
Environmental Safety	Ensuring specific risks are managed including fire precautions and ligature risks	•Specific actions for PoS, ES1, Heather Close •Completion of ligature reduction programme •Visual management - audit of environmental risks
Equipment Safety	Consistent access to ligature cutters and timely checks on all equipment	•Review of emergency equipment standards •Improved audit processes re: equipment •Centralised online equipment audits to improve governance
Staffing	Sufficient staff available on acute wards, staff fully confident to work with people with dementia on Older People's Wards	•Continue current focus on recruitment, including focused reward schemes •Continue to develop new and innovative workforce models •Improved vacancy adverts and social media campaigns •Outdoor recruitment campaign (e.g escalators at Waterloo Underground) •Process improvements in recruitment system – speedier and more efficient to reduce delays •Increase in notice periods •Review of training needs in Older Adults services
Ensuring Inpatient's rights	Ensuring that privacy and dignity needs are sensitively met, that informal patients are fully aware of their rights and that blanket restrictions do not prevent individual needs being met.	Standards to be developed and audited re: observation windows on bedrooms •Development of standardised information re: informal patient rights which will be made fully visible and available in different forms on relevant wards •Review of restrictive practices on Rehabilitation Wards to ensure individual needs can be met

Table Two: CQC Actions

2.3 Our Quality Priorities for 2016/17

The priorities for 2016/2017 have been arranged under three broad headings which, put together, provide the national definition of quality in NHS services: patient safety, clinical effectiveness and patient experience. Progress on achievement of these priorities will be reported on in next year's Quality Accounts.

Patient Safety Priorities

1.Patient Safety Priority (This is a new priority)	
Quality Priority	To reduce the use of restrictive interventions applied to service users within in-patient settings.
Rationale	CQC action Positive and Safe initiative DoH (2014), NICE guidance and CQUIN
Target	Reduce any use of restraint that includes prone restraint.by 20%. Baseline: 220 in Q4/2016
Measure	Datix incidents in Q4/2017
How we will achieve this	Implementation Safe and Therapeutic Services strategy Roll out of Four steps to safety

2.Patient Safety Priority (This is a new priority)	
Quality Priority	To ensure that in-patient services have adequate staffing levels to provide safe and effective care.
Rationale	National Quality Board guidance CQC action
Target	To reduce the number of wards breaching agreed Trust minimum safe staffing levels by 30%. Baseline:15 Wards
Measure	Safer staffing monthly returns - Safecare
How we will achieve this	Process and system improvements to recruitment Improved advertising Efficient use of e-roster

3.Patient Safety Priority	
Quality Priority	To improve rates of completion of risk assessments and associated risk management plans for all service users requiring risk assessment.
Rationale	CQC action Serious incident reviews.
Target	85% of service users in in-patient services and community service users under CPA will have a full risk assessment completed for each in-patient admission or CPA review. Baseline:78%
Measure	This will be measured through clinical audit in Q4/ 2017.
How we will achieve this	The risk assessment tools within PJS are currently being reviewed in order to improve the efficiency of use. Clinical risk training

Clinical Effectiveness Priorities

4. Clinical Effectiveness (Enhanced priority)

Quality Priority	To provide effective physical healthcare assessment and intervention for in-patient service users, early intervention service users and community service users on CPA related to the cardio-metabolic risks associated with severe mental illness.
Rationale	CQUIN, CQC action, Parity of esteem
Target	90% of both in-patients service users and early intervention service users. 50% of community service users on CPA audited will have had an assessment of each of the key cardio metabolic parameters and offered interventions based on need. Baseline:85.4% Inpatients; Community Zero baseline(new scope)
Measure	Audit for CQUIN submission in Q4/2017 Baseline: Inpatients 85.4%, Community (no baseline,- new priority)
How we will achieve this	EPJS review Electronic observations roll out

5.Clinical Effectiveness Priority

Quality Priority	To ensure that service users are involved in the planning of their care and there are personalised care plans.
Rationale	CQC action Service user feedback
Target	>89% of service users will state that they feel involved in their care.
Measure	This will be measured through the patients survey results in response to the question 'Do you feel involved in your care?' Baseline Figure: 89%
How we will achieve this	Development of care planning standards and training review Review documentation within PJS to ensure that care planning is effective for service users and staff.

6.Clinical Effectiveness Priority (This is a new priority)

Quality Priority	We will develop our electronic systems to improve the delivery of care
Rationale	Improve consistency, efficiency and effectiveness of physical and mental health observations.
Target	50% of inpatient teams using electronic observations in practice Baseline: 0 Wards.
Measure	No. of wards using eobs
How we will achieve this	Roll out of eobs project across all inpatient wards.

Patient Experience Priorities

7.Patient Experience Priority (This is a new priority)

Quality Priority	Reduce the number of Acute out of area treatments (OATs) to ensure that service users are cared for closer to home.Reduce the number of external placements to ensure that service users are cared for closer to home.
Rationale	Service user feedback Crisp report on acute care pathway, Feb 2016
Target	A reduction in the number of adult patients admitted to external providers (overspill). Baseline Figure: awaiting data validation.
Measure	This will be measured in monthly performance meetings and data extracted.
How we will achieve this	The Trust Acute Transformation programme has an overspill reduction plan which is addressing the immediate reduction of out of area treatments (OATs).

8.Patient Experience Priority

Quality Priority	Identified carers will be offered a carers assessment and associated care plan.
Rationale	NICE guidance for Psychosis and Schizophrenia in adults. Service user and carer feedback. Care Act (2014) CQC action
Target	>50% of identified carers will have been offered a carers assessment and a carer's care plan. Baseline Figure: 32%
Measure	This will be measured through internal audit.
How we will achieve this	Further Implementation of Carers strategy Review of carer assessment documentation across 4 boroughs

9.Patient Experience Priority (Enhanced priority)

Quality Priority	We will continue to improve the quality of the environments and food within our in-patient services.
Rationale	CQC action Service user feedback.
Target	Patient Led Assessments of Care Environments (PLACE) and Food audit scores will achieve overall > 89.95%. Baseline 89.95% (food)
Measure	PLACE audit reports and hotel services Spot Light reports will be monitored and reviewed.
How we will achieve this	The full redesign of some clinical services is underway (e.g. Douglas Bennett block). Ligature reduction programme – window replacement Refurbishment programme. Food contract renewal

2.4 Audit

2.4.1 Participation in National Quality Improvement Programmes

National quality accreditation schemes, and national clinical audit programmes are important for a number of reasons. They provide a way of comparing our services and practice with other Trusts across the country, they provide assurances that our services are meeting the highest standards set by the professional bodies, and they also provide a framework for quality improvement for participating services.

During 2015/16, five national clinical audits and one national confidential inquiry covered NHS services that the South London and Maudsley NHS Foundation Trust provides.

During that period SLaM participated in 100% of national clinical audits and 100% of national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries that SLaM was eligible to participate in during 2015/16 are listed below:

- The 3 national, Prescribing Observatory for Mental Health - POMH-UK audits:
    - Antipsychotic prescribing in people with a learning disability
    - Prescribing for ADHD
    - Prescribing valproate for bipolar disorder
- The CQUIN 2015/16 Indicator 4a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI)
- The Early intervention in Psychosis Audit (2015/16)
- The national confidential inquiry into suicide and homicide by people with mental illness

The national clinical audits that SLAM participated in for which data collection was completed during 2015/16, are listed below.

POMH-UK audits

Participation in the three Prescribing Observatory Audits (POMH-UK) managed by the Royal College of Psychiatrist's Centre for Quality Improvement

SLAM pharmacy has collected and submitted data for the 2015-16 POMH-UK audits, as required.

- Antipsychotic prescribing in people with a learning disability
- Prescribing for ADHD
- Prescribing valproate for bipolar disorder

Below is a summary of the findings from those audits:

i) Antipsychotic prescribing in people with a learning disability

People with a learning disability prescribed an antipsychotic should have the indication for treatment documented in their notes. Results in 2015 showed that SLaM scored above average

in the national sample for the documentation of treatment in notes for people with a learning disability being prescribed antipsychotics.

In addition, patients should be assessed for known side effects of antipsychotics. Initial results showed SLaM as being below the national average. However, the 2015 re-audit showed SLaM to be above the national average with regards to the assessment of side effects.

Actions: The BPAD CAG has reviewed the data and these data have been presented at the trust DTC. A quality improvement programme is currently underway, led by the BPAD CAG, with support from pharmacy.

ii) Prescribing for ADHD

Children prescribed medication for ADHD should have their physical health monitored before starting treatment and at least once a year during maintenance treatment. Results of the 2015 re-audit indicated the presence of a physical health assessment at the commencement of treatment for all patients. SLaM was below the national average with regards to having all 4 measures documented.

With regards to physical health assessments during maintenance, SLaM was below the national average.

Actions: The CAMHS CAG has reviewed the data and these data have been presented at the trust DTC. A quality improvement programme is currently underway, led by CAMHS CAG with support from pharmacy.

iii) Prescribing valporate for bipolar disorder

Data for this audit have been submitted. The report is due later this year. Pharmacy introduced a quality improvement programme before data collection. Clinicians and patients were reminded of the risks of valproate in pregnancy. Pharmacy identified all women of child-bearing age currently prescribed valproate in the trust and asked clinicians to review the prescription of valproate in these women. Pharmacy informed women who continued treatment of the risks of valproate in pregnancy and the need for adequate contraception.

v) CQUIN Indicator 4a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI) 2015/16

The Trust participated in data collection and entry onto the NHSE online Webform Portal over a period of five weeks during December 2015 and January 2016. Confirmation was received from the Royal College of Psychiatrists. Results from the audit are pending.

vi) Early Intervention in Psychosis (2015/16) (HQIP)

The Trust participated in data collection and submission as required onto the NHSE online Webform Portal during December 2015 and January 2016. Results of the audit are due in April 2016.

The national confidential inquiry that SLAM participated in, for which data collection was completed during 2015/16, is outlined below:

i) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

The Trust Participated in the NCISH. Data for the NCISH reviewed suicide data over a 10 year period (2003-2013). Following the NCISH the Trust completed a themed review of all suicides over a three year period (outlined in the Trust clinical audit Programme below).

Results received in 2015/16 from data collected in 2014/15

National CQUIN Indicator 4a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI) 2014/15

Over a period of six weeks in December 2014 and January 2015 the Trust collected and entered (onto the NHSE online Webform Portal) data for the National CQUIN audit. The Trust was assessed against the following parameters:

Recorded assessment and interventions for the following:

1. Smoking status
2. Lifestyle (including exercise, diet alcohol and drugs)
3. Body Mass Index
4. Blood pressure
5. Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate)
6. Blood lipids

Performance was calculated by NHSE based on the following:

A. The denominator will be the total number of patients in the sample.

B. The numerator will be the total number of patients in the sample for whom there was documented evidence that:

- they were screened for all six measures listed in the CQUIN guidance during their inpatient stay; and
- where clinically indicated, they were – by 28th November 2014 – directly provided with, or referred onwards to other services for interventions for each identified problem (with thresholds for intervention being as set out in NICE guidelines).

Feedback was received from NHSE by SLaM in April 2015 indicating the following compliance:

Organisation name	Number of forms received	% refusal to undergo screening	Analysis 1 Final % score
South London and Maudsley NHS Foundation Trust	100	4.71	**83.00**

2.4.2 Trust Clinical Audit Programme

The reports of 31 local Trust wide clinical audits were reviewed by relevant Committees and the SLaM Quality Sub Committee in 2015/16 and a number of actions have been taken to improve the quality of health care provided. Here are descriptions of four of them:

- **Suicide Prevention: Themed Review of Suicides in SlaM in a Three Year Period**

Following the National Confidential Inquiry into Suicide and Homicide the Clinical Audit and Effectiveness Team completed a review of all Suicides within SlaM over a three year time period (April 2012-March 2015). Audit findings were similar to the NCISH with respect to demographics and method of suicide. Of note is that:

- The suicide ratio between men and women was found to be smaller within SlaM although a higher ratio of male suicides was still present.
- The percentage of associated substance and/or alcohol usage was much lower within SlaM (17%) than National Data (59% history of alcohol misuse, 44% history of substance misuse).

Main themes identified were: Staff communication, clinical record keeping, risk assessment, care planning, staff training and policy review.

Following the audit, results were presented at the Quality Sub Committee. Some of the actions taken forward have been:

- The Clinical Risk Assessment and Management of Harm Policy has been reviewed and risk Assessment Proformas are being redesigned on ePJS
- The Self-harm and Carers re-audits are underway
- Meetings have been arranged with all CAGs to attend to review their NCISH gap assessment and action plan and to formalise trust action plan
- A meeting has been held with CCGs to discuss population based approach to suicide reduction. Further meetings are to be scheduled with each CCG Chair.
- All ligature audits on inpatient wards were completed in 2015.
- An 189 month Estates and Facilities Ligature Reduction Programme has been completed.

- **What Lessons are Being Learnt from Complaints in SLaM?**

  Themes resulting from Complaints was re-audited by the SlaM Corporate Audit Team in October 2015. Prominent themes were identified as: Communication with service users, Communication with family, Staff training, Carers and Clinical Records.

  Cross over is found between the thematic review of complaints and the thematic review of suicides in the themes/policy areas: communication with service users, staff training and clinical records.

  Following the audit

  - there is on-going work on the Experience CQUIN which focusses on Carers, the Family and Carers strategy 2015-2019 has been approved by the Board and a Carers re-audit has been commenced.
  - The report has been disseminated to CAG Projects Officers and Service directors directly for consideration in future Policy and Improvement work.

- **Pressure Ulcers: Assessment and Management of Pressure Ulcers in SLaM**

An audit of Pressure Ulcers within SlaM was completed in two parts. Part One measured assessment for the risk of pressure ulcers within SLaM. Part Two measured assessment and management of all identified pressure ulcers over a one year period. Following the completion of the audit:

- A presentation was given to the Physical Healthcare Committee.
- CAG specific data was written up in separate reports and sent to the relevant CAGs.
- Guidelines for wound management in the Mental Health of Older Adults CAG were created.
- A major Policy review is in progress with a focus on expectations for individual CAGs, this is to be tabled at the Physical Health Committee in July 2016.

- **Addressing Culture in Care Planning**

Following the Audit on Culture in Care Planning 2015:

- Results were presented and discussed at the Equality and Human Rights group.
- The audit was disseminated via a Purple Light Bulletin to CAG Project Officers and Service Leads this was also advertised on SLaM e-news. The Purple Light Bulletin included links to guidance on recovery and support care planning, NICE Guidelines and contact details for the Trust Equalities Manager.
- Questions on ethnicity and religious belief have been included in new integrated assessment.

2.5 Patients participating in research

The number of patients receiving NHS services provided or sub-contracted by the South London and Maudsley NHS Foundation Trust (SLaM) for the reporting period, 1 April 2015 - 31 March 2016, that were recruited during that period to participate in research approved by a research ethics committee was **3879.**

2.6 Commissioning for Quality and Innovation (CQUIN)

As last year, 2.5 % of SLaM income in 2015/16 is conditional on achieving quality improvement and innovation goals agreed between SLaM and any person they entered into an agreement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. The value of these payments for 2015/16 was £5.8m.

2.7 Hospital Episode Statistics Data – HES

SLaM submitted records during 2015/16 to the Secondary Users services for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

	In-Patients - SUS data Apr 2015/ Feb 2016	Out-patients and Community –MHMDS Apr 2015/ Jan 2016 (provisional)
NHS No	98.5%	99.4%
GP Practice code	99.6%	98.5%

Table 3. The percentage of records relating to patient care which included the patient's NHS No and GP practice code.

2.8 Information Governance

The trust's submission for the annual HSCIC information governance toolkit for 2015-16 demonstrated 89% compliance with national health and social care information governance standards (al Level 2 or above), which is satisfactory compliance. SLaM annual submission was independently assessed by internal audit with a significant assurance outcome.

The Trust continued to implement improvements around information governance compliance with national standards and key legislation. There have been a number of initiatives to implement the recommendations of the Department of Health Information Governance Review (Caldicott 2). Following the implementation of KHP Online, which provides instant sharing of relevant patient information between care professionals to support direct provision of care within King's Health Partners, primary care providers in Lambeth and Southwark were included in the

same secure electronic platform to enable integrated care bringing together primary care, physical and mental health information in real time to residents in these boroughs.

Myhealthlocker is the trust's personal health records system which provides service users online access to relevant information about their treatment, care, condition and medication. MHL aims to bring patients to the centre of the discussions and decisions of their care and treatment by eroding sufficient, clear and relevant information about their mental health. The implementation of this system is underway with frequent consultations with service users in terms of the acceptable use, privacy, functionality offered by this platform to support patient centred care.

The Trust continues to provide clear, concise and up-to-date notification material to service users to ensure they are sufficiently information about the way their personal data is utilised with opportunities to opt-out of any scheme if they wish to do so.

2.9 Payment by Results Clinical Coding

SLaM was not subject to payment by results clinical coding audit by the Audit Commission during the 2015/2016 financial year.

There has been development this year to improve the completeness and accuracy of the Mental Health Clustering Tool which may become the payment by results currency in mental health. The Clinical Information System has built in alerts to remind clinicians that a mental health cluster has expired and reminder email alerts are additionally sent out on a regular basis.

2.10 Improving Data Quality

SLaM will be taking the following actions to improve data quality:

- Data Quality of MHSDS and other external submissions are routinely checked prior to the submissions.
- Business Intelligence is in the process of designing an array of solutions and systems aimed at supporting clinicians to improve the data quality.
- A rigorous Quality Assurance process has been implemented.

2.11 National indicators 2015/2016

NHS Outcome Framework Indicators

SLaM is required to report performance against the following indicators:

1. Care Programme Approach (CPA) 7 day follow-up
2. Access to Crisis Resolution Home Treatment (Home Treatment Team Gatekeeping)
3. Re-admission to hospital with 28 days of discharge
4. Service Users Experience of Health and Social Care Staff
5. Patient safety incidents resulting in severe harm or death

2.11.1 Care Programme Approach (CPA) 7 Day follow- up

Follow up within seven days of discharge from hospital has been demonstrated to be an effective way of reducing the overall rate of death by suicide in the UK. Patients on the care programme approach (CPA) who are discharged from a spell of inpatient care should be seen within seven days.

National Target	SLaM 2013/14	SLaM 2014/15	SLaM 2015/16	National Average 2015/16	Highest Trust % or Score 2015/16	Lowest Trust % Score 2015/16
95%	96.9%	97.4%	**96.99%**	96.9%	100%	50%

Table four. Seven day Follow-up
The lowest/highest and National Average scores (for a Trust) are based on the Q1-3 scores in 2015/16 published at the time of writing the quality account available at www.england.nhs.uk/statistics

2.11.2 Access to Crisis Resolution Home Treatment (Home Treatment Team)

Home treatment teams provide intensive support for people in mental health crisis, in their own home. Home Treatment is designed to prevent hospital admissions and give support to families and carers.

The indicator here is the percentage of admissions to the Trust's acute wards that were assessed by the crisis resolution home treatment teams prior to admission.

	National Target	SLaM 2013/14	SLaM 2014/15	SLaM 2013/14	SLaM 2015/16	National Average 2015/16	Highest Trust % or Score 2015/16	Lowest Trust % Score 2015/16
Number of admissions to acute wards that were gate kept by the CRHT teams	95%	94.1%	91.5%	94.1%	**95.9%**	96.9%	100%	18.3%

Table Five. Access to crisis resolution
The lowest/highest and National Average scores (for a Trust) are based on the Q1-4 scores in 2015/16 published at the time of writing the quality account available at www.england.nhs.uk/statistics

Note that Psychiatric Liaison Nurse assessments of patients in Emergency Departments are, as in previous years, included in the gatekeeping performance figures.

