

Public Document Pack

Health and Wellbeing Board Agenda

Tuesday, 19 November 2013

1.00 pm,

Owen Theatre (Centre), University Hospital Lewisham, Lewisham High Street,
London SE13

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Part 1

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

Health and Wellbeing Board Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Tuesday, 19 November 2013.

Barry Quirk, Chief Executive
Monday, 11 November 2013

Councillor Chris Best	Community Services, London Borough of Lewisham
Aileen Buckton	Directorate for Community Services, London Borough of Lewisham
Mayor Sir Steve Bullock (Chair)	London Borough of Lewisham
Elizabeth Butler	Lewisham Healthcare NHS Trust
Jane Clegg	NHS England South London Area
Val Fulcher	Lewisham Healthwatch
Tony Nickson	Voluntary Action Lewisham
Dr Simon Parton	Lewisham Local Medical Committee
Marc Rowland (Vice-Chair)	Lewisham Clinical Commissioning Group
Dr Danny Ruta	Public Health, London Borough of Lewisham
Brendan Sarsfield	Family Mosaic (Housing)
Frankie Sulke	Directorate for Children and Young People

MINUTES OF THE HEALTH AND WELLBEING BOARD

Thursday, 19 September 2013 at 1.30 pm

PRESENT: Sir Steve Bullock (Chair and Mayor of the London Borough of Lewisham), Councillor Chris Best (Cabinet Member for Community Services), Aileen Buckton (Executive Director for Community Services), Tim Higginson (representing Elizabeth Butler, Chair of Lewisham Healthcare NHS Trust), Tony Nickson (Director, Voluntary Action Lewisham), Jane Clegg (Director of Nursing, South London Area Patch, NHS SE England), Katrina McCormick (representing Danny Ruta, Director of Public Health), Ed Knowles (representing Frankie Sulke, Executive Director for Children & Young People), Val Fulcher (representing Elaine Sammarco, Chair of Healthwatch), and Marc Rowland (Chair of Lewisham CCG).

APOLOGIES for absence were received from Frankie Sulke (Executive Director for Children & Young People), Simon Parton (GP, Lewisham Local Medical Committee), Danny Ruta (Director, Public Health, LBL), and Elaine Sammarco (Chair of Lewisham Healthwatch).

IN ATTENDANCE: Cllr Muldoon, Mark Drinkwater (Health Inequalities and Social Care Officer, Voluntary Action Lewisham), Jane Miller (Public Health LBL), Martin O'Brien (LBL), Eileen White (Senior Medical Management & Pharmacy Advisor, LCCG), Carmel Langstaff (Manager, Strategy & Policy, Community Services, LBL), Susanna Masters (Corporate Director, Lewisham Clinical Commissioning Group), Heather Hughes (Joint Commissioning Manager, Adults with Learning Disabilities, LBL/LCCG), Salena Mulhere (Manager, Overview & Scrutiny), John Pye (Head of Trading Standards and Markets, LBL), Emma Wrafter (CUT Films), Laura Beach (Peer Education Project in Schools), and Kalyan DasGupta (Assistant Policy Officer and Clerk to the Board).

The Chair welcomed everyone. Jane Clegg (NHS SE England, London Region) was welcomed to her first meeting.

Best wishes for a speedy recovery were also expressed for Dr Danny Ruta (Director of Public Health, LBL), who could not attend due to illness.

1. Membership Issues

In view of the resignation of Dr Helen Tattersfield as Chair of the Lewisham Clinical Commissioning Group (and therefore also as the Vice-Chair of the Health & Wellbeing Board), and the transfer of her role on the LCCG to Dr Marc Rowland, the Chair proposed that the Item on Membership Issues

(previously scheduled as Agenda Item 10) be taken up as the first item of Board business.

The Board:

1. Unanimously nominated Dr Rowland as the new LCCG representative to the Health and Wellbeing Board and as the new Vice-Chair of the Board.
2. Agreed that Brendan Sarsfield (of Family Focus) should be formally invited to join the Board as a representative from the social housing sector.
3. Approved the process through which an additional voluntary and community sector representative will be identified.

The Chair formally welcomed Dr Rowland as the new LCCG representative and the Board's new Vice-Chair.

2. Minutes of the meeting held on 11 July 2013

The Board agreed the minutes of the meeting of 11 July 2013 as an accurate record.

3. Declarations of Interest

With respect to Item 9 of the agenda (Integrated Health), Tony Nickson informed the Board that he was part of the Community That Cares grant consortium.

With respect to the Board business in general and to a number of items on the agenda in particular, Marc Rowland informed the Board that he was Chair of the Lewisham Clinical Commissioning Group, a GP Partner at the Jenner Practice, Forest Hill, and also a Professional Advisor at the University of South Bank, London.

With respect to Item 3 of the agenda (Protocols), Cllr Muldoon informed the Board that he was an elected governor of South London and Maudsley (SLaM) Trust and represented the constituency of Lambeth, Southwark and Lewisham.

The Declarations of Interest were noted.

4. Lewisham Health and Social Care Scrutiny Protocol (Revised)

Cllr Muldoon, Chair of the Healthier Communities Select Committee, presented the report and invited the Board to consider the Health and Social Care Scrutiny Protocol. The protocol sets out how the Healthier Communities Select Committee will exercise its scrutiny responsibilities, and also forms an agreement between the Committee and the Health and Wellbeing Board,

healthcare commissioners and providers in Lewisham as to how they will relate to each other.

Cllr Muldoon drew particular attention to Sections 3.4 and 3.5 of the Draft Protocol, which state the following:

Neither the legislation nor the guidance defines what constitutes a substantial development or variation in service. NHS bodies and overview and scrutiny committees are advised to aim for a local understanding of the definition, taking into account:

- a) changes in accessibility
- b) the impact of the proposal on the wider community
- c) patients affected
- d) methods of service delivery
- e) evidence based best practice

The final decision as to what constitutes a substantial variation sits with the body exercising the Overview and Scrutiny functions, in this instance the Committee.

The Board was advised that the CCG, Healthwatch and others had already approved the protocol (Appendix A of the submitted report), though it might subsequently be subject to minor amendments by the Head of Law.

The Board:

1. Noted the role of the Healthier Communities Select Committee and
2. Agreed to be a signatory of the Lewisham Health and Social Care Scrutiny Protocol.

5. Lewisham Hospital – Outcome of the Judicial Review and subsequent Government appeal

Aileen Buckton, Executive Director for Community Services, presented the report. She updated the Board on the outcome of the judicial review heard in the High Court on 2-4 July 2013 and of the subsequent appeal lodged by the Government.

Additionally, Aileen updated members on the proposed merger of Lewisham Healthcare with Queen Elizabeth Hospital and on the provision of services at Lewisham Hospital.

The Board was informed that the judge had upheld the *ultra vires* part of the submission by the London Borough of Lewisham, as well as the “4 tests”. However, the Secretary of State had lodged an appeal to contest the ruling that the Trust Special Administrator (TSA) had acted outside of his powers.

The appeal hearing had now been scheduled for 28 October.

A second appeal is also being brought by the Save Lewisham Hospital Campaign.

The following points were highlighted in the discussion:

- Lewisham Healthcare Trust has been striving to maintain continuity for patients. Staff appreciated the actions taken by the Council. It was hoped that, should the merger be agreed, the transition would be smooth and that the patients would not experience any disruption or difference to the services they receive.
- In response to a query about recruitment, it was acknowledged that it had sometimes been difficult to convince staff that the Trust still had a viable future, but the Board were assured that most positions had now been filled. Additional staff would be recruited in the winter, increasing the hospital's capacity to cope with the anticipated seasonal pressures.

The Board:

1. Noted the outcome of the Judicial Review, which found that neither the recommendations of the TSA nor the decision of the Secretary of State to reduce the facilities at Lewisham Hospital fell within their powers;
2. Noted the appeal by the Secretary of State for Health which was lodged on 21 August against the decision;
3. Noted that the planned merger of Lewisham Healthcare with Queen Elizabeth Hospital is unaffected by the outcome of the judicial review or the appeal and is subject to approval from the Secretary of State; and
4. Note that there has been no change to current services at Lewisham Hospital and all services are running as normal.

6. Preventing the uptake of smoking among children and young people and reducing the number of people smoking

Jane Miller, Deputy Joint Director, (Public Health, LBL)) introduced the report and together with John Pye, Head of Trading Standards & Markets, LBL, Emma Wrafter (Cut Films), and Laura Beach (Peer Education Project in Schools) tabled two presentations: "Preventing the uptake of smoking and reducing the number of people smoking" and "Preventing the uptake of smoking in young people".

The report and presentations highlighted the high prevalence of smoking in Lewisham, especially among people on lower incomes and the importance of targeting young people, as most smokers start smoking before they are 18.

The work underway to tackle illicit tobacco was described in addition to two projects using film and peer education with young people.

In addition, Jacob Sakil, ex-Young Mayor of Lewisham, who is currently supporting Cut Films and the Peer Education Project, spoke about his experience of working on this issue with young people. He highlighted the point that many young people, which the projects reach, are generally disengaged from mainstream, and their involvement has led to increases in self-esteem and aspirations. It is therefore important to involve young people in such endeavours beyond just a few schools, exploring broader horizons. The correct kind of support and resources are crucial to success in this project.

In the discussion, members highlighted the following points:

- There may be some merit in tailoring some of the types of warnings already used in relation to the dangers of tobacco, to other areas of concern, such as knives. Retailers are not always prosecuted, where they have sold tobacco irresponsibly, but receive training to improve practice.
- Young people often overestimate the number of smokers and were recognised as an important group to target.
- Stronger links among GPs' surgeries, clinics, neighbourhoods, and schools are crucial to preventing the uptake of smoking among children and young people and reducing the number of people smoking.

The Chair observed that smoking was becoming increasingly socially unacceptable and expressed his appreciation of the work undertaken to prevent young people from smoking.

The Board:

1. Considered the report on progress regarding this priority outcome;
2. Agreed to support officers to be trained to deliver brief interventions;
3. Agreed that all partners would be represented on the Smoke Free Future Delivery Group, and
4. Agreed to champion ongoing initiatives to tackle illicit tobacco, including enforcement and social marketing.

7. Lewisham's Health and Wellbeing Strategy

Katrina McCormick, Deputy Director of Public Health, LBL, presented the report, seeking approval of Lewisham's Health and Wellbeing Strategy and asking the Board to note the accompanying draft delivery plan that set out actions for addressing the nine priorities identified and confirmed in the strategy.

In the discussion, members highlighted the following points:

- The voluntary sector has played an important role in planning the development of the strategy, in organising and operating particular topic delivery groups and in the delivery of area-based projects (e.g. the North Lewisham project, rolled out to Bellingham).
- The strategy has actively engaged various voluntary and community groups. This approach, incidentally, also aligns very well with the Children & Young People's Action Plan (as well as with those of the CCG, LBL, and so on).
- Jane Clegg offered to take back to the NHS any emergent issues.

The Board thanked Katrina for the report and

1. Approved the final version of the Health and Wellbeing Strategy;
2. Noted the current draft Delivery plan, and
3. Agreed that the responsibility for further development of the plan and the monitoring of the plan would be undertaken by the Delivery Group, who would provide regular updates on progress to the Board.

8. An Evaluation of the North Lewisham Health Improvement Programme and the Transfer of Learning

Jane Miller, Deputy Director of Public Health, presented this report highlighting an evaluation undertaken of the North Lewisham Health Improvement Programme (NLHIP). She described the approach, the methodology used to evaluate it, and the evaluation findings (with examples from individual projects). She concluded that the programme had been successful in raising awareness, changing behaviour and improving health outcomes for a proportion of the target population living in Evelyn and New Cross wards in a cost-effective way. It had also provided valuable learning, which could inform future activity, particularly in relation to the integrated prevention agenda.

Jane stressed that one of the strengths of the North Lewisham programme had been the contribution of the area's voluntary and community sector.

She outlined the potential for other projects to learn from the programme.

The evaluation report is on the Lewisham Joint Strategic Needs Assessment website, www.lewishamjsna.org.uk and hard copies are available from Public Health Lewisham.

In the discussion, the following points were highlighted:

- The impact of the programme on behaviour was striking and provided a model for achieving such change.
- The stakeholder group has always had a representative from Neighbourhood 1, and GPs were always involved in the stakeholder meetings. However, the links with GPs' practices can be strengthened further.
- A rich body of data exists for each of the projects that could suggest ways of measuring the impact of Participatory Budgeting on health improvement.
- A future analysis of the project might examine the crucial roles of physical activity, sense of security and income, and training in greater depth.
- Further consideration should be given to how to apply the lessons from this project more widely.

The Board:

1. Noted the health impact of the North Lewisham Health Improvement Programme and progress made in transferring the learning to Bellingham.
2. Endorsed the approach as a way of contributing to the implementation of the Lewisham health and wellbeing priorities at a local level and as part of the integration of health and social care activity at a local level, and
3. Agreed that, as a next step, a report on Participatory Budgeting would come to a future meeting.

9. The role and responsibility of the Health and Wellbeing Board for Pharmaceutical Needs Assessments

Katrina McCormick, Deputy Director of Public Health, presented the report, outlining the requirements and responsibilities of the Health and Wellbeing Board for maintaining and publishing a Pharmaceutical Needs Assessment (PNA).

The report provided an update on the actions undertaken to date by the Council's Public Health Team and set out a proposed process for updating the existing PNA and for developing a plan to ensure that a revised PNA is presented for approval by the Health and Wellbeing Board before April 2015.

