Public Document Pack

Healthier Communities Select Committee Agenda

Monday, 3 December 2018
7.30 pm, Committee Room 3
Civic Suite
Catford
SE6 4RU

For more information contact: John Bardens (02083149976)

Part 1

Healthier Communities Select Committee Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Monday, 3 December 2018.

Janet Senior, Acting Chief Executive
Thursday, 22 November 2018

Councillor John Muldoon (Chair) Councillor Coral Howard (Vice-Chair) Councillor Peter Bernards Councillor Juliet Campbell Councillor Carl Handley Councillor Octavia Holland Councillor Sue Hordijenko Councillor Sakina Sheikh Councillor Bill Brown (ex-Officio)	

MINUTES OF THE HEALTHIER COMMUNITIES SELECT COMMITTEE

Tuesday 9 October 2018, 7.00pm

Present: Councillors John Muldoon (Chair), Coral Howard (Vice Chair), Juliet Campbell, Peter Bernards, Carl Handley, Octavia Holland and Sakina Sheikh.

Apologies: Councillor Sue Hordijenko.

Also Present: Professor Michael Preston-Shoot (Independent Chair, Lewisham Safeguarding Adults Board), David Austin (Head of Corporate Resources), Aileen Buckton (Executive Director for Community Services), Dee Carlin (Head of Joint Commissioning), Robert Mellors (Group Finance Manager, Community Services), Diana Braithwaite (Director of Commissioning & Primary Care, Lewisham CCG), Nigel Bowness (Healthwatch), Georgina Nunney (Principal Lawyer) and John Bardens (Scrutiny Manager).

1. Minutes of the meeting held on 4 September 2018

Resolved: the minutes of the last meeting were agreed as a true record.

2. Declarations of interest

The following non-prejudicial interests were declared:

- Cllr John Muldoon is a day patient at Guy's and St Thomas' NHS Foundation Trust (in relation to item 7).

3. Adult safeguarding annual report

Professor Michael Preston-Shoot (Independent Chair, Lewisham Safeguarding Adults Board) introduced the report. The following key points were noted:

3.1 The Lewisham Safeguarding Adults Board (LSAB) is well established. It is well supported by the council, the police and the Lewisham CCG, and has good engagement from third-sector organisations. It has good budget contributions from the council and the CCG as well as contributions from the two local NHS trusts. There are no current concerns about the health of the LSAB.

3.2 The LSAB has completed two safeguarding reviews – a third is in progress. One potential concern is that all the reviews have related to men of African/Caribbean origin, and two have related to mental health.

3.2 People who may have previously relied on lower-level support are increasingly finding that it is no longer available and as a result are increasingly at risk of experiencing significant harm, which eventually comes to the notice of the

council. This means that many referrals are demonstrating increased acuity and complexity. This trend is expected to continue.

The committee asked a number of questions. The following key points were noted:

3.3 The committee queried whether there is enough training on adult safeguarding for councillors and council staff.

3.4 Adult safeguarding training has been provided for councillors and can be repeated annually, or more frequently if required. Safeguarding training for council staff is monitored alongside training for police and health staff. Council staff have received the required level of safeguarding training.

3.6 The committee asked about the level of awareness of safeguarding issues among the wider public.

3.7 Awareness of safeguarding among the wider public is variable. This is why the LSAB is holding an awareness raising conference in November aimed at the third sector. The LSAB has also run faith-based training which resulted in the appointment of adult safeguarding champions in faith groups in Lewisham.

3.8 The committee expressed concern about the operation of unregulated providers.

3.9 The LSAB knows where most of the unregulated providers are and the council (with its partners) is using its statutory powers to address this issue. Unregulated providers are an area of concern across London and elsewhere in England. The Chair of the LSAB suggested that the Department of Health and Social Care should consider extended regulation in the hope of raising standards in the sector.

Resolved: the committee thanked the chair of the LSAB and noted the report.

4. Responses from Mayor and Cabinet

Cllr Muldoon (Chair) informed the committee of the following responses to referrals from the committee:

4.1 Lewisham and Greenwich NHS Trust provided their communications plan on the changes to the opening hours of sexual health services in the borough. This is in response to the committee's referral at its meeting on 27th June.

4.2 At its meeting on 20th September, Mayor and Cabinet resolved to circulate the Lewisham Healthwatch annual report to all cabinet members. This is in response to the committee's referral at its meeting on 4th September.

Resolved: the committee noted the responses.

5. Budget cuts

David Austin (Head of Corporate Resources) introduced the report. The following key points were noted:

5.1 The council's Medium Term Financial Strategy identified the need for continued cuts to be made to the council's budget over the coming four years.

5.2 This report sets out £21m of cuts proposals against the target of £30m cuts in the two years to 2020/21 - £17m in 2019/20 and £13m in 2020/21.

5.3 The proposals are aligned to the 10 corporate objectives and Lewisham 2020 strategy.

5.4 Officers will be developing and returning with further cuts proposals for the second year (2020/21).

Aileen Buckton (Executive Director for Community Services) introduced budget cut proposal **COM1**: *Managing demand at the point of access to adult social care services*. The following key points were noted:

5.5 In order to manage increasing demands on adult social care services, officers are working towards a preventative approach focussed on identifying people who may need support in the future earlier, and working with individuals and organisations in the community to provide support which could delay the need for a formal package of adult social care services.

5.6 Social workers will look at an individual's strengths, what they can do for themselves, and what other organisations and people, including relatives, in their community may be able to do, in order to make the best use of the available support and make the best use of the social care resources there are.

5.7 COM 1 is part of the Council's work to manage increasing demands on adult social care.

5.8 National guidelines suggest that local authorities should not spend more than 15% of their adult social care budget on care packages of 10 hours or less, as this level of care can often be accessed by other means and by ensuring that correct levels of benefits are in place.

5.9 Lewisham currently spends 15.5% of its adult social care budget on packages of 10 hours or less. To reduce this the council will look at what else it might be able to do for this group of residents and whether there is other support in the community which can be utilised.

5.10 Officers do not expect a large increase in complaints as social workers will be working closely with individuals and their families to reach agreement.

5.11 The eligibility criteria for adult social care services are national criteria set out in the *Care Act* and are not expected to change.

5.12 In complex cases benefits advice will be available from advice services in the voluntary sector.

5.13 The people who would be affected by this proposal are by and large younger and likely to be able to gain a level of independence.

5.14 If someone has very complex needs they will be provided with the appropriate support.

5.15 A panel of senior managers will have oversight of all care package reviews and care packages will be reviewed carefully in line with what is feasible.

5.16 It is also important to think about the needs of carers and do a separate assessment for any services they require.

5.17 The principal social worker is developing training for all social workers on how to talk to residents and their family members about what they are able to do themselves and what other support is available which they may wish to access.

5.18 The council has in recent years developed the *Community Connections* service to work with organisation from the voluntary and community sector to help them grow their services and be more accessible.

5.19 As part of the quality assurance process, regular audits of individual care plans will be carried out to ensure that social workers are taking the same asset-based approach and that there is consistency.

5.20 Officers are confident that the proposed cut can be achieved.

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

5.21 Given that more people will be expected to access support from the voluntary and community sector, the committee queried whether an assessment has been carried out to ensure that the additional capacity is available.

5.22 The committee expressed concern that the proposal would lead to more pressure being put onto friends and family.

5.23 In cases where a small package of care is crucial to an individual and their family, the committee noted that there is a danger of support not being

accessed if family members are expected to take on responsibility for arranging other services.

5.24 The committee also queried whether the identified risk of an increase in complaints could lead to an additional cost to the council.

Aileen Buckton (Executive Director for Community Services) introduced budget cut proposal **COM2**: *Ensuring support plans optimise value for money*. The following key points were noted:

5.25 Like COM 1 this proposal is part of the council's work to manage increasing demands on adult social care.

5.26 As part of this proposal, all newly allocated cases will be based on medium-term goals to support people, where possible, to regain some independence and need less care.

5.27 There is a requirement to visit and reassess a care package annually, but for some people it might be appropriate to go back more frequently in order to adjust their package.

5.28 The proposal also includes an action to complete *Continuing Healthcare* decisions within national guidelines on timeframes so that the council does not continue funding care which should be funded by the NHS.

5.29 The council is also proposing to work proactively with the care market to purchase more personalised provision and fewer block contracts to meet people's individual needs. There is a wide range of care providers in Lewisham, across different categories.

5.30 There is not a significant number of social worker vacancies in Lewisham. There are, however, some occupational therapist (OT) vacancies. There is a currently a shortage of OTs. While recruitment of social workers isn't a problem, retention of social workers is an issue for all London boroughs.

5.31 Officers are confident that they have the workforce, social work staff and commissioners, to support this proposal.

5.32 Emergency reassessments are available (24 hours a day, seven days a week) if someone's circumstances and needs change very quickly, and this is not going to change.

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

5.33 The committee queried whether the adult social care workforce has the capacity to deal with an increased number of assessments, in particular in those cases where people's circumstances and needs change very quickly.

5.34 The committee expressed some concern about the impact of funding reductions for voluntary sector partners at a time when the council is expecting them to provide more support.

Aileen Buckton (Executive Director for Community Services) introduced budget cut proposal **COM3**: *Increase revenue from charging adult social care clients*. The following key points were noted:

5.35 This proposal is focused on increasing revenue by ensuring that the council receives the charges for adult social care that it is owed and that it does not overpay providers.

5.36 As part of this proposal the council is introducing automated systems to provide more accurate billing and invoice processing. This will also allow charges to be adjusted more quickly when people's care needs change.

5.37 This may lead to some undercharging being identified. In such cases social workers will meet with people face to face to explain and discuss.

5.38 If people need advice about benefits they may be entitled to, in order to maximise their income, social workers can signpost to independent advice agencies.

Aileen Buckton (Executive Director for Community Services) introduced budget cut proposal **COM4**: *Reduce costs for learning disability and transitions*. The following key points were noted:

5.39 This proposal is focused on reducing the costs associated with the transition from children's to adult social care services for those with learning disability.

5.40 The council is in the process of establishing a new transition service which works with young people from an earlier age in order to become more independent and develop packages of support at a reduced cost.

5.41 Work needs to be done to develop the market in Lewisham and redevelop some of the educational and employment opportunities for young adults with learning disability so that they are able to stay in the borough.

5.42 Most supported living accommodation for people with learning disability is within the borough. There are currently 125 units in the borough from a range of providers.

The Chair proposed to suspend standing orders to continue the meeting. The Select Committee agreed to suspend standing orders.

Aileen Buckton (Executive Director for Community Services) introduced budget cut proposal **COM5**: *Increase focus of personalisation*. The following key points were noted:

5.43 This proposal is based on increasing the availability of two existing schemes: Personal Assistants and the Shared Lives service.

5.44 Personal Assistants are more prevalent among younger disabled adults. Arrangements need to be put in place, however, for occasions when a Personal Assistant may be unwell, for example.

5.45 The council is looking into the potential of developing training for domiciliary workers which would allow them to progress their career into the health or care market.

Dee Carlin (Head of Joint Commissioning) introduced budget cut proposal **COM6**: *Reduction in mental health residential care costs*. The following key points were noted:

5.46 This proposal is focused on reducing the costs of mental health residential care. It does not involve a reduction of care.

5.47 The council is working with providers to change the model of care of some of the existing residential providers from a Residential Care model to a Supported Living model.

5.48 This would allow service users to maximise housing benefit uptake to reduce costs to the adult social care budget.

5.49 Care would still be provided by the care provider, which will still be registered with the CQC.

5.50 Those who are assessed as requiring residential care will still have access to this.

Dee Carlin (Head of Joint Commissioning) introduced budget cut proposal **COM7**: *Reduction in adult social care contribution to mental health integrated community services*. The following key points were noted:

5.51 This proposal is focused on reducing management costs and overheads by integrating the stand-alone Social Inclusion and Referral Service (SIRS) within the rest of the mental health pathway. This has the potential to enhance services user care.

Resolved: the committee agreed to note budget cuts proposals COM 3 to COM 7 and refer its views on COM 1 and COM 2 to the Public Accounts Committee in the following terms:

> *The committee notes the greater demand on voluntary and community sector (VCS) organisations which would result from the proposals in COM 1 and COM 2 and expresses concern about the impact of funding reductions for VCS partners (as set out in COM 12) at a time when they are being expected to do more. Given this, the committee requests that Mayor and Cabinet does not decide to make these budget cuts until it has carried out and considered an assessment of the extent to which VCS organisations will be able to meet the increased demand as a result of the proposals in COM 1 and 2*.

6. Improving access to and provision of primary care

Diana Braithwaite (Director of Commissioning & Primary Care, Lewisham CCG) introduced the report. The following key points were noted:

6.1 This report provides the committee with an update on the CCG's management of the transition process following the closure of the New Cross walk-in centre.

6.2 In February 2018 the committee expressed concerns about the impact on A&E services and vulnerable groups, such as undocumented migrants and rough sleepers.

6.3 The CCG has been closely monitoring A&E activity and is confident that there has not been a surge in activity as a result of the closure. Officers referred the committee to graph on page 5 of the agenda.

6.4 The CCG established two new services for rough sleepers to provide access to primary care. However, the number of people using the services has been low.

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

6.5 The committee queried whether there had been an increase in demand at the GP Extended Access service.

6.6 The CCG has re-launched the GP Extended Access service and targeted promotion at the north of the borough, around the area that the walk-in centre was based. There has been an increase in usage since the walk-in centre was closed, but there has also been an increase in the number of available appointments.

Resolved: The committee noted the report.

7. Information item: Pathology services

Resolved: the committee noted the report.

8. Information item: Blue Badge applications

Resolved: the committee noted the report.

9. Select Committee work programme

John Bardens (Scrutiny Manager) introduced the work programme.

9.1 The Scrutiny Manager informed that committee that officers had agreed to postpone the item on the work programme on Leisure Centre Contracts until the January meeting as the agenda for the committee's December meeting is already very busy.

Resolved: the Committee agreed the work programme.

10. Referrals

Resolved: the committee agreed to refer its views on item 5, Budget Cuts, specifically proposals COM 1 and COM 2, to the Public Accounts Committee in the following terms:

> *The committee notes the greater demand on voluntary and community sector (VCS) organisations which would result from the proposals in COM 1 and COM 2 and expresses concern about the impact of funding reductions for VCS partners (as set out in COM 12) at a time when they are being expected to do more. Given this, the committee requests that Mayor and Cabinet does not decide to make these budget cuts until it has carried out and considered an assessment of the extent to which VCS organisations will be able to meet the increased demand as a result of the proposals in COM 1 and 2*.

The meeting ended at 22.10pm

Chair:

Date:

This page is intentionally left blank

Healthier Communities Select Committee			
Title	Declaration of interests		
Contributor	Chief Executive		Item 2
Class	Part 1 (open)	3 December 2018	

Declaration of interests

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

1. Personal interests

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

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

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

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

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

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

(d) Beneficial interests in land in the borough.

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

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

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

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

(b) and either

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

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

3. Other registerable interests

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

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

4. Non registerable interests

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

5. Declaration and Impact of interest on members' participation

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

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

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

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

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

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

6. Sensitive information

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

7. Exempt categories

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

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

This page is intentionally left blank

Healthier Communities Select Committee		
Title	Referral to the Health and Wellbeing Board on Lewisham and Greenwich NHS Trust's changes to the opening hours of Sexual and Reproductive Health Services in the borough.	
Contributor	Executive Director for Resources and Regeneration	Item 3
Class	Part 1 (open)	3 December 2018

1. Summary

1.1. This report provides an overview of the error in the dispatch of the papers for the November Health and Wellbeing Board meeting, and the actions taken as a result.

2. Recommendation

2.1. The Committee is recommended to note the report.

3. Background

3.1. At its meeting on 27th June 2018, the Healthier Communities Select Committee considered a report from Lewisham and Greenwich NHS Trust on its proposed changes to the opening hours of Sexual and Reproductive Health Services in Lewisham.

3.2. Following discussion on the item, the Committee resolved to refer its views on the communications in relation to the proposal to the Health and Wellbeing Board. The full text of the Committee's referral is copied below for information:

"The Committee notes the proposed changes to the opening hours of the Sexual and Reproductive Health service and appreciates the importance of making the changes without unnecessary delay. However, during discussions on the proposals, the members of the Committee expressed a number of queries and concerns about how service users would be made aware of the changes, if agreed, particularly those service users who may currently consider attending the outreach service at the Sydenham Green Group Practice, which would no longer be available following the proposed changes.

The Committee therefore seeks further information about the plans for communication and engagement with service users in order to be reassured that the changes will be communicated as effectively as possible and avoid any negative impact on access to sexual and reproductive health services among service users."

3.3. The Committee received a response from Lewisham and Greenwich NHS Trust at its meeting on 9th October 2018, which set out the trust's communications plans for the changes. The Committee noted the response.

4. Timeline

4.1. Officers supporting the Health and Wellbeing Board received a draft referral from the Healthier Communities Select Committee's scrutiny manager on the 4th of September 2018. The finalised referral was received by officers on the 8th of October, along with the formal response from the Lewisham and Greenwich NHS Trust to the issues raised within the referral, (which was subsequently received and noted by the Committee on the 9th of October).

4.2. It was confirmed via email discussion between the scrutiny manager and relevant officers that the referral would be placed on the agenda of the next Health and Wellbeing Board (1st of November) in line with the constitutional process, and that the response already received by the Committee from the Trust would also be provided to the Board, assuming that the Committee were content with the response of the Trust.

4.3. The agenda for the Board meeting on the 1st of November was published on the 24th of October in line with legal requirements for the agenda and papers to be published 5 clear working days in advance of the meeting.

4.4. It was identified on the morning of the 25th of October that the referral had not been included on the summons and agenda as it should have been. As soon as this was identified the officer responsible took legal advice, and the Head of Law confirmed that it wasn't possible to add it to the agenda that had been published unless there were legal grounds for urgency.

4.5. The officer then contacted the Chair of the Committee immediately and apologised unreservedly for the error. He advised that the referral would be placed on the agenda for the next meeting of the Board (currently scheduled for March 2019) to be formally received in line with the constitutional referral process, and he also offered to circulate it to the Board informally so they were aware.

4.6. The Mayor, Cabinet Member, Executive Director and Head of Corporate Policy and Governance were then also advised of the error on the 25th of October. Apologies were also offered to all for the officer error, an assurance given that the Chair of the Committee had been contacted as a priority and an update provided on the legal advice given and proposed course of action.

4.7. On the 26th of October the service manager spoke with the Chair of Overview and Scrutiny and outlined the error and offered her apologies and offered those of the officer responsible also.

4.8. On the 30th of October the Chair of the Committee and the Chair of Overview and Scrutiny wrote to the Head of Corporate Policy and Governance raising their shared concerns about the failure of officers to ensure the referral of the Committee was considered at the November meeting of the Board as it should have been, and also their concerns about a lack of simultaneous notification to the Chair of Overview and Scrutiny and the Mayor at the same time the Chair of the Committee was notified. The Chair's also sought an assurance that such an error would not occur again, and advised that they believed there to be an alternative solution of calling an additional meeting of the Board to receive the referral, however they were not minded to insist on this option being taken forward, given that their concerns as

outlined within the referral had already been taken into account by the Trust, as they had been assured on the 9th of October, and the additional cost an additional meeting would cause.

4.9. The Head of Corporate Policy and Governance responded to the Chair's letter on the 31st of October, adding his apologies for the error to those of the officer and manager, and advising that he had requested that all referrals be managed directly into the issue manager system on receipt in the future to help mitigate against such errors in the future.

5. Future Actions

5.1. All staff have been reminded of the importance of ensuring that due process is followed and that systems are utilised for the effective management of agendas and reports. Managers will continue to support staff learning and development in this area.

6. Legal Implications

6.1. The Constitution provides for Select Committees to refer reports to the Executive, who are obliged to consider the report and the proposed response from the relevant Executive Director; and report back to the Committee within two months (not including recess).

6.2. The constitution also confirms that "No business shall be transacted at a meeting of the Council, other than that specified in the summons, subject to the provisions of Rule 25 (Urgency)".

6.3. Rule 25 Urgency: "Exceptionally a report on a matter of such urgency arising within a very short period before a Council meeting may be considered at a Council meeting notwithstanding that the report has not been included in the summons to the meeting. This may arise where the matter in question is of such urgency that it cannot be delayed to the next ordinary Council meeting. In such circumstances it may be submitted to the Council as an urgency report.

6.4. The subject of an urgency report if known, shall be included in the summons to the meeting even though the report may not be available. In such cases the report may be sent to the Mayor/members separately. The report shall contain a statement of the reasons why it needs to be considered as a matter of urgency.

6.5. If the report is sent so late that it is generally received less than five clear days before the Council meeting, the Chair of Council shall decide on the grounds of urgency stated, whether or not the report shall be considered or deferred to a later meeting. If it is considered, the reasons for it being considered as a matter of urgency shall be recorded in the minutes".

7. Financial Implications

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

Background reports:

Minutes of HCSC 27 June 2018
http://councilmeetings.lewisham.gov.uk/ieListDocuments.aspx?CId=133&MId=5151&Ver=4

Agenda of HCSC 9 October 2018 (draft minutes to be published on the same agenda as this report)
http://councilmeetings.lewisham.gov.uk/ieListDocuments.aspx?CId=133&MId=5022&Ver=4

If you have any queries regarding this report please contact Salena Mulhere 02083143380

Healthier Communities Select Committee		
Report Title	**Public Health cuts consultation outcome**	
Ward	**All**	**Item No. 4**
Contributors	**Executive Director for Community Services**	
Class		**Date: 3/12/18**

1. Summary and Purpose of the Report

1.1 The purpose of this report is to ask the Healthier Communities Select Committee (The Committee) to review the report attached as Appendix 1 for Mayor & Cabinet on December 12th 2018.

1.2 The report in Appendix 1 outlines the consultation conducted as outlined in the report to Healthier Communities Select Committee on September 4th 2018, and revised proposals to balance the cut to the Public Health grant.

2. Recommendations

2.1 The Committee is recommended to review, note and comment upon the consultation activity and proposals for cuts relating to health visiting, substance misuse, community development and community nutrition and physical activity services.

3. Legal Implications

3.1 The Legal implications are as laid out in section 12 of the report attached as appendix 1.

4. Financial Implications

4.1 The Financial implications are as laid out in section 13 of the report attached as appendix 1.

5. Crime and Disorder Act Implications

5.1 The Crime and Disorder Act Implications are as laid out in section 14 of the report attached as appendix 1.

6. Equalities Implications and human rights

6.1 The equalities and human rights implications are as laid out in section 15 of the report attached as appendix 1.

7. Environmental Implications

7.1 There are no environmental implications.

8. Conclusion

8.1 The report in Appendix 1 outlines the consultation conducted as outlined in the report to Healthier Communities Select Committee on September 4th 2018, and revised proposals to balance the cut to the Public Health grant.

8.2 The Committee is recommended to review, note and comment upon the consultation activity and proposals for cuts relating to health visiting, substance misuse, community development and community nutrition and physical activity services.

Mayor & Cabinet		
Report Title	**Public health grant cuts consultation outcome and proposals**	
Ward	**All**	**Item No.**
Contributors	**Executive director for community services**	
Class		**Date: 12/12/18**

1. **Summary and Purpose of the Report**

The government will be making a further cut to the Public Health grant to local authorities for 2019/20. The purpose of the report is to appraise Mayor & Cabinet of the outcome of the consultation agreed on the 4th of September by the Healthier Communities Select Committee on proposals to balance this, and to seek approval for revised proposals following the consultation.

2. Structure of the Report

2.1 The report is structured as follows:

Section 3 sets out the recommendations.
Section 4 sets out the policy context
Section 5 sets out the background
Section 6 Proposal Development and Consultation approach
Section 7 Summarises the consultation activity
Section 8 Neighbourhood Community Development Partnerships
Section 9 Community Nutrition and Physical Activity
Section 10 Health Visiting
Section 11 Substance Misuse
Section 12 sets out the legal implications
Section 13 sets out the financial implications
Section 14 sets out the crime and disorder implications
Section 15 sets out the equalities implications
Section 16 sets out the environmental implications

Appendix 1 Lewisham's 9 health and wellbeing priorities
Appendix 2 Equalities analysis
Appendix 3 consultation analysis
Appendix 4 substance misuse focus group summary
Appendix 5 Health Visiting patient engagement summary

3. Recommendations

Mayor and Cabinet is recommended to:

- note the consultation activity undertaken by officers, the findings of this activity and the Equality Assurance Assessment (EAA) undertaken;
- review and give approval for revised proposals to balance the cut to the Public Health grant for 2019/20.

4. Policy Context

4.1 The services within this paper meet the two key principles of the Lewisham's Sustainable Community Strategy 2008-2020:

- Reducing inequality – narrowing the gap in outcomes for citizens
- Delivering together efficiently, effectively and equitably – ensuring that all citizens have appropriate access to and choice of high-quality local services

4.2 These services also contribute to the following priority outcomes:

- 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
- Healthy, active and enjoyable – where people can actively participate in maintaining and improving their health and well-being

4.3 The services in this report support the council's corporate priorities of:

- Community Leadership and empowerment- developing opportunities for the active participation and engagement of people in the life of the community
- Caring for adults and older people- working with health services to support older people and adults in need of care
- Active, healthy citizens- leisure, sporting, learning and creative activities for everyone

4.4 The Health and Well Being Strategy 2012/22 has been developed by Lewisham's Health and Wellbeing Board (HWB) and sets out the improvements and changes that the board, in partnership with others, will focus on to achieve the board's vision of achieving a healthier and happier future for all. The strategy lays out 9 priorities, attached as appendix 1.

4.5 Lewisham's Children and Young People's Strategic Partnership vision is: "Together with families, we will improve the lives and life chances of the children and young people in Lewisham". This is achieved through a focus upon closing the gaps in outcomes achieved by our children and young people and agreement to ensure that children's and families' needs are prevented from escalating and are instead lowered. The ideal is for all children and young people to require only universal services and where further support is needed this should be identified and provided as early as possible.

5. Background

5.1 The Health and Social Care Act (2012) transferred the bulk of Public Health functions to local authorities. The Council is responsible for delivering Public Health outcomes through commissioning and building partnerships within the borough, region and city.

5.2 In the Spending Review and Autumn Statement 2015 the government announced an in-year cut to the ring-fenced Public Health grant, with further cuts for each subsequent

year to 2019/20. In Lewisham the grant is £24,325,000 for 2018/19 and the cut for 2019/20 will be £642,000. This will reduce the grant for 2019/20 to £23,683,000 and take the total cuts in the grant to date to £3,985,000.

6. Proposal Development and Consultation approach

6.1 Proposals were developed using a marginal benefit comparison process led by Dr. Danny Ruta, Lewisham Director of Public Health. Public Health specialists for each area exemplified cuts and their impacts on Public Health outcomes. A process of prioritisation led by Dr. Ruta was then undertaken to identify and order the cuts with the lowest impact.

6.2 In developing proposals to balance the cut from central government, officers focussed on as far as possible protecting already stretched frontline services from additional cuts.

6.3 As a result of the above process a number of reductions were identified in staffing and 'back office' commissioning arrangements totalling £106,400. These will not impact on any existing staff

6.4 On 22 November 2016 the Executive Director of Resources and Regeneration gave approval to negotiate directly with Lewisham and Greenwich Trust (LGT) to provide sexual health services in Lewisham through a waiver of the contract procedure rules (single tender action). The contract was awarded February 9th 2017, and implemented the Integrated Sexual Health Tariff (ISHT).

6.5 To support LGT with the transition to ISHT, interim payments were agreed as part of this contract award. The tapering off of these payments across the life of the contract, and the implementation of ISHT across London, will result in a cost reduction of £192,294. Any proposed service changes following this will be consulted on separately, as with the realignment of primary care delivery agreed by the Healthier Communities Select Committee on 27 June 2018

6.6 Further proposals totalling £343,306 were considered to be significant service reductions requiring consultation.

6.7 Officers presented these proposals and the consultation approach to the Healthier Communities Select Committee on the 4th of September 2018, and proposed to return to the committee on the 3rd of December with the outcome of the consultation and specific proposals for Mayor & Cabinet approval on the 12th of December 2018. This paper sets out the revised proposals for decision by Mayor & Cabinet.

7 Consultation activity

7.1 Officers conducted a range of consultation activity (as previously described to the Healthier Communities Select Committee, and as set out below) to engage with the public and stakeholders as part of an overall 15 week consultation process.

Public Health cuts consultation timeline

	July	August				September				October					November				December	
	23-Jul-18	06-Aug-18	13-Aug-18	20-Aug-18	27-Aug-18	03-Sep-18	10-Sep-18	17-Sep-18	24-Sep-18	01-Oct-18	08-Oct-18	15-Oct-18	22-Oct-18	29-Oct-18	05-Nov-18	12-Nov-18	19-Nov-18	26-Nov-18	03-Dec-18	10-Dec-18
Full consultation period	Full 15 week consultation period																			
Interim Joint Commissioning Group 26/7																				
Community Service DMT																				
Healthwatch meeting 2/8																				
CYP DMT 8/8																				
Healthier Select Paper																				
Healthier Communities Select Committee 4/9																				
consultation- online 5/9-7/11						10 week public consultation period														
consultation- stakeholders 5/9-7/11																				
PH analysis of consultation and review of proposals																				
Healthier Communities Select Committee 3/12																				
Mayor and Cabinet12/12																				

7.2 Officers consulted across the Council including at Community Services and Children and Young People's Directorate Management Teams.

7.3 Officers consulted with the Lewisham Interim Joint Commissioning Group, Lewisham Clinical Commissioning Group to understand impacts elsewhere in the local health system.

7.4 Officers consulted Lewisham Healthwatch on proposals, on the consultation approach and on equity of access.

7.5 Officers consulted the public, professionals and wider stakeholders through the Council's 'Citizen Space' platform for a period of ten weeks. Lewisham Healthwatch offered support to individuals and groups to ensure equity of access.

7.6 Officers sought to work closely with commissioned providers to develop proposals that mitigated the impact of funding reductions as far as possible.

7.7 Public Health specialists analysed the consultation outcome (Appendix 2) and produced a full equalities analysis (Appendix 1) to inform revised proposals.

7.8 Following and informed by the activity described above officers developed specific proposals for reduction in grants and public health activity, laid out in paragraphs 8 – 11 of this report.

7.9 The Council has a number of statutory duties as conditions of the Public Health grant, including a mandatory visits from Health Visiting and ensuring open access to sexual health services. The reductions described in this report will not compromise the Council's ability to deliver against these duties.

8. Neighbourhood Community Development partnerships (NCDPs)

8.1 Officers consulted on a proposed £10,000 reduction in the grants available for Neighbourhood Community Development Partnerships (NCDPs). This would mean a reduction in the amount of money available for annual grant funding for projects .

8.2 In February 2017 LB Lewisham developed a Community Development Charter which outlines a partnership approach to community development and builds on current neighbourhood and borough-wide assets and networks by the creation of four NCDPs. The partnerships bring together all the relevant voluntary and community sector

partners as well as statutory services in each Neighbourhood to identify local health and wellbeing priorities as well as local resources and community assets to address them.

8.3 The Council provides £100,000 from the Public Health grant to support grants to voluntary and community organisations in all of the four NCDPs. The grants have supported a variety of projects that promote health and wellbeing for local residents. These include befriending groups, community gardens, a soup kitchen, holiday at home schemes, storytelling and dance workshops, physical activity sessions and a Fit Bus scheme. The funding was distributed using a community based participatory budgeting process.

8.3 The consultation focussed on residents' priorities around NCDPs and whether any reduction should be evenly distributed across the 4 neighbourhood partnerships or targeted to those residents with the greatest health and wellbeing needs.115 people responded to this section of the consultation.

8.3.1 The majority of respondents were extremely positive about the services that had been funded by the NCDPs.

8.3.2 The respondents ranked reducing social isolation and loneliness and increasing access to routes to improve health and wellbeing as the most important objectives for the NCDPs to focus on.

8.3.3 The majority of respondents (75%) felt that the reduced Public Health funding should be targeted at those individuals and groups in greatest need rather than distributed equally between the four neighbourhoods

8.3.4 There were mixed views about who is best placed to understand health and wellbeing priorities. Many respondents felt that people from within communities and those who work closely with them (such as voluntary and community sector groups) will have the best understanding of the key issues and many felt that the access to data that public health professionals have helps them to understand both the neighbourhood needs and also place these in a wider context.

8.4 The EAA appears to show that the majority of NCDP grant funded voluntary and community services are reaching residents from all the protected characteristics, in particular services for older BAME people who are socially isolated. The reduction in the Public Health grant will not have a positive impact on any particular group. As the recipients of funding change each year, officers are unable to predict the funded community groups in future years and which protected characteristic groups these organisations may support. As no community groups exist solely as a result of the NCDP funding, we do not expect any groups to stop providing services as a result of the budget cut. In addition, Community Connectors are able to signpost organisations to other sources of funding available.

8.5 The NCDPs, facilitated by Community Connections Community Development workers, will continue to engage with local community and voluntary organisations and identify opportunities to grow local community networks.

8.6 Public Health professionals will continue to support the membership of each of the four NCDPs to identify local health and wellbeing priorities and target the reduced grants to those in greatest need.

9. Community Nutrition and Physical Activity

9.1 Officers consulted on a proposed £10,000 reduction in funding for the Community Nutrition and Physical Activity service delivered by Greenwich Co-operative Development Agency (GCDA).

9.2 This borough-wide service supports communities to become healthier and more resilient through delivery of initiatives such as cookery courses, physical activity sessions and the healthy walks programme, to working with food businesses to make their food healthier. The community development approach supports individuals, groups and organisations to promote healthy lifestyles and the service offers support, training and mentoring for community groups and organisations to deliver local healthy eating and physical activity initiatives

9.3 The online consultation focussed on residents' priorities in this area, and the balance and targeting of delivery supporting individuals or community organisations. 142 people responded to this.

9.3.1 142 people responded on the Community Nutrition and Physical Activity service. 83.1% of people responded in a personal capacity and 16.9% of people responded in a professional capacity. Nearly 45% of responses were from people who are currently using or had previously used the Community Nutrition and Physical Activity service. When asked to prioritise objectives for the service, all six objectives were thought to be extremely or very important by 74% to 88% of respondents to the questions. The top two objectives were 'Supporting a local environment that makes it easier to choose healthy diets and active lifestyles' was seen as Extremely or Very important by 88.2% of respondents to the question, followed by 'Developing a model that enables healthy eating and physical activity interventions to be more widely available in the community' (84.0%).

9.3.2 A slightly higher proportion of respondents disagreed or strongly disagreed that the cuts should be made by reducing services aimed at the community (64.5%) compared to services aimed at the individual (56.4%).

9.3.3 Many respondents were positive of the overall health benefits of programme and in particular the healthy walks elements of the service.

9.3.4 Suggestions on how to deliver the service in order to achieve the same reduction in budget included linking with other services, working with communities to develop volunteer roles to introducing a small charge for the services. Other comments included supporting investment in prevention and the impact of the public sector cuts.

9.4 The equalities analysis indicates the Community Nutrition and Physical Activity service reaches people with protected characteristics in particular BAME, and older people. It is not anticipated that the reduction in funding will have a positive impact on any protected characteristics, however initial analysis indicated there could be a potentially negative impact on age, gender and ethnicity if services aimed at the individual were

reduced. These groups could therefore be disproportionately affected by changes to this component of the service.

9.5 Council officers have discussed potential changes with the service providers and they propose a reduction in the hours of the Training Manager post employed by GCDA as part of the programme. This role will in future focus on training quality, observation and follow up rather than service development.

9.6 The provider feels that this reduction in the Training Manager role will not have an adverse effect on the programme delivery as the training is now well established and other staff have developed the skills and expertise to deliver the training. This change means that the provider is able to protect all other elements of the service from the reduction in budget and will be able to continue delivering the comprehensive service they provide in Lewisham. This means that the EAA anticipates that no protected characteristic group will be disproportionately impacted by the changes proposed.

9.7 Council officers propose a reduction in the hours of the Training Manager post in the programme. This change means that the provider is able to protect all other elements of the service from the reduction in budget and will be able to continue delivering the comprehensive service they provide in Lewisham.