2.11.3 Readmissions to hospital within 28 days of discharge- (Awaiting time lapse and data validation)

*Pending elapse of 28 days from 31/03/15 for full year figure

	SLaM 2013/14	SLaM 2014/15	SLaM 2014/15
Patients readmitted to hospital within 28 days of being discharged			

Table Six. Readmissions to hospital - adult acute patients only

2.11.4. Service Users Experience of Health and Social Care Staff

	SLaM 2014/2015	SLaM 2015/2016	Highest Trust % or Score 14/15	Lowest Trust % or Score 14/15
Service users experience of health and Social Care Staff	8.1	7.6	8.2	6.8

Table seven;. Service Users Experience of Health and Social care Staff

SLaM considers that this data is described for the following reasons:

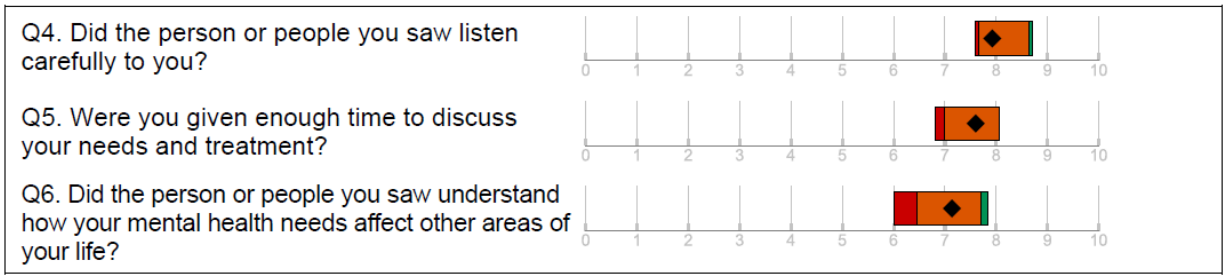
The patient survey responses to the question of how users of services found the health and social care staff of the Trust show that in 2015, overall SLaM scores were slightly higher than the average scores compared to other mental health Trusts. The average Health and Social Care Worker section score for SLaM patients was 7.6 with other Trusts performing in a range of 6.8 to 8.2. This is a decrease from the 2014 SLaM responses which gave an average score for this section of 8.1. However, averages for other Trusts performance also saw a decrease from 2014 where the range was from 7.3 to 8.4.

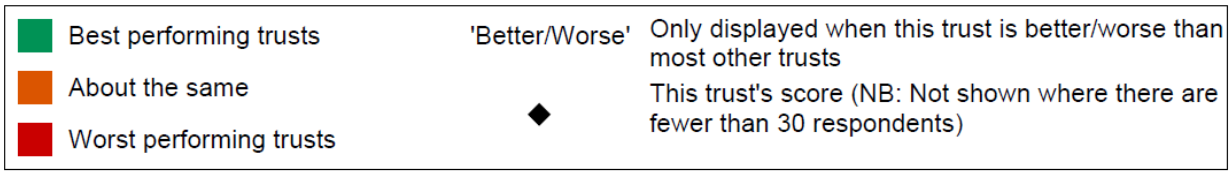
Survey of people who use community mental health services 2015
South London and Maudsley NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
Health and social care workers							
S1	Section score	7.6	6.8	8.2			
Q4	Did the person or people you saw listen carefully to you?	7.9	7.6	8.7	237	8.5	
Q5	Were you given enough time to discuss your needs and treatment?	7.6	6.8	8.0	236	8.0	
Q6	Did the person or people you saw understand how your mental health needs affect other areas of your life?	7.1	6.0	7.8	227	7.8	

Survey of people who use community mental health services 2015
South London and Maudsley NHS Foundation Trust

Health and social care workers





Our performance against the patient survey questions relating to Health and Social Care workers was in the mid-range and average compared with other mental health trusts.

2.11.5. Monitor Risk Assessment Framework Indicators

SLaM is required to report quarterly to Monitor (the Foundation Trust regulator) against a list of published indicators which link to existing commitments and national priorities within the periodic review 2015/2016.
The indicators are:

Indicator	SLaM Performance 2015/16	National Target
Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral (NEW measure introduced late 2015/16)	89.6%	75%
Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral (NEW measure introduced late 2015/16)	99.4%	95%
Percentage of patients who had a 12 month care review (patients on the Care Programme Approach - CPA)	95.4%	95%
Meeting commitment to serve new psychosis cases by early intervention teams	100%	95%
Percentage of patients whose transfer of care (from hospital) was delayed	3.9%	<7.5%
Data Completeness, Mental Health: identifiers - NHS Number, Date of Birth, Post Code, Gender, GP code, Commissioner code	99.2%	97%
Data Completeness, Mental Health: outcomes (for patients on CPA) - accommodation and employment status	52.1%	50%

The results for indicators 1, 2, 3, 6, and 7 are Quarter 4 results. HSCIC publish finalised data for indicators 6 and 7 after completion of the Quality Accounts.

2.12. Patient safety incidents resulting in severe harm or death

The Trust records all reported incidents on a database, in order to support the management of, monitoring and learning from all types of untoward incident. In addition patient safety incidents are uploaded to the National Reporting and Learning Service (NRLS) for further monitoring and inter-Trust comparisons. The NRLS system enables patient safety incident reports to be submitted to a national database which is designed to promote understanding and learning.

During 2015/2016 there were 5586 incidents reported by the Trust meeting the NRLS criteria for a patient safety incident. Of these 52 were categorized as 'severe harm' and a further 26 as deaths.

The process of reporting Trust data to the NRLS and NRLS publication of national data is retrospective by nature. The latest available benchmarked data is for period Q1-Q2 2015/16. For this period SLaM reported:

NRLS Data Q1-Q2 14/15	SLAM 14/15	Average for Mental Health Trusts	Highest Trust % or Score 14/15	Lowest Trust % or Score 14/15
Reported Incidents per 1000 bed days	28.06	41.88	83.72	6.46
Percentage of incidents resulting in severe harm	0.9%	0.4%	1.0%	0.1%
Percentage of incidents reported as deaths	0.4%	0.8%	0.6%	0.2%

Table 7. NRLS data on reported incidents

This year the Trust has taken the following actions in trying to improve further its reporting processes in line with external requirements.

- Review its reporting and management of serious incidents in light of the new Serious Incident Framework 2015; published in March 2015.
- Held a Rapid Improvement Event which looked at the Trust Serious Incident processes and the interface with external reporting.
- Continue the implementation of the national patient safety thermometer to encourage staff to report categories of physical health incidents.

- Working closely with the NRLS regarding improved reporting, mapping and the uploading of incidents to ensure real time information is produced.

- To implement with the NRLS the new Dataset 2 which will ensure that interpretation of Trust data within the NRLS database is more accurate and coherent.

- To ensure that multiple staff in the Trust is trained in auditing and uploading NRLS related data and that this does not solely sit with one member of staff.

- The responsibility of finally approving Trust-wide incidents has now been moved from the DatixWeb central team to the CAG/Services as advised by the NRLS and a concerted effort is being made to clear the back log of incidents currently on the system. Once this has been achieved a more robust and fluid method can be implemented within the DatixWeb central team for monitoring and uploading NRLS incidents which will result in improved data quality and performance within the NRLS remit.

- In April 2016 the Severity grading system was amended to fall in line with the NRLS structure which should ensure more accurate translation of future published reports.

2.13 Duty of Candour

In March 2016 further mandatory Datix (Trust Incident reporting system) fields for the recording of Duty of Candour were added to the Trust's Datix system and the completion of these fields is currently undergoing a two week pilot within the BDP CAG. The results of this pilot will be produced at the end of March 2016. The Duty of Candour mandatory fields that have been added to Datix in March 2016 are as follows:

1. Was the patient/appropriate person informed that an incident occurred?

2. When was the patient /appropriate person informed? (dd/MM/yyyy)

3. Please provide details of the patient/appropriate person who was informed.

4. Was the patient/appropriate person advised about next investigative steps to be undertaken?

5. Following a thorough investigation were details related to personnel or system insufficiencies/failures discussed?

6. Was a copy of this detailed report provided in full to the patient/appropriate person?

7. Were support services offered to the patient/appropriate person affected by the incident?

Part 3: Review of quality performance 2015/2016

3.1 Review of progress made against last year's priorities

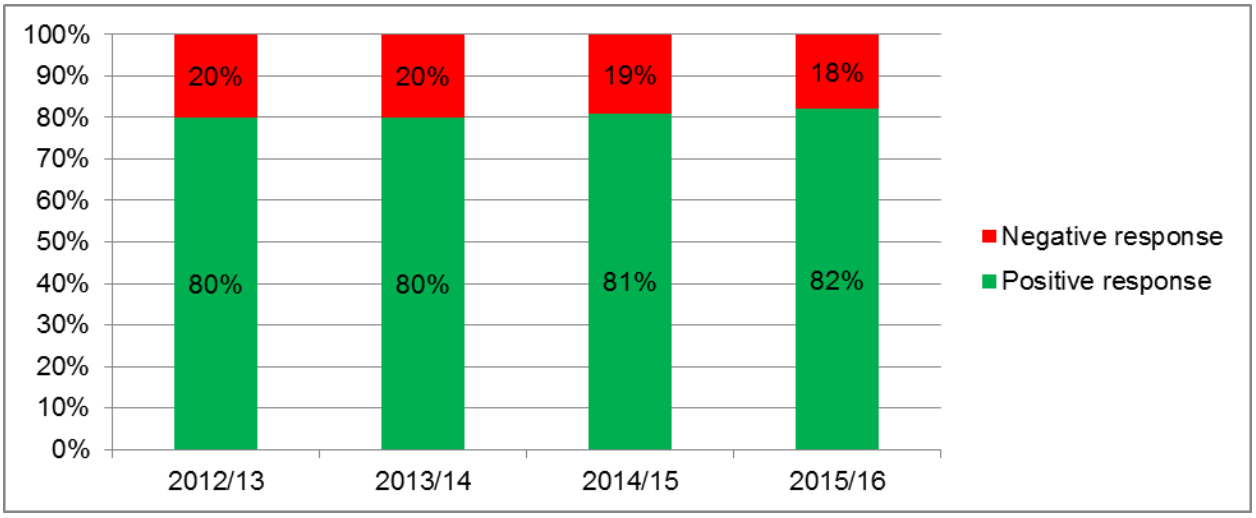
Our 2015/2016 quality priorities were selected after consultations with stakeholders and staff from our services. The following summarises progress made against each priority over the year.

Priority One – Patient Safety: Increase the number of patients who feel safer when in hospital

Violence and aggression on in-patient wards continues to be a challenge in ensuring that all patients benefit from a safe and therapeutic stay in hospital. For 2015/2016 we stated that this was our top clinical Risk, in line with the new National strategy.

Target	We said that in 2015/16 our target was to increase the number of people who when asked say they feel safe in our services. Target >90% of patients feel safe.
Measure	We said we would measure this by asking the question in our patient surveys; "Do you feel safe?"
Headline	**This was nearly achieved.** There were 2560 responses to this question across the inpatient services in 2015/16. 82% of patients responded positively to the question, "Do you feel safe". Whilst there was a very slight increase on the preceding years of 1%, it is below the target of 90%. There was a significant increase from last year in the response rate of 42% and the response once again differed by CAG and borough.

PEDIC Data "Do You Feel Safe"



Graph One

***Positive Response**: Yes, yes, to some extent and yes, definitely

Negative response: No, Definitely not, Not really, Don't know

This priority has been rolled over next year as part of the Trust violence reduction strategy.

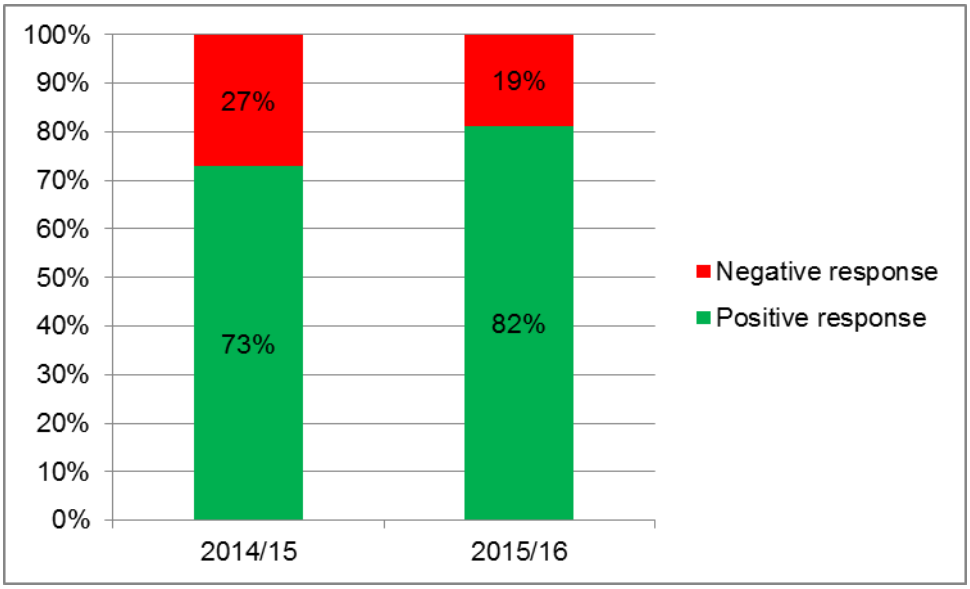
Priority Two – Patient Safety: Access to help in a Crisis

This priority was identified as a recurrent theme during the consultation process from patients, carers and other stakeholders. This had also been raised as an issue by patients in the National survey. In 2014/2015 we said **we would make it easier for patients to access help in a crisis.**

Target	At least 75% of all community patients asked will respond positively to this survey question 'Do you know what to do in an emergency mental health situation?'.
Measure	We will measure this by asking patients about their experience, in the form of surveys.
Headline	**We achieved this.** There were 4489 responses to this question in 2015/16. 82% of community patients responded positively to the question "Do you know what to do in a mental health emergency". This is an improvement of 9% since 2014/15

As outlined earlier in this report the 24/7 Crisis line which is operated 24/7 by mental health professionals was launched in December 2015. This service was advertised on both the SLaM website as well as the South London press newspaper. There is continuing work in developing further publicity and information leaflets to promote this service further.

PEDIC Data "Do you know what to do in a mental health emergency?"



Priority Three – Clinical Effectiveness: Physical healthcare screening

This target recognises the importance in improving our screening of patients for cardio-vascular and metabolic disease. This is a continuation of the CQUIN work during the last two years.

Target	90% of patients audited during the period (inpatients)or for 80% of (community EIP), patients audited during the period the Trust has undertaken an assessment of each of the following key cardio metabolic parameters with a record of associated interventions.
Measure	This was measured through a process similar to the 14/15 National Audit of Schizophrenia, on cardio metabolic risk factors in patients with schizophrenia. • Smoking status; • Lifestyle (including exercise, diet alcohol and drugs); • Body Mass Index; • Blood pressure; • Glucose regulation

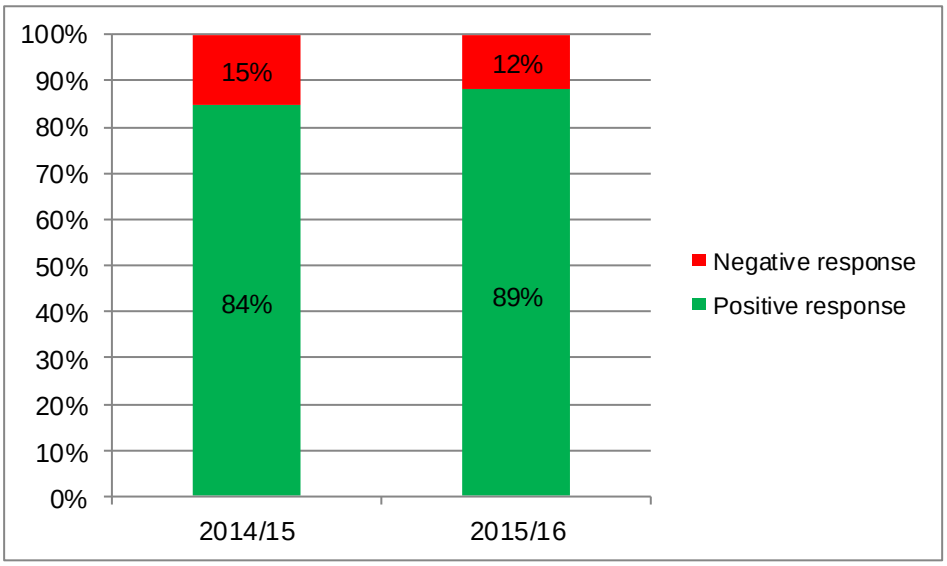
	• Blood lipids.
Headline	**We partially achieved this** The audit sample taken From July/September Q2 patients achieved 85.43%. The audit results taken from Q4 Jan/March for the CQUIN submission and allowing for further quality improvement work throughout the year had shown further improvement with an overall score for Inpatients 91% and for Community EIP 68%.

In response to these findings, the 2015/16 PH CQUIN also emphasised staff training and a widespread physical training programme was provided to nurses and support workers Now most sector wards offer health groups that often include a combination of health education and physical group exercise.

Priority Four – Patient experience; Care planning

In 2015/2016 we aimed to ensure patients identify and achieve outcomes that matter to them, and that users are at the centre of their own care. We wanted to ensure patients are involved in their care and ensure patients understand their care plans in both in-patient and community settings.

Target	Our target is to increase the number >83.5% of people who when asked will say they feel involved in their care.
Measure	We will measure this by asking the questions in our patient surveys; **'Do you feel involved in your care'?**
Headline	**We achieved this.** There were 8299 responses to this question in 2015/16. 89% of people asked responded positively when asked the question "Do you feel involved in your care?". This is an improvement of 5% since 2014/15.



PEDIC Data

"Do you feel involved in your care?"

This year has seen a lot of work involved in improving patient involvement with their care plans and ensuring they are personalised which included an audit on current practice and a workshop which looking at the deficits highlighted from the Care Plan Audit. There was a subsequent Care Planning Workshop to identify actions and take matters forward which will include formulating guidance for staff including updating staff of the tools available on EPJS.

Priority Five – Patient Experience: Carers Assessments

The role of the carer had been raised by carers and services in feedback such as complaints and serious incidents. Where there is an identified carer, they should be offered a carer's assessment. Over the course of five years as part of our five year strategy we would hope to build on the target below further.

Target	Our target is 30% of identified carers will have been offered a carer's assessment.
Measure	Trust Audit Random sample of 100 patients on CPA
Headline	**We achieved this.** The audit showed that 32% of the identified carers were offered a carers assessment. This is an improvement of only 2% since the 2014/15 audit. The methodology changed slightly this year to widen the scope/sample on who an 'identified carer' could be which could have affected the results. Nethertheless, the limited improvement of this Priority has resulted in this priority being rolled over to 2016/17.

There was limited improvement this year due to delay in fully implementing of the Care Act in a consistent way across all four boroughs. Workshops have since been held to agree action to address this which has included interim guidance to staff. This priority has been rolled over to the next year to further improve in this area.

Priority Six – patient Experience; Environments

We said that we would further improve quality of the environments within our In-patient wards and build on the work carried out in 2014/2015.

Target	Improvement in environmental PLACE audit scores from 2014/2015 >95%.
Measure	PLACE (Patient Led Assessment of the Care Environment) audit scores.
Headline	**We achieved this.** The environmental PLACE scores improved this year and both were above the national average.

The following table shows the PLACE scores for the previous three years.

Year	Site	Cleanliness	Condition Appearance and Maintenance
2013	All sites	81.89%	81.28%
2014	All Sites	92.15%	96.22%
2015	All Sites	99.61%	97.68%
2014	% Improvements	10.26%	14.95%
2015	% Improvements	7.46%	1.45%
2014	National Average	97.25%	91.97%
2015	National Average	97.57%	90.11%
2015	% above National Average	2.04%	7.57%

Priority Seven – Patient Safety; Risk Assessments

Based on serious incidents feedback we aimed to improve '**how full risk assessments for Inpatients and Community patients on CPA are documented and used to inform decisions on patient care**'

Target	75% of Inpatients and Community Patients on CPA will have a full documented risk assessment.
Measure	Trust Audit
Headline	**We achieved this.** The audit showed 78% of inpatients and community patients on the CPA had a full risk assessment documented.

Priority Eight – Clinical Effectiveness- Home Treatment Teams support

We said the Adult Mental Health (AMH) model provides an enhanced multi-intervention service into the community. Home treatment teams (HTT) provide intensive support for people in mental health crisis in their own home. We said we aimed ' **this year we will reduce the number of people supported by HTT who then require an admission.'**

Target	No more than 15% of people who have been supported by HTT to then require an Inpatient admission in services where the AMH model has been established.
Measure	We said we would measure this by extracting data on patient admissions from our electronic records system in Q4/2016.
Headline	**We achieved this.** In the HTT services where the AMH model has been established, 9% of HTT episodes resulted in an admission.