The report also proposed that the Director of Public Health is given responsibility for considering and commenting on any local pharmacy applications within the statutory consultation period.

In the discussion, it was suggested that the next step might be to further diversify the potential areas of intervention for pharmacists to consider.

The Board:

1. Noted that, from 1 April 2013, the Health and Wellbeing Board assumed responsibility for the existing Pharmaceutical Needs Assessment - previously published by Lewisham Primary Care Trust - and that the Board must publish its own Pharmaceutical Needs Assessment by April 2015.
2. Noted that, in 2012, NHS South East London assessed the inherited Pharmaceutical Needs Assessment and supplementary statements and concluded that the current Pharmaceutical Needs Assessment and the four supplementary statements are fit for purpose.
3. Noted that, as set out in paragraph 7.1 of the report, a working group would be set up to review and identify any changes needed in local pharmaceutical services and undertake the preparation of a revised PNA which would be presented for approval to the Health and Wellbeing Board in Autumn 2014.
4. Approved the proposed process for preparing any necessary supplementary statements to ensure the current PNA remained fit for purpose.
5. Agreed that the Public Health Director be given responsibility to consider any forthcoming pharmacy applications within the 45-day prescribed time period and to make any written representations as necessary on behalf of the Board.
6. Agreed to consider ways of co-opting pharmacists, opticians, dentists and other specialists relevant to the work of the HWB.

10. Integrated Health and Social Care – an update

Aileen Buckton, Executive Director for Community Services, updated the Board on the progress on Lewisham's Integration Programme, in particular on the Pioneer bid. She also asked members to note that proposals for current and future programme management support will be submitted as part of the plans for the funding to be transferred to local government from the NHS to support transformation in 2013-14 and 14-15. From March 2015, similar funding to support the integration of social care and health will be known as the joint health and social care Integration Transformation Fund.

Aileen highlighted that Lewisham's approach to integrated working would be whole-population based, with a strong emphasis on neighbourhood development.

An Adults Integration Programme Board (AIPB) was proposed to oversee the delivery and evaluation of the Adult Integrated Care programme.

In the discussion that followed, the following points were raised:

- In response to a query from the Chair, it was confirmed that the management of the financial resources would form a workstream under the Integration Programme.
- Cllr Best congratulated the officers concerned on organising the submission of the Pioneer bid. The project was recognised as an excellent opportunity for Lewisham to develop its work with a view to the future.

The Board:

1. Agreed the proposed governance arrangements and the role of the Health and Wellbeing Board in ensuring effective progress of the programme;
2. Agreed to keep the integration of health and social care as a standing item on the Board's agenda.

11. Winterbourne View – Lewisham Health and Social Care Position statement and Action Plan

Heather Hughes, Lewisham's Joint Commissioning Manager for Adults with Learning Disabilities, presented the Lewisham Action Plan to deliver recommendation 57 of the Department of Health's Final report, "Transforming Care: a national response to Winterbourne View Hospital" (2012), into the abuse exposed at Winterbourne View Hospital for adults with a learning disability. She also presented a summary of Lewisham's response to the recent Department of Health's 'Winterbourne Stock Take'.

Heather thanked everyone who had helped with the Winterbourne View Stock Take earlier.

The Chair thanked Heather for her report.

The Board:

1. Noted the Lewisham "Stock Take" summary position and
2. Agreed the action plan.

12. Information Point

Lewisham Warm Homes Healthy People project 2012/13 evaluation

Martin O'Brien (Sustainable Resources Group Manager, LBL) summarised the evaluation of the 2012-13 Lewisham Warm Homes Healthy People project.

In particular, Martin drew members' attention to the case studies and comments reproduced on pp 185-86 of the submitted report as being the most telling testimony to the importance of warm homes to the health of the population and to the value of the project.

Martin stressed the importance of monitoring vulnerable people (through Community Nurses, GPs, etc).

Next steps included a bid for £75,000 that had already been put forward for Lewisham Public Health Funding in 2013/14, to enable the service to be maintained, this time with a greater emphasis on fuel switching and development of the befriending element. Funding for more than one year would allow a dedicated resource to support and develop the required service-delivery partnerships.

In the discussion, the following points were highlighted:

- It is important to issue reminders in good time for vulnerable people to ensure warm homes. For this purpose, neighbourhood meetings can be very useful.
- One important component of the project was an anti-poverty measure/proposal, designed to test if the tariff charged by providers could be reduced.

The Chair thanked Martin for his report.

The Board noted the contents of the report.

13. Health and Wellbeing Board Work Programme

Carmel Langstaff (Strategy & Policy Manager, Community Services, LBL) presented the Health and Wellbeing Board with a draft work programme (included as Appendix 1) for discussion and approval.

RESOLVED that the Board:

- Note the current draft of the work programme;
- Approve the work programme;
- Agree that the work programme will be considered as a standing item at each meeting of the Health and Wellbeing Board.
- Add the following items:
 1. The Big Lottery bid for the 19 November 2013 Board
 2. Food Poverty for a future meeting and
 3. Health Protection for the January 2014 Board

The Chair thanked everyone for attending.

The meeting ended at 3:30pm.

HEALTH AND WELLBEING BOARD			
Report Title	Declarations of interest		
Contributors	Chief Executive – London Borough of Lewisham	Item No.	2
Class	Part 1	Date: 19 November 2013	

Declaration of interests

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

1 Personal interests

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

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

2 Disclosable pecuniary interests are defined by regulation as:-

- (a) Employment, trade, profession or vocation of a relevant person* for profit or gain
- (b) Sponsorship – payment or provision of any other financial benefit (other than by the Council) within the 12 months prior to giving notice for inclusion in the register in respect of expenses incurred by you in carrying out duties as a member or towards your election expenses (including payment or financial benefit from a Trade Union).
- (c) Undischarged contracts between a relevant person* (or a firm in which they are a partner or a body corporate in which they are a director, or in the securities of which they have a beneficial interest) and the Council for goods, services or works.
- (d) Beneficial interests in land in the borough.
- (e) Licence to occupy land in the borough for one month or more.
- (f) Corporate tenancies – any tenancy, where to the member's knowledge, the Council is landlord and the tenant is a firm in which the relevant person* is a partner, a body corporate in which they are a director, or in the securities of which they have a beneficial interest.
- (g) Beneficial interest in securities of a body where:-

- (a) that body to the member's knowledge has a place of business or land in the borough; and
- (b) either
 - (i) the total nominal value of the securities exceeds £25,000 or 1/100 of the total issued share capital of that body; or
 - (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person* has a beneficial interest exceeds 1/100 of the total issued share capital of that class.

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

(3) Other registerable interests

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

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

(4) Non registerable interests

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

(5) Declaration and Impact of interest on 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)

HEALTH AND WELLBEING BOARD			
Report Title	Health and Wellbeing Board Membership		
Contributors	Health and Wellbeing Board	Item No.	3
Class	Part 1	Date: 19 November 2013	

1. Purpose

- 1.1 This report updates the Health and Wellbeing Board regarding the process to identify an additional voluntary and community sector representative.

2. Recommendations

- 2.1 It is recommended that the Health and Wellbeing Board:
- Notes the result of the process through which an additional voluntary and community sector representative has been identified
 - Present the nominated voluntary sector representative to the Council for appointment.

3. Policy context

- 3.1 The Health and Social Care Act 2012 establishes a duty on local authorities to convene Health and Wellbeing Boards for their areas.
- 3.1 The activity of the Health and Wellbeing Board is focused on delivering the strategic vision for Lewisham as established in *Shaping our future – Lewisham’s Sustainable Community Strategy* and in Lewisham’s Health and Wellbeing Strategy.
- 3.2 The work of the Board directly contributes to *Shaping our future’s* priority outcome that communities in Lewisham should be *Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing.*

4. Background

- 4.1 The Health and Social Care Act specifies that the Board’s membership must, as a minimum, include:
- a) at least one Councillor of the local authority who is nominated by the Mayor and may include the Mayor
 - b) the Council’s Director of Adult Services
 - c) the Council’s Director of Children’s Services
 - d) the Council’s Director of Public Health

- e) a representative of the Local Healthwatch organisation for the area
- f) a representative of each relevant clinical commissioning group; and
- g) such other persons or representatives of such other persons as the Council thinks appropriate.

- 4.2 In addition, the Health and Wellbeing Board can appoint such other persons as it considers appropriate.
- 4.3 At the Council AGM, held on 20th March, the Mayor reported that he was appointing himself and Cllr Chris Best as members of the Health and Wellbeing Board.
- 4.4 The Council, in the Constitution, has also made provision that two representatives of the voluntary sector will be appointed to the Board. These representatives will be appointed by the Council.

5. Voluntary Sector Representatives

- 5.1 Tony Nickson, Chief Executive of Voluntary Action Lewisham (VAL) was appointed by the Council to the Health and Wellbeing Board on 26th June 2013.
- 5.2 The Health and Wellbeing Board requested that VAL develop a process through which an additional representative for the voluntary and community sector could be identified. VAL held an election for the representative at the Health and Social Care Forum on 24th October.
- 5.3 The Health and Social Care Forum comprises voluntary sector organisations working in the field of health and care. Officers working in the public sector also attend but do not have voting rights.
- 5.4 Four people were nominated for election. As agreed by the Health and Wellbeing Board, in July 2013, nominations were not restricted to VAL members, although any nominated person would require the endorsement of their organisation. Organisations represented at the Forum by more than one officer were restricted to one vote per organisation.
- 5.6 Peter Ramrayka of the Indo Caribbean Organisation secured a majority of the votes and is recommended to Council for appointment.

6. Voting Members

- 6.1 At its first meeting, the Health and Wellbeing Board considered the Council's proposals for membership and voting rights.
- 6.2 The Health and Wellbeing Board agreed with the Council's proposals regarding membership and voting rights and with the particular provisions that apply to the Health and Wellbeing Board as set out in the Council's Constitution.

- 6.3 Regulation 6 of the Health and Social Care Act regulations modifies the Local Government and Housing Act 1989 (section 13(1)) to enable all members of Health and Wellbeing Boards or their sub-committees to vote unless the Council decides otherwise. This means that the Council is free to decide, in consultation with the Health and Wellbeing Board, which members of the Board should be voting members.
- 6.4 The Council proposed that its officers not be entitled to vote. In addition the Council proposed that where an organisation (Clinical Commissioning Group, Local Healthwatch, or otherwise) appoints and employee to the Health and Wellbeing Board, that employee will not be allowed to vote. The Council also proposed that this rule will not apply to representatives of the voluntary sector appointed by the Council.

7. Financial implications

- 7.1 There are no direct financial implications arising from this report or its recommendations.

8. Legal implications

- 8.1 The legal implications are reflected in the body of the report.

9. Equalities implications

- 9.1 There are no specific equalities implications arising from this report or its recommendations.

10. Crime and disorder implications

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

11. Environmental implications

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

Background documents

None

If there are any queries on this report please contact Carmel Langstaff, Service Manager – Strategy, Community Services, London Borough of Lewisham on 0208 314 9579 or by e-mail at carmel.langstaff@lewisham.gov.uk

Agenda Item 4

Health & Wellbeing Board			
Report Title	Frail Older People in Lewisham: Local demography, health and social care use and literature review. August 2013		
Key Decision	No	Item No. 4	
Ward	All		
Contributors	Dr Ellen Pringle, Speciality Registrar		
Class	Part 1	Date:	19 November 2013

1 Purpose

1.1 This report presents the results of a review of key issues concerning frail older people. The review:

- Provides up to date demographic information on older people in Lewisham and on their use of health and social care
- Reviews evidence on how to identify frail older people (especially those who are not known to health and social care services)
- Identifies risk stratification tools for frail older people in terms of the likelihood of unplanned or frequent hospital admissions and high level use of social care
- Provides an overview of measures that have been found to be effective in reducing use of health and social care services

2. Recommendations

2.1 It is recommended that the Board:

- Note the content of this review.
- Note that the report will inform commissioning intentions and the development of relevant strategies, programmes and activities in relation to frail older people in Lewisham.

3. Policy Context

3.1 The activity of the Health and Wellbeing Board is focused on delivering the strategic vision for Lewisham as established in *Shaping our Future* – Lewisham’s Sustainable Community Strategy and in Lewisham’s Health and Wellbeing Strategy.

3.2 The work of the Board directly contributes to *Shaping our Future’s*

priority outcome which states that communities in Lewisham should be *Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing.*

- 3.3 Frail older people have been the subject of a number of national strategies and initiatives in the last few years, including, this year, the Department of Health's 'Right Care, Right Place, Right Time'. Locally, in Lewisham the Health and Wellbeing Board has identified two of their priorities as delaying/reducing the need for long term care and reducing the number of emergency admissions for people with long term conditions. NHS Lewisham Clinical Commissioning Group has specifically identified frail older people as a priority group.

4. Key Points:

4.1 The report highlights that:

- There are currently (in 2013) 26,800 Lewisham residents aged 65 and over.
- In Lewisham the older population is more ethnically diverse than in England, though less diverse than the younger population locally. More older people live in the south than north of Lewisham.
- The prevalence of long term conditions (LTC) increases with age and increasing deprivation. In England almost half of women over 75 have at least one LTC.
- In Lewisham admission and readmission rates for older people are higher than England. A quarter of people aged 65-69 in Lewisham attended A&E at University Hospital Lewisham in the last three years, 70% of those aged 90 and over attended.
- Older people are more likely to be admitted to hospital when they attend A&E, last year almost 8000 people aged 65 and over in Lewisham had an unplanned admission to hospital. The most common primary diagnoses for admission amongst the over 65s are pneumonia, UTI and COPD. For the over 85s they are pneumonia, UTI and falls.
- About 3500 residents aged 65 and over receive social care services, which represents approximately 14% of the (65+) population. About 200 people aged 65 and over are admitted to care homes each year.
- This population is more likely to die earlier and live in income deprivation than the England average.