10. Substance Misuse

10.1 Officers consulted on a proposed reduction of £127,000 in funding for substance misuse.

10.2 The main substance misuse services are delivered by Change, Grow, Live (CGL) and Blenheim CDP. Both provide a range of interventions targeted at patients and family members suffering from substance misuse.

10.2.1 CGL run the complex needs service within the borough that assesses and triages all those presenting with a substance misuse or alcohol need. Service users receive a systematic assessment for an appropriate treatment which could include pharmacological therapies for opiate dependence and commencement of dose titration within 24 hours of presentation. In addition, there are a range of specialist elements within the service designed to meet specific needs including:

- Hospital Liaison Service - The service works across all local hospitals i.e. GSTT, Kings and LGT to support services users that are treatment naïve, frequent attenders and those with complex needs
- Criminal Justice Liaison - This service works includes a worker located in Lewisham Metropolitan Police custody suite, a worker based in Lewisham National Probation Service (NPS) and Community Rehabilitation Company (CRC) that attends court one day per week, a prison liaison in-reach worker and two Criminal Justice Practitioners that deliver interventions/groups within service
- Mental Health Services (Dual Diagnosis and Psychological Support) - The service aims to enhance the delivery of intervention to service users with co-existing mental health and substance misuse/alcohol issues

- Outreach Service and Homeless Support Service - The service provides a dynamic and proactive outreach service to engage with a range of individuals who have adopted a ‘street lifestyle’ including rough sleepers, beggars, service users involved in prostitution and street drinkers with a view to engaging them in appropriate services and move then into a more settled lifestyle
- Club Drug and Stimulant Support - The service supports a number of individuals using New Psychoactive Substances (Legal Highs), Club Drugs and Crack or Cocaine users
- Residential Rehabilitation and Inpatient Detoxification and Stabilisation
- Parents/Carers Support - The service provides support for carers/parents and significant others of adult drug and alcohol users.
- Work with pregnant individuals in partnership with ante/post-natal services to ensure optimum care.

10.2.2 Blenheim CDP deliver the primary care recovery service which works in partnership with GPs and provides the following interventions:

- Advice, information, brief interventions and extended brief interventions to help prevent and minimise problematic substance misuse or dependency
- Sessions of structured brief advice on alcohol for adults who have been identified via screening as drinking a hazardous or harmful amount
- Extended brief intervention for adults who have not responded to structured brief advice or who may benefit from an extended brief intervention for other reasons
- Assertive in-reach into other services to attract substance misusers not currently engaged with other agencies but not yet engaged in treatment services
- Substitute prescribing services and supervised consumption (e.g. through pharmacies) and the provision of biological drug and alcohol testing facilities
- A Primary Care provision of ambulatory detoxification for those presenting with low to moderate alcohol use
- Community detoxification for drugs, working in partnership with GP’s to titrate and reduce substitute medication with the aim of abstinence and recovery
- Health, smoking cessation; healthy eating and access to physical exercise programmes/facilities),
- Overdose prevention and harm reduction advice, including the provision of Naloxone training and prescribing for injecting drug users presenting as high risk,
- Pro-active relapse prevention advice and support, including prescribing interventions
- Enhanced Blood Borne Virus Service in relation to Hepatitis A / B / C and HIV with access to on site screening, testing and rapid vaccination and robust referral pathways into appropriate treatment services

- Home visits, assessment and referral to early intervention services for all service users who have caring responsibilities for children under 16, these can be conducted jointly with other services.

10.3 The consultation set out the range of activity delivered by the services and sought the views of the public, particularly those who have accessed the provision, as to the areas they felt were of particular importance or any changes that could be made. Throughout the consultation process the addictions team worked closely with Lewisham's Service User Involvement Team (SUIT) to make sure views were gained from actual people accessing the service.

10.3.1 **Online consultation:** Members of the public including service users, carers and professionals responded to the set of questions about the Substance Misuse services. There were a range of responses from current or past service users, members of the public and professionals. They were asked whether they thought that this proposal will affect particular individuals more than others. (Appendix 3)

10.3.2 108 people responded to questions about the Substance Misuse Services. 77.8% of people responded in a personal capacity and 22.2% of people responded in a professional capacity.

10.3.3 5.6% of personal responses were from people who are either currently using the service, had previously used the substance misuse services or have a family member that has used the service; 94.4% of personal responses were from Lewisham residents/members of the public.

10.3.4 Due to the small number of responses from current or previous service users/family members it is not possible to report these findings without potentially identifying individuals. The small number of responses received were across a wide range of views which are not possible to summarise. However two focus groups have taken place with this cohort – see section 10.4 below.

10.3.5 Members of the public identified 'Increase in waiting times for services' as the most likely impact of the proposed funding cuts, with 94.4% stating this was extremely or very likely.

10.3.6 The vast majority of respondents (83.8%) believed the proposed cuts would affect particular individuals more than others. When asked to expand on this the below comments summarise respondent's views:

- Poorest and the most vulnerable (substance misusers/elderly/homeless/mentally ill) in society will be hit the hardest.
- Those with long term addictions will feel it the most
- Those who have accessed the service previously may be more aware of the changes
- Those seeking help will be discouraged

- Negative impact on families, staff providing services, support of those with addiction problems
- BAME and other vulnerable groups affected more

10.3.7 Members of the public were also asked ‘Do you have any other ideas about how we could deliver this service differently in order to achieve the same reduction in funding?’ Suggestions from the public included:

- Providing more online services and/or group sessions to save money.
- Asking sellers of alcohol to contribute to services
- Getting charities, the voluntary sector and previous service users more involved
- Better co-ordination/collaboration with mental health and other healthcare services such as GPs
- Charities / volunteering -Create 'champions' (former users -now 'clean')
- A mobile service /group sessions
- Put the service back into NHS funding
- Educating children at school – substance misuse
- Link in with other sectors to provide things like apprenticeships for people who are moving towards long-term recovery

10.3.8 Overall the majority of respondents thought that cutting funding would lead to short and long-term complications impacting on their physical, mental and social well-being.

10.3.9 Suggestions on how to cope with the potential reduced funding include:

- More learning from and co-production with community as recommended by NHS England and Kings Fund.
- Early intervention should be a critical part of this service. Schools should be trained to identify potential substance misuse.

10.3.10 Professionals also identified ‘Increase in waiting times for services’ as the most likely impact of the proposed funding cuts (93.3%) stating this was extremely or very likely. This was joint with ‘Increase in health related issues/morbidity (93.3%).

10.3.11 97.5% of respondents felt that the proposed cuts to substance misuse services would affect particular individuals more than others. When asked to expand on this view the main themes were that the impact would be most felt by substance misuse staff who will be under increased pressure and stress. The most vulnerable and hardest to reach groups including sex workers and the homeless population would also be more effected and those with complex and/or mental health needs.

10.4 **Consultation events**: In order to supplement the online survey officers organised two consultation events with service users, in order to remain consistent with the online consultation, the commissioning team (addictions) used open ended questions similar to those online. Overall the attendees were reflective of service users engaging with commissioned services. (Appendix 4)

10.4.1 Overwhelmingly, participants felt that cuts of any amount would affect service delivery and quality of care received. It was suggested that if cuts did have to be made, they should not be made to the frontline staff i.e. key workers or on medication. Overall, respondents demonstrated an understanding of the fact that, while the cuts to services and staffing were undesirable, they were necessary because of central Government cuts to Lewisham's Public Health grant.

10.5 Throughout this process, Officers also undertook a full service review of the existing treatment system; utilising the substance misuse needs assessment and other measures to inform the proposed savings for substance misuse treatment provision across the borough. The addictions team met with the current providers to seek their views on the most appropriate way to apply the cuts to the current system, and have been working together to appraise a number of options.

10.6 This process included examining levels of service usage and value for money; considered feedback from consultation with service users, stakeholders and residents and then in response to this considered how the impact of these savings can be best mitigated. In addition a full Equality Analysis Assessment has been carried out. (Appendix 2)

10.7 Taken together, the online consultation, the focus groups and the options appraisals with providers clearly indicate a desire to protect frontline services as far as possible. This is not surprising but it confirms that there are no areas of current frontline provision that are felt to be underperforming or 'a luxury' that could be cut without impacting on service users.

10.8 As such officers have focused their attention on commissioning, management and oversight functions to deliver the vast majority of the cuts.

10.9 This includes the combining of 2 posts within the commissioning team to combine the service user involvement role within a wider remit. While this reduces the number of officer hours dedicated to service users involvement the fact that the Service User Involvement Team (SUIT) which is run by current and ex-service users is now well developed means that this will have limited impact on the level of direct provision.

10.10 With services CGL will combine the Quality Lead with the Deputy Services Manager role. Officers are confident that this will not have an adverse effect on the service. This is because this role was introduced a few years ago when CGLs data quality was relatively poor but this has now been improved to a point where both the service and commissioners are confident that current levels of quality can be maintained without a dedicated resource. This means that CGL are able to protect frontline staff from the reduction in budget thus ensuring the effective service we provide for service users.

10.11 Blenheim CDP will deliver a small element of the saving but this can be delivered as part of their programme of reduced their overall overhead percentage via a merger with another provider.

10.12 The remainder of the savings will be captured from the budget for residential rehabilitation. Officers are confident that this can be managed as, based on historical usage officers, there will be sufficient funding to contain demand for the service assuming that this does not significantly increase from previous years. This budget will be kept under monthly review with any spikes in demand reviewed as part of the ongoing monitoring of the borough's usage of detoxification and rehabilitation services.

10.13 The cuts set out above will reduce the oversight and management of the treatment system in order to safeguard frontline services. At present officers feel that this is the most appropriate way to deliver the cut, primarily due to the work already undertaken to improve quality and data managing procedures and protocols. However, it is important that officers maintain vigilance to ensure that this quality does not slip as lack of effective data and management information can make designing effective and responsive services for the future very difficult.

10.14 The EAA on these proposals highlighted that there are some populations who are overrepresented within the treatment system – males and those from a white background – while younger people tend to be underrepresented but this generally represents patterns of drug and alcohol misuse in the borough. Furthermore the overall assessment is that these cuts are not likely to have any disproportionate equalities impacts due to the efforts taken to protect frontline service delivery.

11. Health Visiting

11.1 Officers consulted on a proposed £196,306 reduction in the budget for the Health Visiting service.

Service Description

11.2 The Health Visiting service, together with the Family Nurse Partnership service, is delivered by Lewisham and Greenwich NHS Trust (LGT). It leads on the delivery of the National Healthy Child Programme (HCP), providing a universal home visiting service to all families from pregnancy up until the child is 5 years old.

11.3 Through health assessments, the service delivers universal interventions to families to ensure the continued development of the child physically and emotionally. Additional targeted and specialist support is offered to more vulnerable families, this includes the Family Nurse Partnership service which supports young parents.

11.4 The contract value for Health Visiting and Family Nurse Partnership in 18/19 is £5,938,327.

Consultation Summary

11.5 Officers have consulted with staff and service users via the Council's online consultation and through attendance at six user activities and groups based in Children and Family Centres across the borough. This approach was based on discussions with LGT about the best way to meet and engage with service users. More information about the online consultation and the six engagement sessions is available in appendices 3 and 5 respectively.

11.6 Officers engaged as early as possible with LGT, informing them in July of potential proposals whilst still in draft form, seeking to work in partnership to try to develop proposals that mitigate the impacts of this reduction in funding, and requesting support in promotion of the consultation with service users and staff to ensure as wide a response as possible.

11.7 There were 119 responses to the online survey, and 34 people responded formally through the on-site engagement visits. Of the online respondents only 22% (16) told us they were service users compared to 91% (31 of 34) of those who responded to the engagement sessions.

11.8 Overall, responses to the online consultation and to the six engagement sessions demonstrate strong support for the service. Of those who responded to the online consultation, and told us that they had used the services, 71% found the service either extremely helpful or helpful, 10% moderately helpful and 19% slightly or not helpful. 97% of those who responded at engagement sessions, and told us they had used the service, found the service very or extremely helpful.

11.9 There was also strong support for specific elements of the service as follows:

- Baby and toddler hubs were rated as moderately to extremely helpful by 94% (15 out of 16) online respondents and 96% of those who responded to the engagement sessions.
- 100% of respondents to both the online consultation and engagement sessions, who told us that they had used the service, found breastfeeding services helpful to extremely helpful, providing an endorsement of the success of breastfeeding support services in the borough in line with the national recognition via Unicef Level 3 accreditation

11.10 'Improving child development,' and 'reducing infant mortality' were among the top 5 important HV outcomes in both the on-line consultation and engagement sessions and as the online respondents were both public and professionals, this suggests the HV role is generally well understood.

11.11 A majority of the respondents believed cuts would be moderately to extremely likely to have an adverse impact on the service Respondents were not being asked to compare the severity of impact on particular elements of the service with another, therefore it is reasonable that respondents would think that most or all elements might be impacted.

11.12 Where questions weren't answered, anecdotal feedback suggests this was due to "jargony" language which assumed a high level of literacy and understanding of the service.

Response to consultation

11.13 Officers recognise the high value placed on the Health Visiting service and its contribution to early intervention and prevention of escalation, and have been working to try to mitigate any impact of a cut to the service as much as possible.

11.14 The proposed cut to the Health Visiting service is £196,306 against the current budget of £6,096,224. If accepted, this would leave a budget of £5,899,918. The contract value for Health Visiting and Family Nurse Partnership in 18/19 is £5,938,327. The pricing schedule submitted in the 2016 tender has a planned uplift of £115,649 from 18/19 to 19/20 taking the anticipated contract value to £6,053,976.

11.15 This leaves a funding gap of £38,409 from the current contract value and of £154,058 against the anticipated 19/20 contract value should the cut be taken.

11.16 The Trust have confirmed that the service is holding a number of HV vacancies, in part due to a national shortage of health visitors, and that this budget reduction can be identified through these vacant posts. There are 48.48 Band 6 Health Visitors referenced in the contract Pricing Schedule. The 18/19 costing for a single Band 6 Health Visitor is £53,841 so a reduction of £154,058 could be found through 2.9 Band 6 vacancies.

11.17 As the number of vacancies confirmed by the Trust are beyond the value of the cut this would mean that the impact on current service delivery of this approach would be negligible in 19/20, though future tendering for the service would be with this reduced funding envelope.

11.18 Whilst we could anticipate an impact when the service is commissioned with a reduced budget from 2020, we would expect the current and any potential provider to have more time to respond to a tender with innovation and partnership working (for example more mobile working and further integration with partners (such as Children and Family Centres) to further mitigate any impact.

11.19 Additionally, the HV service is part of the Early Help review, which will deliver a renewed approach to our services for children and families and that may be able to further mitigate any impact.

11.20 Officers will continue to seek to work with the provider further until the implementation of the cut, should it be agreed, in April 2019.

Equalities

11.21 Equalities data was provided from the service provider, Lewisham and Greenwich Trust, for the period April 2017 (Quarter 1 2017-18) to September 2018 (Quarter 2 2018-19), broken down by quarters. The total number of recorded Health Visiting appointments in this time period was 172,892, giving an average quarterly caseload of 24,699.

11.22 The caseload is predominantly female. The gender breakdown of the child caseload aligns to population data with an approximate 50/50 split. Additionally there are a small percentage of cases where genders were not identified. Both the online consultation and the engagement sessions were accessed predominately by females: 72% online and 91% at on-site visits.

11.23 A quarter of the caseload identify as British, with a further 15% identified from another white background, 47% from BME origins and 12% not identified. This aligns with Lewisham population data. Participation in the consultation showed a much higher proportion of people identifying as “white”: 79% online and 73% at engagement sessions, this is not representative of Lewisham population data and we

recognise that this is therefore an area where consultation methods need to be stronger.

11.24 Consultation data demonstrated that 71% of online respondents were 46+, whereas engagement session users were predominately younger with 48% aged 30-35.

11.25 No engagement session users considered themselves to have a disability, but 19% online did.

11.26 Any change or impact on the service is likely to be felt more by women than men, and by children as the main service users. However, as the budget reduction will firstly come from vacant posts, and the removal of vacant posts will be done fairly and in line with caseload size and complexity and local health needs, it is not expected that there will be a disproportionate impact on any particular protected characteristic group. A full EAA is provided in Appendix 2

12. Legal Implications

12.1 The Council has statutory duties in relation to improvement and protection of public health. These a duty to take appropriate steps to improve and protect the health of people who live in their area (Health and Social Care Act 2012); a duty to deliver 'mandated functions' being the weighing and measuring of children, provision of health checks for eligible people, open access sexual health services, public health advisor services, and information and advice about local health issues (Local Authorities (Public Health Functions …) Regulations 2013); and requirements in relation to drug and alcohol and age 1-19 services ('conditions of public health grant').

12.2 The report explains that the grant to be received by the Council in relation to the public health function is to be reduced, and sets out the reasoning for and consultation carried out in relation to the consequent cuts to contracts with the Council's partners for provision of public health services, including the consideration given to equalities implications. If approved, the implementation of these proposals will take place through the funds applied during allocation of grants.

12.3 The Council has a public sector equality duty (the equality duty or the duty - The Equality Act 2010, or the Act). It covers the following protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. In summary, the Council must, in the exercise of its functions, have due 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.

12.4 It is not an absolute requirement to eliminate unlawful discrimination, harassment, victimisation or other prohibited conduct, or to promote equality of opportunity or foster good relations between persons who share a protected characteristic and those who do not. It is a duty to have due regard to the need to achieve the goals listed above. The weight to be attached to the duty will be dependent on the nature of the decision and the circumstances in which it is made. This is a matter for Mayor and Cabinet, bearing in mind the issues of relevance and proportionality. Mayor and

Cabinet must understand the impact or likely impact of the decision on those with protected characteristics who are potentially affected by the decision. The extent of the duty will necessarily vary from case to case and due regard is such regard as is appropriate in all the circumstances.

12.5 The Equality and Human Rights Commission (EHRC) has issued Technical Guidance on the Public Sector Equality Duty and statutory guidance. The Council must have regard to the statutory code in so far as it relates to the duty. The Technical Guidance also covers what public authorities should do to meet the duty. This includes steps that are legally required, as well as recommended actions. The guidance does not have statutory force but nonetheless regard should be had to it, as failure to do so without compelling reason would be of evidential value. The statutory code and the technical guidance can be found on the EHRC website.

12.6 The EHRC has issued five guides for public authorities in England giving advice on the equality duty. The 'Essential' guide provides an overview of the equality duty requirements including the general equality duty, the specific duties and who they apply to. It covers what public authorities should do to meet the duty including steps that are legally required, as well as recommended actions. The other four documents provide more detailed guidance on key areas and advice on good practice.

13. Financial Implications

13.1 Expenditure on public health in Lewisham is funded through the ring-fenced Public Health Grant.

13.2 In 2019/20 this grant will reduce by £0.642m. This report describes the approach commissioners are taking to achieving matching reductions in expenditure.

14. Crime and Disorder Act Implications

14.1 Section 17 of the Crime and Disorder Act recognises that there are key stakeholder groups who have responsibility for the provision of a wide and varied range of support services to and within the community. In carrying out these functions, section 17 places a duty on partners to do all they can to reasonably prevent crime and disorder in their area.

14.2 The purpose of section 17 is simple: the level of crime and its impact is influenced by the decisions and activities taken in the day-to-day of local bodies and organisations. The responsible authorities are required to provide a range of services in their community. Section 17 is aimed at giving the vital work of crime and disorder reduction a focus across the wide range of local services and putting it at the heart of local decision-making.

14.3 The Government's Modern Crime Strategy highlighted drugs and alcohol of 2 of the 6 major drivers of crime in Britain with the social and economic cost of drug use and supply to society is estimated to be £10.7billion of which about £6 billion is attributable to drug-related crime. 45% of acquisitive offences (c. 2 million offences) are thought to be committed by heroin and/or crack users. The delivery of efficient substance misuse services is key to fighting crime in the borough as services to treat addictions are widely recognised as the most effective route to tackling associated crime and disorder issues.

15. Equalities Implications

15.1 The proposals in of this report cover a wide range of changes to existing services, which have been considered for equalities impacts as outlined against each proposal within sections 8-11.

15.2 The proposals and consultations outlined in this report informed a details equalities analysis attached to this report as appendix 2.

16. Environmental Implications

16.1 There are no environmental implications.

Appendix 1: Lewisham's 9 health and wellbeing priorities

1. achieving a healthy weight
2. increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years
3. improving immunisation uptake
4. reducing alcohol harm
5. preventing the uptake of smoking among children and young people and reducing the numbers of people smoking
6. improving mental health and wellbeing
7. improving sexual health
8. delaying and reducing the need for long term care and support.
9. reducing the number of emergency admissions for people with long-term conditions.

Author		Directorate	
Date		Service	Public Health

1. The project or decision that this assessment is being undertaken for

The government will be making a further cut to the Public Health grant to local authorities for 2019/20. In Lewisham the grant is £24,325,000 for 2018/19 and the cut will be £642,000. The purpose of this Equality Analysis Assessment is to examine the impact of the proposed changes to public health commissioned services on those with protected characteristics living in Lewisham. It also outlines the activity that the Council will take to ensure that equal opportunities are promoted and that no group is disproportionately discriminated against. This will feed into revised proposals presented to the Healthier Communities Select Committee 3rd December before being taken for approval by Mayor & Cabinet 12th December.

The services commissioned by Public Health facing changes are:

- Neighbourhood Community Development Partnerships (NCDPs)
- The Community Nutrition and Physical Activity service
- Substance misuse services
- Health visiting services

More details of the services and the proposed changes are below.

1. <u>Neighbourhood Community Development Partnerships (NCDPs)</u>

Description of NCDPs

In February 2017 LB Lewisham developed a Community Development Charter which outlines a partnership approach to community development and builds on current neighbourhood and borough-wide assets and networks by the creation of four Neighbourhood Community Development Partnerships (NCDPs). The partnerships bring together all the relevant voluntary and community sector partners as well as statutory services in each Neighbourhood to identify local health and wellbeing priorities as well as local resources and community assets to address them.

Public Health has provided £100,000 to support grants to voluntary and community organisations in all of the four NCDPs. The grants have supported a variety of projects that promote health and wellbeing for local residents. These include befriending groups, community gardens, a soup kitchen, holiday at home schemes, storytelling and dance workshops, physical activity sessions and a Fit Bus scheme. The funding was distributed using a community based participatory budgeting process.

Description of proposed changes to NCDPs

A £10,000 (10%) reduction in the grants available for NCDPs. Officers consulted on whether this should be evenly distributed across the four neighbourhood partnerships or targeted to those residents with the greatest health and wellbeing needs. The Council proposes that Public Health professionals will continue to support the membership of each of the four NCDPs to equally identify local health and wellbeing priorities and target the reduced grants to those in greatest need.

2. <u>Community Nutrition and Physical Activity Service</u>

Description of Community Nutrition and Physical Activity services

This borough-wide service delivered by GCDA (Greenwich Co-operative Development Agency) supports communities to become healthier and more resilient through delivery of initiatives such as cookery courses, physical activity sessions and the healthy walks programme, to working with food businesses to make their food healthier. The community development approach supports individuals, groups and organisations to promote healthy lifestyles and the service offers support, training and mentoring for community groups and organisations to deliver local healthy eating and physical activity initiatives.

Description of proposed changes to Community Nutrition and Physical Activity services

A £10,000 (5.8%) reduction in funding for the Community Nutrition and Physical Activity service. Council officers have discussed potential changes with the service providers and the Council proposes a reduction in the hours of the Training Manager post in the programme. This role will in future focus on training quality, observation and follow up rather than service development.

The providers feel that this reduction in the Training Manager role will not have an adverse effect on the programme delivery as the training is now well established and other staff have developed the skills and expertise to deliver the training. This change means that the provider is able to protect all other elements of the service from the reduction in budget and will be able to continue delivering the comprehensive service they provide in Lewisham.

3. Substance misuse services

Description of substance misuse services

The main substance misuse services are delivered by Change, Grow, Live (GCL) and Blenheim CDP. Both provide a range of interventions targeted at patients and family members suffering from substance misuse. CGL run the main complex needs service in the borough which assesses and triages all those presenting with a substance misuse or alcohol need. Service users receive a systematic assessment for an appropriate pharmacological therapy for opiate dependence and commencement of dose titration within 24 hours of presentation. In addition to this there are a range of specialist elements within the service designed to meet specific needs:

- Hospital Liaison Service. The service works across all local hospitals i.e. GSTT, Kings and LGT to support services users that are treatment naïve, frequent attenders and those with complex needs
- Criminal Justice Liaison. This service works includes a worker located in Lewisham Metropolitan Police custody suite, a worker based in Lewisham National Probation Service (NPS) and Community Rehabilitation Company (CRC) that attends court one day per week, a prison liaison in-reach worker and two Criminal Justice Practitioners that deliver interventions/groups within service
- Mental Health Services (Dual Diagnosis and Psychological Support). The service aims to enhance the delivery of intervention to service users with co-existing mental health and substance misuse/alcohol issues
- Outreach Service and Homeless Support Service. The service provides a dynamic and proactive outreach service to engage with a range of individuals who have adopted a 'street lifestyle' including rough sleepers, beggars, service users involved in prostitution and street drinkers with a view to engaging them in appropriate services and move then into a more settled lifestyle
- Club Drug and Stimulant Support. The service supports a number of individuals using New Psychoactive Substances (Legal Highs), Club Drugs and Crack or Cocaine users
- Residential Rehabilitation and Inpatient Detoxification and Stabilisation
- Parents/Carers. The service provides support for carers/parents and significant others of adult drug and alcohol users.
- Work with pregnant individuals in partnership with ante/post-natal services to ensure optimum care.

Blenheim CDP deliver the primary care recovery service which works in partnership with GPs and provides following interventions:

- Advice, information, brief interventions and extended brief interventions to help prevent and minimise problematic substance misuse or dependency
- Sessions of structured brief advice on alcohol for adults who have been identified via screening as drinking a hazardous or harmful amount
- Extended brief intervention for adults who have not responded to structured brief advice or who may benefit from an extended brief intervention for other reasons
- Assertive in-reach into other services to attract substance misusers not currently engaged with other agencies but not yet engaged in treatment services
- Substitute prescribing services and supervised consumption (e.g. through pharmacies) and the provision of biological drug and alcohol testing facilities
- A Primary Care provision of ambulatory detoxification for those presenting with low to moderate alcohol use

- Community detoxification for drugs, working in partnership with GP's to titrate and reduce substitute medication with the aim of abstinence and recovery
- Health, smoking cessation; healthy eating and access to physical exercise programmes/facilities),
- Overdose prevention and harm reduction advice, including the provision of Naloxone training and prescribing for injecting drug users presenting as high risk,
- Pro-active relapse prevention advice and support, including prescribing interventions
- Enhanced Blood Borne Virus Service in relation to Hepatitis A / B / C and HIV with access to on site screening, testing and rapid vaccination and robust referral pathways into appropriate treatment services
- Home visits, assessment and referral to early intervention services for all service users who have caring responsibilities for children under 16, these can be conducted jointly with other services.

Description of proposed changes to substance misuse services

A reduction of £127,000 (3%) in funding has been proposed for substance misuse services. Council officers have discussed potential changes with the service providers and the Council proposes that the service combine the Quality Lead with the Deputy Services Manager (DSM) role. This has been successful in other services across the UK. It is also proposed that the fixed term contract for the psycho-social worker is not renewed after March 2019.

The providers feel that combining the DSM role would not have an adverse effect on the service and this, alongside the removal of the psycho-social worker role, means that they are able to protect frontline staff from the reduction in budget thus ensuring the minimum negative impact on the effective service they provide in Lewisham.

4. <u>Health visiting service</u>

Description of Health Visiting service

The service is delivered by Lewisham and Greenwich Trust (LGT), and comprises a wide range of activity outlined below:

- Delivery of the statutory National Healthy Child Programme (HCP), including mandated checks delivered through a universal home visiting service to all families from pregnancy up until the child is 5 years old.
- MECSH, a structured programme of sustained nurse home visiting for families at risk of poorer maternal and child health.
- Family Nurse Partnership (FNP), an evidence based support programme for first time young parents aged 22 and under until the child reaches the age of two.
- The Freedom Programme, a 12 week programme for clients who disclose they are experiencing domestic abuse.
- A 'link' Health Visitor for every Lewisham GP practice.
- Targeted 'listening visits' to support better maternal mental health, including a joint home visit with Lewisham Children and Family Centres (CFC) colleagues.
- Development of Baby and Toddler Hubs across all four CCG and CFC Neighbourhoods, with further Baby Hubs planned during 2018.
- Longer term plans to develop a virtual Health Visitor who can respond to families' questions or concerns online. This will support a move to make health visiting a 7-day-a-week service, building on the introduction of a 6-day-a-week service for new birth visits.
- Breastfeeding programme included Peer Supporters, Breastfeeding Hubs and an Open College Network accredited Peer Support training programme.
- The service is trialling a mental health post-natal group in conjunction with CFC colleagues, "Understanding your Baby", for mothers who have been in receipt of listening visits. The "Understanding your Baby" programme is delivered weekly over an eight week period and provides a two-hour session for up to eight mothers and their babies.
- Active involvement in the Lewisham Safeguarding Children's Board, as well as wider arrangements to safeguard vulnerable children and families including regular attendance at Early Help Panel and potential to be lead professional for relevant targeted cases.

Proposed changes to Health Visiting service

- The proposed cut to the Health Visiting service budget is £196,306 against a budget of £6,096,224. If accepted, this would leave a budget of £5,899,918
- The contract value for Health Visiting and Family Nurse Partnership in 18/19 is £5,938,327. The pricing schedule submitted in the 2016 tender has a planned uplift of £115,649 from 18/19 to 19/20 taking the anticipated contract value to £6,053,976.
- This leaves a funding gap of £154,058 should the cut be taken.

This leaves a funding gap of £38,409 from the current contract value and of £154,058 against the anticipated 19/20 contract value should the cut be taken.

The Trust have confirmed that the service is holding a number of health visitor vacancies, in part due to a national shortage of health visitors, and that this budget reduction can be identified through these vacant posts. There are 48.48 Band 6 Health Visitors referenced in the contract Pricing Schedule. The 18/19 costing for a single Band 6 Health Visitor is £53,841 so a reduction of £154,058 could be found through 2.9 Band 6 vacancies.

As the number of vacancies confirmed by the Trust are beyond the value of the cut this would mean that the impact on current service delivery of this approach would be negligible in 19/20, with no impact on equalities.

Whilst we could anticipate an impact when the service is commissioned with a reduced budget from 2020, we would expect the current and any potential provider to have more time to respond to a tender with innovation and partnership working (for example more mobile working and further integration with partners (such as Children and Family Centres) to further mitigate any impact.

Additionally, the Health Visiting service is part of the Early Help review, which will deliver a renewed approach to our services for children and families and that may be able to further mitigate any impact.

Officers will continue to seek to work with the provider further until the implementation of the cut, should it be agreed, in April 2019.

2. **The protected characteristics or other equalities factors potentially impacted by this decision**

☒ Age	☒ Ethnicity	☒ Maternity	☒ Language spoken	☐Other, please define:
☒ Gender	☒ Gender identity	☒ Disability	☐ Household type	
☒ Religion	☐ Carer status	☒ Sexual orientation	☒ Income	

The list of protected characteristics or other equalities factors potentially impacted by this decision was produced by looking at service-level data on the current reach of services in terms of characteristics of service users (see section 3 of this EAA).

3. The evidence to support the analysis

A thorough assessment of the data and research required to perform this EAA was undertaken at the outset of the work.

The following data sources were identified:

1) **Demographic data from 2011 Census, Office for National Statistics, Greater London Authority** – used to determine the prevalence of having a protected characteristic in the Lewisham population.
2) **Service monitoring data** for all of the services listed above, including age, gender, ethnicity and deprivation data (where available) to determine the current reach of service to different population groups.
3) **Stakeholder Consultation** – as described below.

Changes to services may impact the protected characteristics selected by affecting the reach of services. The current uptake of services by protected characteristics is described below.

Uptake of services by protected characteristics

1. **<u>Neighbourhood Community Development Partnerships</u>**

National Institute for Health and Care Excellence (NICE) guidance endorses community engagement as a strategy for health improvement. There is a substantial body of evidence on community participation and empowerment in addressing the social determinants of health and removing barriers for marginalised and vulnerable groups, and on the health benefits of volunteering.[1] Each NCDP meets quarterly and in 2017-2018, 170 community groups and statutory partners came together to raise and resolve issues of community concern.

There are limited data on the beneficiaries of the NCDPs by protected characteristic. However, the funded projects are targeted at particular groups so we are able to deduce who these beneficiaries are likely to be and therefore which protected characteristics may be impacted by the proposed budget cuts. It should also be emphasised that community development offers more benefits that simply the sum of the benefits to the individual participants who are involved, for example by strengthening relationships between different community groups and by building up partnership working.

Neighbourhood priorities are updated every year and a different set of community groups are awarded the funding each year. This makes it difficult to estimate the potential impact on beneficiaries with particular protected characteristics as the recipients of funding are changed each year. However, there are some commonalities in the types of community groups that have received funding over the past two years:

- The majority of community groups are providing services to older people and people with long-term health conditions (both physical and mental) or disabilities. These beneficiaries are often socially isolated and may also be marginalised.
- Several community groups target older people. For example, Lee Green Lives runs a project called Positive Aging, which aims to promote social inclusion and to support and improve the health and wellbeing of the older community in Lee Green; another project delivered by a group of community organisations provides cultural-themed Holidays from Home events to increase social opportunities for older people, reduce social isolation and engage older BAME (Black, Asian and Minority Ethnic) communities; whilst 1Life Fit Bus collects older isolated people and takes them to a number of physical activity sessions in the Downham area as well as other NCDP funded projects. However, there are also some community groups that support younger people, such as Inspiring Imagination which works with young people between the ages of 10-19, and there are several with a focus on intergenerational projects, for example Urban Connect is a project which runs intergenerational cookery sessions amongst other activities.
- Some community groups also target people with disabilities. Headway Heads Up to Fitness and Food provides healthy eating courses and physical activity sessions for people recovering from brain injury; whilst Red Ribbon offer a range of support services to people who are infected with and affected by HIV.
- There are also community groups aimed at particular ethnic groups, for example The Pioneers project addresses social isolation among older adults from African, Caribbean and Asian communities.
- Whilst there are no currently funded projects that explicitly target Lesbian, Gay, Bisexual and Transgender (LGBT) people, the Lewisham Forum is connected to the Stephen Lawrence Foundation, which supports LGBT people from BAME groups.
- The majority of community groups target activities to areas of higher deprivation.
- Explicit language support is built into some of the groups.

In addition, the NCDPs support signposting to other services and groups, which may support people with protected characteristics, for example TAGS, a swimming group for transgender people.

2. <u>Community Nutrition and Physical Activity services</u>

The World Health Organisation considers that an unhealthy diet is one of the major risk factors for a range of chronic diseases and physical inactivity is the fourth leading risk factor for mortality, accounting for 6% of deaths. NICE Guidance on Behaviour Change at population, community and individual levels (NICE 2007, 2014) confirms overwhelming evidence that changing people's health-related behaviour can have a major impact on health. Both documents also cite the importance of community development/engagement in helping people to stay healthy.

There are many aspects to the Community Nutrition and Physical Activity services, some aimed at improving skills and resilience of individuals through direct delivery of initiatives or delivering brief interventions, such as:

[1] Public Health England (PHE) (2015) A guide to community-centred approaches for health and wellbeing.

- delivering a 6 week community cookery programme
- running the healthy walks programme
- delivery of physical activity sessions
- raising awareness and brief interventions on healthy eating and physical activity at events and others aimed at promoting a healthier local environment and developing community cohesion through:
    - training and mentoring local community organisations to deliver physical activity and healthy eating sessions
    - raising awareness sessions on the National Healthy Start scheme and the Lewisham Vitamin D scheme
    - working with businesses to implement the Healthier Catering Commitment scheme
    - working with communities to strengthen assets and support community development

Not all aspects of the service collect data on protected characteristics. The local community organisations that are supported with training and community development vary each year, but there are commonalities in the groups that receive support that indicate they reach people with protected characteristics. Most groups are based in areas with higher deprivation.