TOTAL	2015/16	2015/16	2015/16	Q4	Total	%
	Q4					
	Jan	Feb	Mar			
New episodes receiving Home Treatment	95	106	117	**318**	**318**	
Not Admitted During HTT Episode	85	97	106	**288**	**288**	
Admitted During HTT Episode	10	9	11	**30**	**30**	**9%**

A key aim of the AMH model has been for HTTs to develop close interface working with community teams to intervene early and reduce the need for crisis admissions. There has been a recent focus on strengthening working relationships with acute in-patient teams. HTT linking working roles have been developed to meet regularly with in-patient staff and attend ward meetings with the aim of facilitating timely in-patient discharges from hospital and reducing length of stay.

Dialectical behavior therapy (DBT) awareness training for mental practitioners has been rolled out across the HTTs to support the use of DBT informed interventions. As well as providing a basic understanding of DBT the training has equipped staff with a range of interventions to support service users in developing distress tolerance / management skills.

Priority Nine – Clinical Effectiveness: Substance Misuse

Co-morbid substance use is very common in people with mental health problems (30-50% and in some groups even higher), so working with people with dual disorders is core to modern mental health care. **We will increase the frequency with which people in SLaM services are asked about their use of alcohol and non-prescribed drugs so that we can work more effectively with them to maintain their safety and plan recovery.**

Target	50% of service users from our adult acute Inpatient and Adult Community teams will have both a drug and alcohol assessment and an AUDIT (Alcohol Use Disorders Identification Test) completed.
Measure	Trust Audit
Headline	**We achieved this partially** There was an improvement in adult acute inpatient services where 67% of service users had a drug and alcohol assessment. However the Trust did not achieve the targets for community service users. It has been agreed that this will be CQUIN target next year.

3.2 National patient survey of people who use community mental health services: SLaM report 2015

The national patient survey was returned by 246 SLaM patients giving a response rate of 30% which is just above the national average for all mental health trusts of 29%

Overall, SLaM's results fell in the amber section in 10 out of the 10 sections of the survey meaning, our results were 'about the same' as most other trusts. In the final 'Overall' Section, SLaM performed 'about the same as other trusts. In the graphics below the Trust score is represented by a small diamond. If the score is placed in the amber section of the Red, Amber, Green (RAG) rating then that result is considered 'about the same' as most other trusts. If the score is in the red section of the RAG, the result is considered 'worse' than most other trusts and likewise if the score is in the green section, the result is considered 'better' than most other trusts.

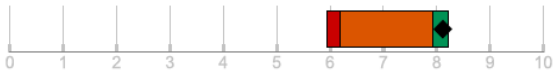
Out of the 41 individual questions in the survey, the top ranking scores for SLaM compared to other mental health trusts in England was found for the following 3 questions:

Section 2: Organising Your Care

Q9. Do you know how to contact this person if you have a concern about your care?

Section 5: Changes in Who You See

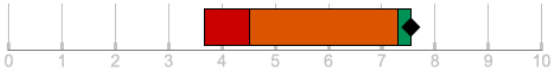
Q18. What impact has this had on the care you receive?



Better

Section 6: Crisis Care

Q22. When you tried to contact them, did you get the help you needed?



Better

For no questions in the 2015 Survey of people who use community mental health services did SLaM perform among the worst performing trusts.

Improvement Plans

The Trust is looking to improve on a range of patient experience areas throughout 2016/17 all of which are closely related to the National Community Survey, the Friends & Family Test (FFT), our internal patient experience surveys and are inclusive of other areas that are equally important to service users, carers and staff.

The number of responses for the FFT and the patient experience surveys has increased from the previous year. For 2015/16, the Trust received over 8500 survey and FFT responses, approximately over 1000 more responses. The overall FFT score for the Trust was 84.3%, comparing very favourably against other mental health trust. The FFT score suggests that patients and carers would recommend their friends or family to use our services. The Trust is also one of only a small number of NHS organisations to provide demographic breakdowns of the experiences of patients. This is published as part of the Trust's annual Equality Information to show the experience of patients with different protected characteristics has changed over time.

In terms of the internal survey questions highlighted below, they will remain as the same patient experience priorities for all of services

1. Do you feel involved in your care?
2. Are staff kind and caring?
3. Do you know how to make a complaint?
4. Do you know what to do in an emergency mental health crisis?
5. Do we treat you as an individual by considering your culture, spirituality, disability, gender, sexuality, age and ethnicity?
6. Do you feel safe here?
7. Has the purpose and side effects of your medication been explained to you?

The Trust will further undertake a benchmarking exercise against a number of the survey questions above. This will provide an in-depth understanding, and help the Trust to direct resources more appropriately. Each CAG will be expected to provide series of action plans, against underperforming areas the action plans will be reassessed for progress, followed by implementation and expected improvements.

3.3 National Staff Survey 2015 – Results

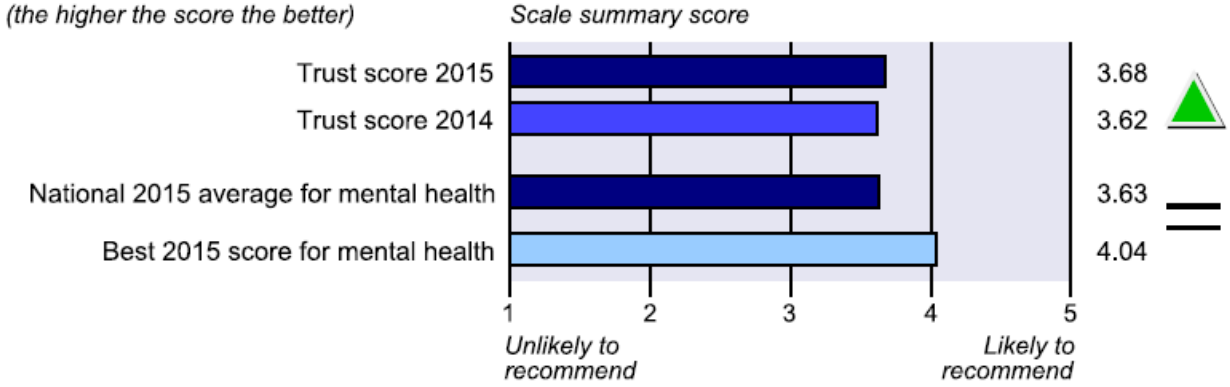
1699 staff at South London and Maudsley NHS Foundation Trust took part in this survey. This is a response rate of 38%1 which is below average for mental health / learning disability trusts in England, and compares with a response rate of 42% in this trust in the 2014 survey.

Number of Staff recommending the Trust

In the 2015 staff survey, SLaM performed slightly better than the year before on the question 'would staff recommend the trust as a place to work or receive treatment?'. SLaM performed slightly above the national average on this question. The SLaM Trust score for this question was 3.68 compared to the national average score of 3.63 for other mental health trusts.

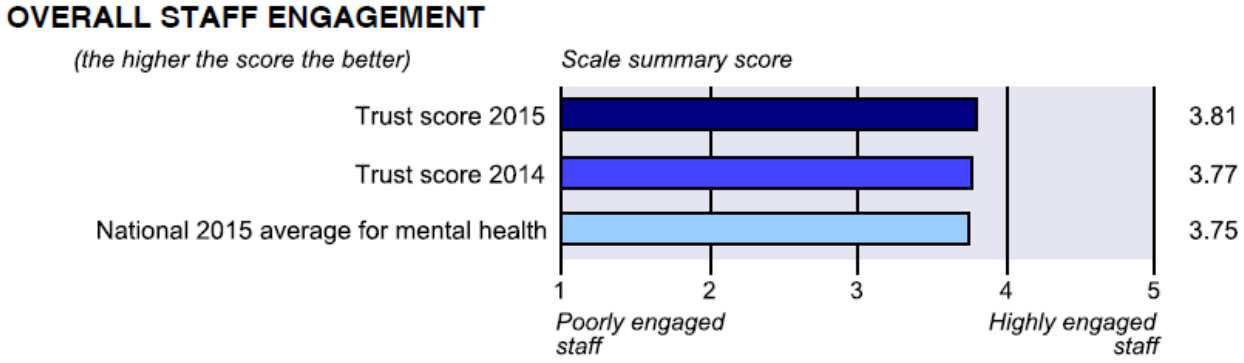
		Your Trust in 2015	Average (median) for mental health	Your Trust in 2014
Q21c	"I would recommend my organisation as a place to work"	59%	56%	59%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	60%	59%	58%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.68	3.66	3.61

KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment



Overall Staff Engagement

The Trust score for overall staff engagement has gone up to **3.81** (3.76 in 2014). This is higher than the national average for all mental health/learning disability Trusts which was 3.75.



Key Findings – overall Trust

<u>The following are the top five ranking scores for the Trust compared to Mental Health Trusts in England:</u>

- Percentage of staff appraised in last 12 months.
  Trust Score: 96% **National Average: 89%**

- Effective team working (scale summary score).
  Trust Score: 3.90 **National Average: 3.82**

- Percentage of staff able to contribute towards improvements at work.
  Trust Score: 76% **National Average: 73%**

- Quality of non-mandatory training, learning or development (scale summary score).
  Trust Score: 4.10 **National Average: 4.01**

- Effective use of patient / service user feedback (scale summary score).
  Trust Score: 3.81 **National Average: 3.68**

<u>The following are the lowest five ranking scores for the Trust compared to Mental Trusts in England:</u>

- Percentage of staff working extra hours
  Trust Score: 81% **National Average: 74%**

- Percentage of staff experiencing physical violence from staff in last 12 months
  Trust Score: 5% **National Average: 3%**

- Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
  Trust Score: 77% National Average: 84%

- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
  Trust Score: 36% National Average: 32%

- Percentage of staff experiencing discrimination at work in last 12 months
  Trust Score: 20% National Average: 14%

<u>The following is the area where the experience of staff has improved on the previous annual survey:</u>

- Percentage of staff appraised in last 12 months.
  Trust Score 2015: 96% Trust Score 2014: 87%

- Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month
  Trust Score 2015: 27% Trust Score 2014: 32%

- Staff recommendation of the organisation as a place to work or receive treatment (scale summary score).
  Trust Score 2015: 3.68 Trust Score 2014: 3.62

<u>The following is the area where the experience of staff has deteriorated most on the previous annual survey:</u>

Percentage of staff working extra hours.
Trust Score 2014: 81% Trust Score 2013: 77%

At a Trust wide level, there are themes that have been identified in the lowest five ranking areas that are of concern and work needs to be undertaken to address these.

The report reminds us that SLaM is in the worst 20% in terms of the percentage of staff who experience physical violence (from other staff), the percentage of staff who receive harassment, bullying or abuse from patients and those who experience discrimination. All of which are reported as being worse for BME staff.

At a local level, each CAG and Directorate will be asked to develop an Action Plan in relation to the responses in the staff survey. This should be based on the requirements

identified within the report for their specific areas as some CAGs may need to develop and improve approaches to particular themes. There will need to be regular updates on progress through the CAG HR Business Partners. It is important that local issues are identified and staff are given the opportunity to work towards their resolution and for the CAGs to reassure their staff that they have heard the feedback and are addressing it.

We need to ensure we maintain our areas where we have scored in the top 20% of mental health and learning disability Trusts.

We will continue to engage with the Nursing Directorate to develop and improve upon our approaches to the management of violence and aggression as experienced by our staff whilst at work as Nurses and Healthcare Support workers report this the highest. We will ask the Nursing Directorate if further audits of violence and aggression can be undertaken especially in the B&D, Psychological Medicine and Psychosis CAGs where this is reported the highest.

We will need to continue to reinforce the importance of the new annual performance review (appraisal) process which commenced in 2015. We have updated the ratings guide and redesigned the recording form. The performance review process allows an open dialogue about what is good and what needs to improve.

We will continue work to support the development of the BME Network and develop activities, priorities and terms of reference including formal nominations for the Chair and vice Chair roles.

We will need to conduct further analysis for the reasons why staff are working and reporting working extra hours. We will start this analysis in B&D and CAMHS. We will also undertake a review of our approach and policy for flexible working arrangements within the Trust.

We will follow up on the areas where staff have reported suffering from workplace stress and ascertain whether Individual workplace risk assessments have been conducted plus compare sickness absence rates for this reason.

HR Business Partners will work with their respective CAGs and Directorates to identify if there are areas where reports of bullying, harassment, abuse or violence from staff to other staff are not being followed up.

We recognise that we will not have an easy fix to some of the work that needs to be done but equally we know that we all have a part to play in making SLaM a better place to work.

3.4 SLaM Equality Objectives 2013-16

During 2015-16 the trust has continued to deliver its equality objectives:

1. All SLaM service users have a say in their care

2. SLaM staff treat all service users and carers well and help them achieve the goals they set for their recovery

3. All service users feel safe in SLaM services

4. To improve the representation of BME staff and staff with a disability in all aspects of meaningful engagement, participation and inclusion within the Trust

5. Show leadership on equality through our communication and behaviour

The Trust's Policy Working Group has helped support policy leads to use equality impact assessments (EIAs) in the development and review of Trust policies. This has helped increase the quantity and quality of EIAs and identified actions and helped improve the Trust's understanding of how policies affect service users with different protected characteristics and what the Trust can do about this.

Ensuring all service users feel safe and involved in their care in SLaM services are two of the Trust's equality objectives 2013-16. We have published information on the feelings of safety reported by service users with different protected characteristics and examples of work underway to ensure all service users feel safe as part of our annual equality information. This is available on our website at: **2015 Trust-wide equality information.**

We published an update on our equality objective delivery in January 2016. This is available on our website at: **A report on our progress on equality in 2015**. We will continue to deliver our equality objectives and will engage with service users, carers, staff and other stakeholders during 2016 to assess the impact these have had and develop new equality objectives for 2017-20.

Healthier Communities Select Committee		
Title	HealthWatch reports on the Polish and Tamil communities access to health and wellbeing services in Lewisham.	
Contributor	Scrutiny Manager	Item 4
Class	Part 1 (open)	18 May 2016

1. Purpose

HealthWatch Bromley and Lewisham has written two reports: *The Polish Community and Access to Health and Wellbeing Services in Lewisham*; and *The Tamil Community and Access to Health and Wellbeing Services in Lewisham*.

The reports draw attention to the issues with accessing health and wellbeing services raised by members the Polish and Tamil communities in Lewisham. Based on its findings, the report makes recommendations to providers and commissioners.

HealthWatch Bromley and Lewisham have requested a response to the report and its recommendations from the Committee.

3. Recommendations

The Committee is asked to:

- Note the content of the reports
- Direct any questions to the representatives from Healthwatch Bromley and Lewisham present at the meeting
- Formulate a response to the recommendations in the reports as per the Healthwatch Lewisham and Bromley Report & Recommendation

For further information, please contact John Bardens, Scrutiny Manager, on 02083149976.

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The Polish Community and Access to Health and Wellbeing Services in Lewisham

April 2016

Healthwatch Bromley and Lewisham, Community House, South Street, Bromley, BR1 1RH, 0208 315 1916

Contents

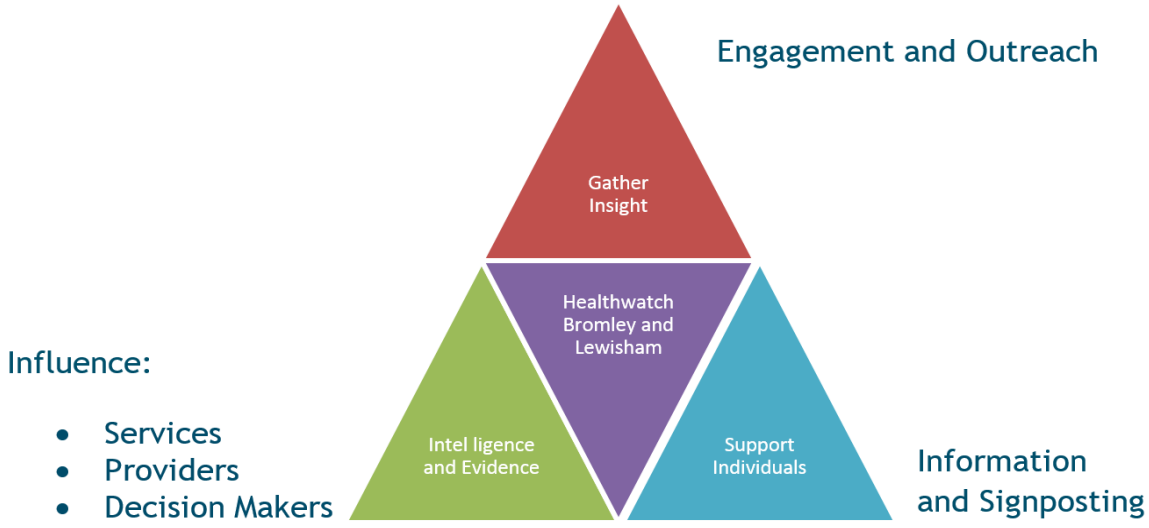
1. About Healthwatch Bromley and Lewisham

Healthwatch Bromley and Lewisham ((HWBL) is one of 152 local Healthwatch organisations that were established throughout England in 2013, under the provisions of the Health and Social Care Act 2012. The dual role of local Healthwatch is to champion the rights of users of health and social care services and to hold the system to account for how well it engages with the public.

The remit of Healthwatch Bromley and Lewisham as an independent health and social care organisation is to be the voice of local people and ensure that health and social care services are safe, effective and designed to meet the needs of patients, social care users and carers.

Healthwatch Bromley and Lewisham (HWBL) gives children, young people and adults in Lewisham a stronger voice to influence and challenge how health and social care services are purchased, provided and reviewed within the borough.

Our approach is to encourage broad public involvement and to inform, influence and help shape future commissioning and provision.



- We gather insight through our engagement, outreach and participation activities.
- We listen to views and experiences of local health and social care services and help people share their views and concerns about health & social care
- We use what we have heard in our Influencing role –
  - telling service providers and commissioners and those who monitor services what the public have told us;

- asking providers and commissioners questions and make suggestions so that services are fair for everyone;
- using our Enter and View powers to visit some services to see and report on how they are run;
- sitting on both Bromley and Lewisham Health and Wellbeing Board and on other decision-making or influencing groups, ensuring that the views and experiences of patients and other service users are taken into account;
- recommending investigation or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC).

- We support individuals by providing information and signposting about services so they can make informed choices. We also signpost people to the local independent complaints advocacy service if they need more support.

2. Acknowledgements

Healthwatch Bromley and Lewisham would like to thank the Polish Cultural Centre for providing a platform to engage with its members.

We would like to encourage people who speak up on behalf of seldom heard groups to consider this report in their work and to consider joining Healthwatch Bromley and Lewisham to amplify this voice.