- 4.2 Projections suggest that there will be an increase in the 65+ and 85+ populations of Lewisham of about 12% and 20% respectively between 2010 and 2022. So that by 2023 there will be almost 30,000 people aged 65 and over in Lewisham. The number of older people with multiple long term conditions and disabilities in England is expected to increase in the next ten years. The prevalence of obesity is increasing in older people by about 5% per year.

5. Next Steps

- 5.1 Officers recommend that in the development of commissioning intentions, the detailed planning for the Integrated Adult Care Programme and the delivery of the Health and Wellbeing Strategy objectives that due regard is given to findings of the review.

6. Financial implications

- 6.1 There are no specific financial implications arising from this report or its recommendations.

7. Crime and disorder implications

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

8. Equalities implications

- 8.1 The recommendations of this report will contribute to improved health outcomes and wellbeing for older adults.

9. Environmental implications

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

10. Conclusion

- 10.1 The review will inform the planning of services for frail older people, a key focus of the Integrated Care Programme. It will improve health outcomes and quality of life for these residents.

If there are any queries on this report please contact, **Katrina McCormick, Deputy Director of Public Health**, 020 8314 9056.



Frail Older People in Lewisham

*Local demography, health and social care use and
literature review*

August 2013

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Acknowledgements

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Meic Goodyear, Public Health Information Specialist, London Borough of Lewisham

Janet Smith, Payments Monitoring Officer, NHS Lewisham Clinical Commissioning Group

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Executive Summary

In the UK people are living longer lives; the chance of surviving from birth to the age of 85 has more than doubled for men in the last three decades. This increased survival is resulting in a rise in the number of older people in the population. Over 85 year olds are currently the fastest growing demographic group in the UK. Health and social care use increase with age; eighty percent of people over 65 years old will need social care in the later years of their lives.

Amongst this growing population of older people are those that are more vulnerable; frail older people. This group are at greater risk of adverse outcomes, including disability, morbidity, mortality, hospitalisation and admission to care homes. Frailty also leads to loss of independence and impairs the quality of life and psychological well-being of older people.

Frail older people have been the subject of a number of national strategies and initiatives in the last few years, including, this year, the Department of Health's "Right Care, Right Place, Right Time". Locally, in Lewisham the Health and Wellbeing Board have identified two of their priorities as: Delaying/reducing the need for long term care and reducing the number of emergency admissions for people with long term conditions. And NHS Lewisham Clinical Commissioning Group has specifically identified frail older people as a priority.

This report aims to help inform those planning services for frail older people in Lewisham by:

- Providing up to date demographic information on older people in Lewisham and on their use of health and social care
- Reviewing evidence in how to
 - Identify frail older people (especially those who are not known to health and social care services)
 - Risk stratify frail older people in terms of their likelihood of unplanned or frequent hospital admissions and high level use of social care
 - Reduce healthcare use amongst the highest users of health and social care.

Demographics and Service Use

There are currently (in 2013) 26,800 Lewisham residents aged 65 and over. This population are more likely to die earlier and live in income deprivation than the England average. In Lewisham the older population is more ethnically diverse than in England, though less diverse than the younger population locally. More older people live in the south than north of Lewisham. Fourteen per cent of people of all ages in Lewisham have a disability or long term condition (LTC) that affects their day to day activities. The prevalence of long term conditions increases with age and increasing deprivation. In England almost half of women over 75 have at least one LTC.

In Lewisham admission and readmission rates for older people are higher than England. About a quarter of people aged 65-69 in Lewisham attended A&E at University Hospital Lewisham in the last three years, though almost 70% of those aged 90 and over did. Older people are more likely to be admitted to hospital when they attend A&E, last year almost 8000 people aged 65 and over in Lewisham had an unplanned admission to hospital. The most common primary diagnoses for admission amongst the over 65s are pneumonia, UTI and COPD. For the over 85s they are pneumonia, UTI and falls.

About 3500 residents aged 65 and over receive social care services, which represents approximately 14% of the (65+) population. About 200 people aged 65 and over are admitted to care homes each year.

Projections suggest that there will be an increase in the 65+ and 85+ populations of Lewisham of about 12% and 20% respectively between 2010 and 2022. So that by 2023 there will be almost 30,000 people aged 65 and over in Lewisham. The number of older people with multiple long term conditions and disabilities in England is expected to increase in the next ten years. The prevalence of obesity is increasing in older people by about 5% per year.

Frailty

There are a variety of definitions of frailty; a lack of resilience in the event of minor stressor events is a key element. Although many frail older people also have disabilities or co-morbidities up to a quarter may not have, making identification a challenge. In the UK between a quarter and half of those aged over 85 are thought to be frail.

Identification Tools

There are a variety of tools available to identify frail older people, from simple self-assessment screening questionnaires through to complex healthcare professional completed assessments. This report describes and compares some of these tools. Many of the tools described have been shown to identify those at increased risk of hospital admission or mortality.

Risk Stratification

Similarly there are many risk stratification tools, aiming to quantify an individual's risk of future health care. There are also tools aiming to identify risk of social care admission but these are not currently well enough developed to be useful. At present these tools are unable to identify the interventions that would be most effective for those frail older people at risk.

A key question in considering frail older people is which group to target for interventions, those with very high use of services (a small number) or those who are not currently using services but who are frail and hence also at risk of worse outcomes. It may be that the second group could benefit from simple, existing interventions but they do not receive them as they are not known to those who could recommend them. Deciding on a target group is vital in selecting a tool and influences the implementation structure and context. Assuming that frail older people not currently known to health and social care services are identified as a target for future intervention, the following are recommended as next steps:

- A more detailed review of implementation of frailty identification tools in practice, including their impact, feasibility and comparison to Lewisham of the context in which they implemented. (population factors and existing services including non-statutory).
- Mapping of existing services for older people in Lewisham, with a view to considering how these might be incorporated into an identification and referral process.
- Trial a simple identification tool in a small area to understand how large the population of unidentified frail older people is.
- On the basis of above consider piloting a programme of screening older people for frailty, providing those at risk with a more comprehensive assessment which acts to sign post individuals to existing preventative services.

Background

In the UK people are living longer lives; the chance of surviving from birth to the age of 85 has more than doubled for men in the last three decades¹. This increased survival is resulting in a rise in the number of older people in the population. Over 85 year olds are currently the fastest growing demographic group in the UK². Health and social care use increase with age; eighty percent of people over 65 years old will need social care in the later years of their lives³.

Amongst this growing population of older people are those that are more vulnerable; frail older people. This group are at greater risk of adverse outcomes, including disability, morbidity, mortality, hospitalisation and admission to care homes. Frailty also leads to loss of independence and impairs the quality of life and psychological well-being of older people⁴

Frail older people have been the subject of a number of national strategies and initiatives in the last few years, including, this year, the Department of Health's Right Care, Right Place, Right Time". It focuses on improving the out-of-hospital care for vulnerable older people, encouraging integrated working across primary care, urgent and emergency care and social services. The Department of Health has proposed a series of proposals, which will be tested and discussed this year, with recommendations expected in October. The proposals are:

- Staying healthy for longer (*focus on prevention and managing long term conditions*)
- Named clinician (*single named contact to co-ordinate an individual's care*)
- Improving access (*easier booking of appointments and access to advice*)
- Out of hours (*safe and consistent service*)
- Choice and control (*supporting patient choice*)
- Joining up services (*sharing of information and co-ordination of care*)

In Lewisham the Health and Wellbeing Board have identified two of their priorities as: Delaying/reducing the need for long term care and reducing the number of emergency admissions for people with long term conditions. And NHS Lewisham Clinical Commissioning Group has specifically identified frail older people as a priority.

This report aims to help inform those planning services for frail older people in Lewisham by:

- 1) Providing up to date demographic information on older people in Lewisham and on their use of health and social care
- 2) Reviewing evidence in how to
 - Identify frail older people (especially those who are not known to health and social care services)
 - Risk stratify frail older people in terms of their likelihood of unplanned or frequent hospital admissions and high level use of social care
 - Reduce healthcare use amongst the highest users of health and social care

1. Demographics and Trends in Lewisham

Current demographic information and trends relating to older people in Lewisham and their current usage of health and social care in the borough.

As there are no direct data available on “frail older people” in Lewisham the information presented here relates to older Lewisham residents (mostly aged 65 years and older). In addition attributes or behaviours that may contribute to or indicate frailty are considered (such as long term conditions, A&E usage, hospital admissions and social care use). Some information such as loneliness and long term condition prevalence and trends amongst older people is provided at England-wide level, as it is not available at a lower level.

1.1. Population Profile

There are currently about 26,800 residents in Lewisham aged 65 years or over⁵, this represents 10.5% of the population of the borough. This is similar to the picture across London (11%), but lower than the UK as a whole where 16% of the population are aged 65 or over⁶. There are about 3600 Lewisham residents aged 85 years and over, which is about 1.3% of the population. As expected the number of residents per five-year age band over 65 declines with increasing age. (Figure 1)

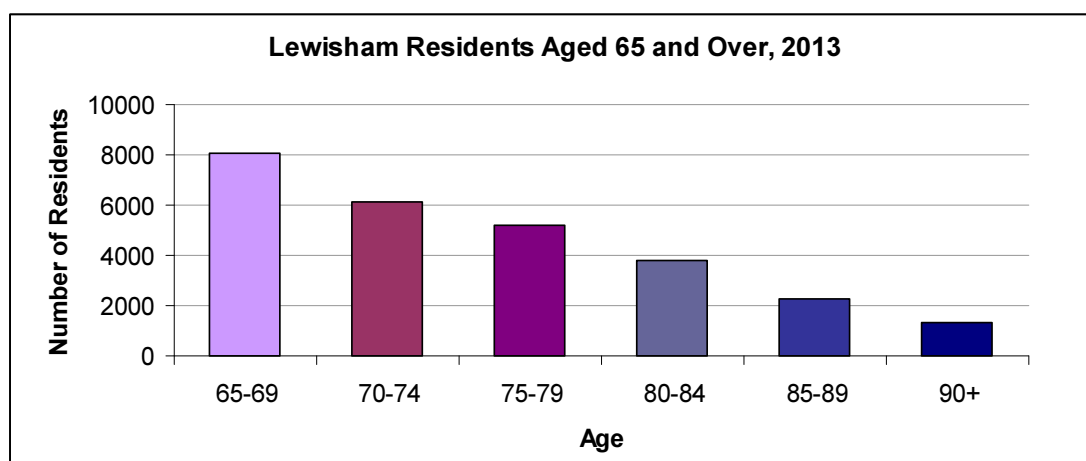


Figure 1 – Number of Lewisham Residents aged 65 and over by Five Year Age Band (2013)

The differences between the population of Lewisham and that of England as a whole (such as greater deprivation and greater ethnic diversity) are also reflected in the 65+ population. A greater proportion of 65+ Lewisham residents are from ethnic minorities than across England as a whole. And a greater proportion of residents aged 60 and over are in income deprivationⁱ than England as a whole.⁷

ⁱ Income Deprivation Affecting Older People Index (IDAOP) is the proportion of adults aged 60 or over living in pension credit (guarantee) households as a percentage of all adults aged 60 or over.