Examples of groups supported include:

- Afghan and Central Asian Women's Association
- Action For Refugees in Lewisham
- Ubuntu
- Local housing associations (Phoenix, Lewisham Homes and Hexagon)
- Wheels for wellbeing
- Supported housing (Apax and Phoenix Futures)
- Lewisham Pensioners Forum
- Lewisham Carers
- HealthWatch
- Bromley and Lewisham Mind

Data is available for the physical activity sessions and training events, cookery clubs and walking for health programme.

Of the 155 people who attended physical activity sessions and training events in 2017/18:

- 76.0% were female; 24.0% were male
- 54% were White; 44% were BAME; 2% declined to answer
- 16% identified themselves as having a disability; 73% stated that they had no disability; 10% declined to answer
- 42% were aged 64 or over; 38% were aged 45-64; 9% were aged 35-44; 4% were aged 27-34; 2% were aged 18-26 and 5% declined to answer
- 21% identified themselves as having a long term condition

Of the 140 people who attended the cookery clubs in 2017/18:

- 83% were female; 17% were male
- 33% were BAME; 27% were White; 3% declined to answer; 37% were unknown
- 31% were aged 46-59; 28% were aged 60 or over; 17% were aged 36-45; 9% were aged 26-35; 1% were aged 0-25; and 14% declined to answer

Of the 618 people who registered with Walking for Health (Health Walks and Nordic Walks) in 2017/18:

- 21.5% were male
- 39% were from BAME groups
- Approximately 16% are aged 45-54, 33% are aged 55-64 and 28% 65-74
- 20% stated that they had a long-term health condition or disability
- 44.8% stated that they had a condition that would be benefitted by physical activity (heart disease/diabetes/hypertension/COPD and/or asthma), with some people experiencing more than one condition; 5.6% stated that they had mental health issues
- 20% were from the 20% most deprived areas

As with the NCDPs, the community development approach taken by the service offers more benefits that simply the sum of the individual participants who are involved, for example by strengthening relationships between different community groups. This benefit is difficult to quantify but should not be disregarded.

3. Substance misuse services

The current substance misuse services in Lewisham reach over 900 people on average each year.[2]

Data from 2015/16 until 2018/19 Quarter 2 on overall service users show that:

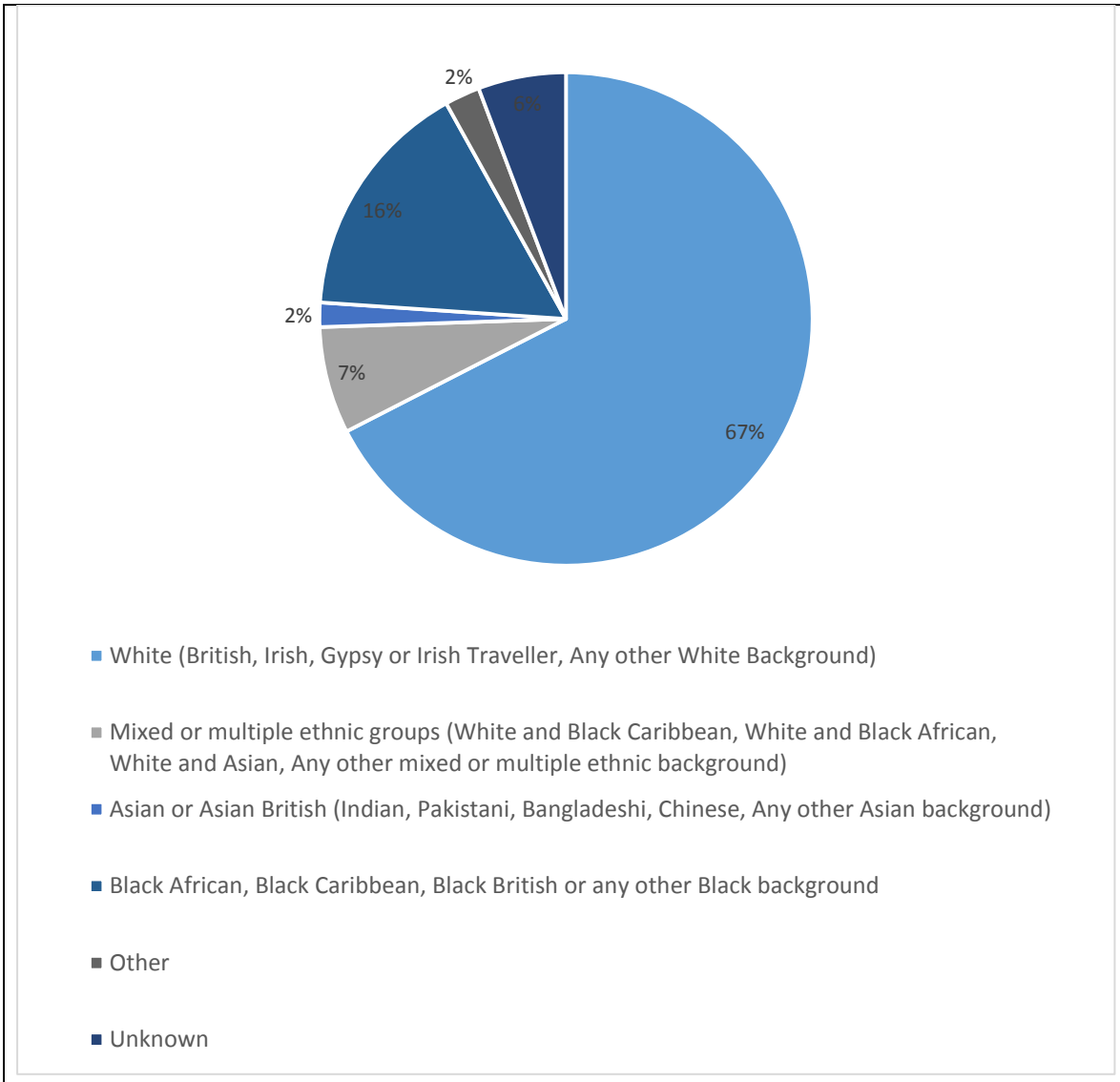
- 72.1% are male and 27.7% are female (0.2% unknown)
- 96.4% are aged 25-64; 1.8% are aged 18-24; and 1.8% are aged 65 and over (see Table 1)
- 67.5% are White (British, Irish, Gypsy or Irish Traveller or Any other White Background); 15.9% are Black African, Black Caribbean, Black British or any other Black background; 7.0% are Mixed or multiple ethnic groups (White and Black Caribbean, White and Black African, White and Asian, Any other mixed or multiple ethnic background) (see Figure 2)
- 11.8% consider themselves to have a disability; 80.7% do not consider themselves to have a disability; 3.8% prefer not to say; and 3.7% are unknown
- Of those who consider themselves to have a disability: 26.6% have a mental health condition; 24.2% have a physical or mobility-related disability; 15.8% have a cognitive or learning disability; 10.4% have a visual, speech or hearing-related disability; and 8.1% have a longstanding illness or health condition. Other types of disability accounted for 14.9% of the disabled service users
- 76.3% are straight or heterosexual; 2.6% are gay or lesbian; 2.5% are bisexual; and 5.5% are other. 12.7% preferred not to say and 0.5% are unknown
- 0.6% were pregnant at the time of using services
- There are no data on religious beliefs, gender identity or language spoken

Table 1. Substance misuse services users 2015/16 – Q2 2018/19, by age group

Age band	Number	Percentage
18-24	67	1.8%
25-29	211	5.6%
30-34	353	9.4%
35-39	573	15.2%
40-44	528	14.0%
45-49	725	19.3%
50-54	731	19.4%
55-59	333	8.8%
60-64	177	4.7%
65 and over	67	1.8%

Figure 1. Substance misuse services users 2015/16 – Q2 2018/19, by ethnic group

[2] Average of 2015/16, 2016/17 and 2017/18



4. Health visiting service

Equalities data was provided from the service provider, Lewisham and Greenwich Trust (LGT) for the period April 2017 (Quarter 1 2017/18) to September 2018 (Quarter 2 2018/19), broken down by quarters. The total number of recorded Health Visiting appointments in this time period was 172,892, between, giving an average quarterly caseload of 24,699.

LGT record gender identity as Male, Female and X (either not stated, not specified or other). The Health Visiting caseload is predominantly female which would fit with the usual mother and baby Health Visiting model. The gender breakdown of the caseload is:

- Female: 116,702 (67%)
- Male: 56,601 (33%)
- X: 3 (0%)

As would be expected the caseload is predominantly aged between 0-10. It is not possible to look at a 0-5 age group from the data provided. The most dominant age banding recorded for parents is 30-39 but attention should also be drawn to the potentially extremely vulnerable caseloads at 11-17 which is likely to contain teenage pregnancies and at 50+ where special guardianship orders could be in place.

Table 2. Health Visiting Caseload by Age Group

Age	Number	Percentage
0-10	107,663	62%
11-17	36	0%
18-24	7,278	4%

25-29	12,083	7%
30-34	18,861	11%
35-39	19,030	11%
40-44	6,611	4%
45-49	958	1%
50+	372	0%

A quarter of the caseload identify as British, with a further 15% identified from another white background, 47% from BME origins and 12% not identified.

Table 3. Health Visiting Caseload by Ethnic Group

Ethnicity	Number	Percentage
British	43,888	25%
Any other White background	26,257	15%
Code Not Recognised	22,934	13%
African	20,379	12%
Caribbean	14,439	8%
Any other mixed background	11,178	6%
Any other Black background	5,196	3%
Any other ethnic group	5,137	3%
White and Black Caribbean	5,104	3%
Any other Asian background	4,957	3%
White and Black African	3,041	2%
White and Asian	2,596	2%
Indian	2,003	1%
Chinese	1,937	1%
Not stated	1,113	1%
Irish	980	1%
Pakistani	915	1%
Bangladeshi	838	0%

99.88% of the caseload did not have a religion identified.

Stakeholder Consultation

The public consultation for the proposed changes to public health services was approved by the Mayor and Cabinet on 4th September 2018 and took place between 5th September 2018 and 7th November 2018.

The consultation involved three elements:

1. Online engagement with the public and service users through an online consultation survey delivered via CitizenSpace. This survey aimed to:
    - Identify service areas which are considered priorities
    - Obtain views on different ways in which services could be accessed with less or no funding for that area
    - Obtain views on how the council could facilitate this

2. Online engagement with healthcare and professional stakeholders through an online consultation survey delivered via CitizenSpace.

3. A number of stakeholder meetings with service users:
    - Attendance by officers at a Substance Misuse service user consultation event
    - Six service user engagement visits by officers to Health Visiting delivery sites

The findings from all of these elements of the consultation exercise have been used to inform this EAA.

Demographic characteristics of online consultation respondents

There were 165 responses to the online consultation. 82.4% of respondents agreed to share their personal demographic information.

Age

Of the respondents that answered the question about age (156), 17.0% were aged 55-59 (see Table 4 below). When compared to the population estimates for Lewisham as a whole, it appears that the views of young people (0-24) are under-represented in the online consultation. Conversely, the views of people aged 45 to 74 are over-represented in the online consultation.

Table 4. Age breakdown of online consultation respondents and 2017 Lewisham population

Age	Percentage of consultation respondents	Percentage of Lewisham population[3]
Under 18	0%	22.7%
18-24	0.6%	8.2%
25-29	3.0%	9.4%
30-34	6.0%	10.2%
35-39	8.5%	9.8%
40-44	7.9%	7.8%
45-49	9.7%	7.1%
50-54	10.3%	6.5%
55-59	17.0%	5.2%
60-64	9.7%	3.7%
65-69	13.9%	2.8%
70-74	6.1%	2.2%
75-79	1.9%	1.7%
80-84	0%	1.3%
85+	0%	1.3%

Gender

Of the respondents that answered the question about gender (147), 80.3% were female. In 2017, it is estimated that just over half (50.7%) of Lewisham's population of 301,300 are female[4] so the views of Lewisham males are under-represented in the online consultation responses.

Disability

Of the respondents that answered the question about disability (144), 21.5% considered themselves to be a disabled person. The online responses are therefore broadly representative of the Lewisham population in terms of disability: the 2011 Census asked about long-term health problems and disabilities and found that in Lewisham, 14.4% of the population reported that were living with a long-term health condition that limited their day-to-day activities: 7.1% reported that they were limited a lot and 7.3% reported that they were limited a little.[5]

Of those respondents who considered themselves to be a disabled person (38), the most common disability type was longstanding illness or health condition (see Table 3 below).

Table 5. Disability type amongst those respondents who consider themselves to be a disabled person

Disability type	
Physical or mobility related	15.8%
Visual or hearing related	7.9%
Mental health condition	13.2%
Cognitive or learning disability	7.9%
Longstanding illness or health condition	23.7%
Other	21.1%

[3] Office for National Statistics (ONS) 2017 mid-year population estimate. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

[4] Office for National Statistics (ONS) 2017 mid-year population estimates.

[5] Table KS301UK. 2011 Census: Health and provision of unpaid care, local authorities in the United Kingdom.

13 responses identified access requirements.

Ethnicity

Of the respondents that answered the question about ethnicity (155), 83.9% were White (see Table 6 below). The Greater London Authority (GLA) estimated that 51.6% of the Lewisham population are White, 26.4% are Black, 10.3% are Asian and 11.6% are Mixed or Other ethnic groups.[6] This means that the views of White people are over-represented in the online consultation, and the views of all other ethnic groups are under-represented.

Table 6. Ethnic group breakdown of online consultation respondents

Broad ethnic group	Percentage of consultation respondents
White	83.9%
Black African, Black Caribbean, Black British or any other Black background	8.4%
Asian or Asian British	3.9%
Mixed or multiple ethnic groups	2.6%
Other	1.3%

Pregnancy and maternity

Of the respondents that answered the question about pregnancy/maternity (152), 2.6% were currently pregnant and 2.6% had been pregnant in the last six months. We do not have a reliable comparator data source for this protected characteristic at local authority level.

Religion/belief

Of the respondents that answered the question about religion/belief (135), 51.6% stated that they had no religious belief and 40.7% were Christian. Responses for each of the other religions stated (Buddhism, Hinduism, Judaism, Islam or Sikhism) were under 2.5%. Comparison with the Annual Population Survey estimates for the population by religion in Lewisham suggests that views of people with no religion are over-represented in the online survey and that the views of people from all religions are under-represented. The Annual Population Survey estimates that in 2017, 54.3% are Christian, 35.6% are no religion, 4.1% are Muslim, 3.2% are Hindu; and 2.7% are any other religion.[7]

Sexual orientation

Of the respondents that answered the question about sexual orientation (133), 94. 0% were straight or heterosexual, 3.8% were gay or lesbian, and 2.3% were bisexual. We do not have a reliable comparator data source for this protected characteristic at local authority level, however the Annual Population Survey has released experimental statistics on sexual identity at a local authority level, using estimates based on a survey.[8] In Lewisham, it is estimated that 89.0% of the adult population identify themselves as heterosexual or straight; 2.5% identify themselves as lesbian, gay or bisexual; and 8.5% don't know, refuse to answer or identify themselves as other (i.e. neither heterosexual/straight, lesbian, gay or bisexual). According to this data, responses to the online consultation are broadly representative of the Lewisham population in terms of sexual orientation.

Gender reassignment

Of the respondents that answered the question about gender reassignment (132), 99.2% were the same gender that they were at birth. We do not have a reliable comparator data source for this protected characteristic at local authority level.

Marriage and civil partnership

[6] Greater London Authority (GLA) GLA 2016 Ethnicity Projections Central Trend Based

[7] Greater London Authority (GLA) Population by Religion, Borough https://data.london.gov.uk/dataset/percentage-population-religion-borough. Data from ONS Annual Population Survey.

[8] This means they are subject to sampling variability. This is because the sample selected is only one of a large number of possible samples that could have been drawn from the population.

No question about this protected characteristic was included in the online consultation.

Language spoken

No question about language spoken was included in the online consultation.

Owing to the small sample size of the resident respondents to the online consultation and the representation of those with protected characteristics in the sample as described above, the consultation results outlined below should be interpreted with caution since they may not be representative of all resident viewpoints within the borough.

General consultation findings

In the free text sections of the survey the main themes that emerged from general comments were:

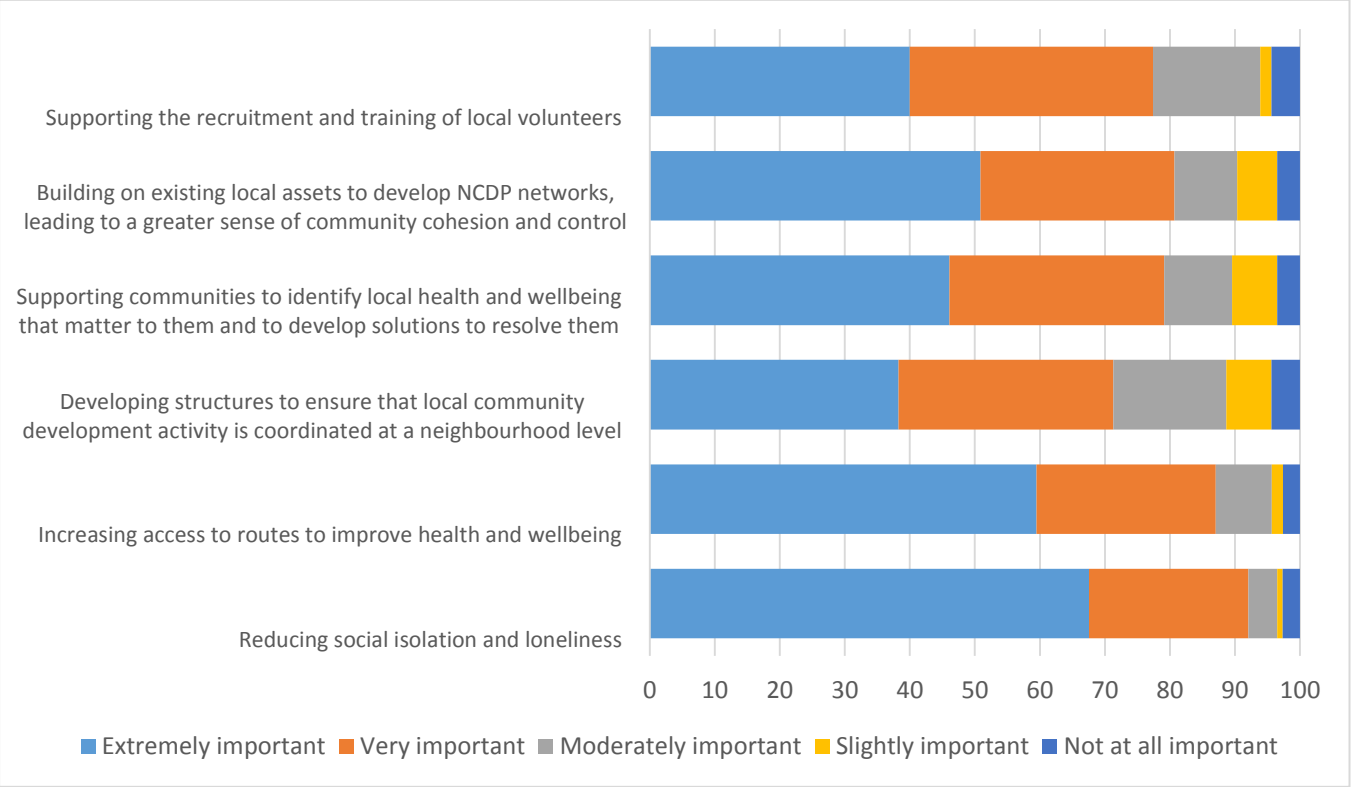
- Opposition to changes for several reasons (likely negative effect on most vulnerable residents/lack of investment in prevention)
- Greater use should be made of the voluntary sectors resources and facilities

Consultation findings by service area

1. **<u>Neighbourhood Community Development Partnerships</u>**

130 people responded to the set of questions about the NCDPs. 105 of these were members of the public and 25 were professionals. Respondents were asked how important they thought particular objectives were for the NCDPs. The most supported objective was 'Reducing Social Isolation' (see Figure 2 below).

Figure 2. How important do you think the following objectives are for NCDPs?



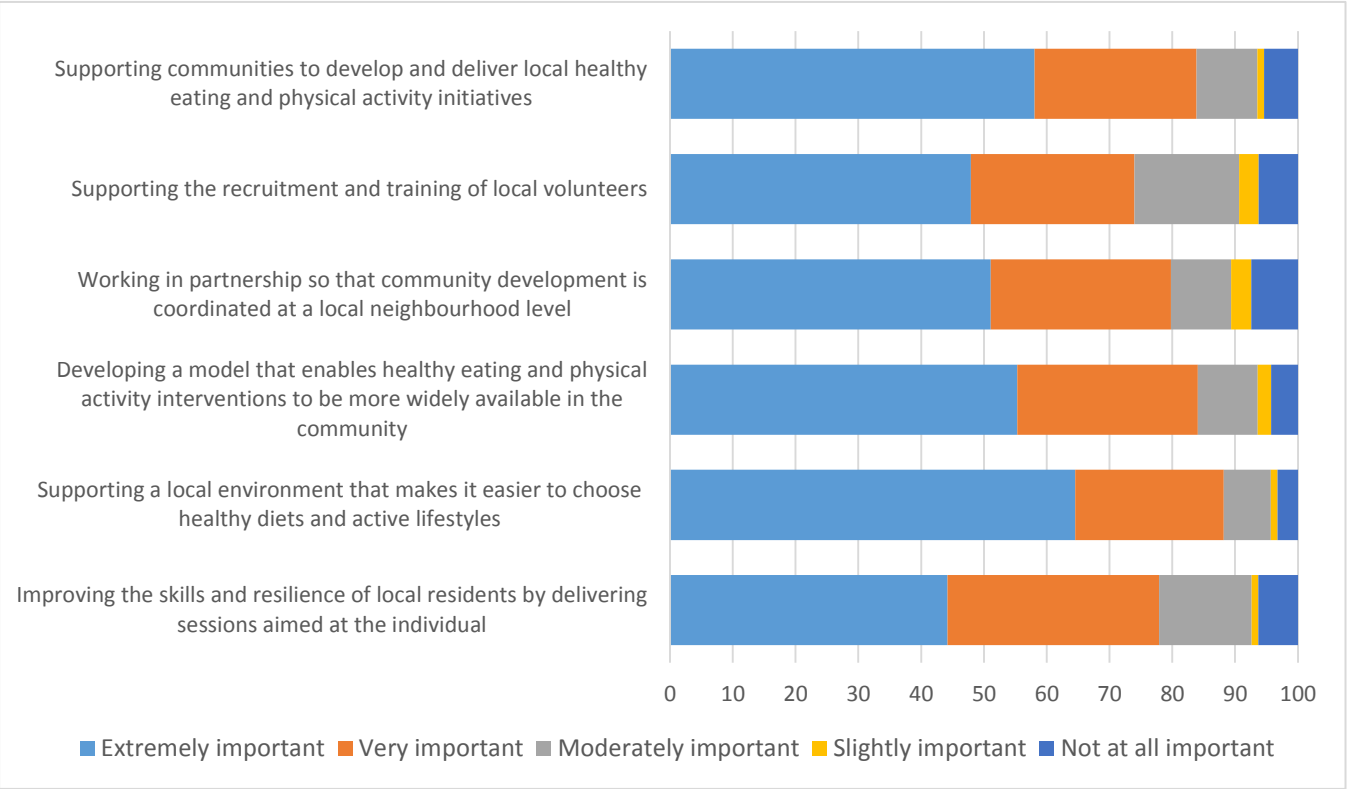
Respondents were asked about whether the grant reduction should be evenly distributed across the four neighbourhood partnerships or targeted to those residents with the greatest health and wellbeing needs.

- Of the 109 people that answered the question, 32.1% agreed or strongly agreed that we should distribute the grant reduction equally between the four NCDPs; 22.1% disagreed or strongly disagreed; and 35.8% were undecided.
- Of the 110 people that answered the question, 73% agreed or strongly agreed that we should maintain funding for individuals and groups most in need (i.e. target the reduction at those less in need); 13% disagreed or strongly disagreed; and 14% were undecided.

2. Community Nutrition and Physical Activity service

142 people responded to the set of questions about the Community Nutrition and Physical Activity services. 118 of these were members of the public and 24 were professionals. Respondents were asked how important they thought particular objectives were for the Community Nutrition and Physical Activity services. The most supported objective was 'Supporting a local environment that makes it easier to choose healthy diets and active lifestyles' (see Figure 3 below).

Figure 3. How important do you think each of the following objectives are for the Community Nutrition & Physical Activity service?



Respondents were asked whether we should make cuts by reducing services aimed at the individual or by reducing services aimed at the community.

- Of the 94 people that answered the question, 11.8% agreed or strongly agreed that we should make cuts by reducing services aimed at the individual; 56.4% disagreed or strongly disagreed; and 30.8% were undecided.
- Of the 93 people that answered the question, 12.9% agreed or strongly agreed that we should make cuts by reducing services aimed at the community; 64.5% disagreed or strongly disagreed; and 22.6% were undecided.

3. Substance misuse services

The consultation set out the range of activity delivered by the services and sought the views of the public, particularly those who have accessed the provision, as to the areas they felt were of particular importance or any changes that could be made.

Online consultation

108 people responded to the set of questions about the Substance Misuse services. 6 of these were current or past service users, 78 were members of the public and 24 were professionals. When asked whether they thought that this proposal will affect particular individuals more than others, the vast majority of respondents (83.8%) believed the proposed cuts **would** affect particular individuals more than others.

Consultation event

No formal demographic data collection took place but from observation the groups were diverse and participated well. On reflection, more representation from women and BAME services users would have been beneficial to reflect Lewisham's wider community. Overall the age range was diverse and reflective and included family members/carers of service users engaging with commissioned services.

To remain consistent with the online consultation, the commissioning team (addictions) used open ended questions similar to those in the online consultation.

Service users discussed how they thought the proposed cuts will impact service delivery and service users. Key themes were:

- The cuts will affect carer health and mental health due to the added pressure of services potentially not offering the same level of care and support to decline in frontline staff
- Concerns with young people's mental health
- Cuts will have a detrimental effect on dual diagnosis
- Staff will leave affecting the quality of services
- Reduction of aftercare will impact abstinence as it assists with reintegration and relapses prevention. It was felt that aftercare groups and already too large
- Fear that medication/OST (opioid substitution therapies) will be reduced and there will be less choice
- Areas not of priority may be overlooked i.e. outreach

When asked whether they thought that this proposal will affect particular individuals more than others, service users discussed several protected characteristics:

- Women – it was felt that women were already underrepresented amongst service users and don't access services at the best of times due to fear of repercussions i.e. losing children or social services involvement
- OST service users
- Aftercare service users – it was feared there will be less support in regards to relapse prevention
- Young people – services are already diluted and links with mental health and accessing services takes too long
- Vulnerable service users will be at risk
- Ex-offenders – it was felt that this group may find it hard to access services and may be out of touch with reality due to length of sentences and not being prepared for release
- Those affected by domestic violence and abuse
- Young people transitioning into adult services
- Parents and service users with children
- Older adults

Overwhelmingly, participants felt that cuts of any amount would affect service delivery and quality of care received. It was suggested that if cuts did have to be made, they should not be made to the frontline staff i.e. key workers or to medication.

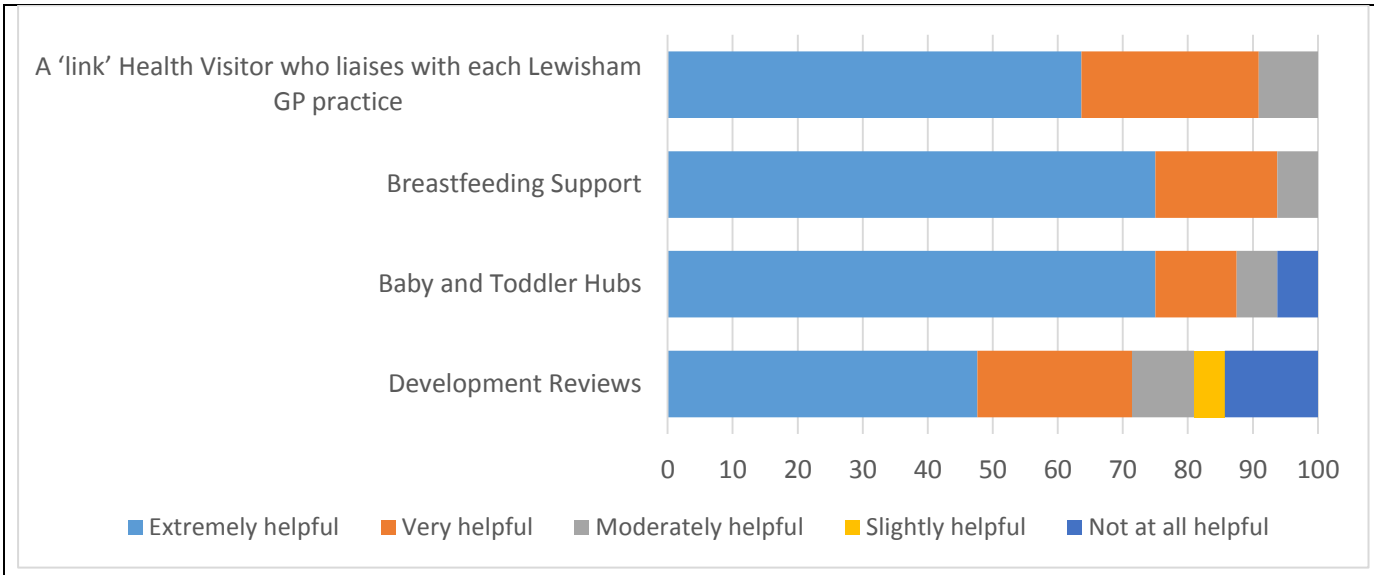
4. <u>Health visiting services</u>

Online consultation

119 people responded to questions about the Health visiting service. 22 respondents answered as a current or previous service user, 77 as a member of the public and 20 in a professional capacity.

Service users were asked how helpful different aspects of the health visiting service were. Breastfeeding support was seen as the most helpful service (Figure 4).

Figure 4. How helpful did you or your family member find the different types of support offered by Lewisham's Health Visiting service?



Members of the public were asked to rank what they felt were the most important outcomes for the Health Visiting service. 'Reducing infant mortality' was ranked as the most important outcome for the health visiting service, followed by 'Improving life expectancy and healthy life expectancy'. Professional respondents were also asked this question and selected the same outcomes as most important.

Service user consultation events

Engagement took place across six sessions around the borough: 2 breastfeeding support groups, 1 Dad's Network session, 1 Baby Hub, and 2 nursery drop offs. The vast majority of those attending were past or current users of Health Visiting services. A point of general feedback from consultees was that the language used was jargony- e.g. 'school readiness'.

Responses to questions regarding the Health Visiting service outcomes

- An overwhelming endorsement of the success of breastfeeding services in the borough in line with the national recognition via Unicef Level 3 accreditation
- Breastfeeding support was the Health Visiting outcome considered most important by over 78% of respondents
- Free text response supported this endorsement with women using describing the breastfeeding support as, 'life-saving' and many referring to the fact they would have given up without it
- The flexible, drop-in and regular aspects to the service were also positively viewed by respondents
- 'Improving child development' and 'Increasing vaccination coverage' were the second and third most important outcomes respectively.

Responses to views about cuts

- There was universal disapproval but the free text comments indicated concern that services were already over-stretched and would lead to longer time, more expensive problems.
- There were a significant number of respondents that specifically mentioned maternal mental health as an area that would be adversely affected by proposed cuts

Response to views about whether particular individuals would be more affected by cuts

- The following groups were mentioned by several respondents; women suffering domestic abuse, single parents, poor people, first time mums, women who are socially isolated, young mothers and those with mental health issues.

Service improvements that may achieve the same savings

- Many respondents mentioned groups sessions both in response to this question and in relation to services they found particularly helpful
- Some respondents mentioned telephone support but others seemed to value the direct contact and telephone support would remove the peer support benefit afforded by groups

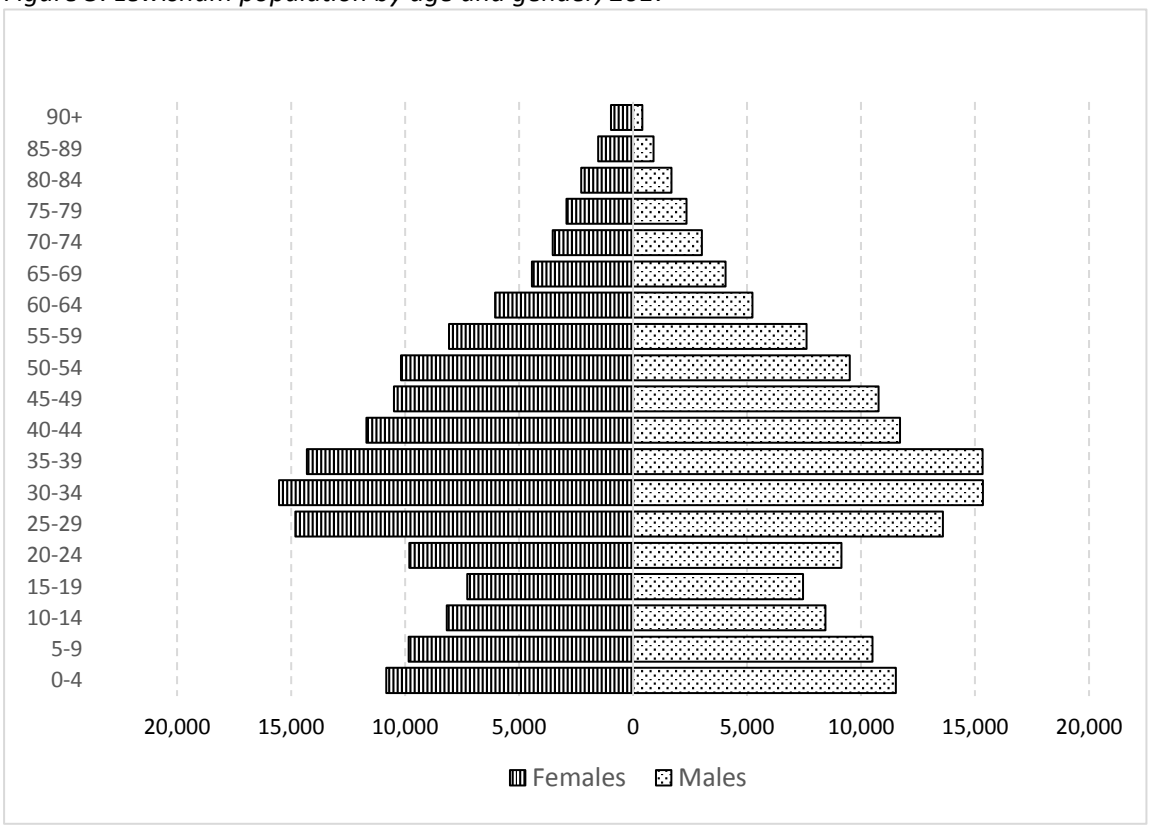
Contextual data: The Lewisham population

Gender

In 2017, it is estimated that just over half (50.7%) of Lewisham's population of 301,300 are female.[9]

Age

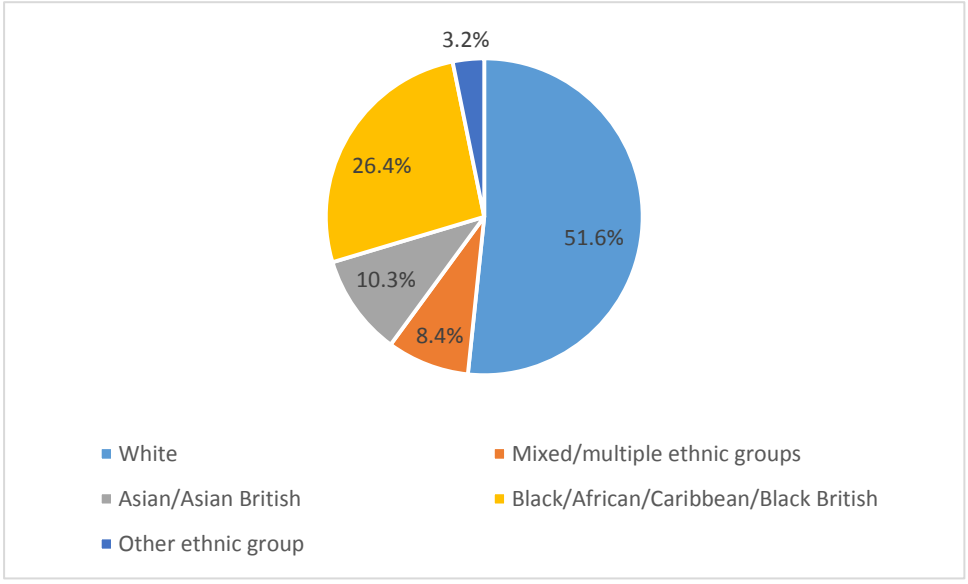
Figure 5. Lewisham population by age and gender, 2017



Source: Office for National Statistics (ONS) 2017 mid-year population estimate.
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

Ethnicity

Figure 6. Lewisham population estimates by broad ethnic group, 2018



Source: the Greater London Authority 2016 Ethnicity Projections Central Trend for 2018

Disability status

[9] Office for National Statistics (ONS) 2017 mid-year population estimates.