3. The Polish community of Lewisham

Since Poland and seven other central and Eastern European countries (collectively known as the A8) joined the EU in May 2004 around 66 per cent of all A8 citizens migrating to the UK have been Polish citizens. Between the year ending December 2003 and the year ending December 2010 the Polish-born population of the UK increased from 75,000 to 532,000 making it one of the three largest non-UK born population groups in all countries and most regions of the UK.[1]

London has 123,000 Polish-born residents (24 per cent of the UK total) which makes it the second largest ethnic minority group after Indian.[2]

Lewisham has a population of about 286,000 people and is the 15th most ethnically diverse local authority in England with two out of every five residents from a black and minority ethnic background. [3]

[1] http://www.ons.gov.uk/ons/rel/migration1/migration-statistics-quarterly-report/august-2011/polish-people-in-the-uk.html
[2] http://www.theguardian.com/news/datablog/2011/may/26/foreign-born-uk-population

[3] Lewisham's Joint Strategic Needs Assessment 2016 (http://www.lewishamjsna.org.uk/)

According to the 2011 Census there are 27,826 people from White other ethnic minority groups living in Lewisham.[4] Polish was the second most spoken language in Lewisham after English and accounts for 1.6% of the population followed by French 1.5%. This suggests that Polish migrants are the largest group of people who don't speak English as their first language.[5]

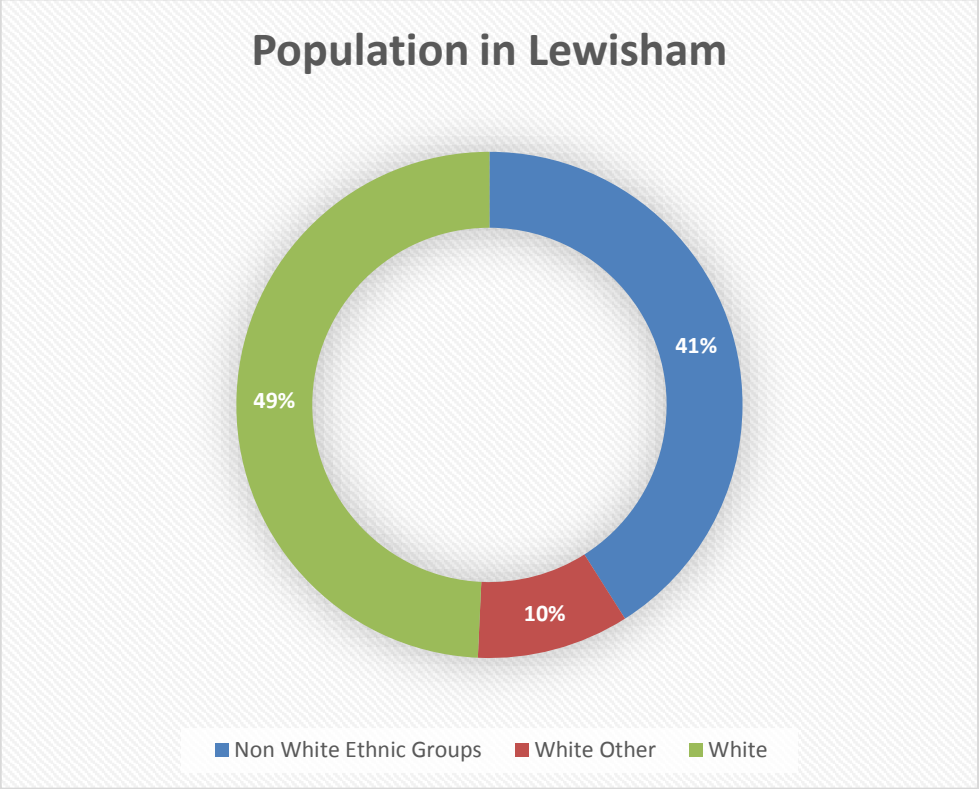


Figure 1 [6]

4. Purpose of the engagement

National evidence suggests that public bodies and services need to do more to take protected characteristics within communities into account when developing services. The Department of Health in 2012 published an NHS Patient Experience Framework developed by the NHS National Quality Board. It provides evidence based guidance on a number of issues known to affect the patient experience.[7] These include the need for respect for cultural issues, the need for information, communication and education as well as for emotional support.

[4] https://lewisham.gov.uk/inmyarea/Documents/2011CensusSecondReleaseDec2012.pdf
[5] http://localstats.co.uk/census-demographics/england/london/lewisham
[6] Lewisham JSNA, 2016
[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215159/dh_132788.pdf

People from BME communities report numerous issues with access to health services. Barriers include dissatisfaction with mainstream services which they perceive as lacking in understanding and consideration. This situation can result in poorer health compared to other groups, with unnecessary visits to Accident and Emergency, higher rates of hospital admission, and the likelihood of more complex, intrusive interventions.[8]

Through this report, Healthwatch Bromley and Lewisham draws attention to the experiences of access to health and social care services faced by members of the Tamil community living in Lewisham. The report presents themes that emerged through Healthwatch engagement and highlights the key issues that are important for this community. Recommendations are provided, where possible, to support decision making and commissioning of services which will improve access for this community.

The report will be submitted to commissioners at NHS Lewisham Clinical Commissioning Group and Lewisham Council to the Lewisham Health and Wellbeing Board, Lewisham Healthier Communities Select Committee, Healthwatch England and local providers of services. The report will be made public on Healthwatch Bromley and Lewisham websites.

5. Healthcare in Poland - Background

In Poland there is a national Healthcare system called Narodowy Fundusz Zdrowia offering free medical care, however according to research around 65% of Polish people also access private care. [9]

The care accessed privately is primarily dental, genealogical and medical tests services. Patients often use the two systems to supplement each other. The main reason behind it is to speed up the process of diagnosis and access to treatment. For example, a patient might use free healthcare for an initial visit and diagnosis, but pay for medial test and go back to the free healthcare system for diagnosis and ongoing medical treatment. [10]

It is possible that Polish migrants are used to the above system and therefore try to replicate similar behaviour patterns in respect of their health care in the UK.

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[8] Good Access in Practice, BME Health Forum 2010
[9] http://www.nfz.gov.pl/
[10] http://www.bankier.pl/wiadomosc/Przyszlosc-prywatnej-sluzby-zdrowia-i-opieki-medycznej-w-Polsce-2264989.html

6. Methodology

Healthwatch Bromley and Lewisham gathered information about access to services for Polish people living in Lewisham by attending an open day at the Lewisham Polish Centre in October 2015. We gathered the information from 18 people by conducting one to one interviews and distributing a '*story gathering*' form with an option to send feedback in a pre-paid envelope.

The Healthwatch Bromley and Lewisham researcher speaks Polish and was able to translate responses from the one to one interviews and the story gathering forms.

Participants were asked to share experiences that had taken place in the last 12-24 months.

HWBL gathered equality and diversity data alongside the prevalence of long term conditions amongst the participants. This can be found in Appendix 2.

7. Findings: The Themes

Lack of trust

When speaking to participants the reoccurring theme was lack of trust towards health care professionals. It is a theme that underlines several other themes identified in this report.

Lack of trust can be formed as a result of one or a combination of factors such as a bad personal experience and or cultural differences. For example, there is a difference in the structure of the Polish health care system in comparison to the NHS. In Poland some specialist care is accessed directly such as genealogical or dermatological.[11]

In addition, according to one of the local Polish magazines, Polish people preferred to go to 'their own' doctors. And a receptionist from one of Polish Health Care clinics stated that 'often Polish doctors have better qualifications than British ones'.[12]

A couple of participants expressed lack of trust in the skill and knowledge of NHS pharmacists saying: 'Pharmacists here don't know much themselves; they have not been to university to get a degree'. This again is a difference as most Polish pharmacies' customer facing roles are often staffed with qualified staff whereas pharmacies in England might have a pharmacist working in the background.[13]

Referrals and GP services – negative comments

Many of the participants complained about GPs not referring them for tests or to a specialist which delays or in their eyes disables diagnosis and treatment. In many participants' eyes GPs do not seek to *'get to the bottom of the problem'* and fail to treat patients. Some patients feel that the treatment offered by their GPs is insufficient and ineffective. One participant told Healthwatch that she had a spine operation in the past. She still experiences problems with her back and for the past three years she has been asking her GP for a referral for an MRI scan. She has not received it and was only able to access physiotherapy which didn't help her problem. Another participant told Healthwatch *'I haven't got a good experience with GPs. They don't want to send for tests and don't give referrals. It is difficult*

[11] http://www.prawapacjenta.eu/index.php?pId=840
[12] https://goniec.com/wiadomosci/spoleczenstwo/12377-nhs-vs-nfz-czyli-gdzie-jest-gorzej
[13] https://forum-farmaceutyczne.org/topic/414-czy-analityk-medyczny-moze-pracowac-w-aptece/

to have tests and diagnosis for serious illnesses such as cancer. We were waiting for a long time for someone to react (to pay attention and diagnose cancer) so we took matters in our own hands and found a doctor who did something about our concerns'. A female participant said: *'My Husband fainted and had a seizure but he didn't get a referral for an MRI scan or any other tests'.* Another female participant said that after a number of *'pleas'* with her GP she got referred for a test to diagnose the condition she suspected she had for a long time. Until then the doctor was only prescribing some drops and ibuprofen to treat the symptoms, but did not look for the root of the problem. The tests confirmed her self-diagnosis and she was finally offered a treatment to manage the condition instead of just 'dampening' the symptoms. Although she got the referral and a subsequent diagnosis, she said she had to *'fight for it'* and the final decision to send her for a test was a result of her determination and perseverance. Another young mother was unhappy with the lack of a referral to see a specialist: *'I went to see a GP in relation to my long term skin condition. I got a referral for blood tests and afterwards I should have been referred to a dermatologist or to another specialist.'* A middle aged carer of her mum expressed her anger in relation to the lack of referrals to specialists: *'It is very hard for an elderly person to receive a referral despite requesting one, even if this person is not well. My mum has a lot of long term conditions and health issues such as heart problems, high blood pressure, arthritis and varicose veins. I'm very unhappy with the service.'*

Many patients who complained expressed feeling left on their own with their conditions and felt that professionals did not care. This is a worrying fact as many people with long term conditions may live undiagnosed and as a result their health may worsen over time resulting in needing more care later on. In addition, patients can be emotionally, mentally and physically harmed as a result of delayed diagnosis or lack of it. This can have a ripple effect on their families as many participants were parents of children below 16 years old.

Use of private Polish Clinics

As a result of the negative experience of treatment and/or access to NHS care many participants told Healthwatch they access private health care. One patient said '*my son has allergies (food and pollen) but only gets a cream (from his GP) so I went to Poland and got £100 worth of treatment and medicines. Now I contact my doctor via skype to get more medicine'.* Another female patient accessed private healthcare for support in tests and diagnosis, however she couldn't afford

an ongoing treatment privately and went back to the NHS. Another female participant complained: *'I don't use GPs as I can never book an appointment even if I try. So I need to somehow look after myself and take matters in my own hands to get help. I try to help myself or go to the Polish clinic.'* A young Polish female suffering long term conditions said: *I tried to see my GP about a month ago. I had symptoms of "woman's" nature. It was hard to get an appointment so I went to a private Polish clinic. The NHS is a disaster.'*

A middle aged man told the Healthwatch that he uses the NHS only for minor issues with his child. As a result of problems in accessing referrals to see a specialist and obtain the right treatment and long waiting times he is accessing private healthcare. Another young woman told Healthwatch that if she wasn't happy with the received treatment she would go to one of the Polish health centres.

Paracetamol

Many participants were referred to doctors who advised patients to use paracetamol instead of treating the condition. A middle aged female participant said: *'Doctors here cannot give anything but paracetamol.'* Another participant praised her doctor for her professionalism saying *'she doesn't just prescribe paracetamol'* which indicates that this is an established theme within the community that many members identify with. It is even used as a 'measuring tool' to assess the professionalism of a GP. It reflects the dissatisfaction with NHS services and a lack of trust in the care provided by GPs. It also confirms the members of the community are worried that they are not accessing an adequate treatment and care.

Staff attitudes

Some participants complained about staff attitudes. A female participant with multiple long term conditions who needed access to the healthcare system frequently told Healthwatch that she wasn't happy with the way her GP treats *her 'He is only looking at a computer. He treats me like a number.'* The same GP then asked her embarrassing questions relating to habits she never had which suggests he was looking at a wrong file or there were errors in her medical records. Another participant said her GP refused a requested treatment and told her to go to Poland to get help. She later filed a complaint, however the matter was unresolved as the GP no longer worked there.

NHS staff skills - Varied service 'depending on who you see'

Many participants told Healthwatch they have a mixed experience using NHS services and it often *'depends on who you see'*. These comments related to staff in primary and secondary care. A middle aged mum told Healthwatch: *'some GPs are good and some are very bad. I had to change GP as he did not treat me seriously. He didn't explain his diagnosis or opinion and didn't give me reassurance. The new GP is very thorough and caring.'* Another participant told Healthwatch she underwent an operation at Lewisham Hospital and commented that some nurses were brilliant and provided excellent care where as others *'didn't have a clue what they're doing and how to do things they needed to do. To the point that I had to give them instructions myself.'* The participants recognised that there is an inconsistency in the level of skills amongst the NHS staff and it is worrying that some may access excellent care where others may simply not depending on the individual they saw. The comments suggest that there is an inconsistency in the skills of the staff. This reflects badly on NHS services overall and has a negative impact on patients' satisfaction.

Interpreting

Many members of the community had a good level of English and didn't express the need for translation services. However, about a half did not speak English confidently enough to communicate with health professionals and needed support. Most people in this group use family and friends to translate with a few saying they need a translation in relation to more serious medical issues. However, some participants with multiple health conditions, that don't speak English well, said that they experienced significant barriers in accessing health care as a result.

'I know from my own experience and from the experience of my 60 years old mum that it's very hard to access a translator. Even if you ask for the service. Every time my mum needs to book a visit or needs a GP visit someone needs to go with her.'

'My English is not the best. I try to communicate however when I struggle to speak (use correct words) health professionals ignore me. No one ever suggested to use a translator although I know I'm eligible to one. When I ask, they refuse and blame lack of time etc.' Another participant complained about cancelled appointments as the result of interpreters not turning up. During her visit at one of the local hospitals she was told she can only access an interpreter once.

Healthwatch discovered that people who cannot communicate well in English feel ignored and as a result cannot access appropriate care. The research also suggests that patients are not offered translation or when they request the service they are refused.

In addition, the use of family and friends poses problems for patients' confidentiality and translation quality which may have impact on treatment outcomes.

Happy with the NHS services

Healthwatch was pleased to hear that participants shared a number of positive experiences and many said they are generally happy with the NHS. The services people were happy about were: maternity wards, midwives, free prescriptions for children, walk in centres and eye and vision care at Kings College Hospital.

GPs – positive comments

A number of participants praised their GPs for having a caring attitude and giving quick referrals. One participant described why she was happy with her GP: *'My current doctor is very caring; this ensures that I'm involved in the treatment. She explains the treatment plans, refers me for tests appropriately and timely. She explains medicine and discussed with me the treatment time. She doesn't clock watch. She gives me enough time when I need it. I don't mind waiting for the appointment as I know that when I need more time she gives it to me and that's the price to pay.'* Another participant said she was happy with the timely and responsive care in relation to her Varicose Veins problem.

Management of long term conditions - positive comments

A few people praised the NHS for good care in managing long term conditions especially Diabetes. Another middle age patient with Diabetes said she is happy with how NHS services support her in her condition. She praised the fact that all

her necessary tests are done in timely, regular manner and are all arranged to fit in a day. Another female patient told Healthwatch she was happy with her GP and other services monitor her condition and prompt her to attend a visit.

7. Conclusion

Healthwatch found that the main themes were lack of referrals for tests and referrals to see specialists and a lack of trust towards healthcare professionals. Healthwatch found that a number of participants had to *'fight'* to access tests and as a result to receive a diagnosis. Participants also felt there is inconsistency in the services as a result of varied skillset amongst the staff. As a result of the above mentioned themes participants were often using local Polish private clinics. Despite uncovering many negative themes, Healthwatch was pleased to hear that many participants were generally happy with the NHS with caring GPs who refer appropriately and a management of long term conditions.

8. Recommendations

As a result of our findings through our engagement with Polish community members in Lewisham, Healthwatch Bromley and Lewisham sets out the following recommendations to improve access to services for the Polish community.

COMMISSIONERS AND PROVIDERS:

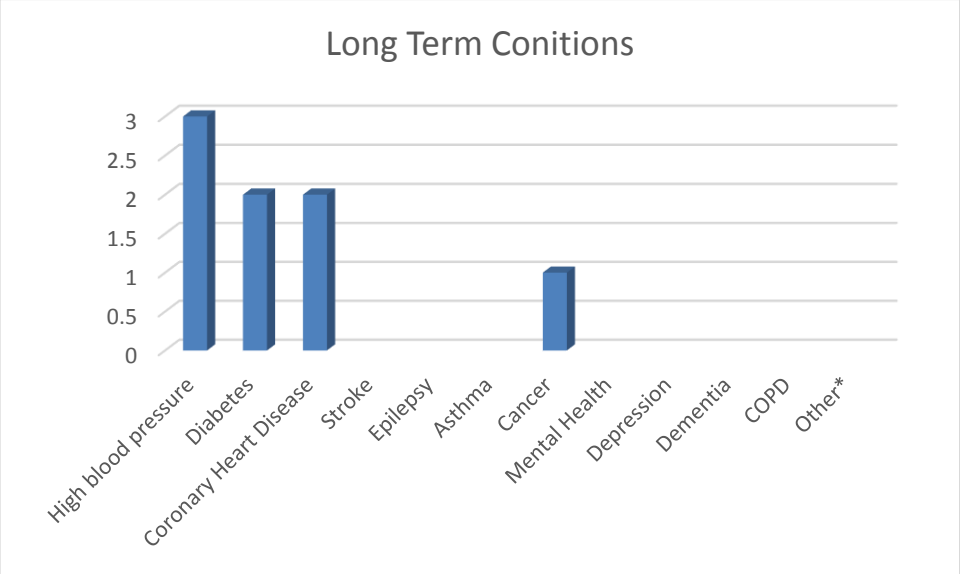
- Provide appropriate training to staff to enable improved communication, customer services and cultural awareness.
- Provide information about services available locally, how to access them, what to expect with focus on vulnerable groups and migrants that are new to the system and do not speak English as their first language. The information could be in a form of a booklet or as information sessions delivered through local groups.
- Ensure patients understand the treatment plan and treatment options available to them such as medical test or escalation to the specialists.
- Improve access to interpreting services both in primary and secondary care settings.
- Clarify interpreting eligibility criteria.
- Staff to engage with patients and provide reassurance around treatment plans, diagnosis, and NHS service availability.
- Promote and share good practice of services that are performing well to inspire good practice amongst the staff.

9. Appendices

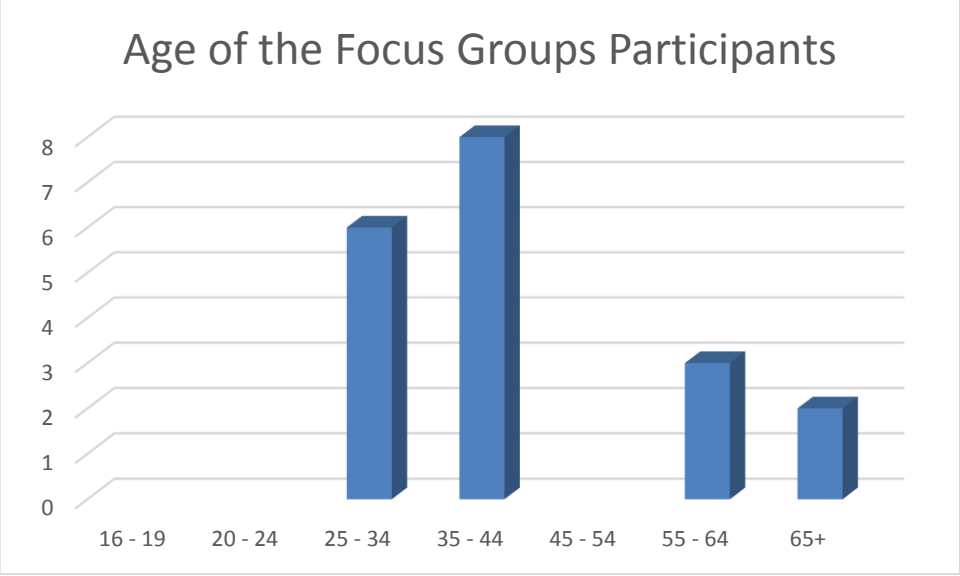
Appendix 1 - Equality and Diversity Data and Long Term Conditions

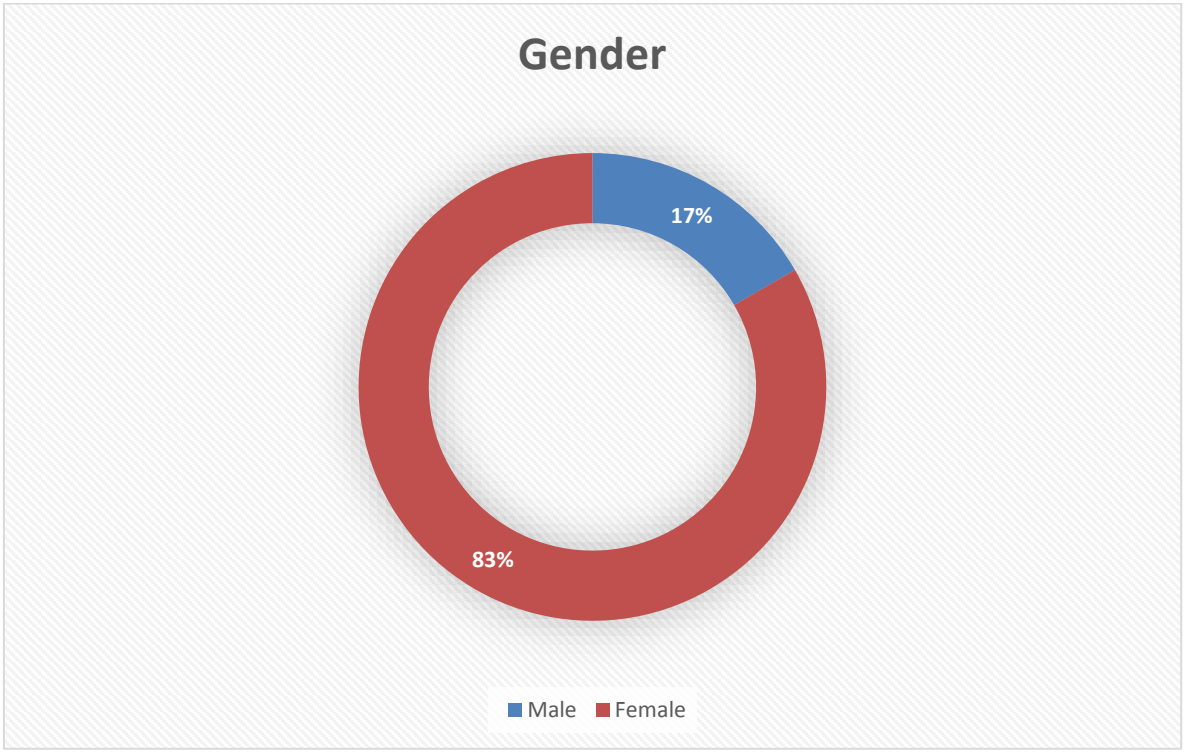
Healthwatch engaged with people from the Polish Community in Lewisham by face to face interviews with 18 people at the Lewisham Polish Cultural Centre.