Ethnicity

Lewisham has an ethnically diverse population, although this is less apparent in the over 65 age group at present. In 2013 73% of Lewisham residents aged 65 and over are white, compared to only 61% of those aged 16-64 years. (Figure 2 and Figure 3)

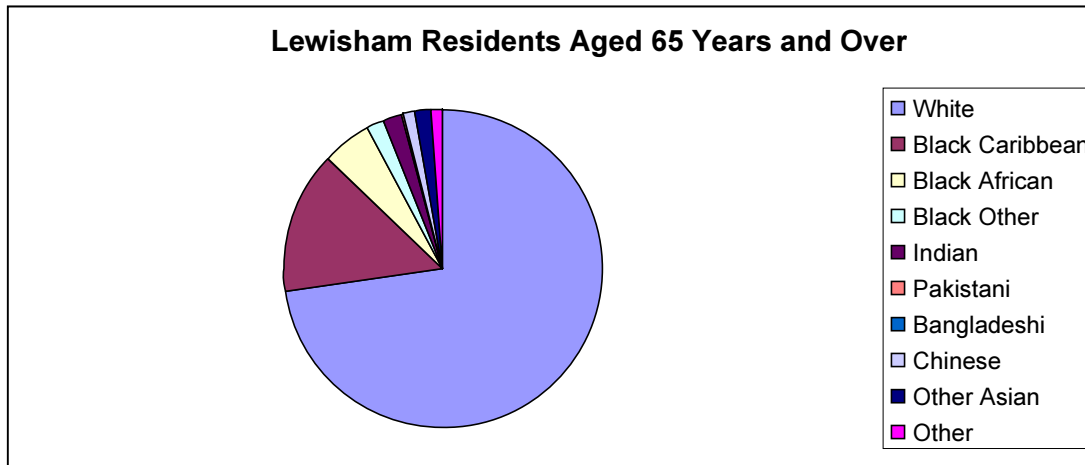


Figure 2 - Lewisham Residents Aged 65 Years and Over by Ethnicity, 2013
(Data from 2011 GLA Demographic Projections)

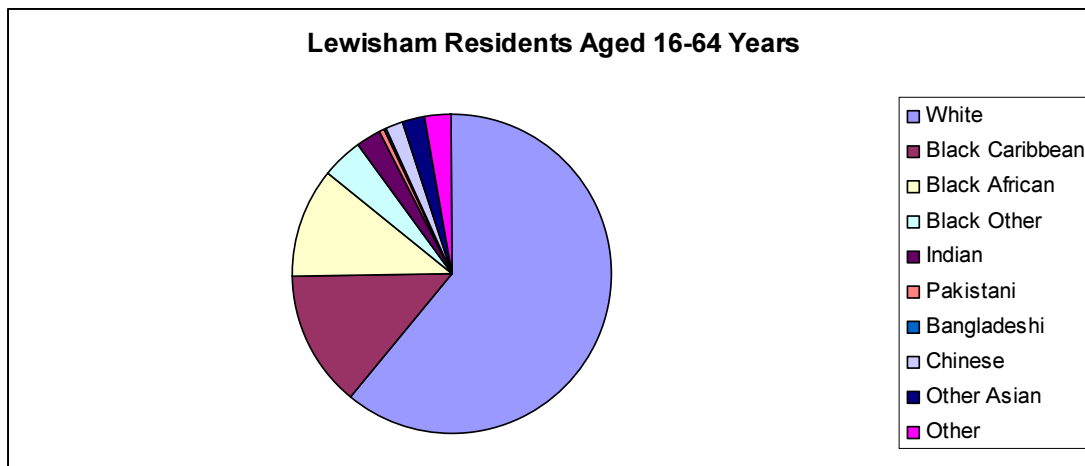


Figure 3 - Lewisham Residents Aged 16-64 Years by Ethnicity, 2013
(Data from 2011 GLA Demographic Projections)

Location

The size of the over 65 population varies across the borough; making up as little as 7% of residents the northern wards of the borough (Evelyn, New Cross and Brockley) and as much as 14% in the southern wards of Grove Park, Downham, Sydenham and Catford South.⁵

Ward	Number of Residents aged 65 and over (2013 GLA Projection)	Proportion of population aged 65 and over (%)
Bellingham	1870	12.5
Blackheath	1810	12.5
Brockley	1370	7.6
Catford South	2100	13.6
Crofton Park	1740	11.5
Downham	2160	14.6
Evelyn	1240	7.0
Forest Hill	1760	11.7
Grove Park	2220	14.9
Ladywell	1560	10.5
Lee Green	1990	13.4
Lewisham Central	1780	9.5
New Cross	1160	6.9
Perry Vale	1810	11.5
Rushey Green	1640	10.4
Sydenham	2180	13.7
Telegraph Hill	1450	8.6
Whitefoot	1900	13.0

Table 1 - Number and Proportion of Residents Aged 65 and Over by Ward

Key Messages

- *There are currently 26,800 Lewisham residents aged 65 and over.*
- *Compared to England a lower proportion of the population of Lewisham is aged 65 or over.*
- *Although the 65+ population of Lewisham is more ethnically diverse than England it is less diverse than the younger population in Lewisham.*
- *Lewisham has a greater proportion of residents aged 65 and over living in income deprivation than England as a whole.*
- *There are more older people living in the wards in the southern part of Lewisham than in the north.*

1.2. Mortality and Life Expectancy

Lewisham's directly standardised mortality rates for cancer, respiratory conditions, circulatory conditions, coronary heart disease and COPD in the over 65s are significantly worse than nationally.⁷ Only the over 65 mortality rate for stroke was not significantly different from the national average. Therefore Lewisham has a directly standardised all cause mortality rate for the over 65s that is significantly worse than the England average.⁷

In 2008-10 life expectancy at birth in the borough was 76.7 years for men and 81.3 years for women; this ranked Lewisham 341st and 319th respectively of the 404 local authorities nationally. The life expectancy at 65 was 16.6 years for men and 19.9 for women in the borough. Lewisham ranks lower nationally in life expectancy at age 65 than at birth; 381st for men and 323rd for women.

Simple life expectancy rates do not take into account the quality of life, both healthy life expectancy and disability free life expectancy attempt to address this. Both healthy and disability free life expectancy for men and women in Lewisham are significantly lower than the national figure. (Table 2)

	Disability Free Life Expectancy (Aged 65) (Years (95% CI)) (life free from longstanding limiting disability or illness)		Healthy Life Expectancy (Aged 65) (Years (95% CI)) (years living in good or reasonably good health)	
	Male	Female	Male	Female
Lewisham	7.5 (7.3 – 7.7)	8.6 (8.4 – 8.8)	11.2 (11.0 – 11.5)	13.5 (13.3 – 13.8)
London	8.3 (8.3 – 8.4)	9.3 (9.3 – 9.3)	12.5 (12.4 – 12.5)	14.6 (14.6 – 14.7)
England	8.1 (8.1 – 8.1)	9.1 (9.1 – 9.1)	12.5 (12.4-12.5)	14.5 (14.5 – 14.5)

Table 2 - Healthy and Disability Free Life Expectancy Aged 65, Lewisham (2001 Data)⁷

Key Messages

- Over 65 mortality rates are higher in Lewisham than England as a whole for all causes except stroke.
- Life expectancy at birth in Lewisham is currently about 77 for men and 81 for women, lower than the England figures.
- Life expectancy at 65 in Lewisham ranks 381st for men and 323rd for women, of a total of 404 local authorities.
- Healthy life expectancy at 65 is also lower in Lewisham than both London and England.

1.3. Health

1.3.1. Self Reported Health and Wellbeing

In 2011 83% of the population of Lewisham reported their health as being good or very good. But 14% of residents reported having a longstanding health condition or disability that limited their day to day activities. Half of those, 19,500 people, reported that it limited their activities “a lot”.⁸ Information is not available on the age of these individuals or the nature of the conditions that affect their health and limit their activities.

As part of the Measuring National Well-being Programme loneliness amongst people aged 52 years and older has been reported by age and by existence of a longstanding illness or disability. Loneliness increased with older age and with the existence of a long term condition. Overall 27% of those aged over 52 years were lonely sometimes or often compared to 46% of those aged 80 and over. And 45% of those aged over 52 with a longstanding condition or disability that limits them reported feeling lonely sometimes or often.⁹

1.3.2. Long Term Conditions

The prevalence of long term conditions increases with age, nationally those aged over 75 were three times more likely to report having a long term condition than those aged 16-44.¹⁰

At a local level QoFⁱⁱ provides us information on the number of people listed on registers for some of these common long term conditions (LTC)ⁱⁱⁱ. (Table 3)

ⁱⁱ Quality and Outcomes Framework for GPs

ⁱⁱⁱ A condition that can not be cured but can be controlled by medication or other treatment or therapies. (Department of Health)

Long Term Condition	Number of people on condition register	Prevalence (amongst all GP registrations, unless age specified)
Dementia	1014	0.3
Heart failure	1529	0.5
Epilepsy (>18yrs)	1362	0.6
Atrial fibrillation	2162	0.7
Stroke/TIA	3344	1.1
COPD	3497	1.1
Cancer	3639	1.2
Hypothyroidism	5537	1.8
Coronary heart disease	5561	1.8
Chronic kidney disease (>18yrs)	5101	2.1
Diabetes Mellitus (>17yrs)	13479	5.6
Asthma	17136	5.7
Obesity (>18yrs)	24351	9.9
Depression (>18yrs)	24802	10.4
Hypertension	33599	11

Table 3 - Number and Prevalence of Long Term Conditions in Lewisham using QoF data 2011

Again, this local information is not broken down by age group. However some of these conditions are likely to affect predominantly older individuals, such as dementia and others are more prevalent with increasing age. (Table 4)

Long Term Condition	Prevalence (Age Groups <50) (%)	Prevalence 60-69 (%)	Prevalence 70-79 (%)	Prevalence 80+ (%)
Stroke	<1	1	1	2
COPD	<1	2	2	2
Diabetes	<1-5	8	10	8
Cancer	<1	2	3	4
Musculoskeletal	1-11	22	30	37

Table 4 - Prevalence of Some Long Term Conditions by Age, England and Wales 2009 (Data from General Lifestyle Survey 2009)

Not only are older individuals more likely to have a long term condition (LTC) they are more likely to have multiple LTCs. In England almost half of woman aged 75 and over have more than one long term condition¹¹. (Table 5)

	16-24		25-34		35-44		45-54		55-64		65-74		75+	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
% with 1 LTC	14	19	17	16	26	24	26	26	31	30	37	25	35	26
% with 2 or more LTCs	4	6	4	6	10	11	18	16	23	25	32	38	43	49

Table 5 - Proportion of People with Long Term conditions by Age, England 2009

Lower income levels are associated with a higher prevalence of long term conditions. In England 25% of those in the lowest income tertile have at least two LTCs compared to only 13% of those in the highest income tertile.¹¹ This is relevant throughout Lewisham given the high levels of deprivation as well as in understanding health inequalities within the population. Smoking and obesity are more prevalent in individuals from more deprived areas¹², which contributes to this difference.

The challenge with this information on long term conditions is that it is hard to distinguish those with stable, well managed LTCs who are able to live independently and rarely need to seek healthcare and those whose conditions require frequent health and social care input. And although long term conditions are associated with frailty not everyone with a LTC is “frail”.

1.3.3. Dementia

Dementia is a condition that, in the vast majority of cases, affects older people and is associated with significant social care and healthcare costs. The Department of Health have produced a calculator to estimate the prevalence of dementia locally, both diagnosed and undiagnosed as well as predicting future trends. It estimates that in 2011/12 there were a total of 1926 people living with dementia in Lewisham, 1474 of those living in the community and a further 452 in residential and nursing care. The majority are female and about 40% of those living in the community are aged 85 and over. The prevalence of dementia increases markedly with age, at about 1% of 65 to 69 year olds and almost one in four people aged over 90. Almost two thirds care home residents in Lewisham aged 65 years and over have dementia. It is estimated that just under half of all people with dementia are undiagnosed in Lewisham. Although the diagnosis rate in Lewisham does not seem to vary significantly from the national average the CCG area ranks 45th -53rd of all CCGs in terms of the proportion of dementia cases diagnosis.

^{iv} Varies slightly dependent upon the prevalence figure used.

1.3.4. Falls

Falls are more common in older people; they can result in loss of confidence, continued fear of falling, activity restriction, reduced functional ability, loss of independence, social isolation and thus increased dependency on carers and services.¹³

The rate of emergency hospital admissions for accidental falls is significantly higher in Lewisham than the England average, at 3,367 per 100,000. (London as a whole, with a rate of 2,850 per 100,000 is also higher the England average).

At University Hospital Lewisham (UHL) A&E there were just under 700 attendances by people aged 65 and over with a diagnosis of fall in 2012/13. The numbers increased with increasing age^v. (Figure 4)

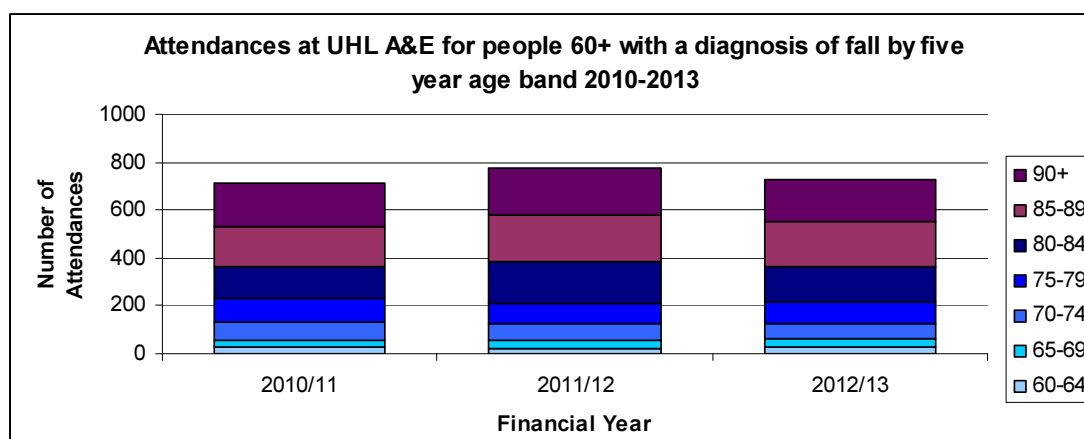


Figure 4 - Attendances at University Hospital Lewisham by people aged 60+ with a diagnosis of fall by five year age band 2010-2013.

Key Messages

- 14% of people of all ages in Lewisham have a disability or long term condition that affects their day to day activities.
- Loneliness increases with both age and the presence of a long term condition, in England and Wales almost half of people over 85 are sometimes or often lonely.
- The prevalence of long term conditions increases with age and increasing deprivation. In England almost half of women over 75 have at least one LTC.
- There are approximately 1900 people with dementia in Lewisham.
- Each year about 700 people aged 65 and over attend A&E at UHL with a fall, this is higher than the England average.

^v Note this only refers to attendances at UHL, and does not include Lewisham residents who attend A&E at King's College Hospital or Guy's and St Thomas' NHS Trust.

1.4. Healthcare use

Use of health services increases with increasing age; locally A&E attendance and inpatient admissions demonstrate this.