The 2011 Census asked about long-term health problems and disabilities. It found that in Lewisham, 14.4% of the population reported that were living with a long-term health condition that limited their day-to-day activities: 7.1% reported that they were limited a lot and 7.3% reported that they were limited a little.[10]

Sexual orientation

The Annual Population Survey has released experimental statistics on sexual identity at a local authority level, using estimates based on a survey.[11] In Lewisham, it is estimated that 89.0% of the adult population identify themselves as heterosexual or straight; 2.5% identify themselves as lesbian, gay or bisexual; and 8.5% don't know, refuse to answer or identify themselves as other (i.e. neither heterosexual/straight, lesbian, gay or bisexual).

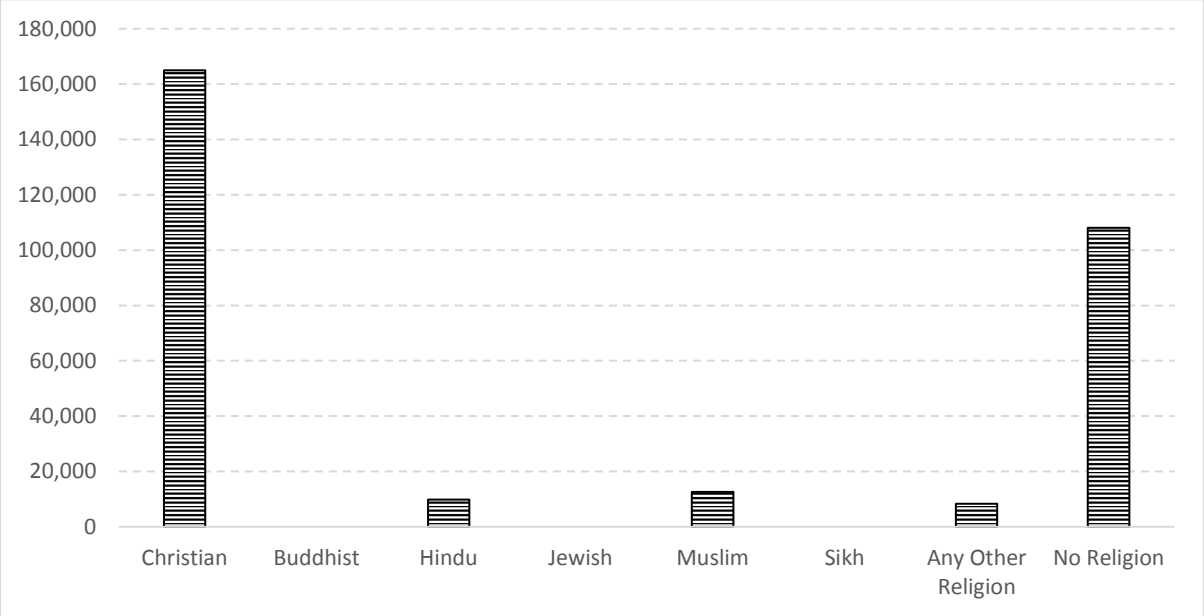
Gender identity

The ONS 2021 Census topic consultation identified a need amongst a number of data users for information about gender identity for policy development and service planning; especially in relation to the provision of health services. These requirements are strengthened by the need for information on those with the protected characteristic of gender reassignment as set out in the Equality Act 2010.

Religious belief

The Annual Population Survey estimates the population by religion in Lewisham. It estimates that 54.3% are Christian, 35.6% are No Religion, 4.1% are Muslim, 3.2% are Hindu; and 2.7% are Any Other Religion.

Figure 7. Lewisham population estimates by religion, 2018



Source: Greater London Authority (GLA) Population by Religion, Borough https://data.london.gov.uk/dataset/percentage-population-religion-borough. Data from ONS Annual Population Survey.

Maternity/pregnancy

Of live births in Lewisham in 2017, 2.0% of mothers were aged under 20 and 9.4% of mothers were aged 20-24 (see Table 7).

Table 7. Number and percentage of live births in Lewisham, by age of mother, 2015-2017

Age of mother	2015		2016		2017	
	Number	Percentage	Number	Percentage	Number	Percentage
Mother aged under 20	116	2.4%	114	2.4%	97	2.0%
Mother aged 20-24	499	10.4%	466	9.9%	445	9.4%
Mother aged 25-29	1,032	21.4%	958	20.3%	951	20.0%
Mother aged 30-34	1,612	33.5%	1,628	34.5%	1,617	34.0%

[10] Table KS301UK. 2011 Census: Health and provision of unpaid care, local authorities in the United Kingdom.

[11] This means they are subject to sampling variability. This is because the sample selected is only one of a large number of possible samples that could have been drawn from the population.

Mother aged 35-39	1,228	25.5%	1,219	25.8%	1,303	27.4%
Mother aged 40-44	292	6.1%	308	6.5%	313	6.6%
Mother aged 45 and over	35	0.7%	28	0.6%	25	0.5%
Total	4,814		4,721		4,751	

Source: Office for National Statistics. Live births in England and Wales down to local authority local area. Downloaded from Nomis.

Language spoken

The 2011 Census Residents showed that English is not the main language for 16.5% of Lewisham residents. European EU languages such as Polish, non-EU European languages, South Asian and East Asian languages were the most commonly spoken non-English languages. The School Language Census, taken in Summer 2017, showed over 160 languages are spoken by Lewisham pupils.

Income

In relative terms, Lewisham remains amongst the most deprived local authority areas in England: it is the 48th most deprived of all 326 English Local Authorities and the 10th most deprived borough in London. Concentrations of deprivation are highest in the north and south of the borough.

4. The analysis

The findings of the consultation; demographic data from the 2011 census, the ONS and the GLA; and service monitoring to date, have been brought together in this section to inform the impact assessment. For each service, the impact of the proposed changes has been classified as positive, negative, neutral or equivocal for each of the nine protected characteristics.

Impact assessment by service

1. Neighbourhood Community Development Partnerships

Positive impacts of changes to this service:

There are not expected to be any overall positive impacts for any of the protected characteristic groups.

Negative impacts of changes to this service:

There are not expected to be any overall negative impacts for any of the protected characteristic groups.

Equivocal impacts of changes to this service:

Age, Gender, Ethnicity, Disability, Sexual orientation, Gender identity, Maternity, Income, Language spoken

Since data is not routinely available from participants of the NCDPs for any of the protected characteristics, it is unclear if the proposed changes will have any disproportionate impact on residents in these protected characteristic groups. In addition, recipients of funding change each year, so we are unable to predict the funded community groups in future years and which protected characteristic groups these organisations may support. As no community groups exist solely as a result of the NCDP funding, we do not expect any groups to stop providing services as a result of the budget cut. In addition, Community Connectors are able to signpost organisations to other sources of funding available.

2. Community Nutrition and Physical Activity service

Positive impacts of changes to this service:

There are not expected to be any overall positive impacts for any of the protected characteristic groups.

Negative impacts of changes to this service:

There are not expected to be any overall negative impacts for any of the protected characteristic groups.

Neutral impacts of changes to the service:

Age, Gender, Ethnicity, Disability, Sexual orientation, Gender identity, Maternity, Income, Language spoken

The Community Nutrition and Physical Activity service has managed to achieve good reach to BAME groups generally and to older people (aged 65 or over), particularly amongst the Walking for Health activities. These groups could therefore be disproportionately affected by changes to this component of the service. However, as the service has agreed with the provider that the savings will come from a back office function it is believed there will be no adverse impact on overall service delivery compared to current performance, so no disproportionate impact on residents of a particular protected characteristic group is expected.

Since data is not routinely available for pregnancy/maternity, religion/belief, gender reassignment, sexual orientation, marriage/civil partnership, language spoken, or income from users of the Community Nutrition and Physical Activity services, it is unclear if the changes would have any disproportionate impact on residents in these protected characteristic groups. However, again, the protection of frontline services should result in a neutral impact on these protected characteristics.

3. **Substance misuse services**

Positive impacts of changes to this service:

There are not expected to be any overall positive impacts for any of the protected characteristic groups.

Negative impacts of changes to this service:

There are not expected to be any overall negative impacts for any of the protected characteristic groups.

Neutral impacts of changes to the service:

Age, Gender, Ethnicity, Disability, Sexual orientation, Gender identity, Maternity, Income, Language spoken

Many of the potential impacts identified by the online survey and service user consultation events will be minimised by the proposal to protect frontline staff and the provision of medication from the budget cut. By prioritising frontline staff and the provision of medication, the level of frontline support to service users should not be affected so we therefore expect the impact to be neutral across protected characteristics.

Service data showed that females are under-represented compared to the Lewisham population and this was also raised in the service user consultation event. However this is in line with national treatment data (in 2016-17 69% of all clients in treatment were males)[12] and as changes to frontline services will be minimised, females should not be disproportionately affected. Black and Asian ethnic groups are also under-represented in services compared to the Lewisham population and were one of the groups identified by the online consultation respondents as being more likely to be affected by the cuts. However, again, the minimisation of any changes to frontline staff and medication provision should not result in a disproportionate impact by ethnic group.

Since data is not routinely available for religion/belief, gender reassignment, marriage/civil partnership, language spoken, or income from users of the substance misuse services, it is unclear if the proposed changes will have any disproportionate impact on residents in these protected characteristic groups. However, the protection of frontline staff and the provision of medication should result in a neutral impact on these protected characteristics.

4. **Health visiting services**

Positive impacts of changes to this service:

There are not expected to be any overall positive impacts for any of the protected characteristic groups.

Negative impacts of changes to the service:

There are not expected to be any overall negative impacts for any of the protected characteristic groups.

Neutral impacts of changes to services:

Age, Gender, Ethnicity, Disability, Sexual orientation, Gender identity, Maternity, Income, Language spoken

Any change or impact on the service is likely to be felt more by women than men, and by children as the main service users. In addition, respondents to the service user consultation events felt that women suffering domestic

[12] Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 2016-17 data. https://www.gov.uk/government/statistics/substance-misuse-and-treatment-in-adults-statistics-2016-to-2017

abuse, single parents, poor people, first time mums, socially isolated women, young mothers and those with mental health issues would also be disproportionately affected by the cuts. However, as the budget reduction will come from vacant posts (and/or something else) the Trust have confirmed that there will be no adverse impact on overall service delivery compared to current performance. As agreed with LGT the removal of vacant wte from health visiting teams will be done fairly in line with caseload size and complexity and local health needs. This means that we do not expect there to be a disproportionate impact on residents of a particular protected characteristic group.

Since data is not routinely available for religion/belief, gender reassignment, marriage/civil partnership or income from users of the health visiting services, it is unclear if the proposed changes will have any disproportionate impact on residents in these protected characteristic groups. However, again, the maintenance of the current levels of service delivery should result in a neutral impact on these protected characteristics.

5. Impact summary

NCDPs	**Positive:** None **Negative:** None **Neutral:** None **Equivocal:** *Age, Gender, Ethnicity, Disability, Sexual orientation, Gender identity, Maternity, Income, Language spoken*
Community Nutrition and Physical Activity Service	**Positive:** None **Negative:** None **Neutral:** *Age, Gender, Ethnicity, Disability, Sexual orientation, Gender identity, Maternity, Income, Language spoken* **Equivocal:** None
Substance misuse services	**Positive:** None **Negative:** None **Neutral:** *Age, Gender, Ethnicity, Disability, Sexual orientation, Gender identity, Maternity, Income, Language spoken* **Equivocal:** None
Health visiting service	**Positive:** None **Negative:** None **Neutral:** *Age, Gender, Ethnicity, Disability, Sexual orientation, Gender identity, Maternity, Income, Language spoken* **Equivocal:** None

6. Mitigation

The potential negative impacts of changes to the Community Nutrition and Physical Activity Service will not take place as the savings will relate solely to reduction in managerial staff with no changes to service delivery. For the Substance Misuse Service the proposal to protect frontline staff and the provision of medication from the budget cut should mitigate impacts of cuts to all service users. For Health Visiting the budget reduction will come from vacant posts the trust have confirmed that there will be no adverse impact on overall service delivery compared to current performance.

Close and careful monitoring of service use and health outcome data following the introduction of the proposed changes, particularly to capture data on protected characteristics among service users, will be vital to identify if there are any unforeseen negative impacts on these groups and to work to mitigate them if they arise.

Signature of Head of Service	

For further information please see the full Corporate Equality Policy.

ANALYSIS OF ONLINE CONSULTATION

Contents:

1. Demographic characteristics of online consultation respondents

There were 165 responses to the online consultation. 82.4% of respondents agreed to share their personal demographic information.

Age

Of the respondents that answered the question about age (156), 17.0% were aged 55-59 (see Table 1 below). When compared to the population estimates for Lewisham as a whole, it appears that the views of young people (0-24) are under-represented in the online consultation. Conversely, the views of people aged 45 to 74 are over-represented in the online consultation.

Table 1. Age breakdown of online consultation respondents and 2017 Lewisham population

Age	Percentage of consultation respondents	Percentage of Lewisham population[1]
Under 18	0%	22.7%
18-24	0.6%	8.2%
25-29	3.0%	9.4%
30-34	6.0%	10.2%
35-39	8.5%	9.8%
40-44	7.9%	7.8%
45-49	9.7%	7.1%
50-54	10.3%	6.5%
55-59	17.0%	5.2%
60-64	9.7%	3.7%
65-69	13.9%	2.8%
70-74	6.1%	2.2%
75-79	1.9%	1.7%

[1] Office for National Statistics (ONS) 2017 mid-year population estimate. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

80-84	0%	1.3%
85+	0%	1.3%

Gender

Of the respondents that answered the question about gender (147), 80.3% were female. In 2017, it is estimated that just over half (50.7%) of Lewisham's population of 301,300 are female[2] so the views of Lewisham males are under-represented in the online consultation responses.

Disability

Of the respondents that answered the question about disability (144), 21.5% considered themselves to be a disabled person. The online responses are therefore broadly representative of the Lewisham population in terms of disability: the 2011 Census asked about long-term health problems and disabilities and found that in Lewisham, 14.4% of the population reported that they were living with a long-term health condition that limited their day-to-day activities: 7.1% reported that they were limited a lot and 7.3% reported that they were limited a little.[3]

Of those respondents who considered themselves to be a disabled person (38), the most common disability type was 'longstanding illness or health condition' (see Table 2 below).

Table 2. Disability type amongst those respondents who consider themselves to be a disabled person

Disability type	
Physical or mobility related	15.8%
Visual or hearing related	7.9%
Mental health condition	13.2%
Cognitive or learning disability	7.9%
Longstanding illness or health condition	23.7%
Other	21.1%

13 respondents identified access requirements.

Ethnicity

Of the respondents that answered the question about ethnicity (155), 83.9% were White (see Table 3 below). The Greater London Authority (GLA) estimated that 53.5% of the Lewisham population are White, 27.2% are Black, 9.3% are Asian and 10.0% are Mixed or Other ethnic groups.[4] This means that the views of White people are over-represented in the online consultation, and the views of all other ethnic groups are under-represented.

Table 3. Ethnic group breakdown of online consultation respondents

Broad ethnic group	**Percentage of consultation respondents**
White	83.9%
Black African, Black Caribbean, Black British or any other Black background	8.4%
Asian or Asian British	3.9%
Mixed or multiple ethnic groups	2.6%
Other	1.3%

[2] Office for National Statistics (ONS) 2017 mid-year population estimates.

[3] Table KS301UK. 2011 Census: Health and provision of unpaid care, local authorities in the United Kingdom.

[4] GLA 2016 Ethnicity Projections Central Trend Based.

Pregnancy and maternity

Of the respondents that answered the question about pregnancy/maternity (152), 2.6% were currently pregnant and 2.6% had been pregnant in the last six months. We do not have a reliable comparator data source for this protected characteristic at local authority level.

Religion/belief

Of the respondents that answered the question about religion/belief (135), 51.1% stated that they had no religious belief and 40.7% were Christian. Responses for each of the other religions stated (Buddhism, Hinduism, Judaism, Islam or Sikhism) were under 2.5%. Comparison with the Annual Population Survey estimates for the population by religion in Lewisham suggests that views of people with no religion are over-represented in the online survey and that the views of people from all religions are under-represented. The Annual Population Survey estimates that in 2017, 54.3% are Christian, 35.6% are no religion, 4.1% are Muslim, 3.2% are Hindu; and 2.7% are any other religion.[5]

Sexual orientation

Of the respondents that answered the question about sexual orientation (133), 94.0% were straight or heterosexual, 3.8% were gay or lesbian, and 2.3% were bisexual. We do not have a reliable comparator data source for this protected characteristic at local authority level, however the Annual Population Survey has released experimental statistics on sexual identity at a local authority level, using estimates based on a survey.[6] In Lewisham, it is estimated that 89.0% of the adult population identify themselves as heterosexual or straight; 2.5% identify themselves as lesbian, gay or bisexual; and 8.5% don't know, refuse to answer or identify themselves as other (i.e. neither heterosexual/straight, lesbian, gay or bisexual). According to this data, responses to the online consultation are broadly representative of the Lewisham population in terms of sexual orientation.

Gender reassignment

Of the respondents that answered the question about gender reassignment (132), 99.2% were the same gender that they were at birth. We do not have a reliable comparator data source for this protected characteristic at local authority level.

Owing to the small sample size of the resident respondents to the online consultation and the representation of those with protected characteristics in the sample as described above, the consultation results outlined below should be interpreted with caution since they may not be representative of all resident viewpoints within the borough.

2. Consultation responses by service area: Neighbourhood Community Development Partnerships (NCDPs)

Please note that all percentages below refer to only those who have answered each question, and do not include those who did not answer.

130 people responded to the section regarding NCDPs however such a small proportion were from those responding in a professional capacity, the results of personal and professional responses have been combined.

a. Quantitative analysis

[5] Greater London Authority (GLA) Population by Religion, Borough https://data.london.gov.uk/dataset/percentage-population-religion-borough. Data from ONS Annual Population Survey.

[6] This means they are subject to sampling variability. This is because the sample selected is only one of a large number of possible samples that could have been drawn from the population.

All Responses[7]

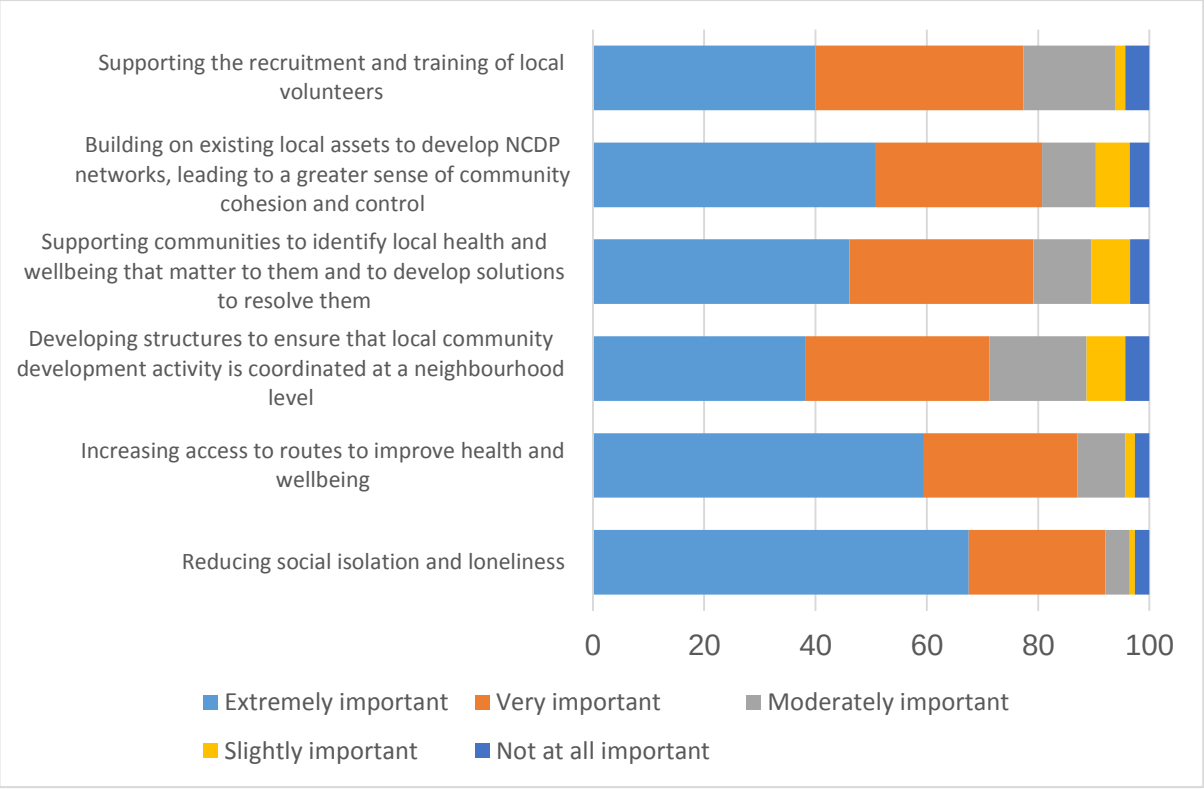
10.3% of responses were from people who are currently using services funded by the NCDPs; 11.3% of responses were from people who had previously used services funded by the NCDPs.

Public health professionals were most frequently stated as best placed to understand health and wellbeing priorities at a neighbourhood level, followed by members of the four NCDPs:

- 31.1% of respondents thought Public Health professionals
- 28.6 % of respondents thought members of the four NCDPs
- 17.6% of respondents thought other local voluntary and community sector groups
- 4.2% of respondents thought Local Assemblies
- 16.8% of respondents thought it was something other than the options suggested
- 1.7% of respondents thought Local Councillors

Respondents also rated how important they thought the NCDP's six objectives were (Figure 1).

Figure 1. How important do you think the following objectives are for NCDPs?



'Reducing Social isolation and loneliness' (92.1%) and 'Increasing access to routes to improve health and wellbeing' (87.1%) were the two objectives which received the highest numbers of responses stating they were either Extremely or Very Important.

Respondents were also asked questions about funding. 72.7% of respondents agreed to some extent that funding should be maintained for individuals and groups most in need (i.e. target the reduction at those less in need) (Figure 2); 32.1% of respondents agreed to some extent that the grant reduction should be distributed equally between the four NCDPs (see Figure 3).

Figure 2. How far do you agree we should maintain funding for individuals and groups most in need (i.e. target the reduction at those less in need)?

[7] Whilst respondents were asked to identify whether they were answering the consultation in a personal or professional capacity, for NCDP questions the professional response was so low it is not possible to analyse this separately

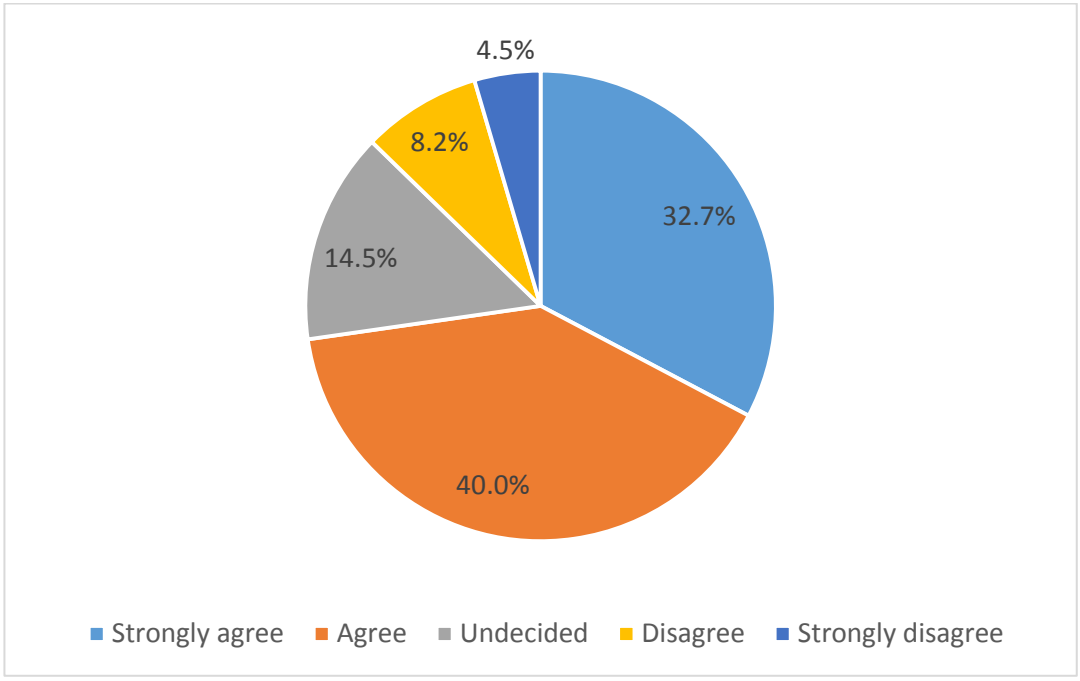
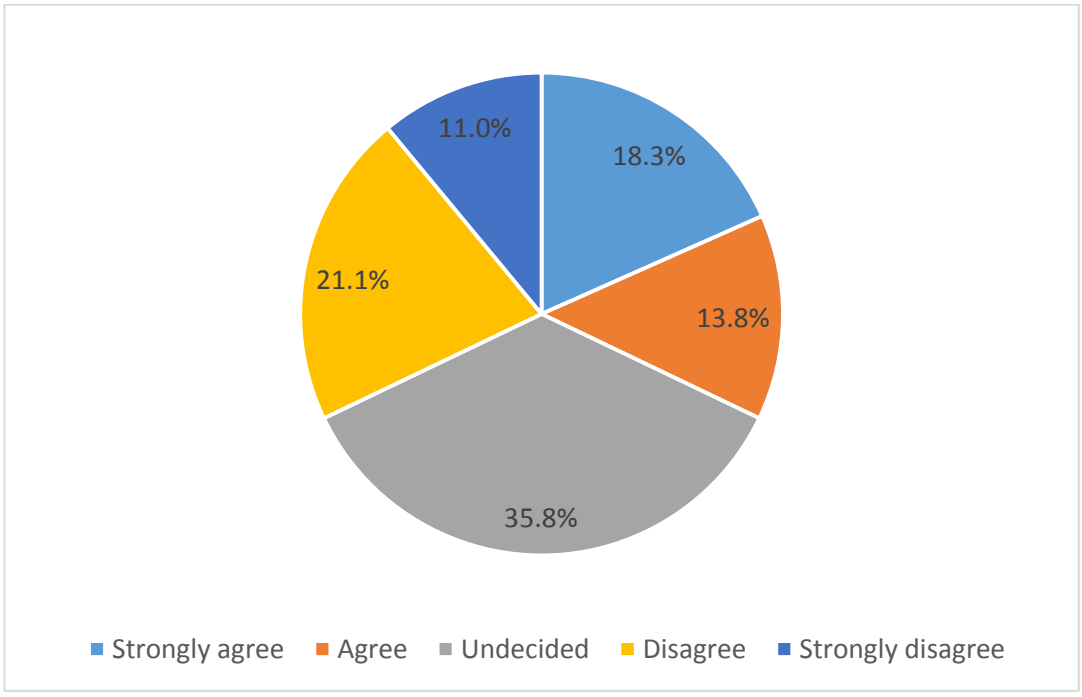


Figure 3. How far do you agree we should distribute the grant reduction equally between the four NCDPs?



a. Analysis of free text comments

Free text comments to 'Do you have any other ideas about we could deliver this service differently in order to achieve the same reduction in funding?':

- Greater use of the voluntary sector, including people and facilities
- Reducing administrative costs by managing more aspects centrally than across the four neighbourhoods
- Focusing on the more deprived areas of the borough

Free text comments to any other comments section:

Focused on opposition to any reduction in funding related to health services.

3. Consultation responses by service area: Community Nutrition and Physical Activity service

Please note that all percentages below refer to only those who have answered each question, and do not include those who did not answer.

142 people responded to section on the Community Nutrition and Physical Activity service. 83.1% of people responded in a personal capacity and 16.9% of people responded in a professional capacity. However not all respondents gave answers to all questions and for some areas the response from those answering in a professional capacity was so low it may have been possible to identify the individual, therefore the results have again been combined.

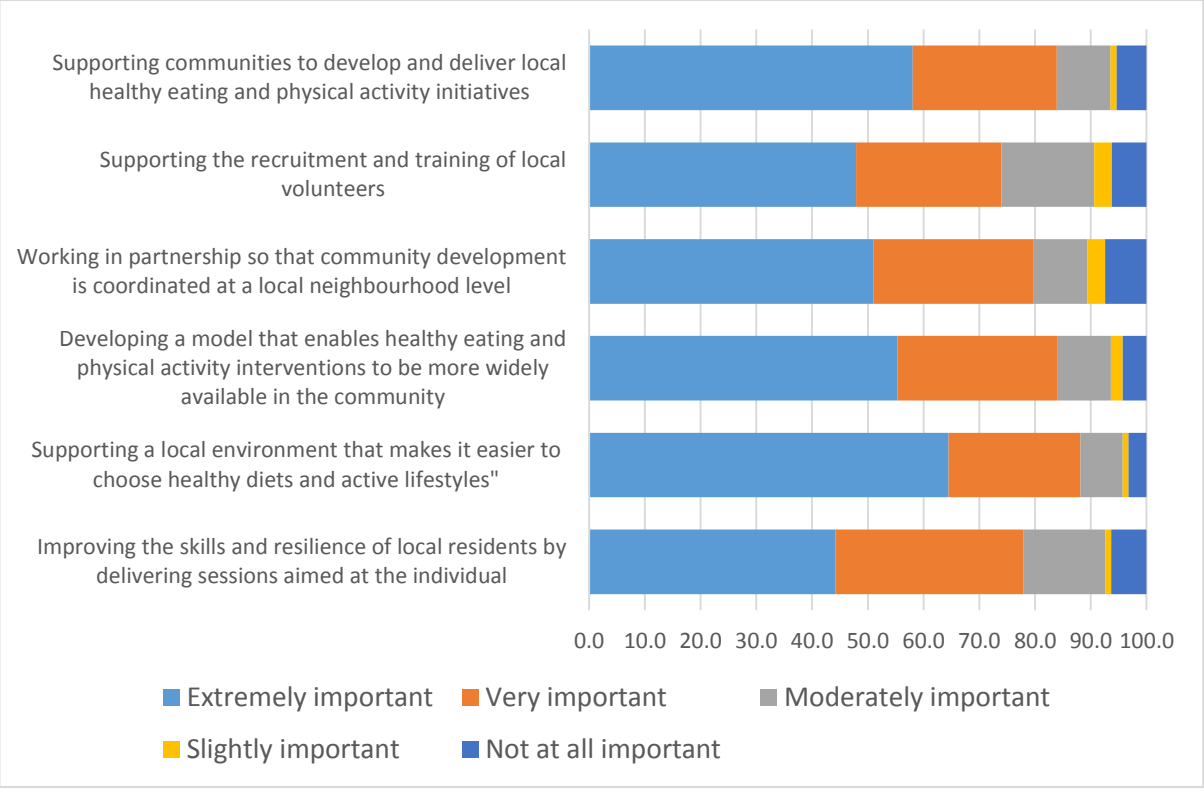
a. Quantitative analysis

All responses

33.9% of responses were from people who are currently using the Community Nutrition and Physical Activity service; 11.0% of responses were from people who had previously used the Community Nutrition and Physical Activity service.

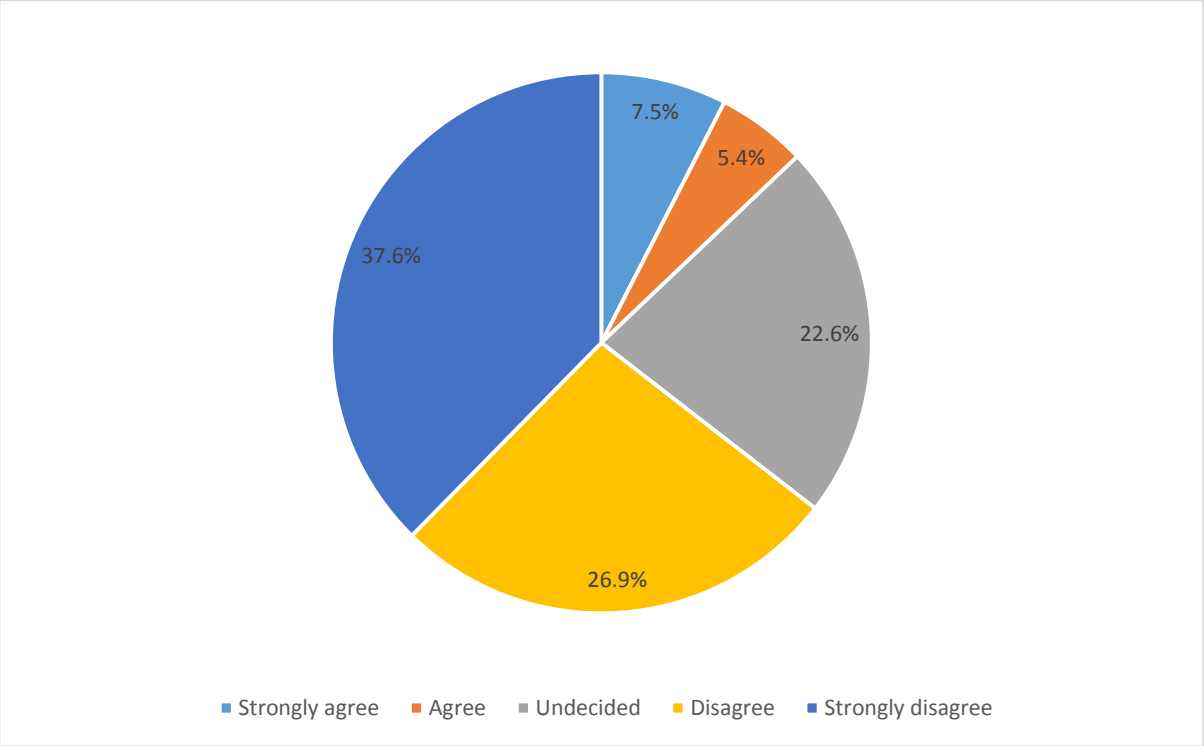
Respondents rated how important they thought a list of six objectives were for the Community Nutrition and Physical Activity service (see Figure 4).

Figure 4. How important do you think each of the following objectives are for the Community Nutrition and Physical Activity service?