Two of the respondents said they were carers and 13 were parents or guardians of a child/children under 16 years of age.



*Other consisted of: Dermatological Problem, Underperforming Thyroid x 2, Headaches, Low Blood Pressure, Arthritis, Varicose Veins x 2 and Spine Problems x 2

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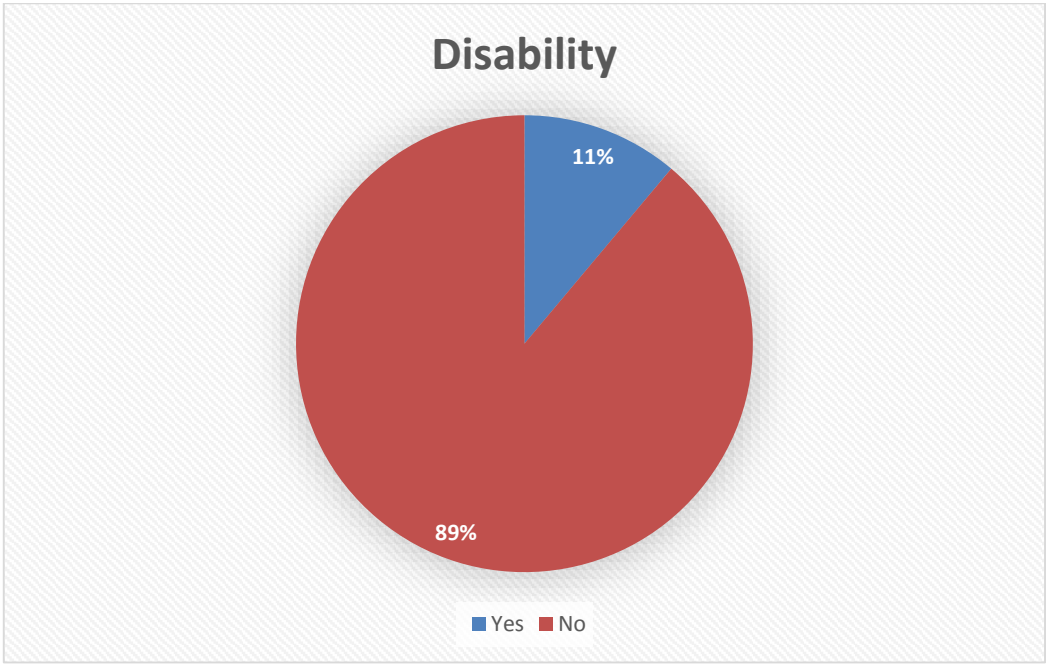
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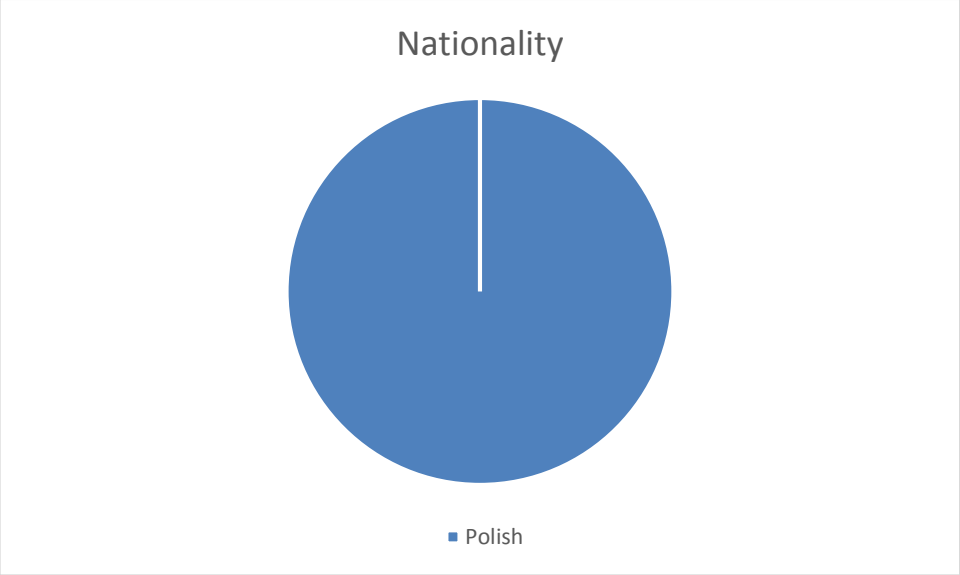

Appendix 2 - Healthwatch Bromley's core functions

They are:

- Gathering the views and experiences of service users, carers, and the wider community
- Making people's views known
- Involving locals in the commissioning process for health and social care services, and process for their continual scrutiny
- Referring providers or services of concern to Healthwatch England, or the CQC, to investigate
- Providing information to the public about which services are available to access and signposting people to them
- Collecting views and experiences and communicating them to Healthwatch England
- Work with the Health and Wellbeing board in Bromley on the Joint Strategic Needs Assessment and Joint Health and Wellbeing strategy (which will influence the commissioning process).

The Polish Community and Access to Health and Wellbeing Services in Lewisham

Any enquiries regarding this publication should be sent to us at admin@healthwatchbromley.co.uk

You can download this publication from www.healthwatchlewisham.co.uk

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The Tamil Community and Access to Health and Wellbeing Services in Lewisham

April 2016

Healthwatch Bromley and Lewisham, Community House, South Street, Bromley, BR1 1RH, 0208 315 1916

Contents

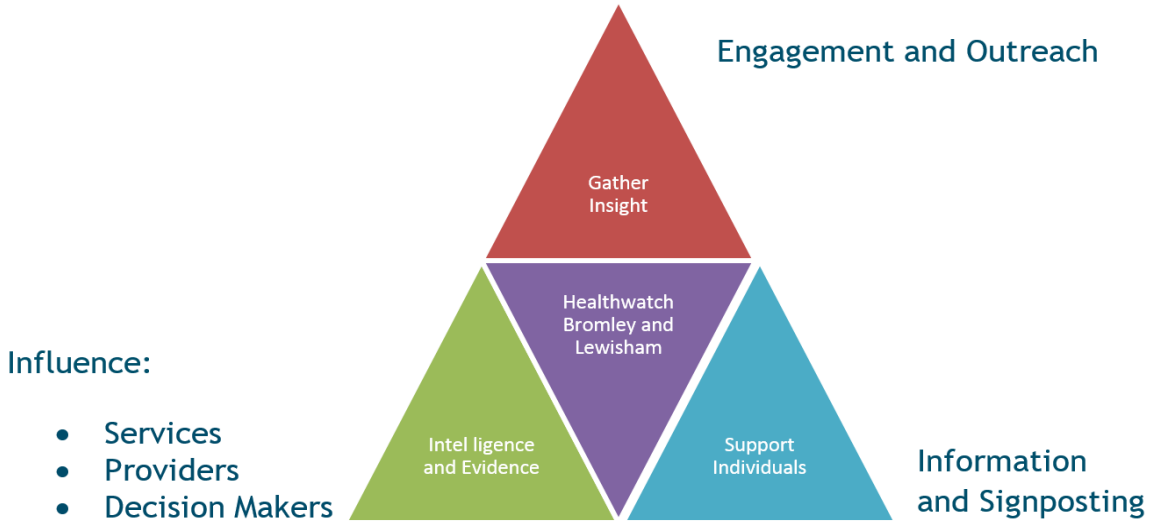
1. About Healthwatch Bromley and Lewisham

Healthwatch Bromley and Lewisham ((HWBL) is one of 152 local Healthwatch organisations that were established throughout England in 2013, under the provisions of the Health and Social Care Act 2012. The dual role of local Healthwatch is to champion the rights of users of health and social care services and to hold the system to account for how well it engages with the public.

The remit of Healthwatch Bromley and Lewisham as an independent health and social care organisation is to be the voice of local people and ensure that health and social care services are safe, effective and designed to meet the needs of patients, social care users and carers.

Healthwatch Bromley and Lewisham (HWBL) gives children, young people and adults in Lewisham a stronger voice to influence and challenge how health and social care services are purchased, provided and reviewed within the borough.

Our approach is to encourage broad public involvement and to inform, influence and help shape future commissioning and provision.



- We gather insight through our engagement, outreach and participation activities.
- We listen to views and experiences of local health and social care services and help people share their views and concerns about health & social care
- We use what we have heard in our Influencing role –
  - telling service providers and commissioners and those who monitor services what the public have told us;

- asking providers and commissioners questions and make suggestions so that services are fair for everyone;
- using our Enter and View powers to visit some services to see and report on how they are run;
- sitting on both Bromley and Lewisham Health and Wellbeing Board and on other decision-making or influencing groups, ensuring that the views and experiences of patients and other service users are taken into account;
- recommending investigation or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC).

- We support individuals by providing information and signposting about services so they can make informed choices. We also signpost people to the local independent complaints advocacy service if they need more support.

2. Acknowledgements

Healthwatch Bromley and Lewisham would like to thank South East London Tamil Elders and Family Welfare Association (SELTEFWA) for providing a platform to engage with their members.

We would like to encourage people who speak up on behalf of seldom heard groups to consider this report in their work and to consider joining Healthwatch Bromley and Lewisham to amplify this voice.

3. The Tamil community of Lewisham

Lewisham has a population of about 286,000 people and is the 15th most ethnically diverse local authority in England with two out of every five residents from a black and minority ethnic background. [1]

Lewisham Joint Strategic Needs Assessment (JSNA) 2016 data estimates of the breakdown of ethnic groups present in Lewisham are shown in Figure 1. Non-white ethnic groups in Lewisham account for 41% of the population.

Downham Tamil Association estimate that there are approximately 8000 members of the Tamil community in Lewisham.[2]

In 2011, Tamil was in the top ten most requested languages for translation services in the borough.[3]

[1] Lewisham's Joint Strategic Needs Assessment 2016 (http://www.lewishamjsna.org.uk/)
[2] Downham Tamil Association, 2016
[3] London Borough of Lewisham - Translation, Interpretation and Transcription Service

Research suggests that the biggest Tamil migration happened in three stages: post-colonial, during the 1960s and 70s and post 1983. The population of people born in Sri Lanka that live in England and Wales increased by 88% from 2001 to 2011 based on Census figures and the country remains amongst the most important sending countries for asylum seekers to the UK. [4]

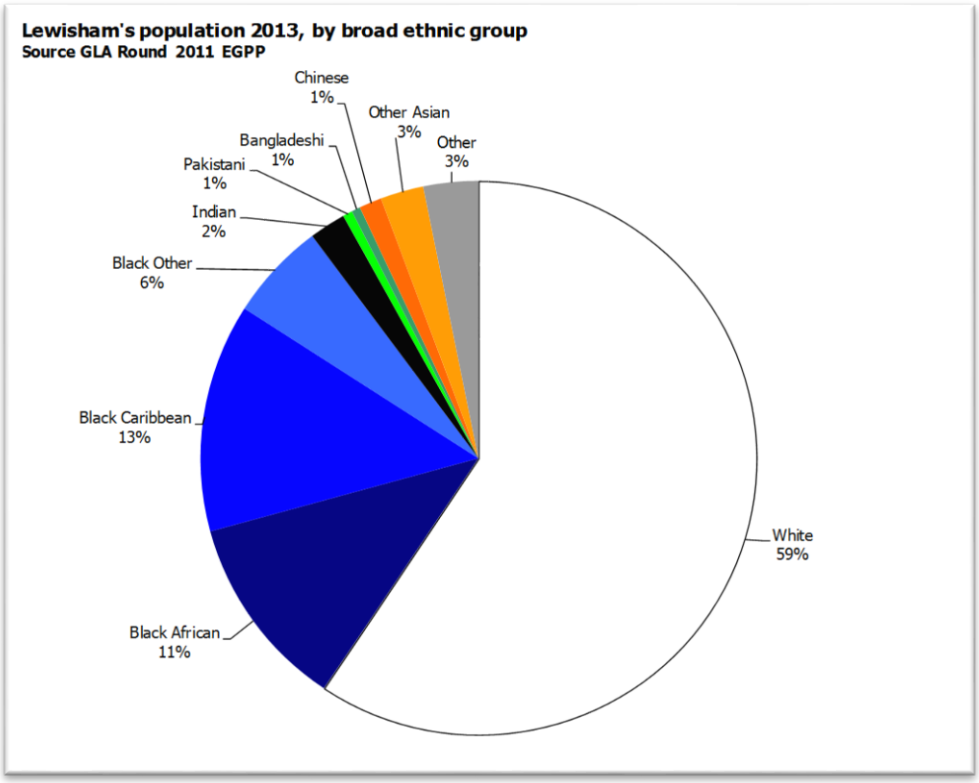


Figure 1 [5]

4. Purpose of the engagement

National evidence suggests that public bodies and services need to do more to take protected characteristics within communities into account when developing services. The Department of Health in 2012 published an NHS Patient Experience Framework developed by the NHS National Quality Board. It provides evidence based guidance on a number of issues known to affect the patient experience.[6] These include the need for respect for cultural issues, the need for information, communication and education as well as for emotional support.

[4] Diversity and Diaspora: Everyday Identifications of Tamil Migrants in the UK, Demelza Jones, University of Bristol 2013
[5] Lewisham JSNA, 2016
[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215159/dh_132788.pdf

People from BME communities report numerous issues with access to health services. Barriers include dissatisfaction with mainstream services which they perceive as lacking in understanding and consideration. This situation can result in poorer health compared to other groups, with unnecessary visits to Accident and Emergency, higher rates of hospital admission, and the likelihood of more complex, intrusive interventions.[7]

Evidence suggests that older people from ethnic minorities experience higher proportions of long term illnesses. In the White British population 27% of people aged 50-64 report a limiting long-term illness such as diabetes, hypertension and stroke. This proportion rises to range of 36% - 54% amongst people from some ethnic minorities.[8]

However, the ageing of ethnic minority communities and the implications for health and health care needs has received far less attention. In fact 'ageing' and 'ethnicity' are rarely integrated within health research.[9]

There are over 4.6 million individuals belonging to minority ethnic groups in the UK, with a quarter million aged 60 years or over.[10]

Through this report, Healthwatch Bromley and Lewisham draw attention to experiences of access to health and social care services faced by members of the Tamil community living in Lewisham. The report presents themes that emerged through Healthwatch engagement and highlights the key issues that are important for this community. Recommendations are provided, where possible, to support decision making and commissioning of services which will improve access for this community.

The report will be submitted to commissioners at NHS Lewisham Clinical Commissioning Group and Lewisham Council to the Lewisham Health and Wellbeing Board, Lewisham Healthier Communities Select Committee, Healthwatch England and local providers of services. The report will be made public on Healthwatch Bromley and Lewisham websites.

[7] Good Access in Practice, BME Health Forum 2010
[8] 2001 Census
[9] Health inequalities amongst older people from ethnic minority groups in Britain, Sharon M. Holder, University of Southampton 2008
[10] 2001 Census

5. Methodology

Healthwatch Bromley and Lewisham gathered information about access to services for Tamil people living in Lewisham by organising a focus group in November 2015. It took place in Catford, Lewisham and was organised in partnership with SELTEFWA.

The focus group was attended by 12 individuals all of whom were over 65 years old and had multiple long term conditions including High Blood Pressure, Diabetes, Coronary Heart Disease and Arthritis.

Most participants were communicating in English and there was no need for an interpreter. On occasions when participants didn't understand parts of the conversation or needed help in explaining their point, other members of the group supported them and helped to translate.

Participants were asked to share experiences that had taken place in the last 12-24 months.

HWBL gathered equality and diversity data alongside the prevalence of long term conditions amongst the participants. This can be found in Appendix 2.

6. Findings: The Themes

6.1 GP Appointments: Availability and a Booking System

All participants were over 65 and many had multiple long term conditions. They told Healthwatch that it was important to them to be able to access help when they need to, to ease their concerns and conditions. Most participants said they face significant barriers and often are unable to see their GP when they are experiencing symptoms or feeling unwell. *One participant said "At our age every day is a bonus. One day you might be OK but another you might not be. As a result you should be able to see a GP when you need to, not wait two weeks if you're not well. You can't predict when you're unwell. There should be more urgent appointments available."* Many complained about difficulties in booking an urgent appointment when they wanted to see a doctor on that day *"When you call in the morning the phone is engaged till 8.40am. You can hear the message 'we're very busy right now', when you get through you hear: 'all the appointments are gone'."* Another frustrated participant summed up her experience with the booking system at her GP: *"You ask a question: Can I see the doctor? You hear back: No, you can't, all the appointments are booked."* An elderly woman with multiple long term conditions said *"I had to fight for it."*

"It's not has been the case in the past…"

Participants told Healthwatch that in the past they were able to see their GP when they needed and they had easy access to same day appointments. They clearly remember having no problems accessing health services and so are more disappointed to face challenges in accessing health care now that they are older and experiencing more health problems.

Another issue raised by participants was the long wait for a pre-booked appointment, which delays their treatment and prolongs their discomfort and pain. *"You need to wait 2 -3 weeks for the appointment"* said one elderly woman and others confirmed they face waiting times from 10 days to three weeks with some patients facing even longer times. An elderly woman waited 23 days to see her GP to ask for a referral. At the time of speaking to Healthwatch she was facing yet more waiting time for the referral appointment.

Some participants felt there should be more information about the appointment system while at the GP surgery. *"People who come later to the surgery, go (to see a GP) before me."* This made participants feel confused and meant that they were not sure if they had missed their appointment or if there were other reasons to explain why other patients got to see a GP ahead of them. This suggests patients have a need to understand practices processes and procedures which might be achieved for example by providing a practice leaflet.

6.2 GP appointment time

The second major issue for the participants was insufficient time at the GP appointment. Many participants worried that they did not have enough time to explain their symptoms and related issues and circumstances that might be important for the diagnosis or for prescribing the right treatment. Many participants echoed a statement of an elderly woman: *"10 minute appointments are not enough"*.