1.4.1. A&E Admissions^{vi}

With increasing age individuals are more likely to have an A&E attendance, to be brought to A&E by ambulance and to be admitted. Fifteen percent of all attendances at A&E at UHL are amongst people aged 65 and over. Almost 60% of individuals aged 65-69 attending A&E self-referred compared to less than a quarter of those aged 90+. (Table 6)

Source of Referral	Proportion of A&E Attendances					
	65-69	70-74	75-79	80-84	85-89	90+
<i>Emergency Services</i>	2.6%	3.3%	3.2%	4.3%	4.9%	5.2%
<i>General Medical Practitioner</i>	10.8%	12.1%	12.3%	11.9%	10.9%	9.5%
<i>Health Care Provider (Same or Other)</i>	3.7%	3.1%	3.4%	3.2%	3.1%	3.1%
<i>Other</i>	24.5%	29.3%	36.0%	43.2%	48.1%	58.0%
<i>Police</i>	0.6%	0.3%	0.3%	0.4%	0.4%	0.3%
<i>Self Referral</i>	57.7%	51.8%	44.7%	37.0%	32.8%	23.8%

Table 6 - Source of Referral for A&E Attendances by Age, 2010-2013

A greater proportion of older A&E attendees arrive by ambulance (88% of those aged 90+ compared to 40% of those aged 65-69). Once in A&E older people are more likely to be admitted to hospital. (Figure 5)

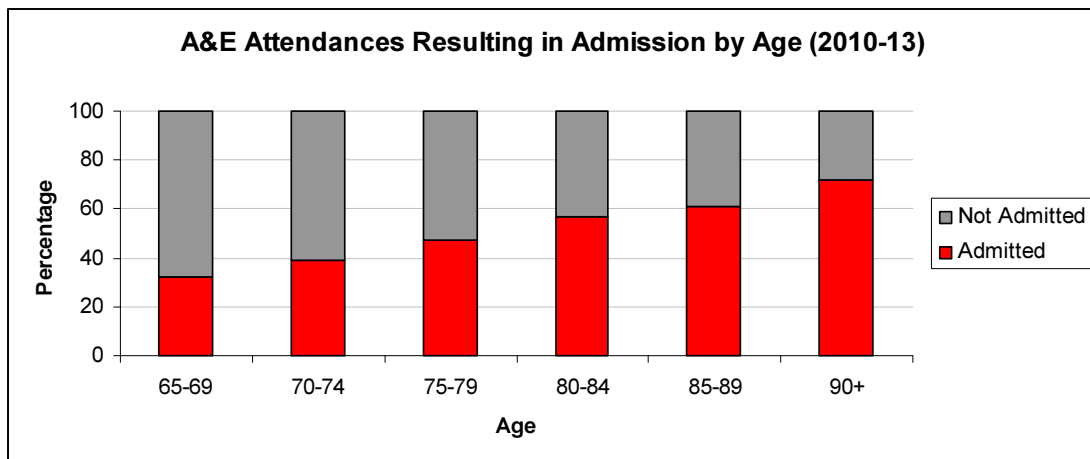


Figure 5 - Admission Rates Following A&E Attendance by Age, 2010-2013

^{vi} This data includes only admissions to University Hospital Lewisham (not King's College Hospital or Guy's and St Thomas' NHS Trust)

Although this data is useful in noting that if a 90 year old attends A&E he is more likely to be admitted to hospital than a 65 year old it does not tell us about the appropriateness of the admission (or the initial reason for the attendance). This would require an audit of A&E attendances/admissions.

A&E Admissions from Care Homes

Exploring a similar question an audit of admissions to A&E from care homes in Lewisham was carried out in November 2011. It aimed to explore the reasons behind admissions to A&E from care homes, as they had been identified as being relatively high. A Self Survey Audit which asked several questions including reasons for A&E attendance, existence of advanced care plans and GP involvement prior to A&E attendance. The audit found that residents referred to A&E seemed to have “serious medical conditions”, there was GP involvement with over 55% of residents prior to referral to A & E. Two-thirds of residents were not on the GP end of life register; however, 51% of residents had advanced care plans in place. It is not possible to know whether other primary care interventions would have been able to prevent these admissions, but this small audit of 53 admissions to A&E from care homes in Lewisham did not find significant evidence of these admissions being inappropriate¹⁴.

Multiple A&E Attendances

Over the last three years a number of individuals aged 65 and over have had multiple attendances at A&E. (Table 7)

Number of Attendances (over 3 years, 2010-2013)	Number of People (by age band)					
	65-69	70-74	75-79	80-84	85-89	90+
1	1409	1275	1220	1048	803	550
2 to 4	458	443	521	496	422	310
5+	54	66	61	77	56	45
Total	1921	1784	1802	1621	1281	905

Table 7 – Number of A&E Attendances by Age (2010-2013)

Although the number of people with multiple attendances is lower in the older age groups as a proportion of the general population of that age the number of multiple admissions in older age groups is greater.

Number of Admissions	% of Lewisham residents with UHL A&E attendance in the last 3 years (by age band)					
	65-69	70-74	75-79	80-84	85-89	90+
1	24.8	28.6	35.1	42.1	55.6	69.8
5+	0.7	1.1	1.2	2.0	2.4	3.5

Table 8 - A&E Attendances as a proportion of population by age (2010-2013)

1.4.2. Hospital Admissions^{vii}

Emergency hospital admission rates in people aged 65 and over are higher in Lewisham than England as a whole, at 29,161 per 100,000. Similarly, at 17% the emergency re-admission rates (within 28 days) for those aged 75 and over in Lewisham are higher than England (15%) but the same as London.

In 2012-13 in Lewisham almost 8000 people aged 65 and over were admitted to hospital. There were ten individuals who were admitted ten or more times and 187 people who were admitted five or more times in the year. The largest number of people with five or more admissions was in the 80-84 age-band. (Table 9 and Figure 6)

Age Band	Number of People with 5 or more Hospital Admissions in 2012-13
65-69	24
70-74	28
75-79	34
80-84	52
85-89	43
90-94	21
95+	7
<i>Total</i>	<i>187</i>

Table 9 - Number of People (aged 65+) with 5 or more Hospital Admissions in 2012-13 by Age

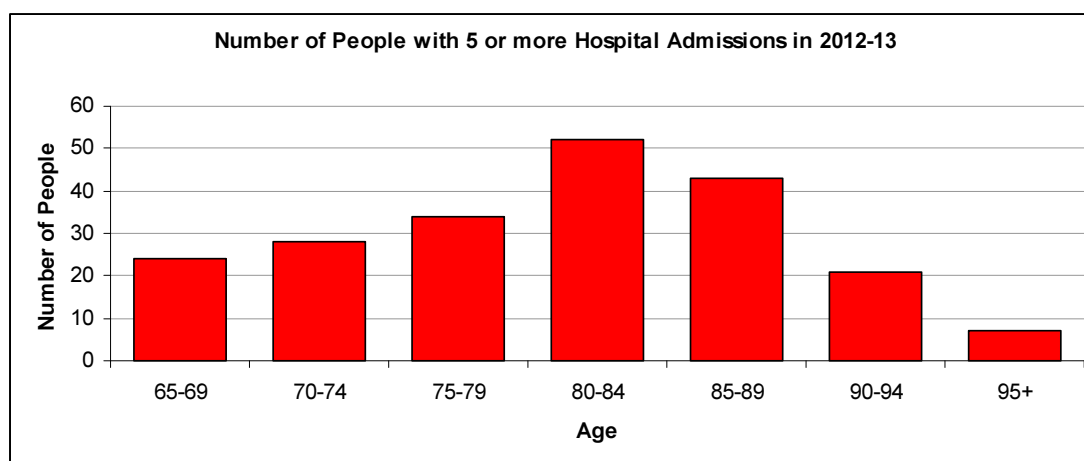


Figure 6 – Number of People aged 65+ with five or more hospital admissions by age (2012-13)

Although there are fewer admissions of people aged over 90, taking into account the numbers of residents of that age, their risk of admission is likely to be higher than younger individuals. However in terms of service planning it is useful to note that the 80-84 year age band has the largest number of people with multiple admissions.

^{vii} Hospital admissions for those registered with a Lewisham GP rather than Lewisham residents

The most frequent primary diagnoses for emergency admissions to hospital in Lewisham GP-registered patients in 2012-13 were UTI, pneumonia, falls, COPD and chest pain.

Primary Diagnosis	Number of Admissions (aged 65+, 2012-13)
Urinary tract infection, site not specified	557
Lobar pneumonia, unspecified	344
Repeated falls	258
Chronic obstruct pulmonary dis with acute lower resp infec	196
Chest pain, unspecified	183
Pneumonia, unspecified	178
Person with feared complaint in whom no diagnosis is made	177
Congestive heart failure	156
Acute renal failure, unspecified	119
Unspecified acute lower respiratory infection	118
Atrial fibrillation and flutter	106
Syncope and collapse	105
Fracture of neck of femur	102
Cerebral infarction, unspecified	96
Diarrhoea and gastroenteritis of presumed infectious origin unspec	95
Unstable angina	95
Cellulitis of other parts of limb	91
Constipation	90
COPD with acute exacerbation, unspec	87
Acute myocardial infarction, unspecified	82
Transient cerebral ischaemic attack, unspecified	70
Unspecified haematuria	64
Other chest pain	61
Retention of urine	59
Orthostatic hypotension	58
Mechanical complication of urinary (indwelling) catheter	57
Unspecified injury of head	54
Dyspnoea	50

Table 10 - Primary Diagnosis Codes Used in at least 50 Emergency Admissions in 2012-2013 in those aged 65+

Some of the primary diagnosis codes used are similar and contain the same underlying condition. Combining these highlights some differences in the most common primary diagnosis for admissions amongst 65-84 year old and those over 85. COPD and chest pain are more prominent in the younger population where as falls and no diagnosis made are more prominent in the older group. But overall pneumonia and UTI are the commonest diagnosis in both age groups.

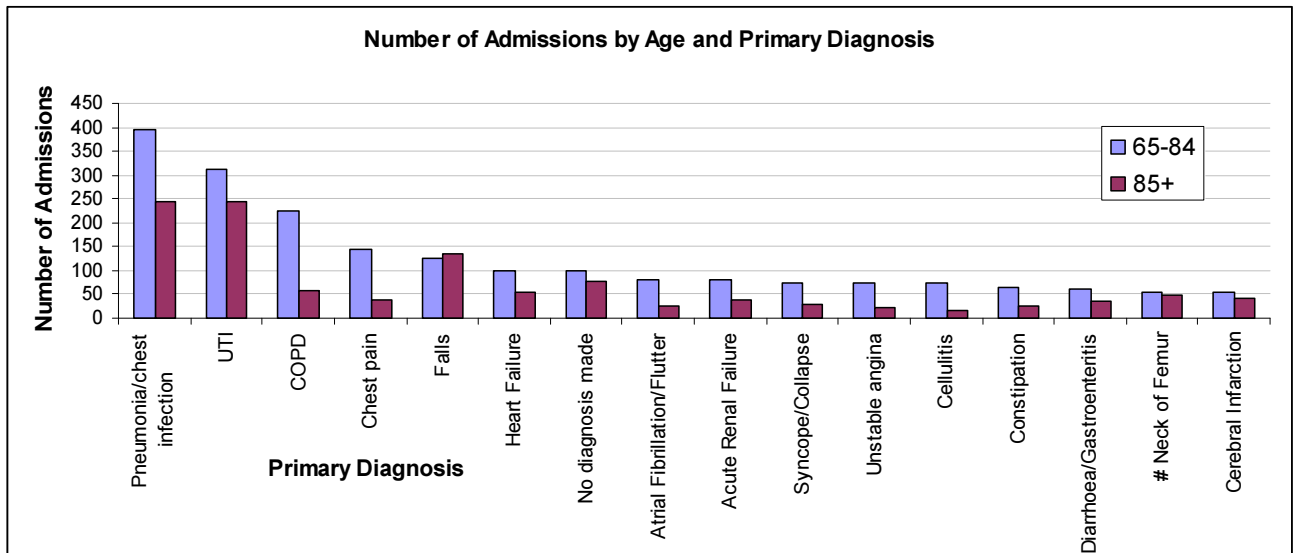


Table 11 - Number of Admissions for Lewisham Registered Patients by Age and Primary Diagnosis, 2012-2013

Key Messages

- *Lewisham’s admission and re-admission rates for older people are higher than England.*
- *A&E attendances increase with age, older people are also more likely to arrive by ambulance and to be admitted to hospital.*
- *About a quarter of people aged 65-69 in Lewisham have attended A&E at least once in the last three years. Compared to almost 70% of those aged 90 and over.*
- *Last year almost 8000 people aged 65 and over in Lewisham had an unplanned admission to hospital.*
- *The most common primary diagnoses for admission amongst the over 65s are pneumonia, UTI and COPD. For the over 85s they are pneumonia, UTI and falls.*

1.4.3. NHS Continuing Healthcare

Individuals who are not in hospital but have ongoing, complex healthcare needs may be eligible for NHS Continuing Healthcare; a package of care that is arranged and funded solely by the NHS. Given the complexity of these patients' needs the number of people in receipt of this funding is a useful guide as to the number of people with complex healthcare needs locally. Last year just over 300 people started to receive continuing care funding, most of those (247) were over 65. The majority of people receiving continuing care are in a nursing home or receiving homecare.