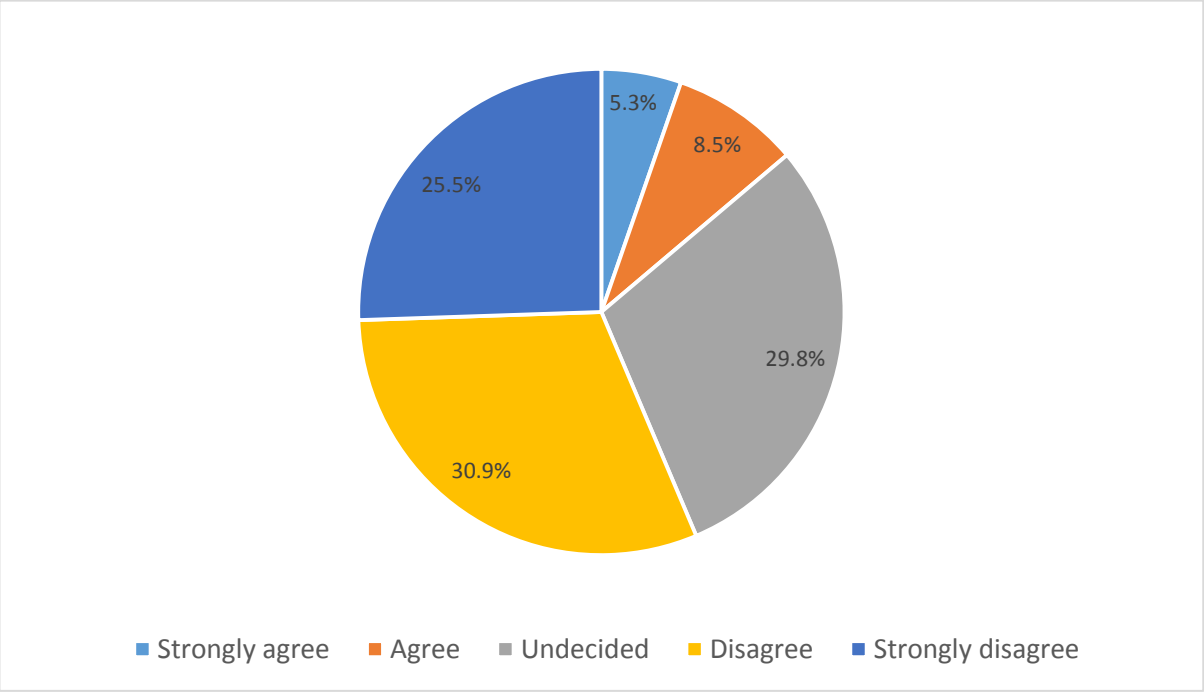
'Supporting a local environment that makes it easier to choose healthy diets and active lifestyles' was seen as Extremely or Very important by 88.2% of respondents to the question, followed by 'Developing a model that enables healthy eating and physical activity interventions to be more widely available in the community' (84.0%).

Figure 5. How far do you agree we should make cuts by reducing services aimed at the community?



64.5% of respondents disagreed to some extent that the cuts should be made by reducing services aimed at the community; 56.4% of respondents disagreed to some extent that cuts should be made by reducing services aimed at the individual (see Figure 5).

Figure 6. How far do you agree we should make cuts by reducing services aimed at the individual?



b. Analysis of free text comments

Respondents were asked if they have any other ideas about how we could deliver a Community Nutrition and Physical Activity Service differently in order to achieve the same reduction in funding. Comments are summarised below:

- Develop community projects run by volunteers
- Link with other services – increase joint working with supermarkets to support healthier choices
- Explore fundraising/charge small amount to access services
- Increase council tax and reduce chief officer salaries
- Concentrate interventions on the youngest in society (aged 12-20) through youth groups to maximise long term benefits
- Promote programme via churches and other places of worship to set up groups using volunteers from their own community
- Reduce outsourcing of services to private corporations
- Share knowledge and resources with partners to reduce running costs

The section finished by asking if there were any further comments:

- Don't cut funding to the healthy walks programme as benefits to mind and body are considerable
- Those who are too intimidated to join gyms or similar engage in this service
- Ease of access to unhealthy food and drink options needs to be addressed by local authority – fast food outlets are more likely to be situated in poorer estates
- Those who make the budget decisions should join in the activities to realise just how important this is to those are benefiting
- External review of Health Eating cookery club to assess impact against local health priorities
- Benefits of Nordic Walking programme outweigh the costs, which are minimal

4. Consultation responses by service area: Substance misuse services

Please note that all percentages below refer to only those who have answered each question, and do not include those who did not answer.

108 people responded to questions about the Substance Misuse Services. 77.8% of people responded in a personal capacity and 22.2% of people responded in a professional capacity.

a. Quantitative analysis

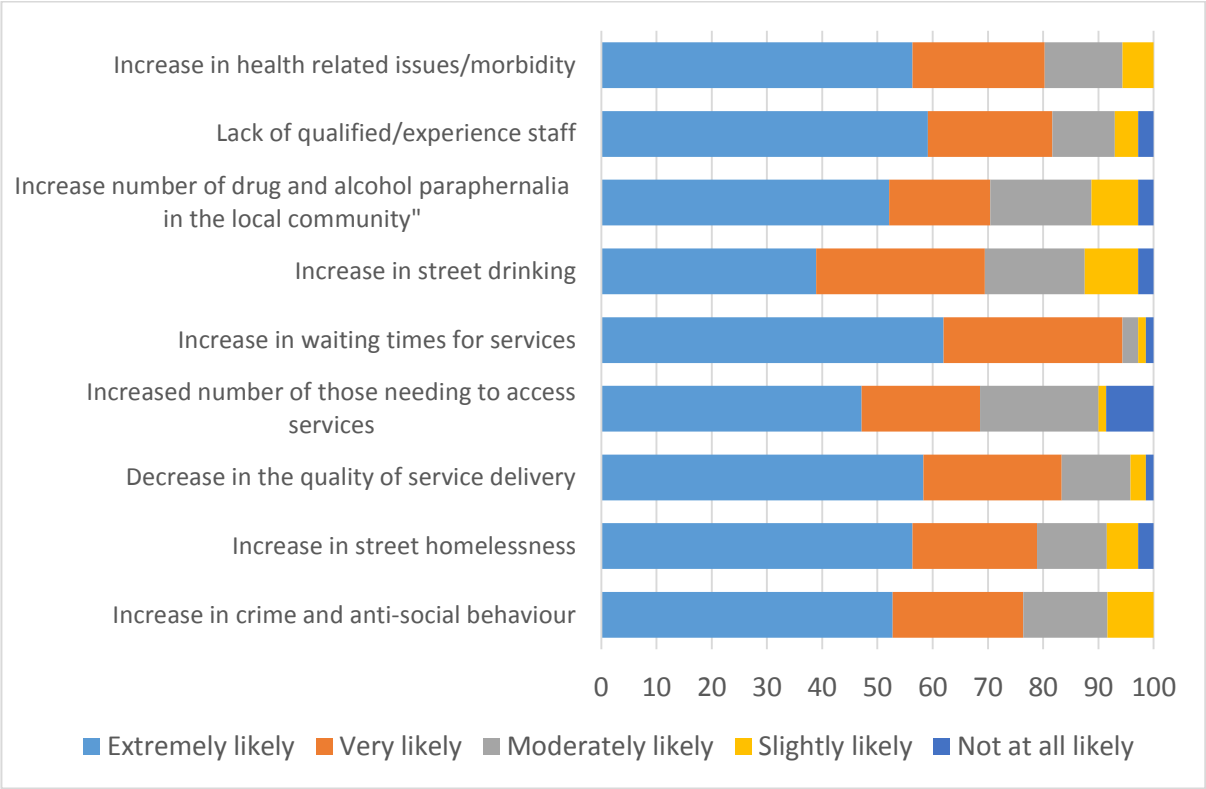
Personal responses

5.6% of personal responses were from people who are either currently using the service, have previously used the substance misuse services or have a family member that has used the service; 94.4% of personal responses were from Lewisham residents/members of the public.

Due to the small number of responses from current or previous service users/family members it is not possible to report these findings without potentially identifying individuals. The small number of responses received were across a wide range of views which are not possible to summarise. However a focus group has taken place with this cohort.

Figure 7. Responses from members of the public on how likely they consider that the funding cuts will impact on[8]

[8] The Service User/Family Member cohort were also asked about the impact of funding cuts however the areas/issues they were asked to consider where different so responses cannot be combined.



Members of the public identified 'Increase in waiting times for services' as the most likely impact of the proposed funding cuts, with 94.4% stating this was extremely or very likely.

b. Analysis of free text comments

The vast majority of respondents (83.8%) believed the proposed cuts **would** affect particular individuals more than others. When asked to expand on this the below comments summarise respondents' views:

- Poorest and the most vulnerable (substance misusers/elderly/homeless/mentally ill) in society will be hit the hardest.
- Those with long term addictions will feel it the most
- Those who have accessed the service previously may be more aware of the changes
- Those seeking help will be discouraged
- Negative impact on families, staff providing services, support of those with addiction problems
- BME groups affected more – those marginalised are more likely to need the services

Members of the public were also asked 'Do you have any other ideas about how we could deliver this service differently in order to achieve the same reduction in funding?' Suggestions from the public included:

- Providing more online services and/or group sessions to save money.
- Asking sellers of alcohol to contribute to services,
- Getting charities, the voluntary sector and previous service users more involved
- Better co-ordination/collaboration with mental health and other healthcare services such as GPs.
- Charities / volunteering -Create 'champions' (former users -now 'clean')
- A mobile service /group sessions
- Get rid of NCDPs and Community Nutrition and Physical Activity services
- Put the funding back into NHS services.
- Educating children at school – substance misuse
- Link in with other sectors to provide things like apprenticeships for people who are moving towards long-term recovery

Any further comments:

The majority thought that cutting funding would lead to short and long-term complications impacting on their physical, mental and social well-being.

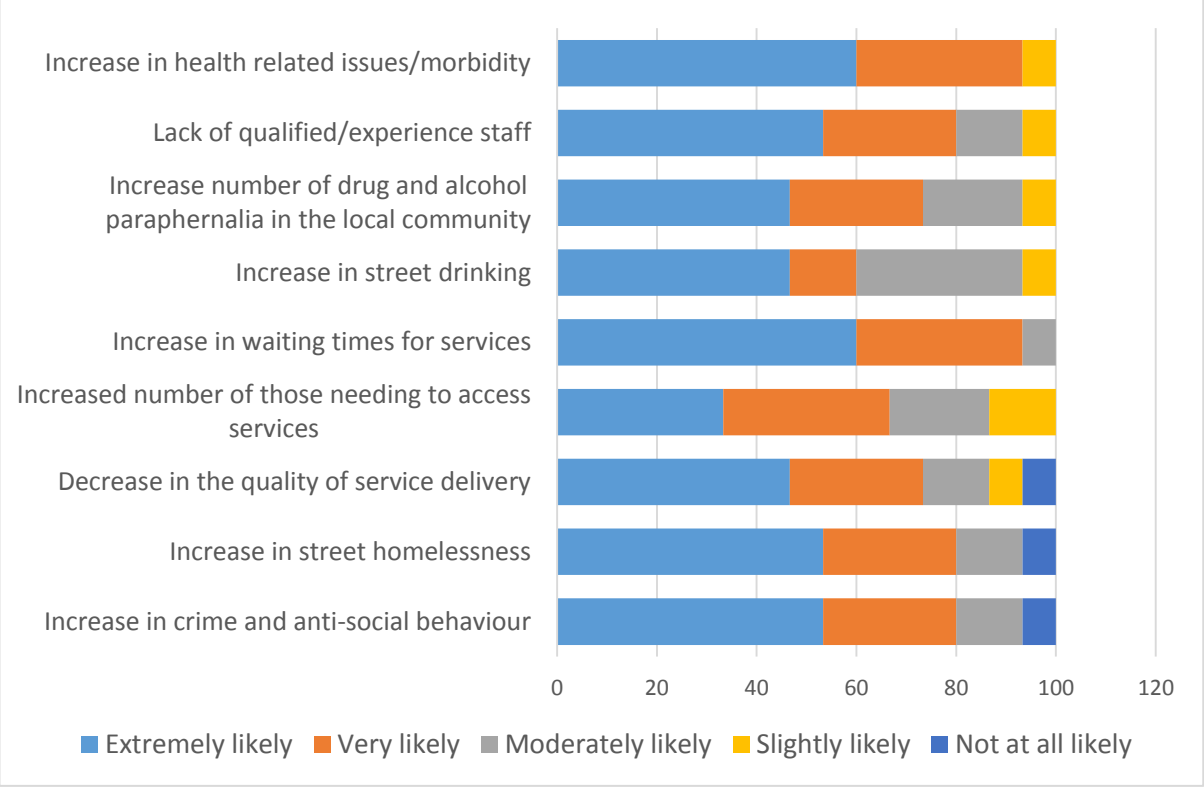
Constructive criticisms on how to cope with the potential reduced funding include:

- More learning from and co-production with community as recommended by NHS England and Kings Fund.
- Early intervention should be a critical part of this service. Schools should be trained to identify potential substance misuse.

Professional responses

a. Quantitative analysis

Figure 8. Responses from those responding in a professional capacity on how likely they consider that the funding cuts will impact on:



Professionals also identified 'Increase in waiting times for services' as the most likely impact of the proposed funding cuts (93.3%) stating this was extremely or very likely. This was joint with 'Increase in health related issues/morbidity (93.3%).

b. Analysis of free text comments

97.5% of respondents felt that the proposed cuts to substance misuse services **would** affect particular individuals more than others. When asked to expand on this view the main themes were that the impact would be most felt by substance misuse staff who will be under increased pressure and stress. The most vulnerable and hardest to reach groups including sex workers and the homeless population would also be more affected and those with complex and/or mental health needs.

"Do you have any other ideas about how we could deliver this service differently in order to achieve the same reduction in funding?":

- focusing resources on areas of most need
- work within contractual agreements

- group sessions for recovering addicts
- efficient transfer between services
- Lewisham and Greenwich NHS Trust to use Queen Elizabeth Hospital's Substance Misuse Team across both their hospital sites, but it would require funding.

Any other comments:

Responses spoke against any budget cuts to this area.

5. Consultation responses by service area: Health visiting service

Please note that all percentages below refer to only those who have answered each question, and do not include those who did not answer.

119 people responded to questions about the Health visiting service. 83.2% of people responded in a personal capacity and 16.8% of people responded in a professional capacity.

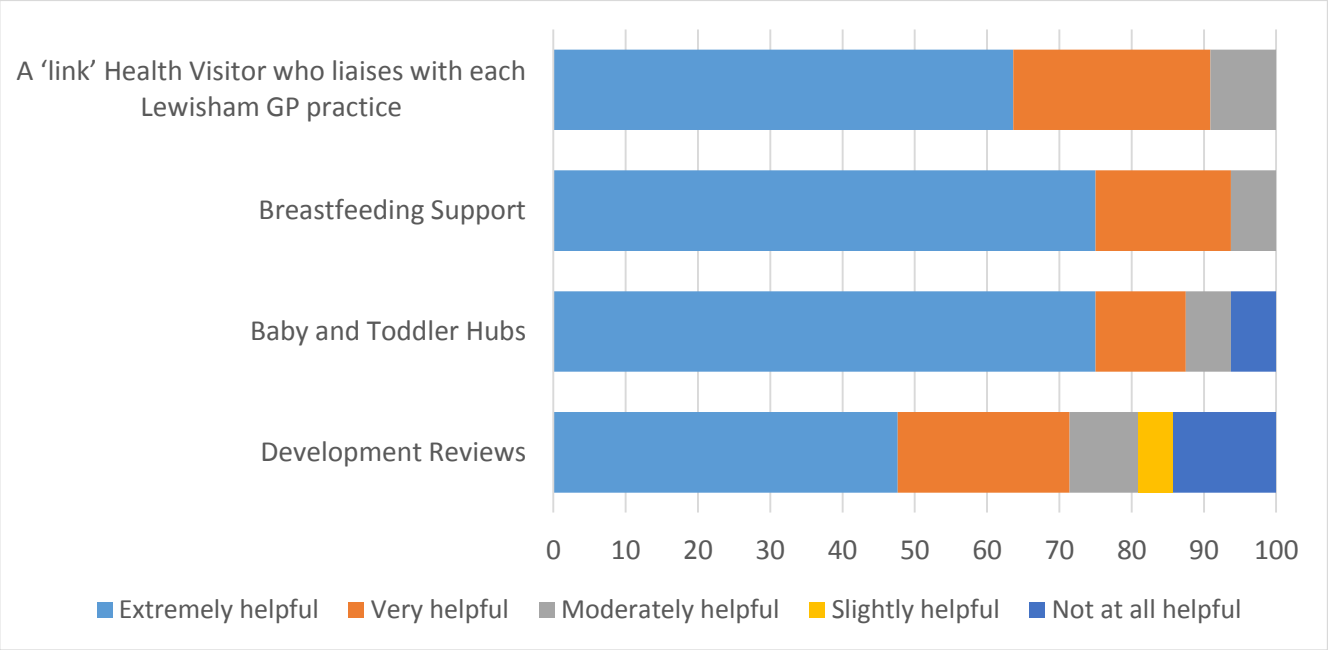
a. Quantitative analysis

Personal responses

22.2% of personal responses were from people who are currently or have previously used the service; 77.8% of personal responses were from Lewisham residents/members of the public.

Service User Responses

Figure 9. How helpful did you or your family member find the different types of support offered by Lewisham's Health Visiting service?[9]



Of respondents who had used health visitor services the feedback was that they found the services helpful. Breastfeeding was seen to be the most helpful (93.8%).

Responses to both the freetext questions for this service user group were focused on concerned about the additional strain that cuts would put on the Health Visiting Service.

[9] Additional support offers were also included in the survey, however so few respondents had used these services it is not possible to include them

Member of the Public Responses

This group were asked to rank what they felt were the most important outcomes for the Health Visiting service.

Table 4. Ranking of the most important outcomes for the Health Visiting service (member of the public)

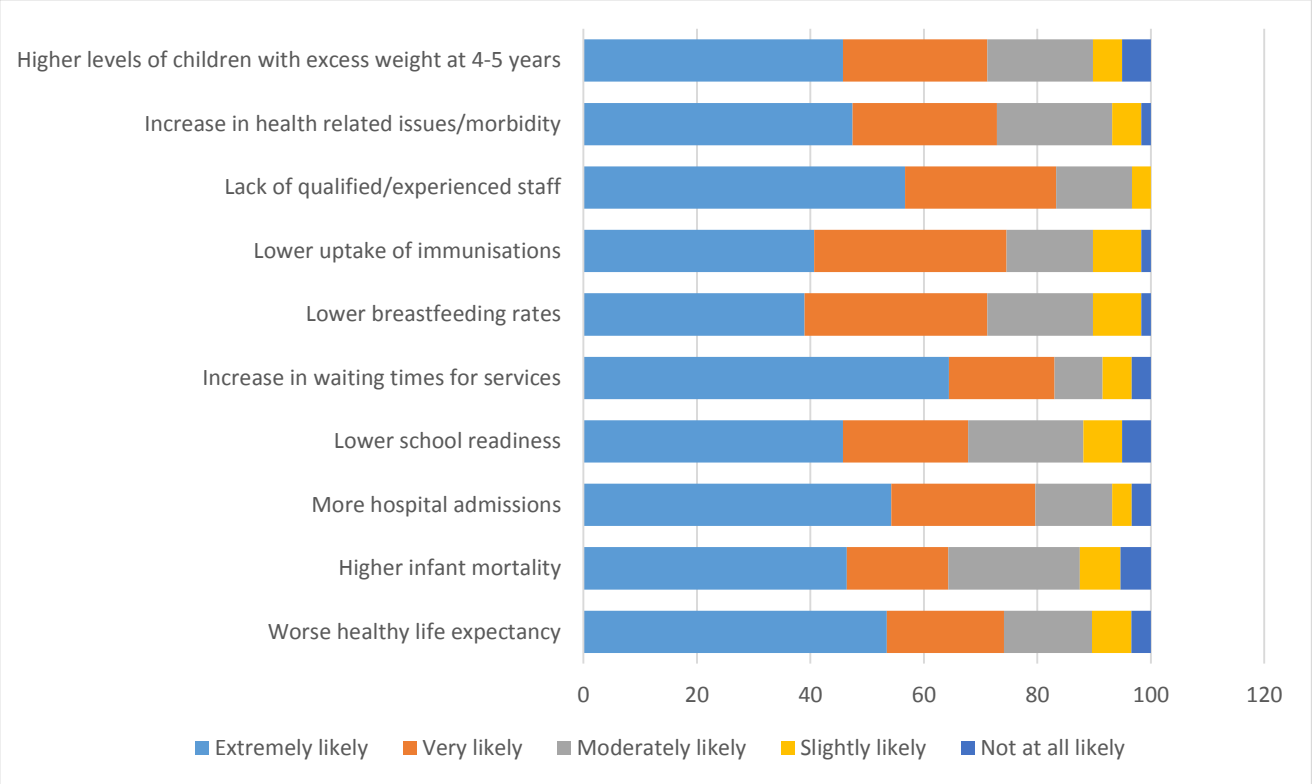
Outcome	Rank
Reducing infant mortality	1
Improving life expectancy and healthy life expectancy	2
Improving child development at 2-2.5 years	3
Reducing the number of children in poverty	4
Reducing hospital admissions caused by unintentional and deliberate injuries in children	5
Improving breastfeeding initiation	6
Increasing breastfeeding prevalence at 6-8 weeks	6
Disease prevention through screening and immunisation programmes	8
Improving population vaccination coverage	9
Reducing excess weight in 4-5 year olds	10
Reducing smoking at delivery	11
Improving school readiness	11
Reducing low birth weight of term babies	13
Reducing under 18 conceptions	14
Reducing tooth decay in children aged 5	15

'Reducing infant mortality' was ranked as the most important outcome for the health visiting service, followed by 'Improving life expectancy and healthy life expectancy'.

This group were asked if they had suggestions for what further outcomes the Health Visiting Service should be working towards. Responses were focused around:

- improving children's diets to improve obesity rates
- improving understanding of the impact of emotional abuse and neglect
- parenting skills
- maternal mental health
- signposting to other services

Figure 10. Do you think it is likely that the proposal to cut funding will affect individuals and the community in the following ways? (Members of the Public)



'Lack of qualified/experienced staff' and 'Increase in waiting times for services' were seen to be the most likely effects of the proposed funding cuts to the service, with 83.3% and 83.1% answering that these impacts were either extremely or very likely respectively.

b. Analysis of free text comments

A freetext question also asked 'Do you have any other ideas about we could deliver this service differently in order to achieve the same reduction in funding?' These can be summarised as:

- Reduce number of senior managers,
- Use midwives and GPs to provide some of the services.
- Hold more community session rather than visiting all homes individually.
- Better targeting to those that most need the service.

The any further comments questions was heavily focused on concerns about the impact of the proposed cuts on families**.**

Professional Responses

Professionals were also asked to rank what they felt were the most important outcomes for the Health Visiting Service. They had three joint top priorities: Improving life expectancy and healthy life expectancy, Reducing infant mortality and Improving child development at 2-2.5 years. These match the three top rankings by members of the public.

Table 5. Ranking of the most important outcomes for the Health Visiting service (responses from professionals)

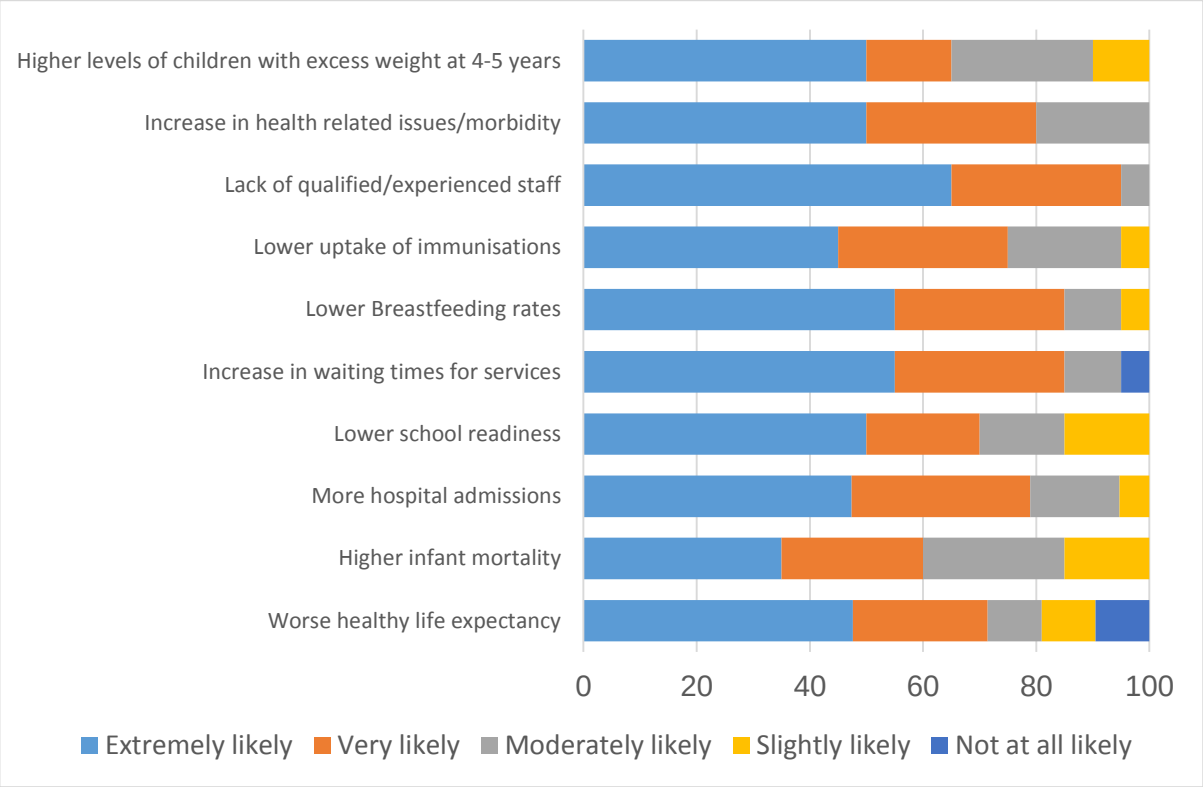
Outcome	Rank
Improving life expectancy and healthy life expectancy	1
Reducing infant mortality	1
Improving child development at 2-2.5 years	1
Reducing hospital admissions caused by unintentional and deliberate injuries in children	4
Increasing breastfeeding prevalence at 6-8 weeks	5
Reducing the number of children in poverty	6

Improving breastfeeding initiation	7
Improving school readiness	8
Improving population vaccination coverage	9
Reducing smoking at delivery	10
Disease prevention through screening and immunisation programmes	11
Reducing low birth weight of term babies	12
Reducing excess weight in 4-5 year olds	12
Reducing under 18 conceptions	14
Reducing tooth decay in children aged 5	15

When professionals were asked what other outcomes they considered the Health Visiting service should be working towards the main themes were:

- domestic violence
- reducing social isolation of new parents
- safeguarding
- perinatal mental health
- working with vulnerable groups
- reducing health inequalities

Figure 11. Do you think it is likely that the proposal to cut funding will affect individuals and the community in the following ways? (Professionals)



'Lack of qualified/experienced staff' was seen as the most likely impact of the cuts by professional respondents, as 95% stated they thought this was extremely or very likely. 85% thought breast-feeding rates would reduce and there would be an increase in waiting times.

c. Analysis of free text comments

Professionals were also asked "Is there any way that you or your organisation can contribute in helping to alleviate the impact of this proposal?" Responses focused on:

- Closer working with community groups/facilities

- Improve working with children's centres
- Better connections between other children's services such as midwifery.

Professionals were also asked "Do you have any other ideas about we could deliver this service differently in order to achieve the same reduction in funding?" There was only a small response to this question so it is not possible to collate responses.

Any further comments:

Concerns around the impact of the cuts and requests that the council should challenge central government regarding funding reductions.

This page is intentionally left blank

Appendix 4 substance misuse focus group summary

Report Title	**Prevention, Inclusion & Public Health Commissioning Team - Adult Partnership Substance Misuse Performance**
Author	**Commissioning Team (Addictions)**
Date of meeting	**October 2018**

1.0 Purpose of Report

1.1 To update the commissioning team and partners on service user views regarding the proposed cuts to the public health budgets.

1.2 No formal demographic data collection took place but from observation: 2 x SU groups 1 x 5 and 1x 6 plus 3 from Lewisham SUIT. Good participation; although more representation from women and BAME services users would have been beneficial to reflect community. Overall the age range was diverse and reflective and included family members/carers of service users engaging with commissioned services.

2.0 Questions Used

2.1 To remain consistent with the online consultation, the commissioning team (addictions) used open ended questions similar to those online.

2.2 The questions used can be found below:

a) What are the positive aspects of the drug and alcohol services that you, family members or those you care for access?
b) How do you think the proposed cuts will impact service delivery and service users?
c) Do you feel that this proposal will affect particular individuals more than others, and if so, how do you think we might help with this?
d) Do you have any suggestions as to how this service might be delivered in a different way, but still achieve the same level of cuts?
e) Will the proposals affect how you and others that will use the services?
f) Any further comments?

3.0 Responses

3.1 Reponses for question 1 are as follows:

- Services are fantastic and they support families through tough times
- Indispensable especially during out of hours i.e. weekends and follow-up appointments
- Key workers are dedicated an ‘make’ the services
- Workers show passion as some commute approximately 2hours to get to work
- Balanced Multidisciplinary Teams with different skill sets.
- Without the services, services users will be completely isolated and wouldn’t leave the house if it wasn’t for interventions and keyworkers
- Services aid motivation and incite hope
- Services are a safe space especially for those who were institutionalised and needed reintegration

3.2 Attendee's gave the feedback below in relation to question 2:

- The cuts will affect carer health and mental health due to the added pressure of services potentially not offering the same level of care and support to decline in frontline staff
- Concerns with young people's mental health
- Cuts will have a detrimental effect on dual diagnosis
- Staff will leave affecting the quality of services
- Reduction of aftercare will impact abstinence as it assists with reintegration and relapses prevention
- Aftercare groups and are too large
- Fear that medication/OST therapies will be reduced and there will be less choice
- Areas not of priority may be overlooked i.e. outreach

3.3 Participants responded the following individuals would be at risk:

- Women – who are underrepresented and wont access services at the best of times due to fear of repercussions i.e. loosing children or social services involvement
- OST service users
- Aftercare service users – feared there will be less support in regards to relapse prevention
- Young people – services are already diluted and links with mental health and accessing services takes too long
- Vulnerable service users will be at risk
- Ex-offenders – who may find it hard to access and may be out of touch with reality due to length of sentences and not being prepared for release
- Those affected by domestic violence and abused individuals
- Young people transitioning into adult services
- Parents and service users with children
- Older adults

3.4 The focus groups didn't have any specific suggestions in regards to this question but the following responses were given:

- Services should be working better together i.e. mental health substance misuse and young people
- Hospitals could pick up work rather than services
- Supplement staff with students/volunteers but it was highlighted that this option could be less safe, cost more to train due to high turnover. It was noted that student counsellors are used to deliver therapeutic interventions

3.5 Participants unanimously felt that the cuts will affects service delivery and went on to say:

- The longevity of peoples recovery was in jeopardy and lives have been saves with Lewisham's currents services i.e. Naloxone rollout across the borough
- The expense of medication i.e. Buprenorphine and the protective factors it has on drug and alcohol related deaths
- Cuts will impact other services i.e. Accident and Emergency admissions and mental health services
- It would affect the number of people accessing services

3.6 Participants had the additional comments to make:

- Services are fantastic and they support families through tough times
- Indispensable especially during out of hours i.e. weekends and follow-up appointments
- Treatment should be ongoing rather than 4 sessions of counselling or 12 weeks of structured treatment
- Medical teams delivering clinical interventions onsite assists with service delivery is positive
- Group work was found to be positive and peer lead support
- Online interventions are not suitable for everyone

4.0 Conclusion

4.1 Overwhelmingly, participants felt that cuts of any amount would affect service delivery and quality of care received. It was suggested that if cuts did have to be made, they should not be made to the frontline staff i.e. key workers or on medication.

Report Title	**CYP Joint Commissioning– Health Visiting user engagement sessions**
Author	**CYP Joint Commissioner**
Date of meeting	**November 2018**

1.0 Purpose of Report

1.1 To provide an overview of service user views regarding the proposed cuts to the health visiting budget.

1.2 Engagement took place across six sessions around the borough: 2 x breastfeeding support groups, 1 x Dad's Network session, 1 x Baby Hub, and 2 x nursery drop off.

1.3 Demographic data collection took place but was not mandatory. High level observation demonstrated good participation from service users; more women were engaged than men, reflective of the service. More representation from BAME services users would have been beneficial to reflect demographics in Lewisham. Overall the age range was diverse and included additional family members/carers of service users such as grandparents.

2.0 Questions Used

2.1 To remain consistent with the online consultation, officers used a combination of closed and open ended questions similar to those online.

2.2.1 The questions used can be found below:

1) Do you/have you used the Lewisham Health Visiting service?
2) Which elements of the Health Visiting service have you used? (Please tick as appropriate)
3) How helpful did you or your family member find the different parts of the service you accessed? (Skip question if none used).
4) Which Health Visiting outcomes do you consider most important? (You can choose more than one)
5) What do you think of proposed cuts to the health visiting service?
6) Do you feel that this proposal will affect particular individuals more than others, and if so, how do you think we might help with this?
7) What improvements could be made to the service in order to achieve the same reduction in funding?

2.2.2 Optional equalities monitoring questions were also included.

3.0 Responses

3.1 Reponses for question 1 are as follows:
Of the 34 responses in engagement sessions

- 31 (91%) had used the HV service
- 3 (9%) said they had not

3.2 Participants identified specific elements of the Health Visiting service used in question 2:

- 2 of 34 (6%) used a targeted or MESCH service, both rated the service extremely helpful.

- 32 (94%) stated they had a new birth visit, 4 stated they had a pre-birth visit
- 25 (74%) stated they had a 6-8 week visit
- 25 (74%) said they had accessed a Baby clinic or Baby Hub
- 27 (79% said they had accessed breastfeeding support
- 6 (18%) said they had a 7-11 month developmental review
- 5 (15%) said they had a 2-2.5 year developmental review

3.3 Of the 31 Participants who said they had used the service:

- 30 (97%) found the HV service very or extremely helpful
- 1 (3%) found it moderately helpful

3.4 The engaged participants rated the priority of Health Visiting outcomes. Participants were able to identify any area as a priority and could select multiple priorities. So, breastfeeding support was selected as a priority by 29 participants, improving child development was selected as a priority by 20 participants, and so on:

Breastfeeding support	29	85%
Improving child development	20	59%
Improving vaccination coverage	17	50%
Disease prevention through screening	14	41%
Reducing infant mortality	13	38%
Reducing the number of children in poverty	11	32%
Outcome: Reducing low birth weight	10	29%
Outcome: Improving life expectancy	8	24%
Reducing hospital admissions	8	24%
Improving school readiness	5	15%
Reducing obesity in 4-5 year olds	5	15%
Reducing under 18 conceptions	2	6%
Reducing tooth decay in children	2	6%
Reducing smoking at delivery	2	6%

3.5 Participants unanimously felt that any cuts would have a negative impact on service delivery.

Comments from service users on the value of Health Visiting included:
"Such a difficult part of a woman's life. Hardest thing I have ever done"
"My HV has been a lifeline and so supportive signposting and referring"
"Fewer breastfeeding clinics would be bad. Critical for baby feeding. Breastfeeding hubs are so important on the day you need them"
"Isolation is a massive risk so good for mothers"

3.6 The majority of participants felt that this proposal will affect particular individuals more than others, with comments linking this to those who may be isolated or in need of more help and support:

Yes	88%
No	6%
No answer	6%

Participants had the additional comments to make:
"Some people are less aware of the support out there so having the structured appointment creates that access opportunity."
"Will affect those that needs more help. Those with no support network. I made friends through this"

“Anyone who is having problems with feeding, low weight, jaundice. Home visits for more vulnerable people.”
“Will affect everybody. It’s a real Mix that use services. Everybody depends on it.”
“Anyone who is isolated and doesn’t have a support network. All my friends don’t have babies so I became isolated the HV called me regularly and reassured me”
“Anyone who has had difficult birth or doesn’t have family support or is new to the community. Anyone experiencing a bad relationship and alone.”

3.7 In response to the question on whether service improvements could be made that may achieve the same savings, 65% of respondents felt that this would be possible, 30% felt it wouldn’t, and 5% did not answer.

Comments included:
“Could be clearer about the offer e.g. Who is responsible for what? How do they link in? GP, Hospital, HV, who to contact if waiting for hospital appointment?”
“More telephone communication. Sometimes just needed a chat not a visit.”
“More groups can see more people plus is more social”
“Getting parents back into the community especially dads. A system where they engage with Dads, Saturday evening service.”
“More venues for drop-ins groups such as hubs. Groups where you can have conversations with HV”

4.0 Conclusion

4.1 It is difficult to draw conclusions from this small sample size. However, overwhelming support for the service can be noted, along with concern from all participants about negative impacts from any cuts, particularly for more vulnerable service users.