Participants told Healthwatch they were particularly frustrated to be rushed at the appointments when they had waited for the visit for a long time. *"You wait two weeks or ten days for the appointment, but when you get there doctor says 'hurry up, we've got other appointments after yours."* An elderly man agreed: *"Doctors give you 5 minutes and then go, go, go, go"*.

Not having enough time at the appointment impacts negatively on patients' trust in their GP and their feeling of reassurance which in turn might impact on the treatment compliance and outcome. Participants felt that when doctors are rushed they are not able to treat patients with sufficient care and don't have time to comfort and reassure them. The short appointment time gives them little time to explain aspects of the treatment which leaves the patient without sufficient knowledge about their condition and unsure how to manage their condition well.

In contrast to the above issues, some participants praised their doctors who took enough time (more than 10 minutes) to listen and talk to them, treat them with care and empathy. Those patients felt reassured, happy with the received care and expressed trust in their doctors.

6.3 Communication and cultural differences

The 2011 data confirms that Tamil was amongst most requested languages as reported by the Local Authority. Despite that, at first SELTEFWA didn't report any communication issues, however after asking a few investigative questions Healthwatch established that 8 out of 10 participants were registered with Tamil Doctors. *"There are many Tamil Doctors. We are lucky"* said an elderly woman. Participants explained that in the first instance they will seek Tamil speaking doctor and only if this was not possible will they opt for a non-Tamil one. This suggests that participants were self-selecting practices to enable easy access to care and to help remove communication barriers. This approach inevitably has its limitations. Not all Tamil people may have access to, or are within the catchment area of GP surgeries with Tamil speaking doctors. Communication also starts being a barrier when accessing other services such as specialist hospital treatment, community and other primary care or social care services.

6.4 Medicines

Participants raised an issue of medicines with the majority confirming they use the repeat prescription option and are happy with the service. They were however

concerned that they did not always understand their medications and expressed the need for more information about how a medicine will work, what the correct dosage and what the possible side effects are. *"They [doctors] should explain what it is for and how to take it".*

Another participant told Healthwatch he used to take an effective medication for his long term condition. However, it is no longer available on the NHS and the replacement one does not work as well. As a result, he is importing his medicines from Sri Lanka. This potentially poses many dangers such as inconsistency of supplies, the drug not being recorded in this notes and as a result his medication clashing with other medicines he might be given. It also raises an issue of trust with his GP and the local health services and potential medicine waste.

6.5 Staff attitudes

Some participants mentioned staff attitudes as a problem. An elderly woman said her GP is *'rude'* and another told in a humoristic way *"You have to be careful with the receptionist otherwise they put you at the back".* Others echoed this statement which suggest the participants are not comfortable in addressing receptionists which might result in barriers to access to health services.

6.6 Long waiting times for referral appointments

Participants experienced long waiting times for referral appointments, with many saying that they were not told of the expected waiting times resulting in patients feeling anxious. The majority of the participants said they wished to receive an acknowledgement of referrals with information on the anticipated waiting time. Some participants told Healthwatch they don't always know what tests they were referred for. This combined with not knowing the length of time for a test or referral appointment could mean that patients lose control over their own condition and are unable to self-care.

One elderly participant has waited to see an Ears Nose and Throat Specialist and after two months of waiting received a letter of acknowledgement. The letter did not explain how long the patient should expect to wait for the actual appointment.

Another participant suffering with a long term condition experienced uncomfortable symptoms and pain. She sought help, however due to the long waiting times for appointments and referrals she waited one year to be treated. This left her frustrated and disappointed in a health care system that left her to deal with the symptoms and pain without timely access to treatment.

As with other themes in this report not everybody echoed this experience. A male participant told Healthwatch he was happy with his GP who issues him referral appointments appropriately and without any delays.

6.7 Joined up services, patients at the heart of the service

Healthwatch heard that the *'doctors just give medicine'* implying that they do not look into the cause of the problem but prescribe medication to ease the symptoms. Participants commented that doctors should look at the person in a holistic way and take more time to get to the bottom of the problem. This implies a need for joint up working with other service providers and putting patients at the heart of the support process.

7. Conclusion

Many participants were happy with the care they received, however Healthwatch Bromley and Lewisham identified barriers that this community faces when accessing services.

The majority of the participants were unhappy with the booking system creating a barrier in accessing GP services when they need to.

Participants were also concerned with the waiting time for referral appointments and tests, some reporting it took 1 year to see a doctor.

The next big issue was not having enough time during an appointment with their GP. Participants complained their appointments were rushed and they did not have enough time to talk to the GP about their condition or to fully explain the symptoms. This could be due to the communication barriers meaning it is difficult for the doctors to get an idea of the patient's problems.

However most participants were accessing a Tamil speaking doctor when possible to reduce the barriers to communication and access. Data from translation services in the borough of Lewisham suggest however that Tamil was one of the most requested languages for translation which suggests that many members of the community require support when communicating with services.

8. Recommendations

As a result of our findings through our engagement with Vietnamese community members in Lewisham, Healthwatch Bromley and Lewisham sets out the following recommendations to improve access to services for the Vietnamese community.

COMMISSIONERS AND PROVIDERS:

- Improve access to GP services including improving access to urgent appointments and improving booking systems.
- Increase the GP consultation appointment time for people who experience with communication problems especially the elderly and those with long term conditions.

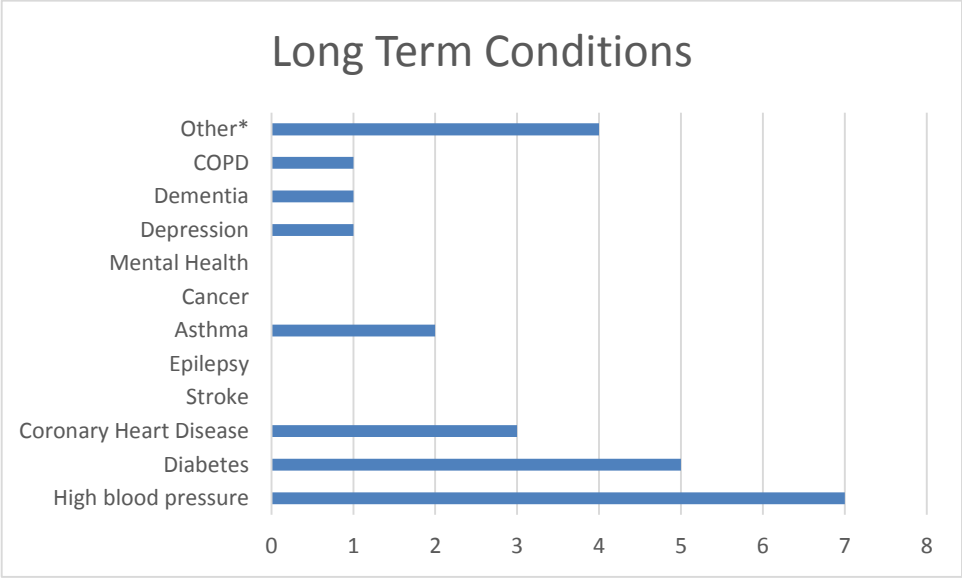
- Improve access to interpreting services both in primary and secondary care settings.
- Enable and encourage health professionals to seek confirmation that the patient understands how the prescribed medicines work, the side effects and the correct dosage and to give patients the opportunity to ask questions about their medicines.
- Provide appropriate training to staff especially front line reception staff to enable improved communication, customer services and cultural awareness.
- Provide clear guidelines and time scales around referrals to specialist services and tests.
- Reduce waiting times for referrals
- Explain to patients what tests they are being referred for and the reason for the referral.
- Special consideration should be given to people who might experience communication problems, elderly patients and to those with long term conditions.

9. Appendices

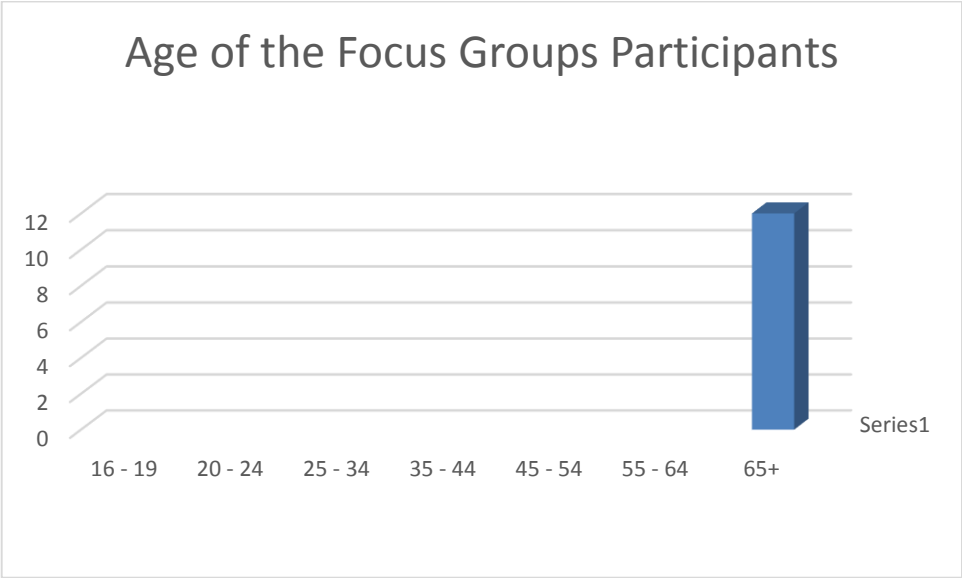
Appendix 1 - Equality and Diversity Data and Long Term Conditions

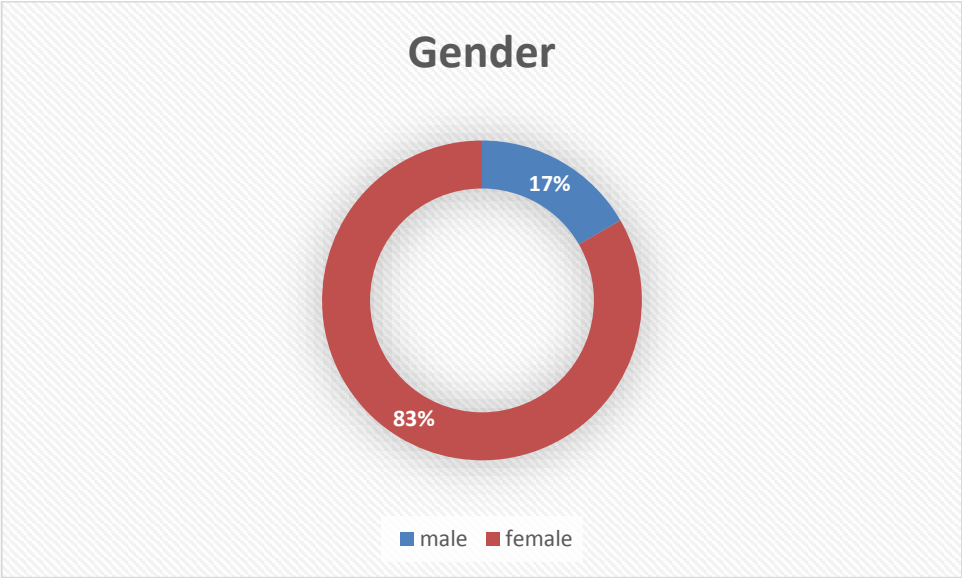
Healthwatch engaged with people from the Tamil Community in Lewisham by organising a focus groups attended by 12 people from SELTEFWA.

None of the respondents said they were carers or parents or guardians of a child/children under 16 years of age.



*Other consisted of: Arthritis (x3) and a problem with a foot

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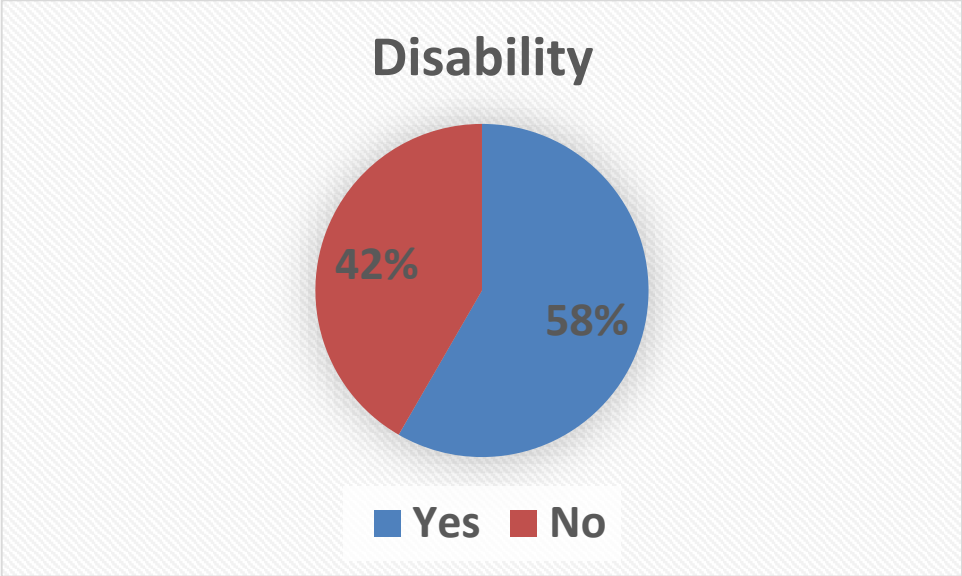
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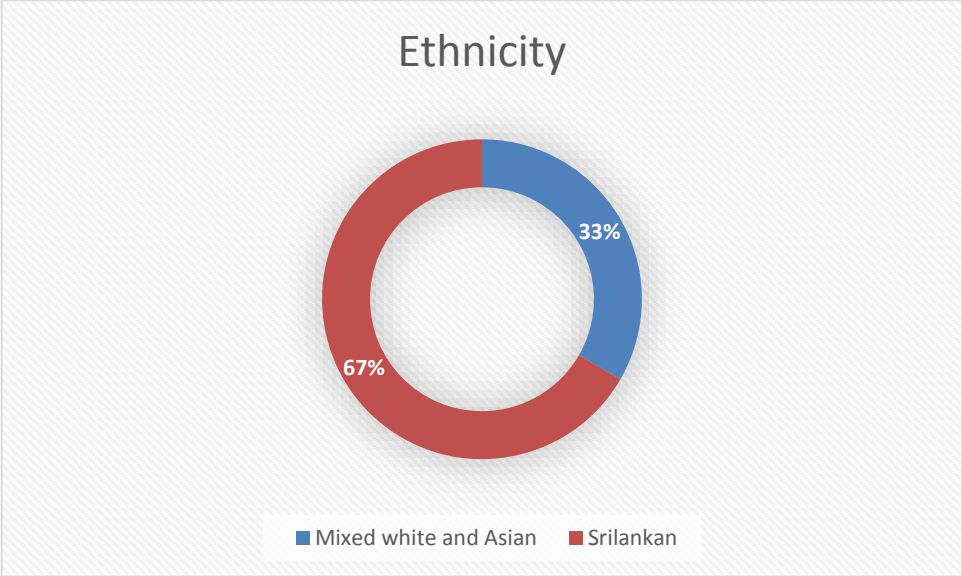
Ethnicity
33%
67%
Mixed white and Asian
Srilankan

Appendix 2 - Healthwatch Bromley's core functions

They are:

- Gathering the views and experiences of service users, carers, and the wider community
- Making people's views known
- Involving local people in the commissioning process for health and social care services, and press for their continual scrutiny
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- Work with the Health and Wellbeing board in Bromley on the Joint Strategic Needs Assessment and Joint Health and Wellbeing strategy (which will influence the commissioning process).

The Tamil Community and Access to Health and Wellbeing Services in Lewisham

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healthwatch
Bromley and Lewisham

Community House
South Street
Bromley
Kent
BR1 1RH

Healthwatch was established in 2013 in accordance with the Health and Social Care Act 2012.

Within this legislation [Arrangements to be made by relevant bodies in respect of local Healthwatch Organisations Directions

Report & Recommendation Response Form

Report sent to	
Date sent	
Details of report	

Date of response provided	
Response (If there is a nil response please provide an explanation for this within the statutory 20 days)	
Signed	
Name	
Position	

January 2016

For office use only	
Date response received	
Within 20 days?	

HEALTHIER COMMUNITIES SELECT COMMITTEE		
Report Title	Update on Free Swimming in Lewisham	
Key Decision	Yes	Item No. 5
Ward	All	
Contributors	Executive Director for Community Services	
Class	Part 1	Date: 18 May 2016

1. Purpose of Report

1.1 The purpose of this report is to update the Healthier Communities Select Committee on the implementation of the proposal to end the offer of free swimming in Lewisham for those aged 16 or under and 60 or over.

2. Recommendations

2.1 The committee is recommended to:

2.2 note the background and information on free swimming and provide comment and feedback at the meeting on the ending of free swimming for those aged 16 or under from 1 October 2016.

3. Policy Context

3.1 Lewisham's Sustainable Community Strategy 2008 – 2020 '*Shaping our Future'* reflects the many individual strategies and plans endorsed by different agencies and partnerships in Lewisham. All are working with our citizens to build a successful and sustainable future. The key principles of this strategy are reflected throughout the new leisure contract to ensure regular delivery to local residents over the life of the contract.

3.2 These key principles are:

- Ambitious and achieving – where people are inspired and supported to fulfil their potential
- Safer – where people feel safe and live free from crime, antisocial behaviour and abuse
- Empowered and responsible – where people are actively involved in their local area and contribute to supportive communities
- Clean, green and liveable – where people live in high quality housing and can care for and enjoy their environment
- Healthy, active and enjoyable – where people can actively participate in maintaining and improving their health and well-being
- Dynamic and prosperous – where people are part of vibrant communities and town centres, well connected to London and beyond.

4. Background and free swimming usage

4.1 In September 2015 Mayor and Cabinet received proposals to save £232,000 form the Obesity/Physical Activity element of Lewisham's Public Health Grant (Saving A16). £200,000 of this saving related to the ending of free swimming in the borough.

4.2 Following a referral from the Health Communities Select Committee Mayor and Cabinet agreed the savings but instructed that officers consider the ending of free swimming alongside wider contractual negotiations with leisure providers that are taking place to deliver £1,000,000 from 1 April 2017 (Saving L7) in order to investigate any possible mitigation.

4.3 Free swimming is available to Lewisham residents aged 16 and under and those 60 or over with a Lewisham Library card. The offer is available at both Fusion and 1Life centres.

4.4 In the financial year 2014/15 just under 14,000 individuals accessed free swims. The total number of free swims in the same period is 66,500. Data from April 2014 to July 2015 showed that the majority of people accessing free swimming do so infrequently - on average 4.8 times over the 15 month period.

5. Proposal to stop free swimming for those aged 16 and under

5.1 Public Health recommended the ending of free swimming from 1 April 2016, as part of identified savings for 2016/17 which was agreed subject to further work to limit the health impacts of the populations benefitting from the offer.

5.2 Following the Mayor and Cabinet decision in September 2015, Culture and Community Development Service has continued to pay for free swimming while considering this budget alongside a wider £1,000,000 savings target to be delivered from 1 April 2017 through a range of contractual and service changes.

5.3 As such it was necessary to determine which elements of the free swimming offer had significant impacts on health and should be protected if possible.

5.4 The Lewisham Public Health team consider that an individual needs to swim on average at least 3 times a month for it to have any physical health benefits. Sport England has a minimum measure of 30 minutes per week.

5.5 The number of those aged 16 or under swimming at a level which would sustain physical health benefits is low. During the period April 2015 to August 2015 less than 1% of 0-16 year olds accessing free swims, swam more than 3 times per month under the free swims programme (20 individuals). This compares to 8.3% of over 60s (133 individuals).

5.6 The low numbers of under 17s receiving any physical health benefit from free swimming questions the cost effectiveness and purpose of the offer.

5.7 Having re-examined the data it is clear that the implementation of the agreed savings for the offer to those aged 16 and under will have minimal health impacts with a more significant impact for the over 60s. As such officers have

confirmed that free swimming will continue for those over 60 under the terms of the Be Active scheme.

5.8 To allow enough time for this change to be effectively communicated to users, and to avoid ending free swimming during the school summer holidays it is recommended that free swimming for those aged 16 or under is stopped from 1 October 2016. Officers will work with Fusion, 1Life and the library service to ensure the change is communicated clearly to residents and users.