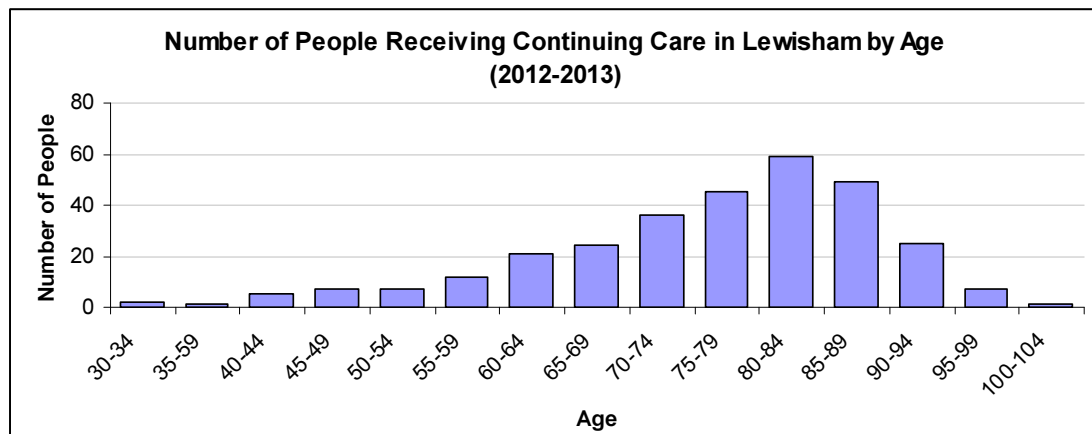


Table 12 - Number of People Receiving Continuing Care in Lewisham by age (2012-2013)

1.4.4. Substance Misuse and Alcohol Treatment Services

Approximately a quarter of adults who underwent treatment for alcohol dependency in Lewisham in 2012/13 were aged 50-64, this is similar to the England average. No-one aged 65 and over was received treatment for alcohol dependence during the year.

The number of older adults in treatment for substance misuse has increased over the last three years, to 176 in 2012/13. In 2012/13 the proportion of 50 to 64 year olds in the Lewisham treatment system was twice that of the England average.

1.4.5. Social Care and Healthcare Use

It is not possible to link social care and healthcare data on a large scale to understand how many people are in receipt of both. However as part of planning for integrated care in Lewisham the number of adults (of all ages) in receipt of both adult social care and district nurse support was estimated. (Figure 7) This found that about 20% of District Nurse cases were also in receipt of Adult Social Care (ASC) Services and that about 40% of ASC clients were also seeing District nurses.

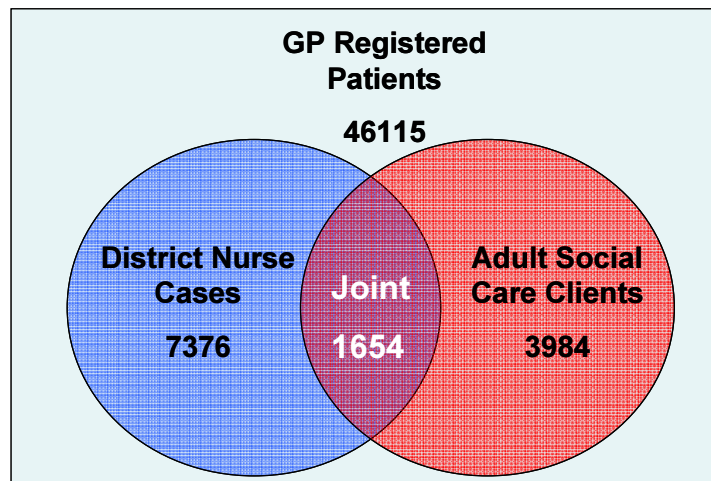


Figure 7 - Sample of Lewisham GP-Registered Patients Showing Overlap of Those Receiving Adult Social Care and District Nurse Input

1.5. Social care Use

In 2011-12 almost 6400 individuals in Lewisham received at least one service^{viii} from social care in Lewisham at some time during the year and just over 3500 of these service users were 65 years old or over. This equates to approximately 14% of all residents aged 65 years and over, though the proportion increases markedly with age; over 40% of residents aged 85 years and older receiving a social care service in 2011/12. (Figure 8)

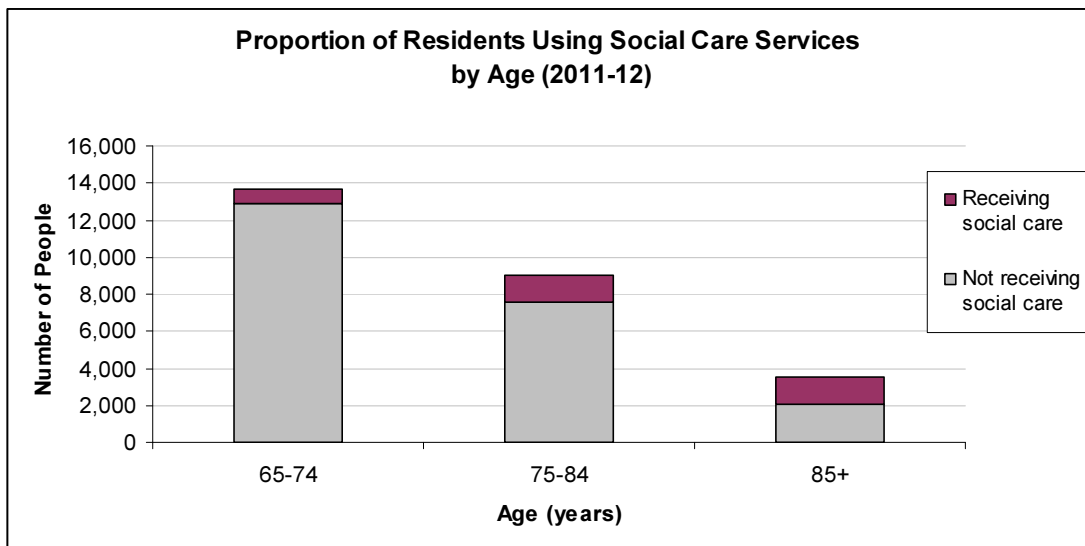


Figure 9 – Proportion of Lewisham Residents Receiving at Least One Social Care Service for at Least Part of the Year 2011-2012 by Age

Over half of service users aged 65 and over received more than one service (or the same service over more than one period of time) in 2011-12.

Number of Services/Episodes of a Service Used 2011-12	Number of Service Users
1	1489
2	742
3	505
4	327
5-9	473
10+	36

In 2011 almost half of service users (aged 65 and over) receiving 5 or more services (/service episodes) were aged 85 years and over. The majority were white (74%), Black Caribbeans were the next largest ethnic group, at 19%. Although the numbers are small, this is higher than the proportion of Black Caribbeans in the 65+ population (15% in 2011). The service use data from 2010-11 also suggest this, 21% of those aged 65 and over using 5 or more services were Black Caribbean.

^{viii} Meals, day care, direct payment, equipment, home care, permanent or short term residential or nursing placement or professional support.

The most frequently used service in 2011-12 was home care^{ix} which accounted for almost half of services provided. Permanent residential and nursing placements each accounted for 5% of services provided. (Though, it is possible that homecare could represent more than one episode in a year for an individual permanent care home placements can not.)

A survey, done as part of the Social Care Outcomes Framework (ASCOF) asked social care clients how satisfied they were with the way staff helped them. 65% of respondents in Lewisham were extremely or very satisfied compared (58% in inner London and 64% in England).¹⁵

1.5.1. Care Home Admissions

In Lewisham there are approximately 200 permanent admissions to care homes each year, giving a rate of approximately 80 per 10,000 residents aged 65 and over. Rates in Lambeth and Southwark are 72 and 78 per 10,000 respectively; however it is not possible to assess whether the differences between these rates are statistically significant.⁷

1.5.2. Rehabilitation Following Hospital Discharge

Eighty-seven per cent of older people (65+) discharged from hospital into their own home or a care home for rehabilitation were in their intended destination (ie home or extra care housing/placement) 91 days after discharge. In England this figure was 82% and 86% for London as a whole¹⁵.

Key Messages

- *About 3500 residents aged 65 and over receive social care services, which represents approximately 14% of the (65+) population.*
- *Half of clients receiving multiple services were aged 85 or over*
- *About 200 people aged 65 and over are admitted to care homes each year*

^{ix} Home care is care provided in an individual's home, normally of a personal nature such help with dressing, washing or toileting.

1.6. Trends

1.6.1. Population

People in the UK and in Lewisham are now living longer lives. In Lewisham life expectancy at birth in 2009-2011 was 77 and 82 years (male and female respectively) compared to 72 and 78 years in 1991-1993.¹⁶

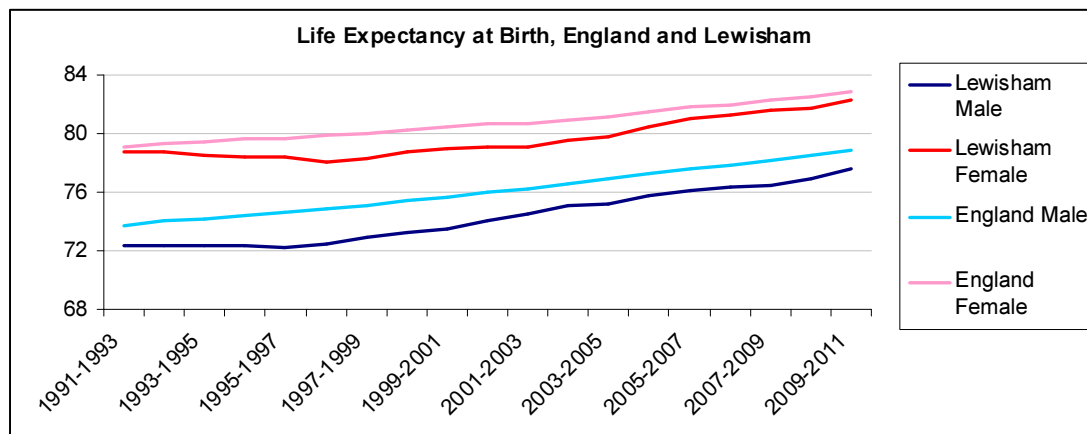


Figure 10 - Life Expectancy at Birth, Lewisham and England¹⁶

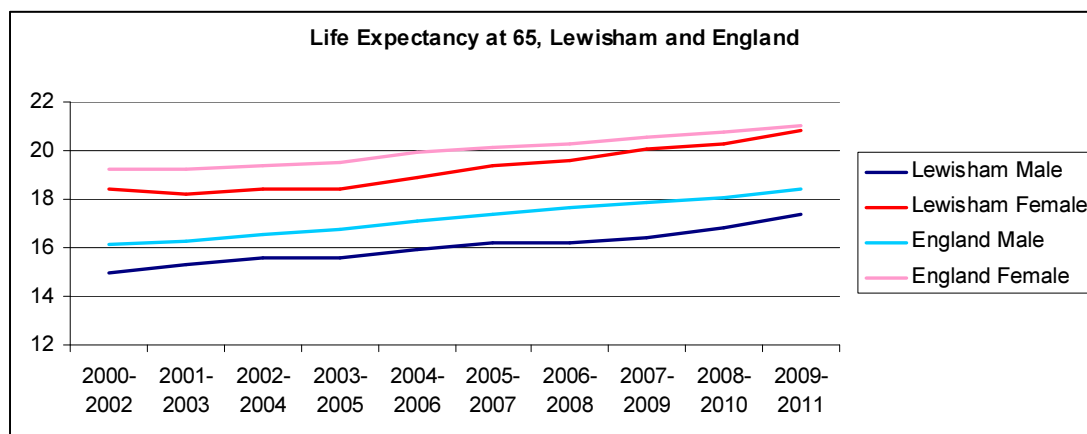


Figure 11 - Life Expectancy at 65, Lewisham and England

This increase in life expectancy is already in some areas and will in others, such as Lewisham lead to a rise in the number of older people in the population. In Lewisham the number of residents aged over 65 years has been stable or even falling slightly over the last decade⁵, despite an overall growth in the population between 2001 and 2011 of about 11%¹⁷.

However population projections suggest that from about 2015 the number of Lewisham residents over 65 years old will begin to rise. (Figure 12) The increase in the number of older people will be larger than in younger population groups, meaning that there will be an increase in the proportion of older people in the population; in 2011 11% of Lewisham residents were aged 65+, by 2041 this is predicted to be 15%.

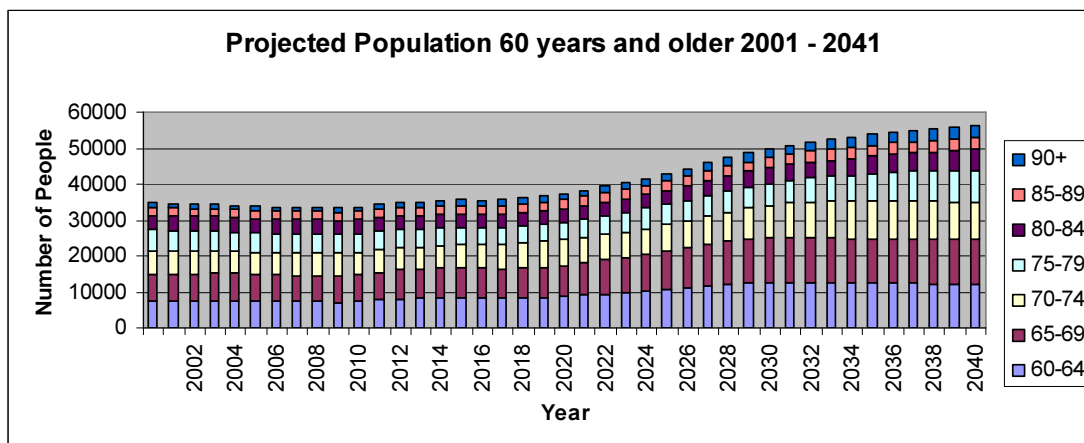


Figure 12 - Projected number of Lewisham residents aged 60 and over 2001 – 2041

The increase in the older population is predicted to be greater at older ages, ie those aged 85 and over. England wide figures suggest that the number of people aged 65 and over will increase by 27% by 2022 and the number of people aged 85 and over by 31%. The projected increases for Lewisham in the same time period are lower at 12% and 20% respectively¹⁸.