This page is intentionally left blank

Healthier Communities Select Committee		
Title	LGT Pathology Services	
Contributor	Lynn Saunders, Director of Strategy, Business and Communications, Lewisham and Greenwich NHS Trust	Item 6
Class	Part 1 (open)	3 December 2018

1. Context

Lewisham & Greenwich NHS Trust (LGT) has provided the briefing below on the future of LGT Pathology Services. The committee received this briefing as an information-only item at its last meeting. At this meeting, the LGT Director of Strategy, Business and Communications, Lynn Saunders, will be present at the meeting to answer any questions from the committee.

2. Recommendation

The committee is recommended to note the contents of the briefing.

Lewisham and Greenwich NHS
NHS Trust

The Future of LGT Pathology Services

1. Summary of Background and Current Service Provision across SEL

(1.1) NHS Improvement have reviewed the national pathology service provision and have advised that it is their intention to establish and implement 29 Pathology Networks across England, each to be run as a hub and spoke model. Nationally all trusts have been advised of the pathology network within which their service is expected to be located. Not surprisingly, the LGT service has been identified as sitting within the South East London network, currently including both Guy's and St Thomas' Foundation Trust (GSTT) and Kings College Hospital (KCH) as providers of pathology services.

(1.2) Within south east London different models currently exist for the provision of pathology services. LGT provides an in-house NHS provided service, including to local primary care (GPs) and to Oxleas Foundation Trust, whilst other providers in the sector (GSTT, KCH and SLAM) all outsource their pathology services to a Joint Venture partnership called Viapath, jointly owned by GSTT

and KCH with Serco as a private sector partner. The Viapath contract expires in 2020.

(1.3) In January 2018 Trust Boards for all acute providers in south east London were asked to consider a strategic outline case (SOC) setting out the options for the future of pathology services in south east London. The LGT Board approved the recommendations of the SOC, noting its inclusion of an NHS option, and responded to the STP advising that the Board required demonstration that an option to provide an NHS provided pathology service should be given equal consideration and evaluation to any option including the private sector.

2. LGT Position

(2.1) South East London STP have established a Pathology Programme Board to progress the development of the options for pathology services and LGT have been involved in that process.

(2.2) In July, SEL Trust Boards received and considered a paper from the SEL Pathology Programme Board, seeking approval to the issue an OJEU notice, which would launch the procurement process jointly across all participating SEL Trusts for the provision of pathology services.

(2.3) The LGT Board considered its position at its meeting at the end of July. Whilst SEL were not ruling out an NHS based bid being received in response to the tender process, it seemed quite possible that no NHS based bid would come forward. Based on this, the LGT Board determined that it should not be named specifically in the OJEU notice in order to enable its executive team to pursue the possibility of developing an NHS network model with an alternative NHS pathology provider.

(2.4) In order not to compromise the SEL procurement process, LGT committed to the SEL Pathology Programme Board that it would take its decision at its meeting in September, on whether to be included within the SEL procurement or to develop an NHS network option with another provider.

(2.5) At its meeting on 25 September the Board agreed that LGT should develop an NHS option with a neighbouring NHS provider. To reach this decision, the Board considered detailed work by the Trust's pathology steering group, which had reviewed the different options for pathology networks, following detailed discussions with neighbouring NHS trusts, namely Barts Health NHS Trust and South West London Pathology[1]. The LGT pathology steering group includes members of our pathology management team, pathology clinical staff and clinical users of the services.

[1] South West London Pathology is a partnership formed from the St Georges University Hospitals Foundation Trust, Kingston Hospital Foundation Trust and Croydon Health Services NHS Trust

(2.6) In taking this decision, the Board recognises the close clinical links between our organisation and the other trusts in South East London, especially the role of GSTT and KCH as specialist ("tertiary") referral centres for patients (particularly when tests for cancer are needed). We will, of course, continue to work with STP partners and the SEL Pathology Programme Board to ensure that these clinical links are not negatively affected by joining a pathology network outside south east London. When rapid patient diagnosis of pathology samples is needed (for example, for haemato-oncology), we will continue to refer samples to the local tertiary centre in south east London.

(2.7) LGT will now be carrying out detailed work over the next few months to enable us to make a decision on which pathology network it would be preferable for us to join in the interest of our patients, our scientific and clinical staff who provide our pathology services, and our local GPs. GPs in Lewisham, Greenwich and Bexley currently receive their pathology services from LGT and we will also want to talk to CCGs and GPs to ensure that we maintain the important clinical links between local GPs and the local hospital pathology services.

Lynn Saunders
Director of Strategy, Business and Communications
October 2018

This page is intentionally left blank

HEALTHIER COMMUNITIES SELECT COMMITTEE		
Title	**'Care at Home': The arrangements for integrating health and care services that support people at home.**	
Contributors	**Executive Director for Community Services**	**Item: 7**
Class	**Part 1**	**3 December 2018**

1. Purpose of Report

1.1 This report outlines the proposal by the London Borough of Lewisham (LBL), Lewisham Clinical Commissioning Group (LCCG), Lewisham and Greenwich NHS Trust (LGT) and South London and Maudsley NHS Trust (SLaM) to bring together a number of services that support adults to live as independently as possible in their own homes.

1.2 This report proposes the development of a formal partnership agreement between the Council and Lewisham and Greenwich NHS Trust ("LGT"), under Section 75 of the National Health Service Act 2006 for the integrated provision of services that support adults in their own homes to improve the quality of service provision.

2. Recommendation

2.1 The Mayor and Cabinet considered a report on 'Care at Home' on 21st November. Members are asked to note the recommendations to:

- Approve the proposal to formally integrate a number of social care and health services that support adults in their own homes.
- Agree that the Council enter into a Section 75 agreement with Lewisham and Greenwich NHS Trust ("LGT") and, in relation to Phase 2, South London and Maudsley NHS Foundation Trust (SLaM) for the integrated provision of services for adults in their own homes.
- Delegate responsibility for reshaping existing arrangements for joint working, which include a Section 75 agreement and necessary associated documents, to the Executive Director for Community Services on the advice for the Executive Director for Resources and Regeneration and the Head of Law.
- Agree to a contribution of £40,000 towards the development of the integrated service.
- Agree that a 'Care at Home Partnership Board' be established within the existing Provider Alliance Development Board as set out in 6.7.
- Note that the recommendations are also subject to approval from Lewisham and Greenwich NHS Trust, South London and Maudsley NHS Foundation Trust and Lewisham CCG as the commissioner of community health services.

3. Executive Summary

3.1 The Government requires every area in England to integrate health and social care by 2020. Lewisham's Health and Care Partners (LHCP)[1] are working together to develop new arrangements for delivering integrated care across the borough.

3.2 Social workers, therapists and district nurses have been working alongside GPs on the same neighbourhood footprint for some time. However, the virtual teams operate with different processes and systems and care remains fragmented.

[1] LHCP includes the London Borough of Lewisham, Lewisham Clinical Commissioning Group, Lewisham and Greenwich NHS Trust, South London and Maudsley NHS Foundation Trust and One Health Lewisham.

3.3 A new way of supporting people at home that builds on the work to date is required. Providers, supported by commissioners, recommend the formal integration of services and functions that provide care at home. The aim is to improve the co-ordination of care, reduce variation and duplication and improve the quality and accessibility of care and support. The working title for the new arrangements is 'Care at Home'. The development of Care at Home will involve reshaping our workforce, building better connections with other services including home care and mental health and creating a shared culture with person centred care at its heart.

4. Background

4.1 Health and care partners across Lewisham recognise that our health and care system needs to change. Lewisham's population is growing, people are living longer - many with a number of long term health conditions - and the demand for care is increasing, both in numbers and complexity (Lewisham's over 60 population is projected to increase by around 33,000 by 2040).

4.2 The cost of delivering our health and care services is increasing yet the support and care delivered across Lewisham is not always provided in the most efficient, effective or co-ordinated way. Information and advice to help people keep healthy and well can be hard to find. Access to services can be difficult and high quality care is also not consistently available. Care is often not well co-ordinated across services, resulting in duplication and confusion, particularly if a person has more than one long term condition.

4.3 Health and care providers are facing recruitment challenges across the system. In south east London 23% of GPs and 33% of nurses are aged over 55 and due to retire in the next decade. Staff shortages are common across health and care including GPs, social workers, occupational therapists, nurses, healthcare assistants and home care workers. This restricts the face to face time professionals can have with patients and service users and increases their workload. The challenges in relation to workforce are set out in detail in Appendix 1: the Outline Business Case (OBC) for Care at Home.

4.4 Our communities have told us that they want:

- More face to face time with health and care professionals.
- Better communication and information sharing across service providers and with families.
- Integrated person centred services with a single entry point.
- Staff across the system with the skills and knowledge to help and support residents to look after their own health and wellbeing, to direct their own care and to choose the support and services they need.
- Better care co-ordination and improved support for people to navigate the health and care system.
- Improved access to mental health services and resources, with better signposting to the full range of services available.
- More diverse communication channels about available services.
- Better training and support for care workers to do an effective job.
- Improvements to the way that issues can be escalated and managed together.

4.5 Health and care professionals have told us that:

- Referral processes to other services needs to improve.
- There needs to be better co-ordination and communication between services, particularly with mental health.
- Multi-disciplinary meetings need to focus more on planned prevention rather than emergencies.

4.6 Care at Home is informed by the success of the Buurtzorg model in the Netherlands. Buurtzorg is a unique district nursing system that involves small self-managed teams

providing a holistic approach to care and support. The team undertakes a range of different tasks that would be more commonly delivered by different professionals in the UK, such as a District Nurse and a home care worker.

5. Policy Context

5.1 Mayor and Cabinet's developing strategic policies and plans are committed to providing dignified and compassionate care services. The Council has agreed to the phased implementation of the Ethical Care Charter which marks a key step towards improving the health, safety and dignity of vulnerable people in receipt of home care.

5.2 In 2014, NHS England published its 'Five Year Forward View' setting out its vision for a financially sustainable health and care system. The later document, Next Steps on the NHS Five Year Forward View, highlighted the need for further integration across health and care. The Government requires health and social care to integrate by 2020 and each local area to produce five year Sustainability and Transformation Plans (STP).

5.3 The 'Five Year Forward View' sets out the expectation regarding new ways of delivering health and care that aim to break down the traditional divides between different parts of the health and care system. Commissioners and providers will work differently to pay for, manage and deliver services. A key new way of working will involve providers entering into new collaborative 'alliance' arrangements to deliver services for a given population.

5.4 Care at Home will contribute to the corporate priority of caring for adults and older people and the Council's commitment to working with health services to support older people and adults in need of care. Once in place, Care at Home will contribute to the Council's priority in relation to inspiring efficiency, effectiveness and equity as well as the delivery of the Sustainable Community Strategy, in particular the priority outcomes of improving health outcomes and tackling the specific conditions that affect our citizens; and supporting people with long term conditions so that they can live in their communities and maintain their independence. Care at Home will also contribute to the aims of Lewisham's Health and Wellbeing Strategy which was published in 2013 and refreshed in 2016.

5.5 Lewisham is one of five devolution pilots across London that is exploring the transfer of powers, decision-making and resources to a local level. Lewisham's devolution pilot is focussed on workforce and estates. The London Workforce Board is looking at the workforce needs across health and care, including home care. As a devolution pilot, Lewisham will be involved in the development of new ways of working such as 'hybrid' or 'bridging' roles, new approaches to apprenticeships and joint training.

5.6 Lewisham Health and Care Partners (LHCP) are committed to supporting people to maintain and improve their physical and mental wellbeing, to live independently and to have access to high quality care when needed. Transforming the care that people receive in the community, so that more people can be cared for out of hospital, is critical to achieving this. Care at Home is a key element of LHCP's plans to deliver the vision for Community Based Care[2]. LHCP's ambition is for community based care to be:

- **Proactive and Preventative** – By creating an environment which promotes health and wellbeing, making it easy for people to find the information and advice they need on the support, activities, opportunities available to maintain their own health and wellbeing and to manage their health and care more effectively.
- **Accessible** – By improving delivery and timely access when needed to planned and urgent health and care services in the right setting in the community, which meet the needs of our diverse population and address inequalities. This includes raising

[2] *LHCP Vision for Community Based Care in Lewisham, 2017.*

awareness of the range of health and care services available and increasing children's access to community health services and early intervention support.

- **Co-ordinated** – So that people receive personalised health and care services which are coordinated around them, delivered closer to home, and which integrate physical and mental health and care services, helping them to live independently for as long as possible.

6. Care at Home: Summary of the Outline Business Case (OBC)

6.1 **Scope:** Phase 1 will focus on bringing together a number of Adult Social Care services with District Nursing. Four integrated teams, one in each neighbourhood, will improve the delivery of co-ordinated, person centred care for adults at a neighbourhood level. The teams will be co-located in the neighbourhoods. A key element of Phase 1 is the development of greater collaborative working with home care providers to the extent that they operate as part of the Care at Home teams.

The first phase of Care at Home will include the following teams and comprise approximately 250 staff:

- Adult social care - Integrated Neighbourhood Team (assessment and care planning), Enablement Care.
- Home based rehabilitation (joint adult social care and therapies service).
- District Nursing (delivered by Lewisham and Greenwich Trust).
- Neighbourhood Co-ordinators (work across Adult Social Care, District Nursing and Primary Care).

In Phase 2, Care at Home will be expanded to include specialist community mental health services including Older Adults Mental Health. Care at Home could potentially include a range of other services in the future such as some preventative services, some supported housing provision, some specialist nursing services and specialist mental health social work teams.

6.2 **Functions:** Care at Home will initially have 3 core functions: co-ordinated assessment, planning and care delivery, supporting hospital discharge and supporting admission avoidance. Each Care at Home team will provide all 3 functions on a neighbourhood basis, with staff working in a flexible way that spans organisational boundaries wherever possible.

6.3 **Collaborative working with Home Care:** The lead home care providers will be involved in both the development and delivery of Care at Home. The providers will play a key role on the Operational Group and will operate as key members of the Care at Home teams, working alongside social care and district nursing staff to co-ordinate care on a day to day basis. A request for Mayor and Cabinet to extend the current contracts to enable the development of the new specification for home care will be made in December 2018.

The new service specification for home care will be co-produced by the Care at Home Teams. Home Care will continue to be organised on a neighbourhood footprint. The specification will be outcomes focused and strengthen the requirement for home care staff to proactively engage in multi-disciplinary assessments, care planning and reviews. An integrated approach to training and apprenticeships across Care at Home and home care will be developed. Opportunities to delegate authority to home care staff enabling them to undertake tasks currently managed by health and care professionals will be fully explored. This could involve the development of enhanced roles with a specific focus e.g. dementia and diabetes.

6.4 **Working with other Health and Care Professionals:** The teams will have especially close working relationships with primary care, mental health (both older adults and working age adults), Community Connections (the consortium of voluntary sector

organisations that support vulnerable and socially isolated adults) and the Single Point of Access (SPA), the first point of contact adult social care and district nursing. Work will be undertaken with these professionals / services to develop more effective multi-disciplinary working, joint training, key working and streamlined referral processes.

The Care at Home teams will also work with a wider range of health and care services including community health services (e.g. podiatry, Speech and Language Therapy, Home Enteral Nutrition), preventative services delivered by health and by the voluntary sector (e.g. Community Connections) and supported housing.

6.5 **Key Deliverables and Outcomes:** The OBC sets out key deliverables in relation to workforce, care delivery and strengthened neighbourhood networks. The expected outcomes and proposed principles and ways of working are aligned to Lewisham's Partnership Commissioning Intentions for Adults 2017-19.

Key deliverables include:

- A shared approach to assessment and care planning for patients / service users with complex health and care needs.
- More co-ordinated care and support through, for example, key working and expanded trusted assessor roles within multi-disciplinary teams.
- New 'bridging' or 'hybrid' roles to reduce duplication, improve quality and staff retention.
- Joint training and on-going support to raise quality, deliver holistic care and improve patient and service user experience.
- Utilising technology to improve communication between health and care professionals and between professionals and patients / service users.
- Co-located teams with staff having access to all relevant information.
- Stronger connections between the statutory health and care sector and the voluntary and community sector.

6.6 **Approach to Delivery:** It is proposed to deliver Phase 1 through three key workstreams: Workforce, Performance and Finance, Pathways and Relationships (including trusted assessor and multi-disciplinary working). A draft outline delivery plan has been included in the OBC. An integrated staffing structure will be developed with professional and clinical support continuing to be provided by respective professional leads through a matrix management arrangement. No changes will be made to terms and conditions. A draft Risk Register has been included in the OBC.

6.7 **Governance:** A Care at Home Partnership Board will be developed within the existing Provider Alliance Development Board[3] to enable a clearer focus on delivering Phase 1 of Care at Home. The OBC proposes that a Section 75 agreement will provide the mechanism to bring the services formally together in Phase 1. The Section 75 agreement will set out the approach to aligning budgets and delegating authority (for example to enable the team to act as 'trusted assessors').

The partnership arrangements required for an expanded Care at Home service beyond Phase 1 will be considered to ensure robust governance and accountability. An options analysis will be developed concurrently with the initial phase.

7. Expected Outcomes and Measuring Success

[3] The Provider Alliance Development Board (PADB) is accountable to the Lewisham Health and Care Partnership Executive Board (LHCP). Members include the London Borough of Lewisham, Lewisham and Greenwich NHS Trust, South London and Maudsley NHS Foundation Trust, One Health Lewisham and Lewisham Clinical Commissioning Group.

7.1 Bringing services that support people at home closer together is expected to achieve a step change in the delivery of care at home. Mayor and Cabinet's developing strategic policies and plans are committed to delivering dignified and compassionate care. Lewisham's Partnership Commissioning Intentions for Adults 2017-19[4] set out the high-level health and care outcomes required to transform health and care in the borough. Care at Home will contribute to Lewisham's overall key outcome measures for Community Based Care, specifically the following:

Better health and care outcomes through:

- An increase in health-related quality of life for those with long term conditions (physical and mental health).

Better service user and patient experience of health and care through:

- Consistent, high quality care, localised where possible and in the most appropriate setting – 'Right care, right time, right quality'
- Holistic care where their mental health needs are treated with equal importance to their physical needs and which integrates physical and mental health and care services
- Personalised care developed in partnership with professionals, empowering people to have choice and control over their care.

Best sustainability across health and care in Lewisham through:

- An increase in the proportion of people feeling supported to manage their long-term conditions
- A reduction in avoidable emergency admissions
- An increase in the proportion of older people (65 & over) who are still at home 91 days after discharge
- A reduction in delayed transfers from hospital
- A reduction in the number of people admitted to residential care or nursing homes
- A reduction in the number of people requiring on-going care and support.

7.2 An integrated performance framework will be established to bring together the existing KPIs and ensure that performance against the key outcomes is being measured.

8. Progress to date

8.1 Lewisham Health and Care Partners have taken a number of steps to improve services at a neighbourhood level, raising quality and building better connections across different organisations and with the voluntary and community sector. A range of health and care services are now organised on a neighbourhood footprint based around GP registered lists in the following geographical areas:

(1) North Lewisham
(2) Central Lewisham
(3) South East Lewisham
(4) South West Lewisham.

8.2 Neighbourhood Co-ordinators (one in each neighbourhood) have been in post since November 2015. The Co-ordinators support multi-disciplinary working, liaising between professionals within the NCT and with services outside it. Funded by the Better Care Fund, the Neighbourhood Co-ordinators work across health and social care to improve multi-disciplinary working for those people with complex health and social care needs. The team facilitates effective liaison between formal and informal health and care providers across Lewisham. 1551 'referrals' (requests for support) were made to the Neighbourhood Co-ordinators in 2017-18 (a 24% increase on the previous year). These 'referrals' range from straightforward signposting or information chasing to supporting the co-ordination of case conferences for more complex cases.

[4] *See: Lewisham's Partnership Commissioning Intentions for Adults 2017-19*

8.3 Three pilots were undertaken to test ways to improve multi-disciplinary working in GP practices between May and October 2017. The pilots involved more frequent multi-disciplinary meetings (MDMs) that included a wider range of professionals, including mental health and home care providers. The evaluation demonstrates a wide range of positive impacts that enabled more co-ordinated, person centred care and support:

- Stronger relationships were developed enabling a culture focussed on delivering co-ordinated, compassionate care.
- The flow of information across different professional teams and the speed of referrals both improved.
- Members of the team developed new skills and knowledge enabling them to case manage more effectively, reducing delays to care.
- The greater involvement of mental health professionals enabled more effective and timely referrals to mental health services.

Participants have commented that they felt the team established a shared culture with compassion at its heart e.g.: *'I felt that everyone involved was committed to providing compassionate care'.* In the feedback, participants commented on the level of professional respect within the MDM (*'there was an overarching respect for each professional attending'*) and the improvements to working relationships (*'we have developed a stronger relationship with the GP practice as a result of our joint working'*).

The learning from the pilots has been used to shape the new Standard Operating Procedure for practice based multi-disciplinary meetings (MDMs). Mental health professionals are now engaging with MDMs more consistently. Funding for training and development activity to improve MDMs has been secured and a programme is being rolled out in November 2018.

8.4 A 16 week 'Flexible Roles' pilot to test how district nurses and home care workers could work better together took place between January and May 2018. A small team of 3 district nurses and 6-8 care workers came together to work as one team in Neighbourhood 2. The team worked more flexibly to co-ordinate care and support and reduce duplication for those patients / service users that had both care and on-going nursing needs. The evaluation has highlighted a number of positive impacts:

- A better understanding of different roles broke down barriers and increased respect and trust.
- Strong relationships were developed that improved communication, preventing delays with care and support.
- A shared culture focussed on delivering high quality, co-ordinated care was developed.
- Through closer working with the district nurses, the care workers developed and enhanced their knowledge and experience, enabling them to manage care more effectively and involve nurses at an early stage to prevent crises.
- A 21% reduction in Emergency Department attendances.

8.5 To further strengthen networking across the neighbourhoods, four Neighbourhood Community Development Partnerships have been established. These neighbourhood partnerships bring together voluntary and community sector organisations and groups in that area to support community development, to work with statutory partners in the area and to build stronger, healthier communities.

8.6 LHCP have committed to co-locating district nurses and neighbourhood adult social care teams to improve multi-disciplinary working. The Neighbourhood 1 team is scheduled to co-locate in by January 2019. Locations for the NCTs in N2, 3 and 4 have been identified and these projects will be managed through the One Public Estate initiative.

8.7 Senior and front line staff from across the health and care system have been actively involved with developing activity to improve multi-disciplinary working. The 'Flexible Roles' pilot was informed by feedback from a workshop with a range of health and care staff in September 2017 to explore the potential to develop greater collaboration within the services that support people at home.

8.8 Engagement with stakeholders has taken place throughout September and October. This has included:

- The Care at Home Steering Group – includes representatives from district nursing, adult social care, primary care, mental health and community health and home care commissioners.
- CCG Clinical Directors.

8.9 LHCP held an engagement event for public and professionals in October 2018. A key focus was improving care and support for people in the own homes. There was positive support for the principle of Care at Home particularly for:

- Better communication and information sharing across service providers and with families.
- Better training and support for care workers to do an effective job.

9. Next Steps

9.1 Further engagement with staff and stakeholders on the proposal for Care at Home will be undertaken. Consideration will be given to the on-going involvement of trade unions in relation to the future development of the service. A formal consultation with staff affected will take place in line with the Council's and LGT's policies and procedures. Full engagement will be sought from the unions representing the staff across the organisations involved.

9.2 By January 2019, the Care at Home Partnership Board will be in place to oversee the following activity:

- The development of the Section 75 agreement to commence in April 2019
- Engagement and communications as part of the wider LHCP engagement and communications plan.
- Workforce development as part of the wider LHCP workforce development plan.
- The inter-operability of IT systems to enable the development of a single assessment and care plan aligning with wider LHCP IT developments.

9.3 An Operational Group has been established and will oversee the following between January and March

- Initial testing of the integrated management structure for the Care at Home teams.
- The development of operational processes for the new Care at Home teams.

10. Financial Implications

10.1 This report seeks approval for a proposal to formally integrate a number of social care and health services that support adults in their own homes. The reasons for this approach are set out in the attached Outline Business Case (OBC).

10.2 The OBC provides an overview of the budgets involved in Phase 1 (section 9.1). The proposal is to ring-fence and align rather than pool budgets. The overall Council budget for the services being considered for integration is £19.588m - £5.588m for social work staff and £14m (approx.) for home services purchased from the 4 lead providers..

10.3 The OBC sets out the resource implications for the implementation of Phase 1 (section 9.2). Implementing Care at Home will require additional investment initially. External

funding, including the Better Care Fund, will provide a significant proportion of this. All providers will also contribute to the additional resources required. The Council will be expected to contribute £40,000. Provision for this will be made through additional resources allocated to the local authority through the Improved Better Care Fund (IBCF).

10.4 Delivering efficiencies and savings for the Council and other partners alongside improvements to care is a key driver for Care at Home. The OBC provides a preliminary indication of the potential return on investment (section 10.8). This draws on data gathered in the recent 'Flexible Roles' pilot. Detailed modelling will provide a more robust indication of the return on investment and the timescales in which that could be achieved. Partners will consider risk and gain share agreements as a key next step.

10.5 Mayor and Cabinet have been asked to delegate responsibility for reshaping existing arrangements for joint working, which include a Section 75 agreement and necessary associated documents, to the Executive Director for Community Services on the advice for the Executive Director for Resources and Regeneration and the Head of Law.

11. Legal Implications

11.1 The Council has various statutory obligations to provide services to individuals, including those services which will be affected by the changes proposed by this report. However, the proposed changes will not alter those obligations and to that extent there are no specific legal implications arising from this report.

11.2 The report proposes that the Council enter into an arrangement (called in this report a 'Section 75 Agreement) with Lewisham and Greenwich NHS Trust (LGT, an NHS body) under which certain functions of LGT and certain health-related functions of the Council will be delivered. The Council has powers to enter into such an arrangement under Section 75 of the National Health Service Act 2006, and will need to comply with relevant regulations (in particular the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000) and relevant guidance.

11.3 Before making the decision, Mayor and Cabinet must be satisfied that the proposal is likely to lead to an improvement in the way in which the Council's functions are exercised. The report including the Appendix sets out the proposed improvements.

11.4 The report seeks a delegation of authority to the Executive Director for Community Services (on the advice from the Executive Director for Resources and Regeneration and the Head of Law) to sign the necessary documentation.

12. Crime and Disorder Implications

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

13. Equalities Implications

13.1 The OBC sets out the preliminary activity undertaken in relation to equalities impact analysis. An Equalities Analysis Assessment will be undertaken on the final operating and delivery model to ensure that its implementation would not affect adversely any resident with a protected characteristic.

14. Environmental Implications

14.1 There are no environmental implications arising from this report.

15. Conclusion

15.1 Care at Home will enable commissioners and providers of health and care services to work better together to improve outcomes for service users and patients. It will achieve efficiencies and more effective and flexible use of resources.

Background Documents

None

If you would like further information on this report please contact Carmel Langstaff on carmel.langstaff@lewisham.gov.uk / 020 8314 9579.

Outline Business Case: Delivering Care at Home in Lewisham

Version 11

Date: **6 November 2018**

DOCUMENT CONTROL: Change Control History

Version	Change Summary	Change author	Date
2	Added 4.2, a diagram showing the relationship with other health and care services, section on governance, further detail on financial and legal implications.	Carmel Langstaff	30/8/18
3	Added staffing details for rehab teams (Page 5). Minor amendments to wording e.g. re: financial implications.	Carmel Langstaff	11/09/18
4	Added section on synergies with other transformation programmes (see 4.4), section on leadership (see 6.1) and reference to the need for a full equalities analysis assessment (see 11).	Rachael Crampton / Carmel Langstaff	12/9/18
5	Clarified position re: business support (see 4.1).	Carmel Langstaff	14/9/18
6	Added sections on population health (3.1), overview of statutory responsibilities / regulatory compliance requirements (4.1 and Appendix 1), reference to Patient Reference Groups (6.2), developed the governance model in Figure 6.	Carmel Langstaff	18/9/18
7	More detail on the resource plan and potential return on investment, draft scope for the Section 75 agreement (appendix 3) and Draft Principles of Collaboration and Co-operation for the Provider Alliance (Appendix 2).	Carmel Langstaff	25/10/18
8	Removed section on Legal Implications following advice from LBL Legal Services.	Carmel Langstaff	29/10/18
9	Amended Sections 4.1, 9.1 and 10 following feedback from providers.	Carmel Langstaff	31/10/18
10	Amended Sections 6.1, 9 and 10 following feedback from providers and commissioners.	Carmel Langstaff	1/11/18
11	Amended Sections 4.2, 4.3.1, 8 and 9.1.	Carmel Langstaff	6/11/18

Reviewers

Version	Reviewer	Role	Date
1	Joan Hutton, Beth Williams	Nominated by PADB to develop the OBC.	12/9/18
2	Aileen Buckton, Martin Wilkinson, Joan Hutton, Beth Williams, Charles Gostling.	Key partners and stakeholders	10/9/18
4	Aileen Buckton, Martin Wilkinson, Ben Travis, Joanne McCaffrey.	Senior leaders	14/9/18
4	Joan Hutton, Beth Williams, Kate Pottinger, Corinne Moocarme, Evelyn Idise, Cha Power, Dan Harwood, Aaron Hamilton.	Care at Home Delivery Group	18/9/18
8	Provider Alliance Development Board and Joan Hutton, Joanne McCaffrey, Beth Williams, Evelyn Idise, Diana Braithwaite.	PADB, senior leaders.	26/10/19

Approvals

Version	Approver	Role	Date
6	Provider Alliance Development Board	Board overseeing 'Care at Home'	28/9/18
9	Provider Alliance Development Board	Board overseeing 'Care at Home'	31/10/18
11	Martin Wilkinson	SRO	6/11/18

1. Purpose of OBC

This Outline Business Case provides the background and strategic context to a more integrated approach to delivering care at home in Lewisham. It outlines the scope, key deliverables and expected outcomes and sets out the case for investment for Phase 1 based on an analysis of the costs, risks and benefits.

2. Background:

In March 2018, Lewisham Health and Care Partners[1] (LHCP) agreed to develop a more integrated approach to supporting people in their own homes. Providers, supported by commissioners, agreed to formally integrate services and functions that provide care at home. The aim is to improve the co-ordination of care, a key element of the shared vision for Community Based Care[2], reduce variation and duplication and improve the quality and accessibility of care and support. The working title for the new arrangements is 'Care at Home'.

London Borough of Lewisham's developing strategic policies and plans are committed to providing dignified and compassionate care services. The Council has agreed to the phased implementation of the Ethical Care Charter which marks a key step towards improving the health, safety and dignity of vulnerable people in receipt of home care.

Lewisham is one of five devolution pilots across London that is exploring the transfer of powers, decision-making and resources to a local level. Lewisham's devolution pilot is focussed on workforce and estates and potentially offers opportunities for health and care providers to work differently in future.

The following activity to develop 'Care at Home' has been undertaken since March:

- LHCP agreed that Martin Wilkinson would provide the strategic lead to oversee the development of 'Care at Home' within his existing MD role.
- A *Provider Alliance Development Board* (PADB) providing high level strategic direction and a *Care at Home Delivery Group* (CaHDG) responsible for the development, planning and implementation of the agreed proposals have been established.
- The PADB agreed that Phase 1 would focus on bringing together a number of Adult Social Care services with District Nursing. The governance arrangements would be developed alongside the operational arrangements.
- Planning for 'Care at Home' has been aligned to the planning of new integrated mental health services for adults.
- Planning for 'Care at Home' has been aligned to the development of new home care contracts, overseen by a separate group.

3. The Case for Change

3.1 Overview

Health and Care Partners across Lewisham have recognised for many years the need for change within our local health and care system. Lewisham's population is growing and people are living

[1] *Members include representatives from Lewisham Clinical Commissioning Group, Lewisham and Greenwich NHS Trust, South London and Maudsley NHS Foundation Trust, One Health Lewisham and the London Borough of Lewisham.*
[2] *LHCP Vision for Community Based Care in Lewisham, 2017.*

longer, many with a number of long term health conditions and demand for care is increasing, both in numbers and complexity. Lewisham's over 60 population is projected to increase by around 33,000 by 2040. 14.4% of people in Lewisham identify themselves as having limitations in carrying out day-to-day activities (equivalent to around 39,000 people). There are significant health inequalities in Lewisham and high quality care is not consistently available all the time. Working together, LHCP want to achieve a sustainable and accessible health and care system to better support people to maintain and improve their physical and mental wellbeing, to live independently and to have access to high quality care when needed.

There are recruitment challenges across the system with shortages in a range of staff areas including qualified and experienced social workers, occupational therapists and district nurses. Staff shortages are causing delays to care and increased costs to providers through bank and agency fees. While work to ensure staff are deployed more effectively is on-going, further integration would provide a greater opportunity for flexibility across organisations. Staff satisfaction varies across providers but is generally considered a challenge. The NHS Draft Workforce Strategy emphasises the importance of better system wide workforce planning with a focus on career progression across organisations to improving recruitment and retention. Developing a shared culture and better relationships within integrated teams would improve communication, reducing duplication and delays to care and support.

Key services that support people at home (social care, therapists and district nurses), have been organised, alongside GPs, on the same neighbourhood footprint. While these virtual 'Neighbourhood Community Teams' (NCTs) have enabled professionals to work better together, care remains fragmented. Organisations have different processes and systems which prevents more integrated working. High quality care is not consistently available all the time as multi-disciplinary working within the NCTs and between the NCTs and mental health and domiciliary care, key providers of support to people at home, varies significantly.

3.2 Challenges and opportunities

There are opportunities for efficiencies in relation to neighbourhood assessment and care planning. Multiple assessments are undertaken across different adult social care and provider services (e.g. the overview assessment, the Enablement assessment and the assessment undertaken by the home care agency). A more integrated approach could potentially streamline these processes. Initial work on the assessment processes of adult social care and district nursing has identified a significant overlap in the information collected. While work to better understand the overlap across adult social care and district nursing is ongoing, a trusted assessor approach has the potential to considerably reduce the time spent on assessments as well as improving the patient / service user experience i.e. by only telling their story once.

There are also opportunities for efficiencies in relation to the delivery of care by ensuring that the right professional is providing the required care. Both adult social care and district nursing have developed roles e.g. support planners and health care assistants who can undertake tasks previously completed by qualified social workers, OTs and nurses. In addition, a team of Neighbourhood Co-ordinators was established in 2015 to support multi-disciplinary working, liaising between professionals within the NCT and with services outside it. The team has effectively reduced time spent by professionals chasing information and freed up capacity for tasks that require professional expertise. 'Hybrid' or 'bridging' roles that span social care and district nursing to create a more

flexible workforce could be developed. Clinical governance issues and concerns could be addressed within a formally integrated service.

The investment in population health also presents opportunities to enable better co-ordination of care. The population health and care programme aims to support health and care professionals, providers and commissioners, to develop new evidence-based, ways of working, which best support the needs of the people of Lewisham and pave the way for similar work at a SE London and London level. The work will collate a range of local health and care data into a single management information system, seek to better understand how it is, and can be, used and then create a common and consistent care record, and population-based tools, to help to inform better care delivery and future service design. Outputs of this work include:

- A single unified care record, showing all relevant health and care data in one place for every person or patient and professionals, which will improve the speed of decision making and safety, help professionals to work more cohesively together and to create single care plans (which in future would be able to be shared via the system itself).
- Specific population-based registries, such as a register of people with diabetes or related needs, which will improve identification of needs, risk stratification and prioritisation, call out and deal with care gaps and improve our understanding of the whole population using a complete data set.
- An analytics platform, with the ability to run queries to support evidence-based decision making, provision or commissioning, using a complete data set to give a single version of the truth.
- An information governance and communications approach to underpin the whole programme and ensure it is legally sound and supports our ambitions and use cases.