5.9 As part of the contractual negotiations with Fusion and 1 Life 60+ free swimming will continue under the funding available for the Be Active scheme. The ending of free swimming for those aged 16 and under will still deliver the full £200,000 per annum saving agreed in the original proposal.

5.10 Officers continue to work with Fusion and 1Life to deliver £1m savings target against the Leisure budget for 2017/18 and the committee with receive a full update on these proposals in September 2016.

5.11 Officers will also continue to work with Fusion and 1Life to increase numbers taking swimming lessons, either as part of the school curriculum or directly with the centres, and to and ensure that scheduling of pool timetables promotes access for all Lewisham residents.

6. Financial Implications

6.1 The cost to the Leisure budget to continue to provide free swimming for under 17s for 6 months (1 April – 30 September 2016) is £92,000. This figure can be absorbed with the Cultural and Community Development Service budget for 2016/17.

6.2 Officers are currently negotiating with both Fusion and 1Life to deliver the £1m savings target against the Leisure budget by 2017/18. These conversations are ongoing, but all possibilities are being looked at to provide a range of options for decision by Mayor and Cabinet during 2016.

7. Legal Implications

7.1 There are no legal implications arising from this report.

8. Equalities Implications

8.1 The Equality Act 2010 (the Act) introduced a new public sector equality duty (the equality duty or the duty). It covers the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

8.2 In summary, 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 The proposal to stop swimming for under 17's clearly has a negative impact on young people. However, the statistics provided in section 5 suggest that those affected are a very small part of the population. Whilst it is unclear what the exact impact on under 17's swimming numbers will be; officers consider that significant numbers of young people will continue to access the swimming facilities within the borough's leisure centres through pay and play provision or via educational provision.

9. Crime and Disorder Implications

9.1 The provision of leisure activities can assist with reducing crime by providing diversionary activities for young people. However, the low numbers currently accessing free swimming is unlikely to have a direct impact on crime and disorder.

10. Environmental Implications

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

Background Documents

None

For further information please contact Petra Marshall, Community Resources Manager on 020 8314 7034 or petra.marshall@lewisham.gov.uk

HEALTHIER COMMUNITIES SELECT COMMITTEE			
Report Title	Adult Integrated Care Programme and the Better Care Fund		
Contributors	Chief Officer, Lewisham Clinical Commissioning Group and Executive Director for Community Services	Item No.	6
Class	Part 1	Date:	18 May 2016

1. Purpose

1.1 This report provides Members of the Healthier Communities Select Committee with an update on Lewisham's Adult Integrated Care Programme and the associated Better Care Fund Plan for 16/17.

2. Recommendations

2.1 Members of the Healthier Communities Select Committee are asked to note:

- The priority areas for focus within the Adult Integrated Care Programme for 16/17
- The specific activity that will be supported by Better Care Funding during 16/17

3. Strategic Context

3.1 The Health and Social Care Act 2012 requires 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.

3.2 The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund.

3.3 The Government's Spending Review in November 2015 announced a requirement for all areas to have a plan for integration between social care and health by 2017, to be implemented by 2020.

4. Adult Integrated Care Programme (AICP)

4.1 Through the Adult Integrated Care Programme, Lewisham Health and Care Partners continue to work towards their vision of achieving by 2020, a viable and sustainable 'One Lewisham Health and Social Care System' that will enable the local population to maintain and improve their physical and mental wellbeing, enable independent living, and have access to person-centred, evidence-informed, high quality, yet cost-effective pro-active care, when it is needed.

4.2 Underpinning this vision, Lewisham Partners remain committed to four high level objectives:

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 enable them to choose how best to improve their health and wellbeing, explicitly addressing health and care inequalities including parity of esteem between physical and mental health.
Better Care - to provide the most effective personalised care and support where and when it is most needed - giving people 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.
Better value for the Lewisham pound – by focusing on delivering population-based health and wellbeing outcomes and higher levels of service quality whilst containing costs over the five year period.

5. AICP Focus for 16/17

5.1 At the end of last year, the Adult Integrated Care Programme Board identified the areas for focus during 16/17. In doing so, the Board was mindful of the work undertaken to date and the need to continue to focus on achieving a significant reduction in avoidable admissions to hospital, an improvement in the timely discharge of people from hospital, a better use and alignment with existing resources available in the community, and the need to retain a focus on prevention and early intervention to enable people to maintain and improve their health and wellbeing and maintain independent living.

5.2 Consequently, the Adult Integrated Care Programme Board have agreed that activity in 16/17 will focus on:

Developing the tools, systems and services to enable people to maintain and improve their own health and wellbeing, and to support independent living. This will include improving digital access to information, advice and support, remodelling the Single Point of Access so that people are referred to the correct service the first time they make contact and developing signposting tools to link people to the support and services they require;

Continuing the development of Neighbourhood Care Networks to support effective working across community health and care services, general practice, wider primary care and the voluntary sector. This will include consideration of what more is needed to sustain effective networks into the future;

Developing new approaches/models for the delivery of community health and care services and improving multidisciplinary working. This will focus on removing barriers and developing new approaches to improve patient experience and satisfaction; and establishing key processes for joint assessment, care planning within the Neighbourhood Community Teams;

Continuing the redesign and development of admission avoidance and hospital discharge services. This will include the development of a rapid response service, ambulatory care unit, home ward and a community discharge and support team.

5.3 During 16/17, focus will also continue to be given to the key enablers: estates, workforce and IMT.

Estates: An Integrated Estates Strategy is being produced to ensure that there are facilities of the right type in the right location to deliver health and care across the borough. A mapping of LBL, SLaM and LGT estates across the borough is currently taking place to inform the strategy.

Workforce: The implications for the workforce and plans for addressing them will be produced as part of the development of the 16/17 priorities. A baseline assessment of existing health and care workforce is being produced.

IMT: A clear picture of partners' IMT plans and of staff and residents' future needs that could be supported by technology will be obtained to ensure that IMT supports staff in new ways of working, such as mobile technology, provides users with better information and advice to support self care, and gives staff and residents access to shared health and care information. The use of technology is also recognised as a tool to support residents to better manage existing conditions.

5.4 In delivering the programme in 2016-17, the AICP Board has ensure that programme plans are being integrated with the wider transformation and improvement work taking place within primary and acute care, and are aligned with wider system resilience plans, Our Healthier South East London Strategy and the Sustainable Transformation Plan which will cover the six south east London boroughs. The programme also needs to ensure progress is made in meeting the BCF national conditions which include maintaining social care provision, action to prevent unnecessary non-elective admissions and support timely discharge; better data sharing; a joint approach to assessment and care planning and investment in out of hospital services.

5.5 For 16/17, the Board has recognised the need to improve the communication, engagement and co-design with key stakeholders across the system and has committed to improving these aspects of the programme. Accordingly the AICP board is developing a communication and engagement plan for 16/17.

6. Devolution Pilot

6.1 As members are aware, Lewisham Council and Lewisham CCG have agreed to be a devolution pilot to assist with the wider understanding of how devolution to London might work. Lewisham is bringing forward a case for change, by June, to test and explore whether being given greater local freedoms in a few areas, including estates and workforce, could help deliver health and social care integration more quickly and/or more effectively across London.

7. The Better Care Fund

7.1 Lewisham's Better Care Fund (BCF) Plan is an integral part of the delivery of Lewisham's Adult Integrated Care Programme (AICP) and will contribute to the delivery of the AICP 2016/17 priority areas. Lewisham's BCF plan includes activity implemented in 2015/16 and sets out a number of new areas which will support the work within the Programme BCF funding in 2016/17

has also been allocated to IMT development and estates refurbishment to support new models and delivery of care.

7.2 The new BCF activity identified for funding during 2016/17 will deliver:

Targeted Support for Falls and Care Homes
A new service to provide rehabilitation for people who have fallen or who are considered to be at risk of falls.
Dementia Services and Support
*A new model of care and an enhanced care pathway***.**
Integrated Management Posts
To develop joint processes across social care and nursing and improving the effectiveness of Neighbourhood Team Co-ordinators.
Co-location of NCTs
To further develop multi-disciplinary working and better co-ordinate all necessary interventions as part of the same care episode.
Admission Avoidance and Hospital Discharge
A team will be established to provide a rapid response to patients at risk of an emergency admission or attendance at A&E and a Home Ward to provide both "step up" care from the community, to prevent an avoidable admission, and "step down" care, for patients ready for discharge but who require on-going medical interventions.
Continuing Care
A redesigned Continuing Healthcare team and associated processes will be piloted.
IMT development
The development of a digital platform to give patients and service users access to a range of information, advice and service, a directory of formal and informal providers; and information on organisations, activities and events to support an individual's health and wellbeing.
Estates
Across all areas of work, assessments are taking place to identify the development or refurbishment needs in relation to estates to support new ways of working and shared use.

7.2 Lewisham's Better Care Fund plan for 16/17 was submitted to NHS England on 3 May. At the time of writing this report, we are awaiting confirmation that Lewisham's plan has been approved.

8. Conclusion

8.1 This information report provides an update on the adult integration care programme and the Better Care Fund and invites members of the Committee to note its contents.

If there are any queries on this report please contact **Sarah Wainer,** Programme Lead, Whole System Model of Care, Lewisham Clinical Commissioning Group
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Healthier Communities Select Committee		
Title	Health and adult social care integration – scoping report	
Contributor	Scrutiny Manager	Item 7
Class	Part 1 (open)	18 May 2016

1. Purpose

At its meeting on 19 April 2016, when deciding its work programme for 2016/17, the Committee agreed to hold an in-depth review into the integration of health and adult social care.

This paper sets out the rationale for the review, provides some background information about the integration of adult health and social care, nationally as well as in Lewisham, and suggests some key lines of enquiry for the review.

2. Recommendations

The Select Committee is asked to:

- Note the content of the report
- Consider and agree the proposed key lines of enquiry and timetable for the review – set out in sections 8 and 9.

3. Background

Ever since the creation of the NHS in 1948, the health and social care systems have remained separate – with healthcare provided by the NHS, free at the point of use, and social care provided by local authorities and means-tested.[1]

But given the ageing population – and increasing number of people living with long-term health problems requiring a range of health and social care services – there is a broad consensus among policymakers that a more joined-up approach is needed.

> *"The traditional divide between primary care, community services and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need."* – NHS, *Five-year forward view*

So what does the integration of health and social care actually mean? There are many different models and definitions but, in essence, it is about local health and social care providers working together at all levels, looking at *all* of someone's health and care needs and designing joined-up services around these.

[1] House of Commons Library, *Integrating health and social care*, May 2015

Supporters claim that providing more joined-up services, based around a person's needs and in the community, can help people to stay well and live independently for longer. This, in turn, can help save money by preventing unnecessary hospital admissions and help people re-adapt to life at home quicker after a stay in hospital.

Greater health and social care integration has been a policy goal of successive UK governments, but commentators have noted that progress has been slow and that integrated care remains the exception rather than the norm.[2] Some commentators also have queried – given that adult social care is means-tested and health care is free at the point of use – where, in an integrated system, do you decide where one ends the other starts?[3]

Integration across the UK:

Northern Ireland has had integrated health and social care services since 1973.

Scotland introduced legislation in 2014 to integrate health and social care functions and budgets of NHS boards and Local Authorities.

Wales has introduced frameworks for integration and introduced legislation in 2015 requiring local authorities and NHS bodies to enter formal partnership arrangements.

England has passed legislation to encourage integration and introduced a number of policies including the Better Care Fund and devolution.

Source: BMA website

Lewisham Council and Lewisham CCG have agreed to be a devolution pilot to assist with the wider understanding of how devolution to London might work. Lewisham is bringing forward a case for change to test and explore whether being given greater local freedoms in a few areas, including estates and workforce, could help deliver health and social care integration more quickly and/or more effectively across London. The Chief Officer of the CCG and the Executive Director for Community Services are members of the London pilot sub-group and have been sharing experiences and ideas with others to help inform Lewisham's case for change.

There has been some concern expressed through the media about the principle of a national health service in the context of devolution, and the "medicalisation" of social care.

4. Policy context

In recent years, both the Government and NHS have introduced several policy initiatives relating to the integration of health and social care.

As well as introducing a number of statutory duties to encourage integrated working,[4] in June 2013, the Government also set up a pooled budget of existing local government and NHS money called the Better Care Fund.

The Better Care Fund currently stands at a total of £5.3bn.[5] To access the funding, local areas must set out how they will meet certain conditions – for example, how they will prevent

[2] The King's Fund (webpage), *How far has the government gone towards integrating care?*, 8 April 2015
[3] Greater Manchester: The start of something big?, *BBC*, 25 February 2015
[4] *Health and Social Care Act 2012*, *Care Act 2014*

unnecessary hospital admissions, and how they will improve information sharing between health and social care.

The Better Care Fund is intended to incentivise local health and care systems to work more collaboratively when commissioning and providing health and social care services. It is not new or additional funding – it is drawn from existing CCG and LA funding allocations. It is hoped that by refocusing these resources into social and community care services, local areas will be able to provide better care and support to older people and people with long-term conditions.

Local areas submitted their final Better Care Fund plans in April 2016.

Also in 2013, NHS England (and national partners) published a "framework document" on integration – setting out how local areas could use existing structures to take further steps towards integration.[6] NHS England asked local areas to express an interest in trying out new ways of working across their local health and social care systems – in exchange for practical and technical support from the national partners.[7]

Greenwich integrated care pioneer

Teams of nurses, social workers, occupational therapists and physiotherapists work together to provide a multidisciplinary response to emergencies in the community that require a response within 24 hours.

Over 2,000 patient admissions were avoided due to immediate intervention from the Joint Emergency Team (JET). There were no delayed discharges for patients over 65 and over £1m has been saved from the social care budget.

Source: NHS

Fourteen "integrated care pioneers" were set up in 2013, and a further eleven in 2015.[8] The programme is expected to run for five years. (Lewisham is not one of the pioneers.)

In January 2016, NHS England published an assessment of the second year of the integrated care pioneers programme, and set out its priorities for 2016-17. These included growing successful projects and making system changes to underpin these.[9]

In October 2014, NHS England published a five-year plan for the health service called the "Five Year Forward View".[10] This set out the challenges the NHS is facing – including a funding gap of £30 billion – and put forward a number of new models of care to help save £22bn by 2020.

NHS England said the new models of care would bring local health and social care service closer together – and could include things like GP practices offering hospital services, hospitals providing care direct to care homes, and specialists holding clinics in local surgeries.

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[5] Local Government Association (webpage), *About the Better Care Fund*, accessed May 2016
[6] NHS England et al, *Integrated Care: Our Shared Commitment*, May 2013
[7] NHS England (webpage), *Pioneer Support Programme*, accessed May 2016
[8] NHS England (webpage), *About the pioneers*, accessed May 2016
[9] NHS England, *People helping people: Year two of the pioneer programme*, January 2016
[10] NHS England, *Five Year Forward View*, October 2014

NHS England said that the new care models would, among other things, lead to fewer trips to hospital and give people one point of call for a range of health and social care services.[11]

The GP super-practice - Whitstable Medical Practice, in Kent, offers traditional GP services alongside a host of services more associated with hospitals. It runs maternity services, a minor injury unit with X-ray facilities and dedicated diabetes, heart disease and asthma clinics as well as diagnostics and minor surgery.

Source: BBC

Working with care homes – Nurses and doctors from Airedale Hospital in West Yorkshire have set up video link-ups with local care homes. It allows consultations to take place with residents on everything from cuts and bumps to diabetes management. Emergency admissions from these homes have reduced by 35% and A&E attendances by 53%.

Source: BBC

Soon after, in January 2015, NHS England invited local areas to apply to become 'vanguard' areas – working with national partners to test and develop to the new care models. NHS England said the new models would act as the blueprints for the better integration of health and social care across the country.[12]

The first 29 vanguards were announced in March 2015 – by September a total of 50 had been established. (Lewisham is not one of the vanguards.) The new integrated care models include:[13]

- **Integrated primary and acute care system vanguards** – which will join up GP, hospital, community and mental health services
- **Enhanced health in care homes** – which will offer older people better, joined up health, care and rehabilitation services.
- **Multispecialty community provider vanguards** – which will move specialist care out of hospitals into the community

"… the vanguards will develop local health and care services to keep people well, bring home care, mental health and community nursing, GP services and hospitals together for the first time since 1948."

Source: NHS

In November 2015, the Government announced that it would require all parts of the country to fully integrate health and care by 2020, and to develop a plan to achieve this by 2017.[14]

In December 2015, NHS England asked every local health and care system to work together to produce a plan (known as a sustainability and transformation plan) setting out how local services would integrate and become sustainable by 2020.[15]

NHS England said that planning by place for local populations would increasingly supplement planning by individual institutions. It said that each plan should cover the full

[11] NHS England (webpage), *New care models – vanguard sites*, accessed May 2016
[12] NHS England (webpage), *New care models – vanguard sites*, accessed May 2016
[13] NHS England (webpage), *New care models – vanguard sites*, accessed May 2016
[14] HM Treasury, *Spending review 2015*, November 2015
[15] NHS England (webpage), *Sustainability and Transformation Plans*, accessed May 2016

range of health services within a specified geographic area (called a "footprint") – including better integration with local authority services.[16]

Sustainability and transformation plans will be the basis for accessing extra funding in 2016/17 and attracting additional national investment for 2017/18 to 2020/21.[17] NHS England has established a sustainability and transformation fund of £2.1bn for 2016/17, rising to £2.9bn in 2017/18 and £3.4bn in 2020/21.[18] 44 footprints have been identified and full plans are to be submitted in June 2016.[19] A Sustainability and Transformation Plan for SE London is being developed which will include Lewisham.

5. Recent analysis

A recent analysis of a range of integrated care models around the country identified some of the important characteristics (or "key enablers") necessary for effective integration. The report noted that the level of impact achieved in the models it studied was closely related to whether or not any changes were made in certain key areas: information management, payment models and governance. The report also noted, however, that there is no "silver bullet" and that transformational change will realistically take a journey of close to a decade.

The headline findings of the report included: [20]

- **An essential starting point is a shared vision and commitment from a leadership coalition**. There is a clear requirement to have a strong leadership coalition, with clinical and managerial leaders empowered across the system.

- **The flow of information is an essential pre-requisite to make change happen and must be taken out of the 'too difficult' box.** There are no policy constraints that prevent putting in place the essential requirements for information governance to permit the free flow of information.

- **Changes in payment need to be made to fund direct costs of changes in care and change incentives for organisations.** This is, perhaps, the most disappointing and underpowered area of integration in England. It is obvious that care cannot change without the resources to deliver it.

- **Changes in governance are essential to allow change to happen but form must follow function.** At the outset, what is required is a leadership coalition dedicated to a common purpose that makes joint commitments and resourcing decisions.

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[16] NHS England, *Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21*, Dec 2015
[17] Local Government Association (webpage), *What are STPs?*, accessed May 2016
[18] Health and care bodies reveal the map that will transform healthcare in England, *NHS England*, 15 March 2015
[19] The King's Fund (webpage), *Tracking the development of sustainability and transformation plans in England*, accessed May 2016
[20] Local Government Association, *The journey to integration Learning from seven leading localities*, April 2016

Further recent analysis of the evidence around health and social care integration has also identified several other "essential components" of effective integration. These include:[21]

- **a population-based approach**, including early identification and coordinated support to individuals who may be at risk of developing long-term conditions

- **information sharing** that supports the delivery of integrated care, especially via the electronic record, decision support systems, systems to identify and target 'at risk' patients at an early stage

- **effective shared leadership** at all levels with a focus on continuous improvement of quality and outcomes

- **aligning financial incentives** - Current NHS payment mechanisms are poorly designed for integrated care pathways that go across health and social care

- **enabling shared accountability** - At present, different parts of the system are working to different outcomes frameworks and are held to account by different national bodies and regulators.

Torbay Care Trust – integrated health and social care teams use pooled budgets and work alongside GPs to provide a range of intermediate care services. By supporting hospital discharge, older people have been helped to live independently in the community. The results include reduced use of hospital beds, low rates of emergency admissions for those over 65, and minimal delayed transfers of care.