	2013	2018	2023	2028	2033	2038
Over 65s	26,808	27,482	29,878	34,288	39,104	42,667
% of 65+	9.5%	9.3%	9.8%	10.8%	11.9%	12.6%
Over 85s	3,604	3,870	4,323	4,791	5,634	6,293
% of 85+	1.27%	1.30%	1.41%	1.51%	1.71%	1.86%

Table 13 - Projected number and Percentage of 65+ and 85+ Population in Lewisham 2013-2038¹⁸

1.6.2. Location

At present there is a fairly clear pattern in the age of the population across the borough with larger numbers of people aged 65 and over living in the south of the borough. (Figure 13)



Figure 13 - Map of Lewisham Wards by Number of Residents Aged 65 and Over, 2011

However the 2041 projections suggest this is likely to become less clear, though still with fewer older people in the north of the borough. (Figure 14)



Figure 14 - Map of Lewisham Wards by Projected Number of Residents aged 65 and over, 2041

The number of older people is predicted to more than double in some wards, namely Evelyn and New Cross, by 2041. However in other wards, including Sydenham and Blackheath, the expected increase is 40% or less. These differences, as well as the predicted numbers of older people across the borough may be helpful in planning services for older people across the borough.

1.6.3. Ethnicity

As would be expected from the differences in the ethnic mix of the younger and older populations in the borough at present the projected increase in residents aged over 65 differs between ethnicities. The projected ethnic make up of the population aged 65 years and over in 2028 shows a reduction in the proportion of white residents and an increase across all other categories. (Figure 15)

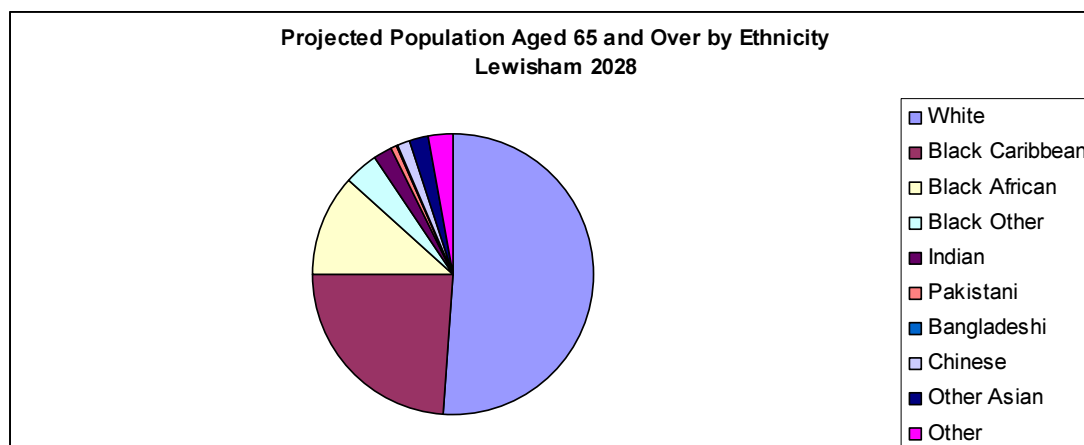


Figure 15 – Projected Population Aged 65 and Over by Ethnicity, Lewisham 2028
(Data from GLA 2011 Demographic Projections)

Ethnicity	2013	2018	Change from 2013	2023	Change from 2013	2028	Change from 2013
White	17,535	17,050	-3%	16,875	-4%	17,251	-2%
Black Caribbean	3,566	4,029	13%	4,889	37%	6,211	74%
Black African	1,207	1,581	31%	2,092	73%	2,762	129%
Black Other	371	453	22%	603	63%	836	125%
Indian	458	542	18%	632	38%	721	57%
Pakistani	76	83	10%	98	30%	112	47%
Bangladeshi	39	55	40%	65	66%	76	92%
Chinese	248	326	31%	402	62%	449	81%
Other Asian	379	481	27%	594	56%	704	85%
Other	285	394	38%	495	74%	623	118%
TOTAL	24,164	24,993	3%	26,746	11%	29,744	23%

Figure 16 - Projected Population Aged 65 and Over Numbers 2013-2028 by Ethnicity

The largest projected increases in older populations are in the Black Caribbean, Black African and Black other groups.

1.6.4. Health

There is much ongoing debate around the question of whether ill-health and disability, both key in predicting future health and social care use, will rise or fall in the face of falling mortality rates in older people. The number of older people with disabilities or LTCs requiring health and social care in the future depends on several factors:

- The prevalence of chronic conditions, which itself may be influenced by a variety of factors including preventative measures earlier in life.
- Treatment - is there optimal treatment available to reduce disability from a LTC or are treatments focused on reducing mortality from LTCs rather than the disabilities they cause?

On the one hand it is possible that the prevalence of disability will fall as mortality rates in old age fall but on the other prevalence could rise as individuals with disabilities survive into old age¹⁹. The trend for healthy life expectancy at 65 in England and Wales has increased approximately in line with the growth in overall life expectancy, suggesting that the prevalence of ill-health may remain fairly constant. However it is important to note that healthy life expectancy is worse in deprived populations, such as Lewisham²⁰.

A recent analysis of health in older people found that obesity prevalence is increasing in that population by about 5% per year¹⁹. Increasing obesity rates in turn will lead to an increase in the prevalence of associated conditions such as cardiovascular disease and stroke. The Nuffield Trust and London School of Economics have estimated that if rates of chronic disease continue to rise in line with recent trends, the number of older people with moderate or severe disabilities is projected to increase by 54% in England.¹⁹

The Department of Health projects that the number of people with one long term condition will be relatively stable over the next ten years. However, those with multiple LTCs is set to rise to 2.9 million in 2018 from 1.9 million in 2008.¹¹

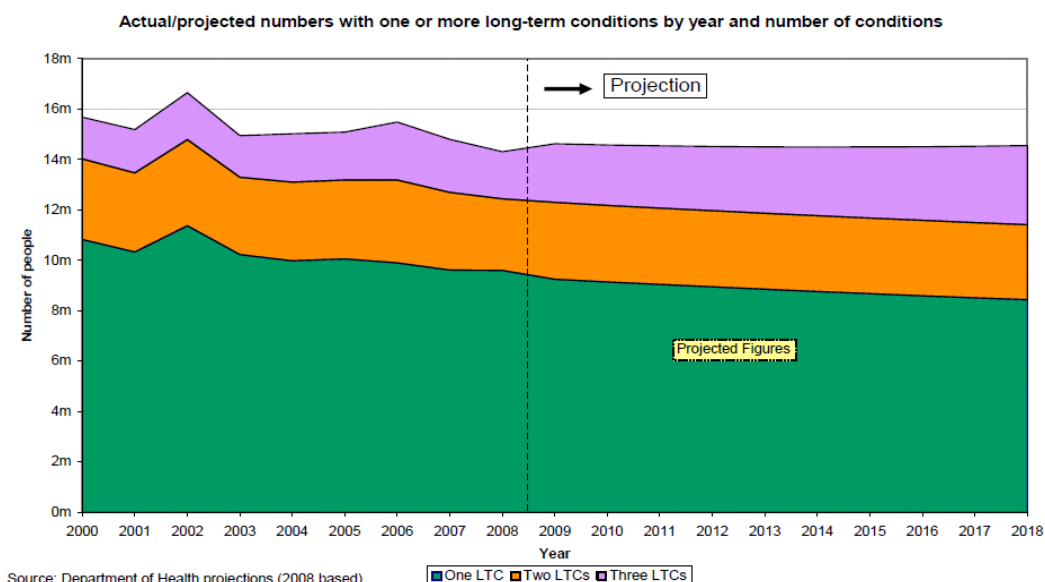


Figure 17 - Actual and Projected Number of People with Long Term Conditions in England and Wales, 2000-2018¹¹

Key Messages

- *Projections suggest that there will be an increase in the 65+ and 85+ populations of Lewisham of about 12% and 20% respectively between 2010 and 2022. So that by 2023 there will be almost 30,000 people aged 65 and over in Lewisham.*
- *Increased life expectancy is leading to this increase in the number of older people.*
- *The number of older people with multiple long term conditions and disabilities in England is expected to increase in the next ten years.*
- *The prevalence of obesity is increasing in older people by about 5% per year.*
- *There is ongoing debate about whether an increase or decrease in the prevalence of ill-health and disability is likely associated with the increase in life expectancy.*

2. Evidence Review

Overview of frailty (concept, prevalence and definitions), tools to identify frail older people and methods to reduce health and social care use in frail older people

Concept of Frailty

Frail older people are at high risk for developing adverse outcomes such as disability, morbidity, mortality, hospitalisation and admission to care homes. Frailty also leads to loss of independence and impairs the quality of life and psychological well-being of older people²¹. It also poses challenges to families and caregivers as well as health, social and other support services. The concept of frailty is therefore useful to help understand the heterogeneity and inequalities of health trajectories with aging and to offer practitioners useful tools for patient care.^{22,23}

Prevalence

Prevalence estimates of frailty differ, depending both on how it is defined and how it is measured. However it has been estimated that in Europe 17% of those aged 65 or older are frail⁴. And in the UK between a quarter and half of people over the age of 85 years are frail²⁴. A UK study of over 600 64-74 year olds, born in Hertfordshire and living in the community found a frailty prevalence of 8.5% for women and 4.1% for men.²⁵

Definitions

Frailty is a relatively new concept, prior to the 1990s it was often seen as another term for disability. Since then definitions of frailty no longer depend on the presence of a long term condition, dependency or need for health and social services^{4,26}. Frailty, disability, co-morbidity and aging are seen as separate but related concepts, one does not necessarily infer or result from the other in an individual. (Figure 18)

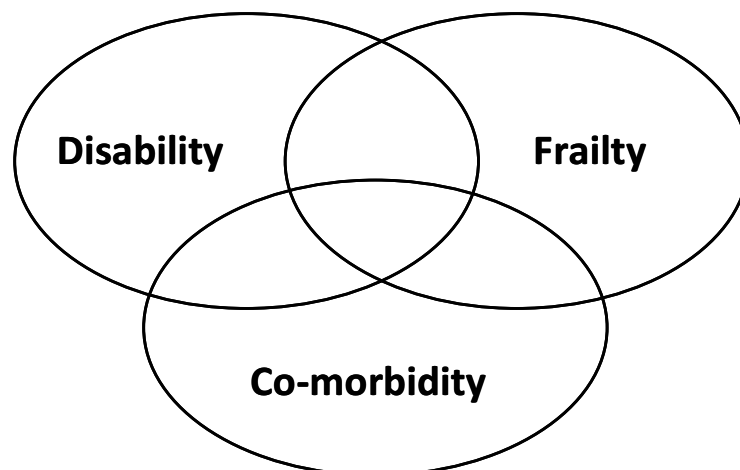


Figure 18 - Disability, Co-Morbidity and Frailty: Separate but associated concepts²⁶

A study in 2001 of over 5000 over 65 year olds explored the relationships between disability, frailty and co-morbidity. It found that less than half of those they defined as frail had at

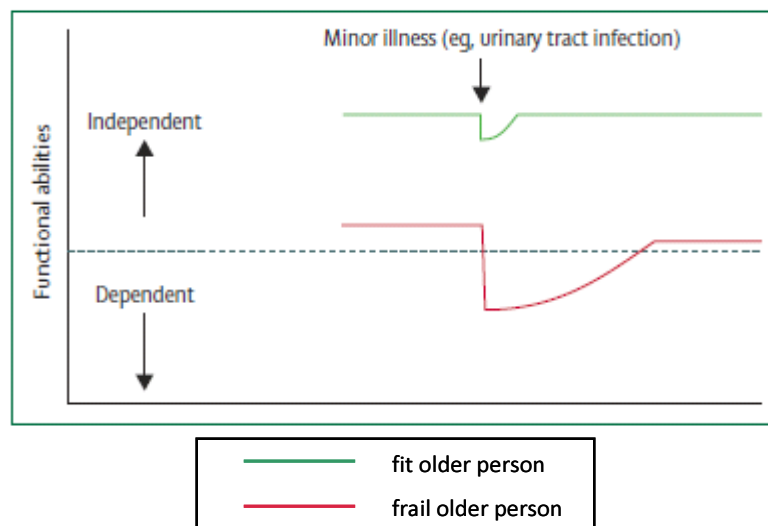
least two long-term conditions^x. Less than a third of the frail were disabled (defined as being unable to perform at least one activity of daily living independently). Over a quarter of the frail had neither a disability nor co-morbidity (at least two long term conditions)²⁶, which makes identifying those individuals challenging.

Frailty

Although the concept of frailty is widely recognised and felt to be useful amongst health and social care professionals there is not a universally agreed definition or criteria by which to judge someone frail. Frailty is not in itself a diagnosis but describes a state, which typically includes:

- an increased vulnerability to stressors due to impairments in multiple, inter-related systems that lead to decline in homeostatic reserve and resiliency;
- failure to integrate responses in the face of stress and
- poor resolution following a stressor event^{4,24,26,27}.