There is an opportunity to align the development of Care at Home with other transformation activity taking place at Lewisham and Greenwich Trust and within Adult Social Care. This is set out in more detail in 4.4.

3.2 Learning from pilots in 2017-18

Three pilots were undertaken to test ways to improve multi-disciplinary working in GP practices between May and October 2017. The pilots involved more frequent multi-disciplinary meetings (MDMs) that included a wider range of professionals, including mental health and home care providers. The evaluation demonstrates a wide range of positive impacts that enabled more co-ordinated, person centred care and support:

- Stronger relationships were developed enabling a culture focussed on delivering co-ordinated, compassionate care.
- The flow of information across different professional teams and the speed of referrals both improved.
- Members of the team developed new skills and knowledge enabling them to case manage more effectively, reducing delays to care.
- The greater involvement of mental health professionals enabled more effective and timely referrals to mental health services.

A 16 week pilot to test how district nurses and home care workers could work better together took place between January and May 2018. A small team of 3 district nurses and 6-8 care workers came together to work as one team in Neighbourhood 2. The team worked more flexibly to co-ordinate care and support and reduce duplication for those patients / service users that had both care and on-going nursing needs. The evaluation has highlighted a number of positive impacts:

- A better understanding of different roles broke down barriers and increased respect and trust.

- Strong relationships were developed that improved communication, preventing delays with care and support.
- A shared culture focussed on delivering high quality, co-ordinated care was developed.
- Through closer working with the district nurses, the care workers developed and enhanced their knowledge and experience, enabling them to manage care more effectively and involve nurses at an early stage to prevent crises.
- A 21% reduction in ED contacts.

4. Care at Home - Initial Scope

4.1 Overview of Care at Home Teams in Phase 1

Lewisham's health and care providers (LBL, LGT, SLaM, OHL and the core GP workforce) have agreed the scope of the first phase of Care at Home. It is proposed that the new arrangements build on the existing Neighbourhood Community Teams (NCTs) to improve the delivery of co-ordinated, person centred care at a neighbourhood level and improve the use of resources to support admission avoidance and hospital discharge.

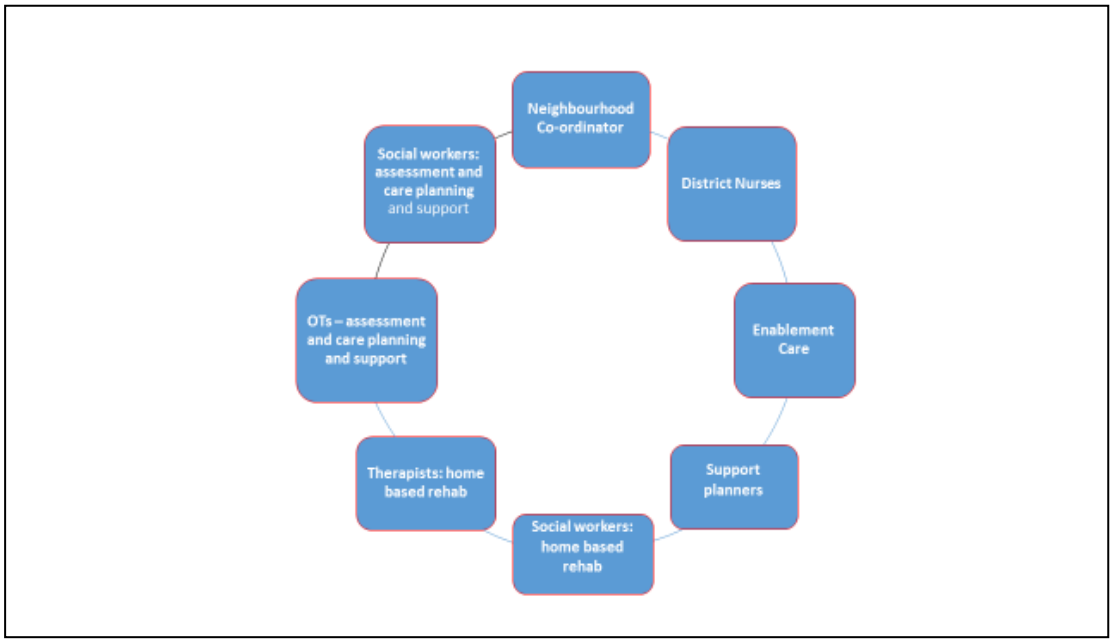
Adult Social Care services are required to fulfil the statutory functions set out in The Care Act 2014. District Nursing and Enablement Care services are subject to CQC regulations.

The first phase of Care at Home will focus on adults and include the following teams:

- Adult social care: Integrated Neighbourhoods (assessment and care planning) – four teams of social workers, OTs, case management officers. Approximately 57 FTE staff in total.
- Home based rehabilitation (joint adult social care and therapies) - a multi-disciplinary supported discharge team that works with the Enablement Care Team to provide up to 6 weeks of home based rehabilitation to people identified as needing support to prevent admission to hospital or to facilitate discharge from an acute bed. An estimated 28 FTE staff in total currently provide homes based rehab.
- Lewisham Adults Therapies Team (LATT) provides long term therapies support for adults living at home. An estimated 30 FTE staff in total.
- Adult social care: Enablement Care Team - the team supports the rehabilitation hub to deliver enablement care and support for up to 6 weeks. It comprises senior enablement officers, enablement work planners, enablement officers and specialist enablement officers. From September 2018, the team will be based on a neighbourhood footprint. Approximately 55 posts.
- District Nursing: four teams of district nurses (a combination of Band 5, 6 and 7 nurses) PCAP (Band 4), health care assistants (Band 3) and a team administrator. Two Band 8a nurses manage two neighbourhoods. Approximately 81 FTE staff in total.
- Neighbourhood Co-ordinators: work across the Neighbourhood Community Teams, supporting multi-disciplinary working, communication and information sharing. Team of 4 FTE posts.

The estimated total number of staff involved is 255. This will need to verified as part of the detailed planning to support implementation. The Care at Home teams will also require administrative support and arrangements for that will need to be considered further. The range of roles that will be within each neighbourhood 'Care at Home' team is shown below (Figure 1).

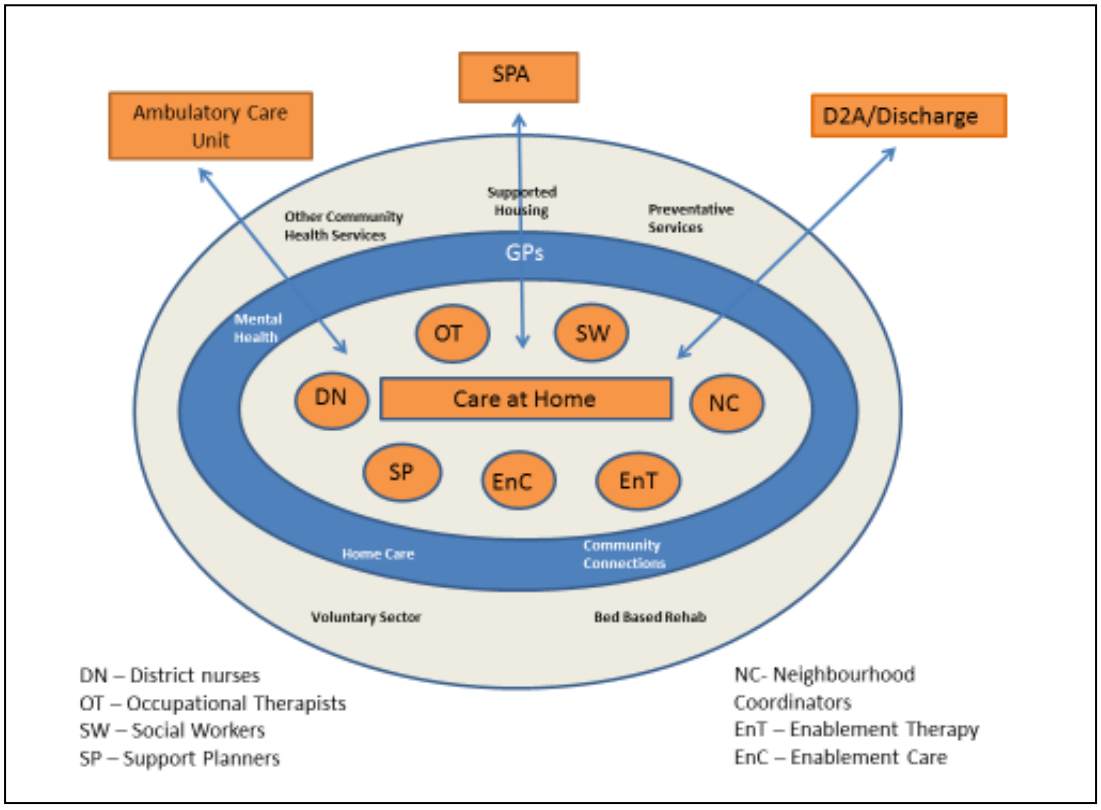
Figure 1: Roles within each Neighbourhood 'Care at Home' team



4.2 Relationship Between Care at Home Teams and Wider Health and Care Services:

The Care at Home teams will work closely with a range of health and care professionals as illustrated below.

Figure 2: Relationship Between Care at Home Teams and Wider Health and Care Services



The teams will have especially close working relationships with primary care, home care, Community Connections (the consortium of voluntary sector organisations that support vulnerable and socially isolated adults) and mental health (both older adults and working age adults). The Care at Home Teams will also work closely with the single point of access which will provide the key mechanism for referrals.

The Care at Home teams will:

- Work in a different, more collaborative way with home care agencies. The lead providers will be involved with operational planning and the day to day co-ordination of care on the ground. Building on the approach to procurement in the last cycle, the specification will be outcomes focussed and a mechanism for charging will be developed to support that. An integrated approach to training across Care at Home and home care will be developed. Opportunities to delegate authority to home care staff enabling them to undertake tasks currently managed by health and care professionals will be fully explored. The specification will also explore the potential for home care providers to develop enhanced roles with a specific focus e.g. dementia and diabetes.
- Build on the multi-disciplinary working with primary care, improving multi-disciplinary meetings (MDMs) and developing new opportunities to work more effectively with GPs. Regular MDMs are now established in every practice (co-ordinating monthly MDMs is a requirement of the Primary Care PMS contract). MDMs involve GPs, social care, district nursing and more recently mental health, although there is considerable variation in terms of quality and effectiveness. Integrated Care at Home teams will support greater consistency across MDMs. Building on the learning from the pilots undertaken in 2017 (see 3.2), Care at Home will look to develop a key worker approach and involve home care providers in practice based MDMs. The teams will also explore opportunities to streamline referral processes from primary care.
- Work more effectively with adult mental health services, especially Older Adults Mental Health. Joint training will improve knowledge of services and criteria for support. Key working will be developed to improve communication and reduce hand offs. Further involvement of OAMH in the SPA will be explored and referral processes will be reviewed. Work is currently underway to test a specific MDM with an older adults mental health focus at South Lewisham Group Practice. This could be developed in other practices with large numbers of older adults. It is envisaged that additional mental health clinical capacity will be required to support Care at Home. This could be a resource that is realigned or may be potentially an additional resource that is required.
- Work more effectively with Community Connections, the consortium of voluntary sector providers that delivers key initiatives to support vulnerable and isolated adults. These include co-ordinating the Neighbourhood Community Development Partnerships as well as connecting individuals to support available in the community. The consortium will be strengthened to include other voluntary sector providers and links with practice based MDMs will be further developed.

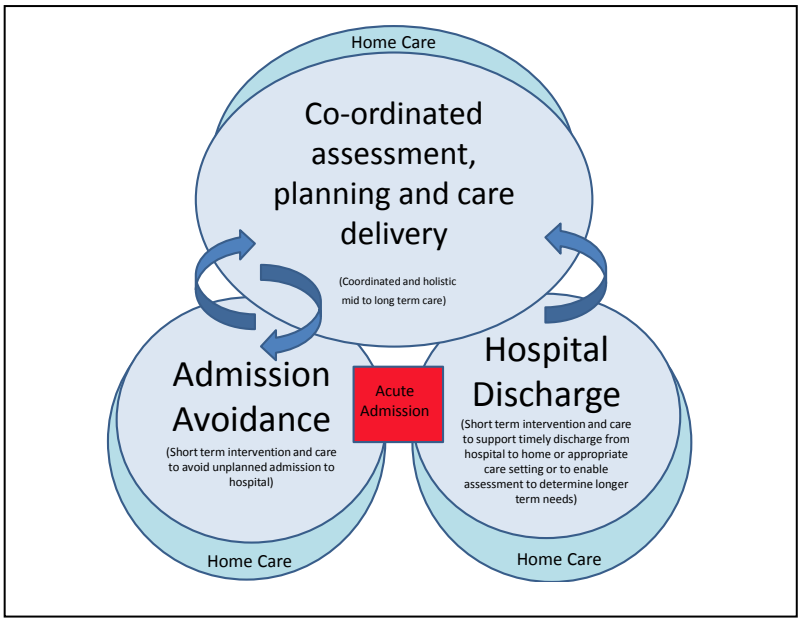
The Care at Home teams will also work with a wider range of health and care services including community health services (e.g. podiatry, SALT, HEN), preventative services delivered by health and by the voluntary sector (e.g. Falls Service, SAIL), supported housing. Both the Single Point of Access

(the first point of contact adult social care and district nursing), the D2A team and hospital discharge service and the Ambulatory Care Unit are key interfaces, reflecting the core functions of Care at Home.

4.3 Core Functions:

Care at Home will initially have 3 core functions: co-ordinated assessment, planning and care delivery, supporting hospital discharge and supporting admission avoidance as represented in Figure 3 below. Each neighbourhood Care at Home team will provide all 3 functions on a neighbourhood basis, with staff working a flexible way that spans organisational boundaries wherever possible. Home care will work closely with the Care at Home teams to support all core functions.

Figure 3: Care at Home teams – core functions



4.3.1 *Co-ordinated Assessment, Planning and Care Delivery:*

The four co-located neighbourhood Care at Home teams will deliver more efficient assessment and care planning through streamlined and shared assessment and care planning processes. Key working and trusted assessor roles will be developed to provide more co-ordinated care and support. The Care at Home teams will include Enablement Care under the same management structure, facilitating more effective multi-disciplinary working across enablement, social care, occupational therapy and district nursing. Demand will be managed more effectively through the development of the Single Point of Access (SPA) as outlined in 4.4.2.

There are opportunities to strengthen the relationships with primary care in relation to assessment and care planning. Improved communication, a joint approach to assessment and care planning, key worker roles and a more flexible workforce will enable greater co-ordination across primary care and Care at Home.

Home Care will continue to be organised on a neighbourhood basis. A new Service Specification will be co-produced by Neighbourhood Care at Home Teams. It will strengthen the requirement for home care agencies to work much more proactively with the Neighbourhood Teams and engage in multi-disciplinary assessments, care planning and reviews. The new specification will be in place by 1st April 2020.

Summary of patient / service users across the services:

- Approximately 300 social care assessments are undertaken each month.
- An average of 162 people receive enablement care support each month.
- An average of 3068 people receive support from the district nursing team each month.
- 1880 people accessed support with their personal care from home care agencies in 2017-18 (an average of 156 a month). 73% of these people were still receiving care at the end of the year.

4.3.2 *Supporting hospital discharge / D2A:*

The Care at Home neighbourhood teams will proactively support people ready for discharge to co-ordinate timely transfer into the community.

The intention is to expand Discharge to Assess (D2A) increasing the numbers and complexity of the patients that can be discharged from an acute bed. Going forward D2A will become the default discharge pathway for all patients to ensure, wherever possible, assessment for longer term care needs will be completed at their ordinary place of residence. Care at Home could proactively work with the discharge teams to 'in reach', identifying people that require care and support and reducing delayed transfers of care. The Neighbourhood Co-ordinators' role could be developed to support better co-ordination of discharged patients / service users into the community.

Building on the learning from the flexible roles pilot, the aim is to develop new 'hybrid' health and care roles, initially in Enablement Care. As Enablement Care provides up to 6 weeks free support through adult social care, developing a hybrid role in this function would prevent potentially complex administration in relation to charging.

Summary of patient / service users across the services:

- Approximately 108 people that require home based and bed based rehabilitation and social care support are discharged each month. On average, 42% of these are discharged through D2A.

4.3.3 *Supporting admission avoidance:*

There is an opportunity to engage social care professionals earlier through a better interface between the ACU and Care at Home. Care at Home could provide short term interventions that may prevent and / or delay the need for a long term package of care.

Approximately 500 people attend the ACU each month. It is estimated that Care at Home could support up to a third of these individuals. Although a more detailed analysis of the data is required, at a first look approximately 170 ACU patients a month could be supported by the Care at Home teams through integrated short term interventions. This support could be delivered by an expanded

Enablement Care function. If the evidence demonstrates a return on investment, a realignment of the resources that are currently used to support these individuals would be necessary to facilitate the shift away from the acute to community services. It is envisaged that additional geriatrician capacity will be required, either through the remodelled ACU or within the Care at Home teams.

4.4 Synergies with other transformation programmes

4.4.1 *Ambulatory Care Unit and Adult Community Services Transformation (ACU/ACS)*

Running alongside the design of 'Care at Home' is the proposal for the development of the Ambulatory Care Unit (ACU) and adult community health services. The aim is to support a reduction in the number of Emergency Department attendances and admissions as well as supporting faster discharge.

This programme of work is looking to develop:

- Ongoing streamlining and redesign of adult community services to ensure good quality and efficient care
- A community hub that provides a single co-ordinated response for adult primary and community care referrals. The principle is for no patient to be sent to hospital (non-elective) without a prior discussion. The hub would build on the existing Primary Care consultant phone-line, based in the Ambulatory Care Unit, to offer a more responsive telephone referral route. It is expected that a service level agreement would provide a consistent call response for advice, triage and clear handover of care.
- The scope beyond general medicine and move the Surgical Assessment Unit in to the ACU followed by cardiology, diabetes and frailty.
- Extended access to the ACU by opening beyond 8pm on a Monday to Friday and at the weekend to support any further admission avoidance.
- The hospital frailty model by extending it to the community through additional community geriatrician capacity.
- Multi-disciplinary working within the ACU / community health services to more effectively support discharge.

Further analysis is required to understand the service demand and activity shifts, resourcing requirements and costs. It is expected that:

- GP visits will be reduced where it is more appropriate for a nurse home visit. South Lewisham, the Jenner and Bellingham Green practices estimate that would have prevented 409 GP visits over the last financial year
- A reduction and shift in ACU follow up activity (currently there are around 225 follow up appointments a month). There is potential to reduce this through different staffing arrangements, telephone follow up or through more effective multi-disciplinary working.
- Mid to moderate frail elderly patients (currently about 70 a week in the Critical Dependency Unit or the ED) could be identified earlier and managed better preventing deterioration of their condition
- Referrals directly from community teams to GPs to co-ordinate care for more complex patients.

The Care at Home and ACU/ACS transformation will need to be aligned to prevent any potential duplication of resources and cohorts. For example, both proposals highlight the need for additional geriatrician capacity and multi-disciplinary support at home.

4.4.2 *The District Nurse and Social Care Single Point of Access (SPA)*

This will be developed concurrently with the Care at Home service to manage demand more effectively. Building on the work to date, planning is underway for a super hub with one phone number, open 7 days a week (8am to 8pm), taking calls from public and professionals. The hub will respond to queries relating to physical health, social care, mental health and safeguarding and ensure that the right support is provided as quickly as possible. The SPA will reduce hand offs and provide a rapid response using joined up technology and access to clinical and professional support at all levels.

Discussions have already taken place with commissioners and social care about synergies between the DN and social care SPA and the vision for the ACU/ACS hub.

4.4.3 *D2A mapping*

The D2A process is currently being reviewed. Mapping took place in August to understand how the current D2A process could be improved and where there is scope to discharge more patients under this model.

4.4.4 *Mental health*

Activity to develop a Mental Health Provider Alliance is on-going. A review of mental health pathways (including crisis pathways, common and serious mental health illness pathways) is being undertaken to identify opportunities to streamline and improve care. There may be opportunities to align activity to the development of Care at Home.

4.5 Key Deliverables:

Workforce:

- More co-ordinated care and support through, for example, key working and expanded trusted assessor roles within a multi-disciplinary team.
- New 'bridging' or 'hybrid' roles to reduce duplication, improve quality and staff retention.
- Joint training and development to raise quality, deliver holistic care and improve patient and service user experience.
- Utilising technology to improve communication between health and care professionals and between professionals and patients / service users.
- Co-located teams with staff having access to all relevant information.

Care delivery:

- An integrated approach to risk stratification
- An integrated approach to service redesign to develop pathways that operate effectively and collaboratively across the system.
- A shared approach to assessment and care planning for patients / service users with complex health and care needs.
- The development of key working across the integrated Care at Home teams to provide more co-ordinated care and support.
- An integrated and co-ordinated approach to transfers of care from hospital to the community.
- An integrated and co-ordinated approach to working with the Ambulatory Care Unit to prevent admission.

Strengthened Neighbourhood Care Networks:

- Better multi-disciplinary working between the Care at Home teams and community based health and care services.
- Stronger connections between the statutory health and care sector and the voluntary and community sector.

4.5 Summary of Key Challenges:

Phase 1 of the Care at Home partnership is large scale and complex. It presents a number of challenges including the following:

- Lack of capacity to lead the change.
- Flow of resources across the providers, for example, if the teams provided short term interventions for patients leaving the ACU, these would need to be resourced.
- Engagement is needed with patients, service users and key providers (primary care, home care, mental health and the voluntary sector) to better understand different needs and pressures across the system.
- Clinical governance issues need to be resolved to enable greater flexibility in roles working across organisational boundaries.
- Activity to develop Care at Home is provider led but will require agreement from commissioners.
- The STP is looking to develop closer working across boroughs with a particular focus on bringing together arrangements for hospital discharge and community based care. This may impact on the development of local plans.

The financial implications are considered more fully in section 9 and the challenges are addressed in more detail in the risk register.

5 Future Scope:

Care at Home will be expanded in subsequent phases to include the following services and functions:

- Specialist dementia care.
- Some community mental health services including Older Adults Mental Health.

Residential and nursing care and specialist services supporting people with Learning Disabilities are *not* currently being considered as in scope. However, Care at Home could potentially include a range of other services in the future such as:

- Some preventative services
- Some supported housing provision
- Some specialist nursing services
- Supported Discharge
- Specialist mental health social work teams
- Emergency Department social care team
- End of life care.

The partnership arrangements required for an expanded Care at Home service beyond Phase 1 will be considered to ensure robust governance and accountability. An options analysis will be developed concurrently with the initial phase.

6 Approach to Delivery

The Provider Alliance Development Board has agreed that activity to develop Care at Home will be provider led but supported by commissioners.

6.1 Management and Staffing Arrangements

It is proposed that:

- The Head of Adult Social Care and the General Manager and Head of Adult Community Services provide joint leadership of the Care at Home teams.
- An integrated management structure is developed whereby operational leadership of the teams is undertaken by either a social care professional or a community nurse lead. Professional and clinical support would continue to be provided by respective professional leads through a matrix management arrangement.

The terms and conditions for staff will not be affected.

6.2 Key activity:

The draft Outline Delivery Plan 2018-19 (Appendix 4) sets out high level approach to the delivery of phase 1. It is proposed that activity is managed within the following three key workstreams:

1. Workforce
2. Performance and Finance
3. Pathways and Relationships (including Trusted Assessor roles and multi-disciplinary working

The key activity is summarised below:

- *Agree resources:* detailed activity and financial modelling to identify and secure the resources required to implement the delivery and operational plans.
- *Establish the operational delivery model:* engage staff, patients and service users in the development of the neighbourhood Care at Home teams. Work with partners including existing Patient Reference Groups to co-produce service redesign activity. Providers to lead on service review activity to deliver strategic objectives for target populations including frailty, diabetes and dementia.
- *Align commissioning processes and establish contract values*: the contractual implications of the proposed model to be resolved (specifically separating the community services element of the overall LGT contract); commissioning processes for key contracts including district nursing and home care to be aligned; the scale of efficiencies and the timetable for delivering them to be agreed.
- *Agree risk and gain share*: proposals relating to risk and gain share to be developed; sovereign boards to agree delegation.

- *Develop an integrated approach to workforce:* develop a joint approach to key workforce development activity. This will involve the development of new, hybrid roles and functions as well as an integrated approach to OD.
- *Develop an integrated approach to ICT:* work with the Strategic ICT group and the Population Health Group to ensure ICT development is fit for purpose and delivers key tools including a single care plan. Information sharing agreements to be agreed.
- *Establish the legal framework*: revise existing and establish partnership agreements including Section 75 agreements; agree approach to aligning resource, delegating functions, accountability for operational delivery and responsibility for aligned budgets.
- *Agree the approach to developing future phases:* map options for an arms-length service and agree approach to implementation.

Activity will be aligned with work being undertaken to develop integrated provider arrangements for adult mental health services.

6.3 Principles / Ways of Working:

Developing new integrated arrangements for care at home will be informed by Lewisham's Partnership Commissioning Intentions for Adults 2017-19, which set out the expectation of providers to deliver advice, support and care that is:

- Population based – which is a way of looking at patients/service users not just as individuals but as a part of a wider population.
- Expanding and strengthening primary and community care - shifting the majority of outpatient care out of hospital. This will result in most of care being provided at home or near to people's homes.
- Promoting health and wellbeing - helping people to get the right advice, support and care in the right place, first time with a shift towards proactive and preventative services and supporting community development.
- Providing an integrated response to the needs of the individual– a holistic response -physical, mental and social needs - giving people control of their own care and empowering them to be independent, make informed choices and take control to meet their individual needs.
- Evidence based and outcome focused - meeting the needs of whole population, addressing inequality and equalities issues.
- Co-produced with patients, service users, carers and wider communities - in partnership with the people and communities.
- A whole system approach - a health and care system that is safe, sustainable and provides high quality care consistently.

7 Expected Outcomes and Measuring Success

Bringing services that support people at home closer together is expected to achieve a step change in the delivery of care at home. London Borough of Lewisham's developing strategic policies and plans are committed to providing dignified and compassionate care services. Lewisham's Partnership Commissioning Intentions for Adults 2017-19[3] set out the high level health and care outcomes required to transform health and care in the borough. Care at Home will contribute to Lewisham's overall key outcome measures for Community Based Care, specifically the following:

[3] *See: Lewisham's Partnership Commissioning Intentions for Adults 2017-19*

Better health and care outcomes through:

- An increase in health related quality of life for those with long term conditions (physical and mental health).

Better service user and patient experience of health and care through:

- Consistent, high quality care, localised where possible and in the most appropriate setting – 'Right care, right time, right quality'
- Holistic care where their mental health needs are treated with equal importance to their physical needs and which integrates physical and mental health and care services
- Personalised care developed in partnership with professionals, empowering people to have choice and control over their care.

Best sustainability across health and care in Lewisham through:

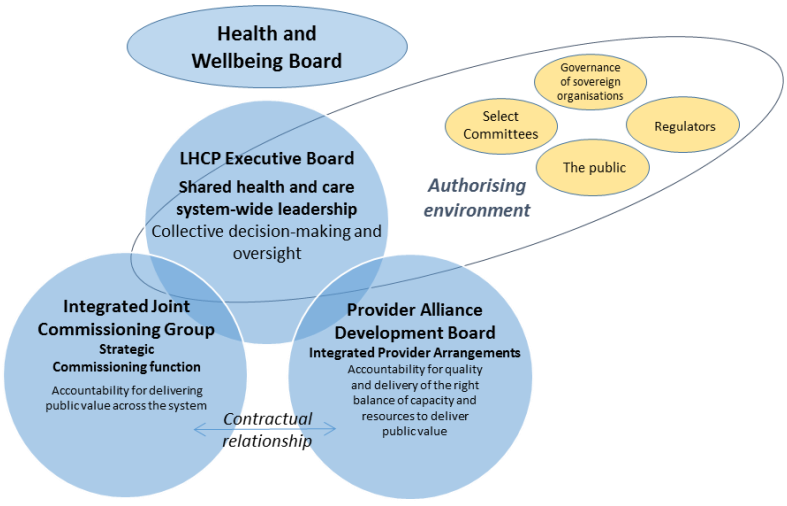
- An increase in the proportion of people feeling supported to manage their long term conditions
- A reduction in avoidable emergency admissions
- An increase in the proportion of older people (65 & over) who are still at home 91 days after discharge
- A reduction in delayed transfers from hospital
- A reduction in the number of people admitted to residential care or nursing homes
- A reduction in the number of people requiring on-going care and support.

All services that will come together within Care at Home have individual performance indicators. Services are subject to statutory requirements, CQC regulations (e.g. Enablement Care and District Nursing) and clinical regulations (e.g. District Nursing) – see Appendix 1. An integrated performance framework will be established to bring together the existing KPIs and ensure that performance against the key outcomes is being measured.

8 Governance

The overarching governance arrangements are summarised below in Figure 5:

Figure 5: Overarching Governance Arrangements



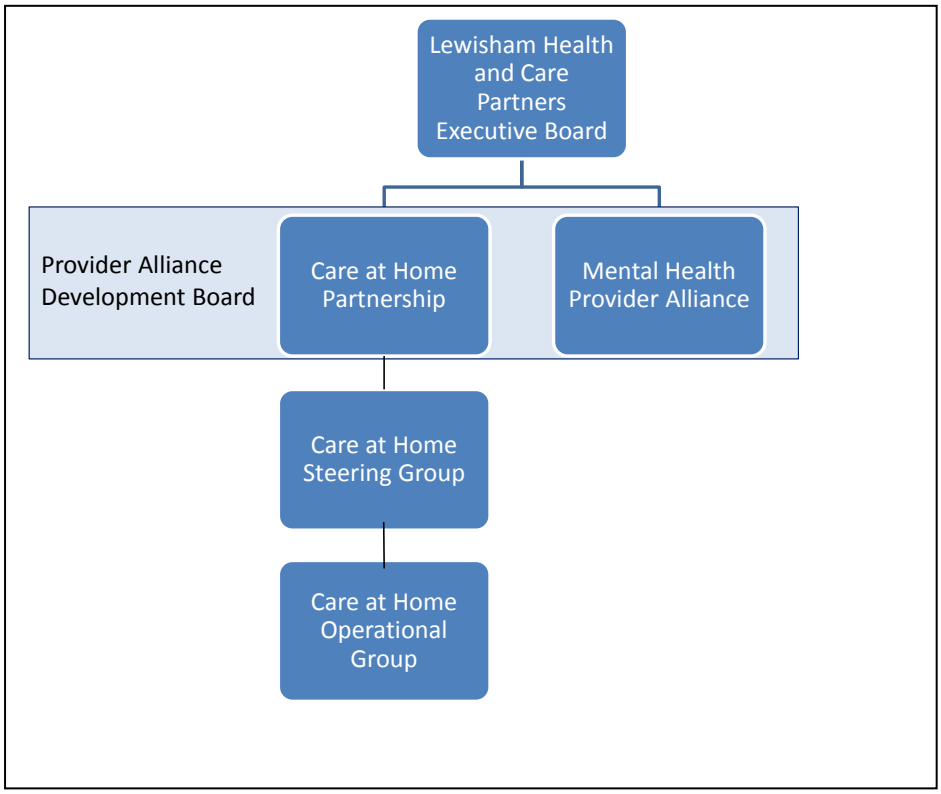
The Provider Alliance Development Board (PADB) was established in June 2018 to oversee the two distinct but related areas of provider development – Care at Home and Adults Mental Health. Given the need to involve different providers at a strategic level, it is proposed that the PADB will be developed to comprise of a Care at Home Partnership and an Adults Mental Health Alliance and envisaged that meetings will form part 1 and part 2 of the PADB as illustrated in Figure 6.

The Care at Home Partnership will provide strategic direction and ensure that the workforce, financial, clinical, legal and governance requirements of the integrated provider arrangements are appropriately managed. The Care at Home Partnership will monitor progress made by both the Care at Home Steering Group (formerly the Delivery Group) and the Care at Home Operational Group.

A Care at Home Delivery Group was set up in July 2018. Given the scope of Phase 1, it is proposed that this Delivery Group becomes a Steering Group focussed on ensuring that Care at Home is aligned to other improvement activity within mental health, primary care, adult community health services and adult social care. The Steering Group will undertake initial planning for future phases of Care at Home and provide oversight of an operational group, comprising the service managers involved in delivering Care at Home that will manage the operational delivery of Care at Home.

Work to improve neighbourhood care (e.g. the development of Local Care Networks, training to support multi-disciplinary meetings) will continue alongside the activity to deliver Care at Home.

Figure 6. Proposed Governance and Partnership Arrangements for Care at Home



9 Financial implications

9.1 Overview of budgets involved

Services:		***Budget:***
Directly managed LBL services	Adult social care: Integrated Neighbourhoods	£3,036,656
	Adult social care: Enablement Care	£1,756,255
	Adult social care: Home Based Rehab	£794,930
LBL Commissioned Services:	Home Care	£14,000,000
LCCG Commissioned Services:	District Nursing	£7,570,394
	Lewisham Adult Therapies Team	£1,335,270
	Supported Discharge (therapies element)	£940,000 (estimated)
	Total:	£29,433,505

The budgets will be finalised as part of the development of the Section 75 agreement.

9.2 Phase 1 Resource Implications

This Outline Business Case describes the work being undertaken to bring together a number of neighbourhood services that currently support residents to live as independently as possible in their own homes within the community. If approved, detailed proposals will be developed regarding reshaping existing arrangements for joint working which include a Section 75 agreement and any necessary associated documents. The first phase of development will seek to ring-fence and align rather than pool budgets.

Providers continue to explore how they can make best use of existing resources to support the new partnership arrangements:

- LGT is considering the potential for additional geriatrician capacity within the Ambulatory Care Unit (ACU) as part of their programme to transform community health services. This will in turn support the provider alliance through stronger links between the ACU and Care at Home.
- The commissioning team are exploring how existing posts could be refocused to provide the additional support (e.g. monitoring) required to improve the quality of home care contracts.
- Adult Social Care and District Nursing are exploring opportunities to provide backfill to release capacity from operational leads through vacant posts.

- Partners are exploring what clinical support they could provide from existing resources. The CCG Clinical Directors have offered to provide on-going clinical advice / input. While they have limited capacity, this input may be sufficient to implement phase 1. In addition, the LMC representative on the Provider Alliance Development Board has identified a GP to provide clinical input from a primary care perspective.
- Some project management support can be provided from the Whole System Model of Care Team (funded through the Better Care Fund). The team will also be able to draw on expertise from the Population Health System programme which will provide mechanisms for data sharing and a joint assessment.

The following table provides an indication of the additional resources that may be required to implement Phase 1.

Area:	***Estimated Cost:***
Financial modelling	10
Project management / support	80
Additional clinical support	10
Communications and engagement	5
Legal expertise	15
ESTIMATED Total:	120k

It is anticipated that the additional resources will be sourced from a combination of provider contributions and the Better Care Fund.

Additional resources may also be required to support the further development of flexible roles within home care. There are opportunities to develop enhanced roles within home care which may release efficiencies elsewhere in the system, but there may be cost implications to that.

As well as additional resources, achieving the core functions set out in section 4.3, will require a change in the flow of resources from the acute to Care at Home. As outlined in 4.3.3, if additional short term interventions were delivered by the Care at Home teams, it would be necessary to realign resources that are currently used to support individuals in acute settings. The potential additional pressures on primary care also need to be recognised. The pilots undertaken in 2017 and 18 (see 3.2) all reduced ED attendances and admissions but involved additional GP input. Further modelling is required to provide details of the resource implications.

10 Return on Investment

Providers are not expected to reduce expenditure in the short-term, however once implemented, Care at Home is expected to generate significant efficiencies for the providers as well as providing better outcomes for service users.

It's possible from preliminary modelling to indicate key areas where efficiencies could be achieved and estimate the level of those efficiencies. However, it should be noted that while this preliminary modelling is informed by the evaluation of the 'Flexible Roles' pilot (see 3.2), this was a relatively small scale pilot. Furthermore, some additional costs may be incurred to achieve the return on investment outlined, for example costs associated with additional care worker hours. It is therefore proposed to undertake detailed modelling to provide a comprehensive and robust analysis of the potential return on investment as well as any potential additional costs.