Source: The King's Fund

In **Hereford**, an integrated care organisation based on eight health and social care neighbourhood teams is in development to support the personal health, well-being and independence of frail older people and those with chronic illnesses such as diabetes, stroke and lower back pain. Early successes include lower bed utilisation and reductions in delayed discharges from hospitals

Source: The King's Fund

Research has also found that while there is "much evidence to show that greater integration and personalisation improves outcomes, the evidence that it delivers financial savings is still in its early stages and there is currently a lack of empirical evidence to show it will be more cost effective".[22]

[21] The King's Fund, *The evidence base for integrated care*, October 2011
[22] Local Government Association, *All Together Now: Making integration happen*, April 2015, p6; King's Fund (webpage) *Integrated health and social care in England: progress and prospects*, accessed May 2016

The Wigan Deal for Adult Social Care

In Wigan, up to 50% of activity in GP practices is socio-economic, not clinical – and 40% of Wigan residents at highest risk of unplanned hospital admission are adults of working age often with complex dependency on public services.[23]

Wigan has made £100m savings since 2010 and needs to save a further £60m by 2018/19. Wigan Council said that this challenge requires a "fundamentally different relationship between residents in the borough and the council and other public services":

Source: Wigan Council website

As well as the over Deal, there is Deal for Adult Social Care. Wigan describes this as "a radical reimagining of how we work", which involves having "different conversations" with residents to better understand individual strengths, gifts and talents, and connecting people with community solutions such as local community hubs, social groups or buddies.

The Live Well Team, for example, are a small team drawn together from different agencies and backgrounds. They are responsible for engaging with adults of working age with a complex dependency on public services. They talk to people about what they can do, rather than what they can't do, and help people to find more personalised care solutions in the community.

So far, Wigan has learnt, among other things, that: it can take time for staff from different agencies to "get it", and relax from organisational pressures; we tend to label people based on our profession; our front doors are designed to keep people out; and the presenting issue is often not where the needs lie.[24]

[23] Presentation supplied by Wigan Council, dated April 2016
[24] Presentation supplied by Wigan Council, dated April 2016

6. Health and social care integration in Lewisham

Lewisham set out its commitment to integrated care in its 2008-2020 sustainable community strategy, *Shaping our future*: "whether working to prevent hospitalisation, caring for people once they are in hospital or supporting people who have had treatment, health and care services in Lewisham need to be provided in an integrated and 'seamless' manner to ensure the best quality services and results".[25]

Lewisham reiterated its commitment to integration in its 2013 Health and wellbeing strategy, *Achieving a healthier and happier future for all*.[26] One of the strategies overarching aims is "to improve efficiency by improving the way services are delivered; streamlining pathways; integrating services so ensuring that services provide good quality and value for money."

The strategy also states that in designing services to achieve its aims it will look to "promote integration and community based care – rearranging services in a way that provides the care and support people need, at the right time in the right place, and establishing neighbourhood-based delivery models where appropriate."[27]

In 2013, Lewisham established its Adult Integrated Care Programme, *Better Health, Better Care and Stronger Communities.* The programme is focused on transforming the way local health and care services are provided. Lewisham's stated ambition is to have joined up and coordinated health and social care services for all adults by 2018**.** The programme is being led by the Adult Integrated Programme Board, whose members include representatives from Lewisham Council, Lewisham Clinical Commissioning Group, South London and Maudsley NHS Foundation Trust, Lewisham and Greenwich NHS Trust, and primary care.

In a recent report to the Health and Wellbeing board, the Executive Director for Community Services set out four priorities for the Adult Integrated Care Programme in 2016-17. These included: developing community health and care services as part of Neighbourhood Care Networks; to continue building Neighbourhood Care Networks in all four areas; to continue the redevelopment of admission avoidance and hospital discharge services; and to provide people with access to a range of health information, advice and support.[28]

Lewisham and its people

292,000 residents

14.5% of residents are living with long-term conditions

9.5% of residents are over 65 (15.9% average in England)

11.8% of resident over 65 receive one of more type of social care service

Source: Local Account, JSNA

[25] Lewisham Council et al, *Shaping our future Lewisham's Sustainable Community Strategy 2008-2020*, 2008
[26] Lewisham Council et al, *Achieving a healthier and happier future for all Health and wellbeing strategy*, December 2013
[27] Lewisham Council et al, *Achieving a healthier and happier future for all Health and wellbeing strategy*, December 2013
[28] *Adult Integrated Care Programme and the Better Care Fund*, report to the Health and Wellbeing Board, 29 March 2016

A further update on the Adult Integrated Care programme is being presented to members in a separate report to this Committee meeting.

Lewisham's 2015-16 annual report on adult social care reiterated the ambition to have joined up and coordinated health and social care services for all adults in Lewisham by 2018. It also reviewed progress made on Lewisham's previous objectives for adult social care. Lewisham's completed or started all of its objectives for 2014-15. Objectives completed included:[29]

- **Developing an accessible and comprehensive website to improve access to information and advice**: The Health and Social Care website and directory of services is now live.
- **Identify people at risk of developing more complex health and care needs at an early stage**: Neighbourhood Team Coordinators are in place and are working with GPs to identify those who are at risk.
- **Ensure the Neighbourhood Teams connect to community health services and wider primary care teams**: Social care and district nursing staff are now organised into neighbourhood teams.
- **Improve outcomes for people receiving enablement, thus reducing the need for long-term care**: Of the 851 people who received enablement support, 522 needed no additional care or support in the 3 months after.

£81.5 million
total budget for adult social care in 2014-15

33% spent on people with learning disabilities

35% spent on older people

The report also set out Lewisham's plans for 2016-17. These include:[30]

- Closer working with GP practices, district nurses and other health services
- Work with local providers to develop services that promote independence
- Continue to play a key role in the wider integration and transformation of health and care in Lewisham.

[29] Lewisham Council, *Local Account for Adult Social Care 2015-2016*, April 2016
[30] Lewisham Council, *Local Account for Adult Social Care 2015-2016*, April 2016

7. Meeting the criteria for a review

A review into the integration of health and adult social care meets the criteria for carrying out a scrutiny review because:

- The issue affects a number of people living, working and studying in Lewisham
- The issue is strategic and significant
- This issue is of concern to partners, stakeholders and the community
- Scrutiny is likely to add value – Lewisham Council is currently developing the way it integrates and works with local partners to improve health and care outcomes. .

8. Key lines of enquiry

- The structure of the Adult Integrated Care Programme
- The priorities, activity and measures of success for the Adult Integrated Care Programme
- The current and planned extent of partnership working, including the voluntary and community sector
- Examples of best practice in integrated care from around the country

Review questions

How is the Adult Integrated Care Programme determining its priorities and areas for integration?

How is the programme involving local partners and maximising community assets?

How is the programme communicating and engaging with the public?

9. Timetable

The Committee is asked to consider the outline timetable for the review:

First evidence session - 13 September 2016

Representatives from the Adult Integrated Care Programme Board: plans, successes and challenges.

Second evidence session - 18 October 2016

Evidence from integrated care pioneer or vanguard areas nearby – for example, Greenwich, North West London, Tower Hamlets, Sutton.

Evidence from national bodies – for example, LGA, King's Fund, Nuffield Trust.

Third evidence session - 24 November 2016

Evidence from other local voluntary sector and expert partners – for example, Healthwatch, Voluntary Action Lewisham, Carers Lewisham, Lewisham Pensioners' Forum, Positive Ageing Council, GPs, Pharmacies, service users/customers.

Report - 12 January

Committee will consider a final report presenting all the evidence and agree recommendations for submission to Mayor and Cabinet.

10. Further implications

At this stage there are no specific financial, legal, environmental or equalities implications to consider. However, each will be addressed as part of the review.

For further information please contact John Bardens, Scrutiny Manager, on 02083149976 or email john.bardens@lewisham.gov.uk.

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Healthier Communities Select Committee			
Title	Select Committee work programme		
Contributor	Scrutiny Manager	Item	8
Class	Part 1 (open)	18 May 2016	

1. Purpose

To advise Members of the proposed work programme for the municipal year 2016-17, and to decide on the agenda items for the next meeting.

2. Summary

2.1 At the beginning of the municipal year, each select committee drew up a draft work programme for submission to the Business Panel for consideration.

2.2 The Business Panel will consider the proposed work programmes of each of the select committees on 24 May 2016 to agree a co-ordinated overview and scrutiny work programme. However, the work programme can be reviewed at each Select Committee meeting so that Members are able to include urgent, high priority items and remove items that are no longer a priority.

3. Recommendations

3.1 The Committee is asked to:

- note the work plan attached at **Appendix B** and discuss any issues arising from the programme;
- specify the information and analysis required in the report for each item on the agenda for the next meeting, based on desired outcomes, so that officers are clear about what they need to provide;
- review all forthcoming key decisions, attached at **Appendix C**, and consider any items for further scrutiny;

4. The work programme

4.1 The work programme for 2016/17 was agreed at the Committee's meeting on 19 April 2016.

4.2 The Committee is asked to consider if any urgent issues have arisen that require scrutiny and if any existing items are no longer a priority and can be removed from the work programme. Before adding additional items, each item should be considered against agreed criteria. The flow chart attached at **Appendix A** may help Members decide if proposed additional items should be added to the work programme. The Committee's work programme needs to be achievable in terms of the amount of meeting time available. If the Committee agrees to add additional item(s) because they are urgent and high priority, Members will need to consider

which medium/low priority item(s) should be removed in order to create sufficient capacity for the new item(s).

5. The next meeting

5.1 The following reports are scheduled for the meeting on 28 June 2016:

Agenda item	Review type	Link to Corporate Priority	Priority
Devolution pilot business case	Standard item	Inspiring efficiency, effectiveness and equity	High
Elective orthopaedics	Standard item	Active, healthy citizens	High
Lewisham and Greenwich NHS Trust Quality Account	Standard item	Active, healthy citizens	Medium

5.2 The Committee is asked to specify the information and analysis it would like to see in the reports for these items, based on the outcomes the Committee would like to achieve, so that officers are clear about what they need to provide for the next meeting.

6. Financial Implications

There are no financial implications arising from this report.

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.

9. Date of next meeting

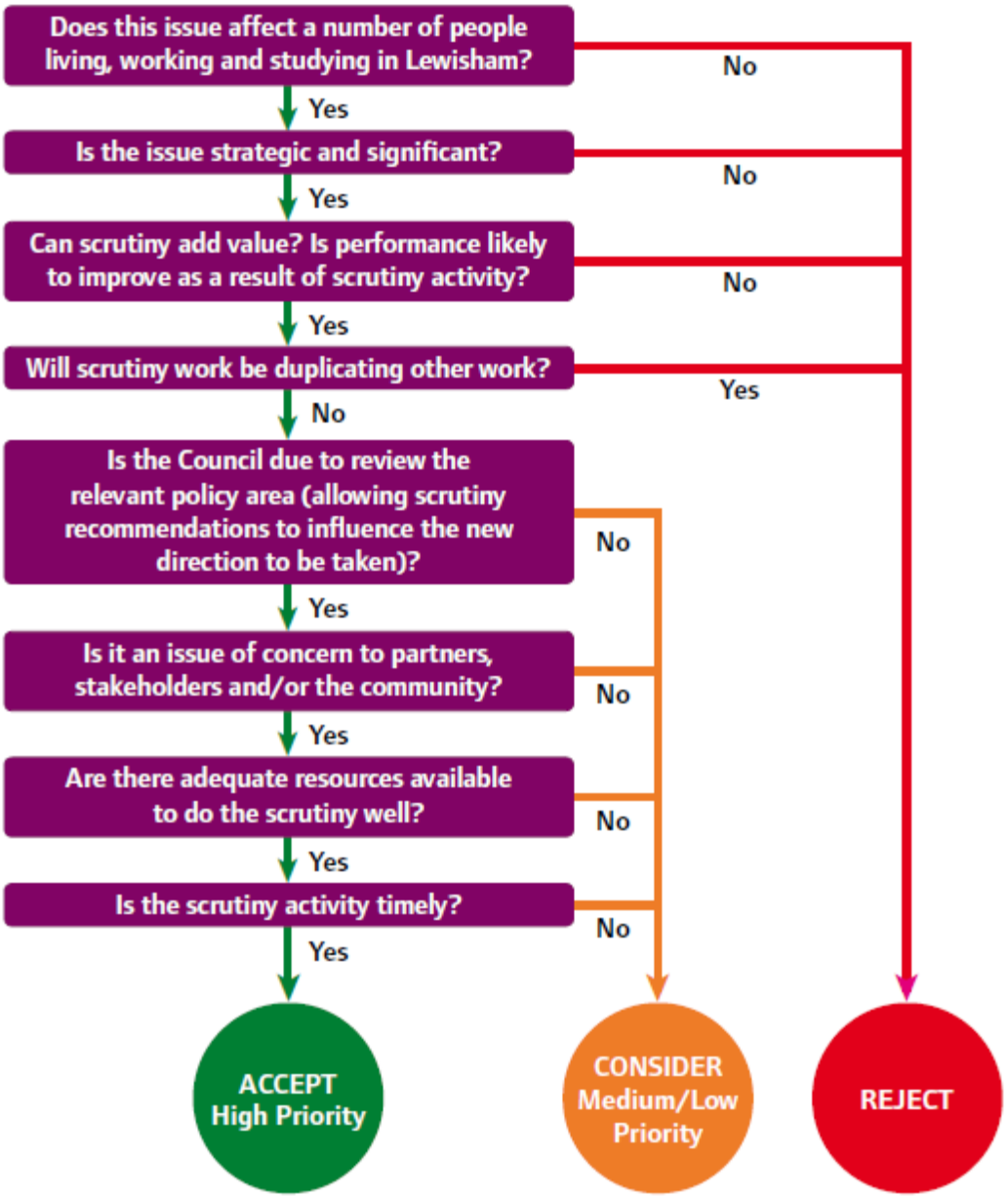
The date of the next meeting is Tuesday 28 June 2016.

Background Documents

Lewisham Council's Constitution

Centre for Public Scrutiny: the Good Scrutiny Guide

Scrutiny work programme – prioritisation process



Healthier Communities Select Committee work programme 2016/17

Programme of work

Work item	Type of item	Priority	Strategic priority	Delivery deadline	19-Apr	18-May	28-Jun	13-Sep	18-Oct	24-Nov	12-Jan	01-Mar
Lewisham future programme	Standard item	High	CP9	On-going								
Confirmation of Chair and Vice Chair	Constitutional req		CP9	Apr								
Select Committee work programme	Constitutional req	High	CP9	Apr								
Sustainability and Transformation Plans	Standard item	Medium	CP9	Apr								
SLaM place of safety changes	Information item	High	CP9	Apr								
Health and social care integration	Standard item	Medium	CP9									
Health and adult social care integration	In-depth review	High	CP9			Scope		Evidence session	Evidence session	Evidence session	Report	Referral
SLaM quality account	Performance monitoring	Medium	CP9									
Free swimming	Standard item	High	CP9									
Healthwatch reports on the Polish and Tamil communities' access to health and wellbeing services in Lewisham	Standard item	Medium	CP9									
Devolution pilot business case	Standard item	High	CP10									
Elective orthopaedics	Standard item	High	CP9									
Lewisham and Greenwich NHS Trust Quality Account	Standard item	Medium	CP9									
Adult safeguarding	Standard item	High	CP9									
Healthwatch annual report	Standard item	Medium	CP9									
Public health annual report	Performance monitoring	Low	CP9									
Lewisham hospital update (systems resilience)	Standard item	High	CP9									
Place-based care	Standard iten	Low	CP9									
LCCG commissioning intentions	Standard review	Medium	CP9									
Transition from children's to adult social care	Standard item	Medium	CP9									
Adult learning Lewisham annual report	Performance monitoring	Medium	CP9									
Access to GP services	Standard item	Medium	CP9									
Implementation of the Care Act	Performance monitoring	High	CP9									
Development of neighbourhood care networks	Standard item	Medium	CP9									
Delivery of the Lewisham Health & Wellbeing priorities	Performance monitoring	High	CP9									
Leisure centre contract	Performance monitoring	Medium	CP9									

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

Meetings					
1)	Tue	19 April	5)	Tue	18 Oct
2)	Wed	18 May	6)	Thu	24 Nov
3)	Tue	28 Jun	7)	Thu	12 Jan
4)	Tue	13 Sep	8)	Wed	01 Mar

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 June 2016 - September 2016

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 Flaherty, 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**
February 2016	**Annual Lettings Plan**	05/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
February 2016	**Development Agreement with the Education Commission for the Archdiocese of Southwark: St Winifreds**	05/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
January 2016	**Lewisham Homes Management Agreement**	18/05/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
January 2016	**Miscellaneous Debts Write Off**	05/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
April 2016	**PLACE/Ladywell Residential Units Lease to Lewisham Homes**	18/05/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
April 2016	**Contract Variation Turnham Primary School Expansion**	18/05/16 Mayor and Cabinet	Sara Williams, Executive Director, Children 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)	Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
April 2016	**Extension of Capita CST (Revenue and Benefits) Support Services Contract**	24/05/16 Overview and Scrutiny Business Panel	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
April 2016	**Special Educational Needs and Disability Information Advice and Support Service**	24/05/16 Overview and Scrutiny Education Business Panel	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
November 2015	**Discharge into Private Rented Sector Policy**	06/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
February 2016	**Disposal of Land at Corner of Deptford Church Street and Creekside**	06/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
January 2016	**Hostels/Private Sector Leased Service Transfer to Lewisham Homes**	06/16 Mayor and Cabinet	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 Damien Egan, Cabinet Member Housing		
April 2016	**Housing Development Programme Update parts 1 & 2**	01/06/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
April 2016	**Austic Spectrum Housing**	01/06/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
January 2016	**New Bermondsey Housing Zone Bid Update**	06/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
March 2016	**Lewisham Adoption Service Statement of Purpose and Childrens Guides**	06/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
March 2016	**Lewisham Fostering Service Statement of Purpose and Childrens Guides**	06/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		

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**
February 2016	**Saville Centre options for future use of site**	06/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
June 2014	**Surrey Canal Triangle (New Bermondsey) - Compulsory Purchase Order Resolution**	06/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
April 2016	**Processing of Dry Recyclables Contract**	01/06/16 Mayor and Cabinet (Contracts)	Kevin Sheehan, Executive Director for Customer Services and Councillor Rachel Onikosi, Cabinet Member Public Realm		
April 2016	**Youth Services Contract Award**	01/06/16 Mayor and Cabinet (Contracts)	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
March 2016	**LED Lighting Project Laurence House**	14/06/16 Overview and Scrutiny Business Panel	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
	Contract Extension for Cleaning and Planned and	14/06/16 Overview and	Janet Senior, Executive Director for Resources &		

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**
	Preventative Maintenance	Scrutiny Business Panel	Regeneration and Councillor Alan Smith, Deputy Mayor		
	Pupil Places Bulge Programme 2016 Contract award	14/06/16 Overview and Scrutiny Education Business Panel	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
April 2016	**Education Commission Update**	29/06/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
April 2016	**Adoption Service Statement of Purpose and Children's Guides**	29/06/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
April 2016	**Fostering Service Statement of Purpose and Children's Guides**	29/06/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		

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**
February 2016	**Health and Social Care Devolution Pilot**	29/06/16 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
February 2016	**Contract Award Security**	06/16 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
April 2016	**Prevention and Inclusion Contract Award**	29/06/16 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Janet Daby, Cabinet Member Community Safety		
January 2016	**Beeson Street Scheme Approval and Proposed form of Investment partnership/procurement route**	13/07/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
March 2016	**Campshill Road Extra Care Scheme**	07/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
	Lewisham Homes Loan Acquisition Programme parts 1 and 2	13/07/16 Mayor and Cabinet	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 Damien Egan, Cabinet Member Housing		
	Phoenix Community Housing Development parts 1 and 2	13/07/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
	The Future of Lewisham Music Service	13/07/16 Mayor and Cabinet	Councillor Paul Maslin, Cabinet Member for Children and Young People and Councillor Damien Egan, Cabinet Member Housing		
February 2016	**Contract Award Planned and Preventative Maintenance**	07/09/16 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
February 2016	**Contract Award Cleaning**	07/09/16 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
February 2016	**Insurance Renewal**	09/16 Overview and Scrutiny Business Panel	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		