10.1 Assessment

Approximately 300 social care assessments are undertaken each month. In Lewisham it is standard practice for social care assessments to be undertaken by a qualified social worker, however this is not a legal requirement. Separate assessments are undertaken by Occupational Therapists, Enablement Care and Home Care. District Nurses also receive on average 950 new referrals each month. There are core questions in all these different assessments that are common to each one.

A 'trusted assessor' approach has been established in relation to the ordering of equipment, where district nurses are 'trusted' to undertake the assessment and order the equipment. Building on this, there are opportunities to create a single assessment for core questions that could be completed by any health and care professional. This would create a range of efficiencies, including:

- One professional would gather the core information in one visit rather than 2 + professionals in 2+ visits. Follow up 'specialist' assessments would be quicker to complete, some non-complex social care assessments could be for example completed over the phone.
- Time spent travelling to visit patients / service users would be reduced.
- Sharing this assessment with home care providers would prevent the need for a new assessment being undertaken by them.
- Some care planning could also be undertaken by a 'trusted assessor'.

Detailed modelling is required to better understand how many shared assessments could be undertaken and the potential savings this could achieve.

10.2 Diabetes

Blood Glucose Monitoring is the highest reason that district nurses support patients in Lewisham (30% of the total). The second highest reason that district nurses support patients in Lewisham is to provide support with insulin administration (29% of the total).

Community health service provision often cannot meet demand and in some areas in the UK the supervision or administration of insulin is undertaken by non-registered practitioners. The Care Quality Commission requires effective systems to be in place to protect people from the risks associated with unsafe use and management of medicines. In addition, the Royal College of Nursing (RCN, 2011) offers clear guidance on accountability and delegation to non-registered practitioners. There are, however, several examples of effective collaborative programmes that support the

quality and safety agenda relating to insulin administration by non-registered practitioners. Diabetes UK has also published a guide to managing insulin administration in the community.[4]

One particular programme in a community nursing team in Shropshire is cited in the Journal of Diabetes Nursing (issue 17/6/15). This demonstrated that through a robust training programme and collaboration with older individuals with diabetes, their families, and registered and non-registered practitioners alike, insulin administration can be undertaken safely within regulatory parameters. Given the logistics of matching certain insulin regimens with food consumption, involving the home care workforce in supporting diabetes management is a holistic and logical approach.

LGT already has a policy in place allowing unregistered Health Care Assistants and Primary Care Assistant Practitioners employed by the Trust to administer insulin. As accountability and supervision remains with the Registered Nurse, delegating this responsibility to carers employed by another organisation would require a strong clinical governance framework.

Although more detailed modelling is required to provide an accurate estimate of the potential saving, if the number of district nursing calls for blood glucose monitoring and insulin administration were both reduced by 50%, this would result in 30% fewer calls.

10.3 Wound Care

Wound care is the third highest reason that district nurses support patients in Lewisham (7% of the total). Leg ulcer care represents 3.5% of the total and pressure ulcer care and monitoring represents 3.7% of the total. The combined figure for wound care, leg ulcer care and pressure care represents 14.2% of the total district nursing visits.

In the 'Flexible Roles' pilot, the district nurses felt that a third of wound / leg ulcer / pressure care cases improved more quickly as a result of the better continuity and co-ordination of care. The improved knowledge of the care workers also had the potential to prevent more pressure sores from developing and or/ accelerating. The potential impact is significant. If for example, 800 patients with pressure sores / wound care needs required 10 fewer visits from a district nurse, the saving is estimated to be **£344,000**. If a further 200 pressure sores are prevented from needing a district nurse input a year, assuming the district nurse input would of 15 visits, this could save an estimated **£64,500**. A more pro-active and co-ordinated approach would also reduce and hopefully prevent staff having to investigate incidents regarding the quality of care in relation to pressure sores.

Detailed modelling would consider the potential financial impact and potential additional costs (e.g. in relation to care workers) in more detail.

10.4 Providing 'Double Handed' Care

[4] https://www.diabetes.org.uk/about_us/news/insulin-delegation-guide

On average, 185 people that require 'double handed' support from home care in Lewisham per year. Without data to ascertain the district nursing input for these patients / service users, it's difficult to estimate the potential efficiencies. However, using the data from the Neighbourhood 2 'Flexible Roles' pilot as a proxy, the district nurses visited these patients an average of 2.2 times per week. If care workers and district nurses were able to co-ordinate joint visits, it would be possible to 'stand down' one care worker, saving an estimated **£58,645** per year (based on figures cited in Curtis L., Burns A., *Unit Costs of Health and Social Care 2017*).

In theory, there is also potential for a co-ordinated visit between a care worker and a district nurse to save on district nursing time too. It has not been possible to obtain the data on the number of visits where two district nurses attend. However, there are on average approximately 430 DN contacts per day. If 10% of these visits require two (Band 5 or Band 4) district nurses and one care worker could be utilised to support one district nurse, a total of 15,695 district nurse visits a year could potentially be saved. The average actual cost per hour of a Band 5 and a Band 4 district nurse is £32.5[5]. Assuming visits lasting 30 minutes, the potential savings would be **£255,043** per year. Even with a more conservative estimate of 5% of total visits, the saving would be **£127,521** per year.

10.5 Reduced hand offs

The team in the 'Flexible Roles' pilot reflected that easier communication between the district nurses and the care workers prevented delays with care. Care workers could contact the nurses directly on their phones as opposed to contacting their office where someone would contact the District Nurse Call Centre who would contact the relevant team who would contact / allocate a nurse (i.e. one call rather than four).

The estimated cost of four hand offs based on 4 x 5 minute calls (using data from Curtis L., Burns A., *Unit Costs of Health and Social Care 2017)* = £7.95. If the District Nurse Call Centre received 100 calls a week from home care agencies, based on the estimated cost of the current approach, it's possible to estimate the potential savings to the system as **£41,340**.

10.6 Reduced Emergency Department Attendances and Hospital Admissions

The 'Flexible Roles' pilot indicated the potential for more co-ordinated care to reduce ED attendance and admissions. Although the evaluation indicated a 21% reduction, excluding one patient who was an outlier, the reduction was 60%. Without data on the potential number of people that could be cared for by an integrated nursing and care team, it is difficult to estimate the saving in terms of ED attendances.

The average cost of an ED attendance in Lewisham is £177.02. In Lewisham, on average 25.51% of ED attendances result in an admission with an average stay of 5 days. The income received from an average stay is £2,281.

It is possible to estimate the costs saved (using the pilot data as a proxy) as follows*:

[5] Curtis L., Burns A., *Unit Costs of Health and Social Care 2017*

	20% reduction in ED attendances	40% reduction in ED attendances	60% reduction in ED attendances
Savings on the cost of ED attendance	£21,242	£42,484	£63,727
Savings on the income received from average admission	£69,821	£139,642	£209,477
TOTAL	£91,063	£182,126	£273,204

*This is based on the 400 people attending ED 1.5 times per year. While this may be a conservative estimate of the number of people that will be supported by Care at Home and the average ED attendance, the pilot data is relatively small scale. Detailed modelling is required to provide a more robust projection in relation the impact on secondary care.

10.8 Summary

This summary uses the pilot data as a proxy for areas where savings are expected. Detailed modelling will provide estimates in relation to assessment and diabetes care and will further test the initial modelling. In addition to the areas highlighted, there are expected to be a number of other areas where efficiencies could be achieved.

Area	Potential saving per year
Assessment and care planning	Requires more detailed modelling
Diabetes care	Requires more detailed modelling
Reducing duplication re: double handed care • Care worker hours • District nursing hours (based on 10% of the total visits)	 **£58,645** **£255,043**
Wound Care: If 800 patients with pressure sores / wound care needs required 5 fewer visits from a district nurse.	**£172,000**
Reducing hand offs: based on the estimated cost of 4 x 5 minute calls and on 100 calls a week from home care agencies to the DN call centre each week.	**£41,340**
Reduction in ED attendances: based on a 40% reduction on 300 people attending ED 1.5 times per year.	**£42,484**
Reduction in admissions: based on a 40% reduction in ED attendances (from 400 people attending ED 1.5 times per year).	**£139,642**
TOTAL	**£709,154**

11 Equalities Implications

Initial consideration of the likely impact of the proposal on the borough's diverse communities has concluded that it will not discriminate against any service users or adversely impact on any characteristics protected under the Equality Act 2010. The aim of the proposal is to positively impact

on patients and service users by improving access to higher quality care and support through better co-ordination and closer working with GPs. More 'joined-up' care will help reduce inequalities for individuals, families, carers and local communities.

An Equality Analysis Assessment (EAA) on the operational delivery model will provide a detailed analysis of the proposed changes to service delivery on each of the 9 protected characteristics: age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. This will include positive and adverse impacts and outline what measures will be put in place (or are planned) to minimise any adverse impact on a particular protected characteristic.

The proposals will disproportionately affect older people, people with disabilities and women as they are more likely to be in receipt of a social care and community health services than the rest of the population.

An updated Information Sharing Agreement is required to enable the partners to share data on use of their services. This data will inform the Equality Analysis Assessment.

Appendix 1: Overview of Statutory Responsibilities and Regulatory Frameworks

1. Statutory responsibilities:

(a) *Adult Social Care*:

The Care Act 2014 aims to put people at the centre of their care and support and maximise their involvement. It requires local authorities to adopt a person-centred approach, shifting away from providing services to meeting needs. The Act sets out the responsibility of local authorities in the promotion of individual wellbeing and on preventing or delaying the need for support. This involves signposting people to any existing community resources, facilities and assets to help prevent their needs from escalating further. Local authorities are required to:

- Establish and maintain an information and advice service, available to everyone, not just people who are entitled to care and support from the council. The service must include help with signposting including to financial advice. Information will be provided in accessible ways not just on a website, or leaflets in a GPs office, but tailored to the needs of local people.
- Facilitate a diverse, vibrant and sustainable market for care and support services that benefits the whole population.
- Promote integration with the NHS and work with other key partners to improve services locally.
- Arrange for an independent advocate to help people communicate their views, wishes and feelings when required.
- Carry out needs or carers assessments where it appears to an authority that a person has some care and support needs. The Act establishes a national minimum threshold at which people will be eligible for support.
- Produce care and support plans and offer a personal budget once an assessment has been made.
- Review Care and Support plans to ensure they continue to meet the needs of the person.
- Operate a deferred payments scheme whereby people can pay for their care costs without selling their home in their lifetime.
- Establish a safeguarding adults board and act if they believe an adult is, or is at risk of, being abused or neglected. They must also set up a safeguarding adults board including key stakeholders. This board will carry out safeguarding adults reviews when people die as a result of neglect or abuse and there's a concern that the local authority, or its partners, could have done more.

(b) Functions of NHS Bodies

The NHS is responsible for the function of providing, or making arrangements for the provision of, services under sections 2 and 3(1) of the 1977 National Health Service Act, including rehabilitation services and services intended to avoid admission to hospital and under section 5(1), (1A), and (1B) of, and Schedule 1 to, the 1977 National Health Service Act.

2. Regulatory Compliance

District Nursing services, local authority Enablement services and home care services are monitored by the CQC.

Appendix 2: Draft Principles of Collaboration and Co-operation

PRINCIPLES OF COLLABORATION AND CO-OPERATION FOR THE PROVIDER ALLIANCE

The Partners shall at all times during the Term act reasonably and in good faith in their dealings with one another and shall operate in accordance the following agreed principles:

1. The need to deliver improved health and care outcomes for the population served by the Partners should not be prejudiced by the individual interests of any Partner.
2. Equality and equity of the Partners.
3. Complementary capabilities applied to common interests.
4. Mutual transparency of data in relation to the Provider Alliance/s and the delivery of the Services.
5. Fair and proportionate distribution of risk and reward.
6. The Provider Alliance/s will be granted autonomy and authority to make decisions and deliver the Services in accordance with an overarching Partnership Agreement/s.
7. The Provider Alliance will, through the proper discharge of all obligations under an overarching Partnership Agreement/s be empowered to pursue its agreed priorities, to reshape how services work, individually and collectively, without restrictive decision making or process.

In consideration of the mutual benefits and obligations under an overarching Partnership Agreement/s, the Partners will work together to achieve the following objectives:

- Improve the health and wellbeing of people in Lewisham.
- Proactively support people's health by starting well, living well, ageing well and at the end of life.
- Improve both mental and physical health.
- Provide services fairly, to reduce local variation in healthy lives.
- Strengthen the social determinants of health and promote healthy lifestyles.
- Enable healthy lifestyle choices and prevent ill health.
- Support improvements in wider determinants of health including housing and employment.
- Ensure services are safe, equitable and of a high standard with less variation.
- Co-ordinate health and care, ensuring safety, quality, value for money and high standards for all.
- Enable people and communities to be active partners in their health and wellbeing.
- Build on the strengths of communities, voluntary groups and social networks.

- Invest in individuals and carers, supporting them to manage their own health.
- Achieve a sustainable system.
- Transform the health and care system, moving our focus from hospital to the community.
- Balance our finances now and in future years.
- Develop our workforce so we have committed, healthy, skilled, people where and when they are needed.
- Develop our collective estate to improve access to and efficiency of health and care services.

Appendix 3: Scope of the Section 75 Agreement

The Section 75 agreement will be between (1) The London Borough of Lewisham (the "Council") and (2) Lewisham and Greenwich NHS Trust ("LGT"). Lewisham CCG commissions key services within the agreement but will be a partner of an overarching partnership agreement, rather than a party to the Section 75.

The objectives and scope of the integrated service are set out in the Business Case for 'Care at Home'. The partners share a vision for the provision of proactive and preventative, accessible and co-ordinated community based care and are committed to seeking the best use of resources to meet the needs of people that receive care at home. The partners agree that fulfilment of the aims and outcomes referred to in the Business Case will lead to improvements in quality and cost and time efficiencies in relation to the way their relevant functions are provided.

The key elements of the Section 75 agreement are as follows:

1. *Delegation of functions:*

- The partners agree to delegate responsibility for completing the 'core' assessment and care planning to each other through the development of 'trusted assessor' and 'key worker' roles.
- Operational management of the integrated teams will be delegated to enable a district nurse or a social care professional to manage the integrated teams.

2. *Leadership:* The partners will provide joint leadership at a strategic level. Relevant resources will be managed and monitored jointly.

3. *Governance:* The Care at Home Partnership Board will oversee the development of the integrated service. The Care at Home Partnership Board reports to the Lewisham Health and Care Partners Executive Board which is accountable to the Health and Wellbeing Board with decisions requiring executive action reported to each organisation's sovereign board.

4. *Access to support services:* The partners will continue to provide all appropriate support services e.g. HR, payroll, legal, IT for their employees.

5. *Performance management:* The partners will develop a shared set of performance indicators.

6. *Information sharing:* The partners agree to open book accounting and transparent sharing of data. Partners will develop a shared IT system that facilitates information sharing.

7. *Operational policies and processes:* The partners agree to develop shared operational policies and processes, utilising the full potential of available technology.

8. *Financial contributions, risk and gain share and shared assets:* Each partner will make the following contribution to Phase 1: £40,000. Partners will agree the risk and gain share and develop a shared asset register.

9. *Duration:* The agreed duration of the arrangements will be 3 years. The agreement will be reviewed annually. Partners will agree arrangements for variation or termination of the arrangements.

Appendix 4: Draft Outline Delivery Plan 2018/19

Area	Key activity	Q2			Q3			Q4		
		July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Resources	Agree outline resource plan									
	Identify financial modelling support									
	Identify clinical support									
	Identify legal expertise									
Scope	Agree initial scope									
	Agree future scope of arrangements to be in place in 2019/20									
Workforce	Joint Provider Workforce Plan developed and agreed									
	Produce joint workforce implementation plan									
	Define and agree approaches to improving competencies and capabilities, recruitment and accelerating talent									
	Identify estate requirements for workforce development.									
	Engage and involve all staff in the development of new operational models									
Operational Delivery Model	Analyse data to assess workforce needs of operational models									
	Identify priority functions for operational delivery model									
	Agree plan for priority operational redesign									
	Identify staff requirements to implement 2018/19 operational model including leadership and management roles									

	Identify staff requirements to implement 2019/20 operational model including leadership and management roles										
	Staff consultation										
	Agree shared approach to risk stratification and population segmentation										
	Agree plan for priority pathway redesign										
	Implement priority pathway redesign										
	Test shared assessment / trusted assessor roles										
ICT	Define provider requirements for data, information and registries from population health system										
	Develop and test shared assessment and care plan										
	Agree joint requirements for local infrastruture and hardware developments										
	Identify ICT strategic and operational requirements to inform estate developments										
Comms and engagement	Develop a Public Engagement Plan to involve the public and service users in the development of new models, pathways and functions										
	Identify key stakeholders and agree stakeholder engagement plan										
	Agree key messages and undertake comms activity with Lewisham patients and residents.										
Commissioning processes / contract values	Detailed financial and activity modelling										
	Scale of efficiencies agreed										
	Contractual implications of arrangements identified										

	Approach to contractual arrangements agreed										
	Approach to procurement of key contracts agreed										
	New home care specification in place.										
Legal Framework	Revise existing / establish new Section 75 and necessary associated documents.										
	Agree process for aligning resources between providers										
	Agree accountability for operational delivery, integrated budgets etc.										
	Sovereign boards to agree proposals for Section 75 for 2019/20										
	Map options for more formal partnership arrangements										
Governance	Agree supporting operational development groups										
	Sharing agreements to ensure appropriate information governance to be established										
	Identify interdependencies with SEL STP groups and workstreams										
	Governance proposals agreed by respective provider organisations										

Appendix 5: Care at Home - Risk Register

Theme	Risk Description	Risk Score			Planned activity to mitigate impact
		Impact	Likeli-hood	Score	
Resources / Procurement	*Limited financial and activity modelling:*	4	3	12	• Key financial / service level data to be collated and analysed. • Develop a sharing agreement to enable data to be shared.
	Home care: • New specification won't raise quality and deliver a more outcomes focussed approach • Lack of sufficient financial incentive • The workforce development between home care and 'Care at Home' may require additional resources	4	3	12	Extension to current contracts will be requested in December 2018.
	Procurement for district nursing: • Complexity of disaggregating the Community Services contract.	1	2	2	On-going work with the CCG commissioners
	Securing provider contributions to the outline resource plan.	4	1	4	Discussion with providers at the Provider Alliance Development Board
	Securing clinical support.	3	2	6	Work out what clinical support required initially and develop a cross programme approach to resourcing.
	Lack of clarity regarding future scope and approach to phased implementation beyond phase 1 and phase 2..	2	2	4	Provider consider options analysis informed by research on other alliance approaches.
Benefits	*Lack of clarity regarding benefits for specific patient cohorts.*	2	1	2	• Build on initial activity with additional work to identify benefits for patients / service users. • Develop communications using the pen portraits. • Plan wider engagement activity for operational staff, patients and service users.
Workforce	*Lack of in depth and shared understanding of skills required and within system currently.*	3	3	9	Secure agreement from providers on draft skills matrix and circulate.
	Workforce engagement doesn't meet objectives.	4	2	8	Detailed planning involving workforce and OD leads.

	No group focussed on workforce / lack of capacity to deliver.	3	2	6	Develop a workforce task and finish group to include primary care providers.
	No integrated workforce plan.	3	4	12	Task and Finish Group to develop a workforce plan that prioritises: • Developing an asset based approach • Developing new / different roles / functions • Developing trusted assessor roles • Developing shared culture and behaviours • Skills development and on-going support for new roles. • Exploring opportunities re: the PA market. • Exploring opportunities re: support planning • Developing key worker principle • Exploring how different roles could work together
Information Technology / Information Sharing	*IT unable to support a shared assessment and care plan.*	4	2	8	Agree timetable with the Pop Health team.
Communications / Engagement	*No communications capacity to deliver activity required:* Need to communicate with staff across the partnership, the public, home care providers	4	2	8	• Produce position statement for home care providers. • Produce initial comms for staff.
	Need to engage service users / patients and families in developing an asset based approach:	3	3	9	Plan approach with engagement leads.
Governance	*Lack of clarity on the organisational model to be developed.*	2	2	4	Agree timetable for options analysis; implementation etc.
	Timeframe for legal advice on organisational model	2	2	4	Identify how providers will approach legal advice at an early stage.
Implementation	*The implementation of Phase 1 may present unforeseen challenges.*	3	4	12	Care at Home Operational Group will support leads to overcome challenges
	Delays with implementation.	3	3	9	Care at Home Steering Group and Operational Group highly engaged.
	Potential disruption to service users during implementation.	5	2	10	Detailed planning will be undertaken once any potential disruption has been identified.
Managing Interfaces	*Lack of clarity re: interface with Mental Health Provider Alliance activity.*	3	3	9	• Interface workshop agreed by Provider Alliance Board • Continue to consider interface with Kenny Gregory and SLaM leads. • Invite OAMH Commissioner to join the Care at Home Steering Group.
	Demand not managed effectively by the SPA.	3	2	8	Get agreement on the timetable / scope for the redesigned SPA.

	Difficult to align the timetable for Care at Home with the redevelopment of the ACU.	2	4	8	Include the ACU leads on the Care at Home Steering Group.
	STP / SEL				TBC

This page is intentionally left blank

Healthier Communities Select Committee			
Title	Select Committee work programme		
Contributor	Scrutiny Manager	Item	9
Class	Part 1 (open)	3 December 2018	

1. Purpose

To advise Members of the proposed work programme for the 2018/19 municipal year 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 considered the proposed work programmes of each of the select committees on 24 July 2018 and agreed 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 2018/19 was agreed at the Committee's meeting on 27 June 2018.

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.

4.3 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).

4.4 Items within each Select Committee work programme are linked to the Council's corporate priorities. Work is currently underway to develop a new corporate strategy, which will give corporate expression to the priorities of the new administration. Once developed, scrutiny work programmes can be adjusted to reflect the new corporate strategy and corporate priorities, if required. It is expected that the new strategy will be approved at full Council in November 2018.

5. The next meeting

5.1 The following reports are scheduled for the meeting on 16 January 2019:

Agenda item	Review type	Link to Corporate Priority	Priority
Delivery of the Lewisham Health & Wellbeing priorities	Standard item	Active, healthy citizens	High
Final LSL (Lewisham, Southwark, Lambeth) sexual health strategy	Standard item	Active, healthy citizens	High
SLaM NHS Foundation Trust CQC report	Standard item	Active, healthy citizens	Medium
Public health annual report	Standard item	Active, healthy citizens	Medium
Leisure centre contract	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

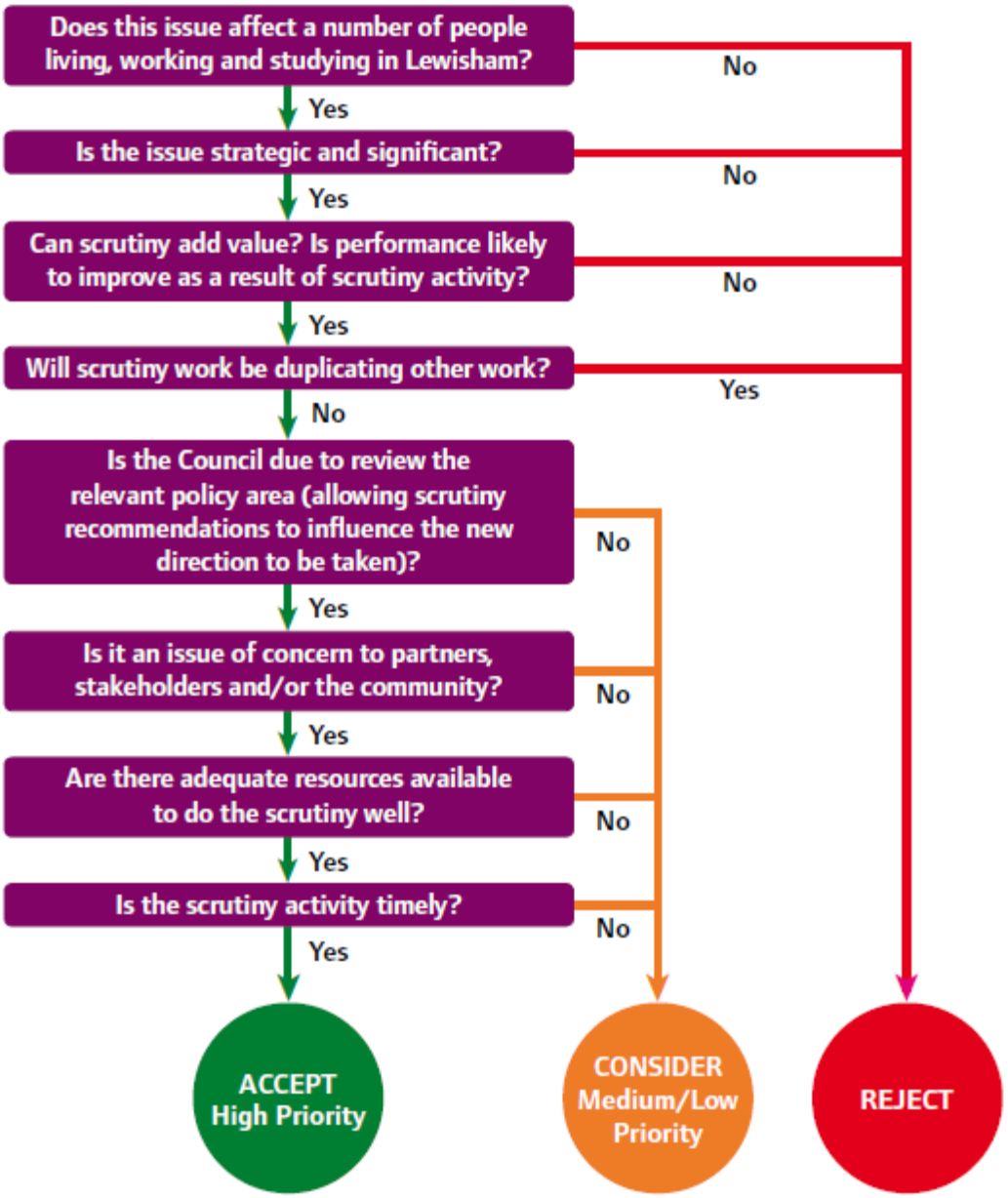
The date of the next meeting is Wednesday 16 January 2019.

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 2018/19

Programme of work

Work item	Type of item	Priority	Strategic priority	Delivery deadline	27-Jun	04-Sep	09-Oct	03-Dec	16-Jan	11-Feb
Lewisham future programme	Standard item	High	CP9	Ongoing			**Budget cuts**			
Confirmation of Chair and Vice Chair	Constitutional req	High	CP9	June						
Select Committee work programme 2017/18	Constitutional req	High	CP9	June						
Sexual and reproductive health services	Standard item	Medium	CP9	June						
Public health grant cuts consultation	Standard item	High	CP9	September						
Draft LSL sexual health strategy	Standard item	High	CP9	September						
Healthwatch annual report	Standard item	Medium	CP9	September						
Overview of adult social care services	Information item	Medium	CP9	September						
TB prevention	Information item	Medium	CP9	September						
Improving access to and provision of primary care	Performance monitoring	High	CP9	October						
Adult safeguarding annual report	Standard item	High	CP9	October						
Pathology services	Information item	High	CP9	October						
Blue badge applications	Information item	Medium	CP9	October						
Public health grant cuts consultation	Standard item	High	CP9	December						
Lewisham hospital update (systems resilience)	Performance monitoring	High	CP9	December						
Pathology services	Standard item	High	CP9	December						
Care at Homes: arrangements for integrating health and care services	Standard item	High	CP9	December						
Partnership commissioning intentions	Information item	High	CP9	December						
Delivery of the Lewisham Health & Wellbeing priorities	Standard item	High	CP9	January						
Final LSL sexual health strategy	Standard item	High	CP9	January						
SLaM CQC report	Standard item	Medium	CP9	January						
Public health annual report	Standard item	Medium	CP9	January						
Leisure centre contract	Standard item	Medium	CP9	January						
Social prescribing in-depth review update	Policy development	Medium	CP9	February						
Adult learning Lewisham annual report	Standard item	Medium	CP9	February						

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

Meetings					
1)	Tuesday	27 June	4)	Thursday	3 December
2)	Thursday	4 September	6)	Tuesday	16 January
3)	Thursday	9 October	7)	Thursday	11 February

This page is intentionally left blank

FORWARD PLAN OF KEY DECISIONS

Forward Plan December 2018 - March 2019

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 toKevin 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**
October 2018	**Budget Cuts**	21/11/18 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Amanda De Ryk, Cabinet Member for Finance, Skills and Jobs (job share)		
August 2018	**Cross Borough Procurement - Capital Letters**	21/11/18 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Paul Bell, Cabinet Member for Housing		
May 2018	**Lewisham Park CAA and Article 4 Direction**	21/11/18 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and		
October 2018	**Mental Health Voluntary Sector Integrated Advocacy Service Contract**	21/11/18 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Deputy Mayor		
October 2018	**Mental Health Voluntary Sector Integrated Dementia Service Contract**	21/11/18 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Deputy Mayor		
October 2018	**Mental Health Voluntary Sector Integrated Prevention and Recovery Service Contract**	21/11/18 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best,		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
			Deputy Mayor		
October 2018	**Care at Home: arrangements for integrating health and care services**	21/11/18 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Deputy Mayor		
October 2018	**Neighbourhood CIL Strategy**	21/11/18 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Mayor Damien Egan, Mayor		
October 2018	**Main Grants Programme 2019 - 2023**	21/11/18 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Jonathan Slater, Cabinet Member for Community Sector		
October 2018	**Treasury Mid-Year Review 2018/19**	21/11/18 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Amanda De Ryk, Cabinet Member for Finance, Skills and Jobs (job share)		
October 2018	**Financial Forecasts**	21/11/18 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Amanda De Ryk, Cabinet Member for Finance, Skills and Jobs (job share)		

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**
October 2018	**Sydenham School Instrument of Government**	21/11/18 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Chris Barnham, Cabinet Member for School Performance		
May 2018	**Amendments to the Constitution**	28/11/18 Council	Kath Nicholson, Head of Law and		
November 2018	**Demolition Contract award for SEND School Expansion Projects**	04/12/18 Overview and Scrutiny Education Business Panel	Janet Senior, Executive Director for Resources & Regeneration and Councillor Chris Barnham, Cabinet Member for School Performance		
October 2018	**Achilles Street Redevelopment Proposals Part 1 & 2**	12/12/18 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Paul Bell, Cabinet Member for Housing		
August 2018	**Ladywell Playtower Project Update and Approval of Changes to Original Proposal**	12/12/18 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Mayor Damien Egan, Mayor		
October 2018	**Housing Assistance Policy**	12/12/18 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Paul Bell, Cabinet Member for		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
			Housing		
October 2018	**Semi Independence Accommodation and Support Framework for Children's Social Care**	12/12/18 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Chris Barnham, Cabinet Member for School Performance		
October 2018	**Inward Investment Projects**	12/12/18 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Mayor Damien Egan, Mayor		
August 2018	**Council Tax Reduction - Consultation 2019-20**	12/12/18 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Amanda De Ryk, Cabinet Member for Finance, Skills and Jobs (job share)		
October 2018	**Provision of Homecare Services (Lead Provider) Extension of Contract**	12/12/18 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Deputy Mayor		
October 2018	**Award of contracts Vulnerable Adults Assessment Service , Young Persons Specialist Service and Mental Health Specialist Service**	12/12/18 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Deputy Mayor		
October 2018	**School Minor Works**	12/12/18	Sara Williams, Executive		

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**
	Programme 2019/20	Mayor and Cabinet	Director, Children and Young People and Councillor Chris Barnham, Cabinet Member for School Performance		
October 2018	**Parking Contract Extension and Proposed Floating Car Club Permit**	12/12/18 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Brenda Dacres, Cabinet Member for Parks, Neighbourhoods and Transport (job share)		
October 2018	**Lewisham Brownfield Land Register 2018**	12/12/18 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Mayor Damien Egan, Mayor		
October 2018	**Public Health cuts consultation outcome and proposals**	12/12/18 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Deputy Mayor		
November 2018	**Corporate Strategy**	12/12/18 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member for Democracy, Refugees & Accountability		
November 2018	**Annual Complaints Report**	12/12/18	Kevin Sheehan,		

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**
		Mayor and Cabinet	Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member for Democracy, Refugees & Accountability		
November 2018	**ACM Cladding Remediation Fund Approval**	12/12/18 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Paul Bell, Cabinet Member for Housing		
November 2018	**Award of a Printing Services Contract for the ICT Shared Service Authorities**	12/12/18 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member for Democracy, Refugees & Accountability		
October 2018	**Planning Service Annual Monitoring Report (AMR) 2017-18**	16/01/19 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Mayor Damien Egan, Mayor		
November 2018	**Gambling Statement**	16/01/19 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Joani Reid, Cabinet Member for Safer Communities		
November 2018	**Adoption of Charter against Modern Slavery and Approval**	16/01/19 Mayor and Cabinet	Aileen Buckton, Executive Director for		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
	of 1st Annual Modern Slavery and Human Trafficking Statement		Community Services and Councillor Joani Reid, Cabinet Member for Safer Communities		
November 2018	**Adoption of Perry Vale and Christmas Estate Conservation Area Article 4 Direction and Conservation Area Appraisal**	16/01/19 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Mayor Damien Egan, Mayor		
November 2018	**Contract Award Carers Specialist Information Advice and Support Service**	16/01/19 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Deputy Mayor		
May 2018	**2 PCSA Contract Awards for Stage 1 of two SEND school expansion projects**	16/01/19 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Chris Barnham, Cabinet Member for School Performance		
November 2018	**Corporate Strategy**	16/01/19 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member for Democracy, Refugees & Accountability		
August 2018	**Council Tax Reduction - Consultation 2019-20**	23/01/19 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Joe Dromey,		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
			Cabinet Member for Finance, Skills and Jobs (job share)		
October 2018	**Council Tax Base**	23/01/19 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Joe Dromey, Cabinet Member for Finance, Skills and Jobs (job share)		
November 2018	**Neighbourhood CIL Strategy**	23/01/19 Council	Janet Senior, Executive Director for Resources & Regeneration and Mayor Damien Egan, Mayor		
October 2018	**Greenvale expansion phase 1: demolition contract award report**	29/01/19 Executive Director for Resources and Regeneration	Janet Senior, Executive Director for Resources & Regeneration and Councillor Chris Barnham, Cabinet Member for School Performance		
October 2018	**Chelwood Nursery Expansion**	29/01/19 Executive Director for Resources and Regeneration	Janet Senior, Executive Director for Resources & Regeneration and Councillor Chris Barnham, Cabinet Member for School Performance		
October 2018	**Rockbourne Community Centre Refurbishment**	29/01/19 Executive Director for Resources and	Janet Senior, Executive Director for Resources & Regeneration and		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
		Regeneration	Councillor Brenda Dacres, Cabinet Member for Parks, Neighbourhoods and Transport (job share)		
November 2018	**Lewisham Transport Strategy and Local Implementation Plan 2019-2041**	06/02/19 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Brenda Dacres, Cabinet Member for Parks, Neighbourhoods and Transport (job share)		
November 2018	**Determined Admission Arrangements 2019-20**	06/02/19 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Chris Barnham, Cabinet Member for School Performance		
October 2018	**New Woodlands Remodelling Contract Award**	19/02/19 Executive Director for Resources and Regeneration	Janet Senior, Executive Director for Resources & Regeneration and Councillor Chris Barnham, Cabinet Member for School Performance		
May 2018	**Stillness School Kitchen and Dining Hall Contract**	26/02/19 Executive Director for Children and Young People	Sara Williams, Executive Director, Children and Young People and Councillor Chris Barnham, Cabinet Member for School		

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**
			Performance		
November 2018	**Annual Budget 2019-20**	27/02/19 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Joe Dromey, Cabinet Member for Finance, Skills and Jobs (job share)		
November 2018	**Adoption of Charter against Modern Slavery and Approval of 1st Annual Modern Slavery and Human Trafficking Statement**	27/02/19 Council	Aileen Buckton, Executive Director for Community Services and Councillor Joani Reid, Cabinet Member for Safer Communities		
August 2018	**Lewisham Strategic Heat Network Business Case**	13/03/19 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Mayor Damien Egan, Mayor		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**