In practical terms this means a small insult can lead to a catastrophic loss of function; such as loss of independence, immobility and delirium.^{4,24}



The green line represents a fit older person who after a minor illness or stressor event such as a urinary tract infection has a small deterioration in function and then returns to previous level of function. The red line represents a frail older person who, after a similar minor illness undergoes a greater deterioration, which may manifest as functional dependency, slower recovery to a functional ability below their previous ability.

Figure 19: Vulnerability of frail older people to a sudden change in health status after a minor illness²⁴

The current debates surrounding the definition of frailty centre on whether it should include solely biomedical factors or also broader cognitive and psychosocial ones. Despite this a number of studies have shown an increase risk in adverse outcomes for the frail, using a variety of definitions and criteria.⁴ It is therefore useful to consider how to identify those who are frail and consider how to minimise the risk of these adverse outcomes. (see later)

^x Myocardial infarction, angina, congestive heart failure, claudication, arthritis, cancer, diabetes, hypertension and COPD.

Frailty and Aging

Aging brings a gradual decline in physiological reserve, through the accumulation of damage to organ systems throughout life; this often leads to functional decline. Age in itself is also a risk factor for many long term conditions which in themselves may reduce an individual's reserve and cause functional decline.²⁸ Aging in an individual is determined by a variety of underlying genetic and environmental factors²⁹. In frailty the decrease in physiological reserve is faster and homeostatic mechanisms start to fail.²⁴ Therefore older people are more at risk of frailty but frailty is not a natural consequence of aging.

Key Messages

- *There is considerable evidence that frailty is associated with adverse outcomes, including disability, morbidity, mortality, hospitalisation and admission to care homes.*
- *Although there are a variety of definitions of frailty, a lack of resilience in the event of minor stressor events is a key element.*
- *Although many frail older people also have disabilities or co- morbidities up to a quarter may not have.*

The following section focuses on three key questions:

- 1) How to identify frail older people (in particular those who are not currently known to health and social care services)
 - a. What tools are available?
 - b. How might those tools be implemented in reality?
- 2) How to identify those older people who are increased risk of hospital admission and high use of social care.
- 3) What can be done to reduce health and social care use amongst frail older people (with particular reference to those with high health and social care use; and those identified through question 2)

During this work it became clear that the identification of frail older people not known to services is a priority locally and hence this became the main focus of the next section.

2.1. Identifying Frail Older People

It is useful to understand how frailty may manifest itself in an individual to consider how best to identify frail older people. Many frail older people could be identified following a “stressor event” such as a fall or minor infection or illness, which, as outlined above, has a significant impact on an individual as a result of their frailty. For example they may suffer reduced mobility or falls, confusion and delirium or fluctuating disability, necessitating a health or social care intervention and often a hospital admission. However, there is an additional challenge for professionals; how to identify frail older people who are yet to experience a stressor event, in effect pre-screening for frailty amongst the general (older) population. Although the tool to identify both these groups as frail could well be the same, the implementation of the tool may need to be different. This section will focus on how to identify frail older people who are not currently well known to health and social care services.

Identification Tools

As with definitions of frailty there is a wealth of tools in the literature that aim to identify older people who are frail and at risk of adverse outcomes. A systematic review in 2011 identified twenty such tools³⁰.

These tools broadly fall into three categories:

- Those that are “rules-based”; defining frailty on the basis of the existence of a set number of criteria, such as the Fried classification;
- Those that are the sum of an individual’s impairments or deficits, such as the Frailty Index.
- And finally those which rely on clinical judgement in interpreting the results of history taking and clinical examination to ascribe and level of frailty to an individual, such as the Clinical Frailty Scale³¹.

Some focus primarily on frailty as a physical syndrome where as others have a broader scope and include social and psychological aspects. The systematic review identified eight key risk factors of the greatest importance to the concept of frailty; these include physical, psychological and social factors;

- Nutritional status
- Physical activity
- Mobility
- Strength
- Energy
- Cognition and mood
- Lack of social contacts
- Social support³⁰

Probably the earliest attempt at developing and validating a comprehensive tool to identify frail older people was in 2000. Fried and colleagues in the USA developed a “phenotype” of frailty and assessed its predictive validity (of an increased risk of falls, hospitalisations, disability and death)²⁶. They used data from the Cardiovascular Health Study of 5,000 people aged 65 and over. The criteria they used represent underlying regulatory systems whose function is impaired in frailty; namely weakness, slowness, reduced activity, low

energy and unintentional weight loss. They defined frailty as at least three of (as assessed by a healthcare professional):

- Unintentional weight loss (of more than 10pounds in the last year)
- Exhaustion (using CES-D depression score)
- Physical activity (based on Kcals of activity per week)
- Walk time (time taken to walk 15 feet (stratified by gender and height))
- Grip strength (stratified by BMI and gender)

Using these criteria frailty was independently predictive of adverse outcomes (falls, hospitalisation, disability and death) with an adjusted odds ratio^{xi} of between 1.3 and 2.24 over 3 years²⁶. This validation was done amongst older people living in the community rather than those living in care homes, which is useful when trying to identify frail older people who are not known to services. Similarly the measurements used are relatively simple and reproducible making it feasible to use in practice; although the self reported weight loss does risk recall bias.

An alternative approach was taken by Rockwood and colleagues (as part of the Canadian Study on Aging and Health) in developing their frailty index, adding an individual's health deficits across a variety of areas³¹. A total of 70 possible deficits are considered, and responses not limited to a binary answer, three or four different variables are offered for some factors. Amongst the 70 variables are; the presence or absence of current diseases, ability in activities of daily living and physical and neurological signs from physical examination. The responses to each of the variables are aggregated to provide a score for an individual. The outputs of this tool have a strong predictive value and the continuous nature of the output score enables monitoring of an individual's frailty over time unlike more rules-based approaches. Although this is the most comprehensive tool in terms of the breadth of factors considered it is time consuming to apply, and unlikely to be practical in day to day clinical practice.

Rockwood and colleagues then went on to consider using clinicians to categorise the frailty of an individual following history taking and examination. Clinicians selected from one of seven categories of frailty on the Clinical Frailty Scale:

1. Very Fit (*robust, active, energetic, well motivated and fit; these people commonly exercise regularly and are in the most fit group for their age*)
2. Well, without active disease (*but less fit than those in category 1*)
3. Well, with treated co-morbid disease (*disease symptoms are well controlled compared with those in category 4*)
4. Apparently vulnerable (*although not frankly dependent these people commonly complain of being "slowed up" or have disease symptoms*)
5. Mildly frail (*with limited dependence on other for instrumental activities of daily living*)
6. Moderately frail (*help is needed in both instrumental and non-instrumental activities of daily living*)
7. Severely frail (*completely dependent on others for the activities of daily living on terminally ill*)

^{xi} The odds ratio compares the likelihood of adverse outcomes in the frail and non-frail groups, an odds ratio of greater than one means that the likelihood of an adverse outcome was higher in the frail group.

Following a clinical interview and with access to information on the individual's diagnoses and previous assessments relating to falls, delirium and cognitive impairment, co-morbidities and function clinicians assigned one of the seven frailty categories above to each individual. The results of the Clinical Frailty Scale and the Frailty Index were strongly correlated and higher frailty scores were associated with a higher risk of death and entry into a care home. The Clinical Frailty Scale is one that would be easier to apply in clinical practice than the frailty index, although the population used in the validation had an over-representation of those with cognitive impairment and in care homes³¹. And it does require the input of an experienced healthcare professional which may limit its use outside healthcare settings.

Following these and other initial tools numerous others have been developed using broadly similar domains in the definition of frailty as outlined above. The mechanism of delivery of the tools varies from self-report questionnaires to healthcare professional scoring or performance tests. Self reported instruments have been developed both as a mechanism of identifying the frail older person independently but also as a pre-screening tool used as a prompt for performing a more comprehensive assessment such as a Comprehensive Geriatric Assessment (CGA). For example the Tilburg Frailty index is a self administered questionnaire which takes about 14mins to complete. It covers three domains: physical, psychological, and social, and asks 15 simple yes/no questions. It has been tested in community-based people aged over 70 and was found to have good predictive validity for disability, need for personal care, need for nursing and informal care and fair for hospitalisation and GP visits³². Where as the abbreviated Comprehensive Geriatric assessment (a-CGA) is based on a notes review and acts as a decision tool for applying the CGA.³²

Each of these tools has been tested in a different setting, with different outcome measures making selecting one tool for the identification of frail older people difficult. There have been a number of attempts in the last few years to provide an overview and analysis of the tools available.^{30,32,33} Perhaps unsurprisingly none have reached a conclusion as to which is the preferred tool; the Frailty Index is probably the most comprehensive measure and the Fried phenotype tool appears the most studied.

In 2008 the European, Canadian and American Geriatric Advisory Panel performed a literature review and suggested an ideal screening tool needed to include the following domains:

- Patient-reported fatigue
- Physical performance
- Walking speed
- Number of co-morbidities
- Nutritional state

Using this approach, SHARE-FI and TFI are most comprehensive tools. The SHARE Frailty Instrument is based on five items: physical exhaustion, loss of weight, strength of grip, walking speed and difficulties in activities of daily living and classifies patients into three (frail, pre-frail and not-frail) groups.

However, in addition to the comprehensiveness of the tool other factors are important including the sensitivity^{xii}, specificity^{xiii} and feasibility of use. The table below summarises and compares the key features of eight of the more comprehensive screening tools used to identify frail older people.

Examples of the questions included in two screening tools (the Tilburg Frailty Index and the Sherbrooke Postal Questionnaire) are included in the appendix).

^{xii} The percentage of people defined as frail by the test who are frail.

^{xiii} The percentage of people defined by the test as not being frail who are not frail.

Tool	DETAILS OF TOOL				GAP DOMAINS						DIAGNOSTIC INDICATORS				
	Format	Equipment ?	Self Report Possible?	Number of Items	Patient Reported	Fatigue	Physical Performance	Walking	Co morbidities	Nutritional State	Population	Outcome Measure	Sensitivity	Specificity	Other
SHARE-Frailty Instrument	Survey, physical test & Web-based calculator	Dynamometer	No	5	X	X	X	X		Primary Care	Mortality				Odds Ratio (2.1-6.9)
Tilburg Frailty Index	Survey	No	Yes	15	X	X	X	X		Primary Care	Mortality	67	61		
											Hospital Admissions (last 12 months)	53	65		
											Development of disabilities	62	71		
Groningen Frailty Indicator	Survey	No	Yes	15		X	X	X		Primary Care	Mortality	73	54		
											Hospital Admissions (last 12 months)	52	55		

											Development of disabilities	71	63
7-Item Rowland	Questionnaire	No	Yes	7	X	X				A&E	Mortality (120 days)	27	82
											Hospital Admission (last 120 days)	23	83
G-8	Questionnaire	(BMI)	Yes	7 + age					X	Cancer Patients	Impairment on CGA	51	97
Vulnerable Elders Survey-13	Self-administered	No	Yes	13	X	X				Cancer Patients	Impairment on CGA	87	62
ISAR (Identification of Seniors at Risk)	Questionnaire	No	Yes	6 + age	X					A&E	Mortality (120 days)	64	51
											Hospital Admission (last 120 days)	65	54
Abbreviated CGA	Screening for CGA	Yes	No	15	X						Impairment on CGA	51	97

Table 14 – Comparison of key features of eight screening tools for frail older people^{32,30}

In addition to these eight, a newer, two-stage, instrument has been developed in the Netherlands to identify frail older people as a target for integrated care. It involves a multistep process and includes the use of information already known to the GP as well as using their clinical experience. The first step of the Easycare-Two Step Older persons Screening (EASYCARE-TOS) involves the GP using the patient record to answer 14 questions about the functioning of the patient in somatic, psychological and social domains; the study found this took between 3 and 10 minutes. Based on the responses the patient is considered frail, not frail or unclear (i.e. there is insufficient information to decide). The second step is a structured assessment, in the model conducted by a primary care nurse, it explores each of the domains in more detail; this took 45-90 minutes on average. Finally a final decision on each patient is made by the nurse and GP which took 2 to 10 minutes; unlike many instruments the final decision of frailty is based on clinical judgement rather than a numerical cut off. The instrument was fairly well received by those involved in the study; six out of seven GP practices involved plan to implement it in their practices³⁴. As described there is a considerable time commitment to using this process, but using a two step approach, and thereby limiting the number of people requiring an in depth assessment, may reduce this. Using a tool as an initial screening for a further assessment means that a high sensitivity is important, but the specificity is less important as those who are not frail can be identified as such in the second step of screening and the screening process does not have side effects or complications.

In summary, there are a large number of tools available to identify frail older people, tested in a variety of settings. If such a tool was used in Lewisham it would most likely be used in primary care and community settings, therefore selecting a tool that has been validated in that population is preferable. There is little information available about the populations the tools were tested on to assess how similar these were to our population in terms of more detailed demographic variables, such as deprivation or ethnicity. It is likely that most of these tools would be appropriate to use in Lewisham to identify frail older people. However there would be an advantage in selecting one tool for use in the borough, to allow comparison and shared understanding between those using the tool locally; i.e. social care, GPs, secondary care, community and voluntary organisations.

Process and Setting for use of Identification Tools

In deciding which tool to use to identify frail older people locally it is important to consider how and in what setting it would be implemented. Using a two step process seems to be the most pragmatic solution; using an initial screening tool to identify those who require further assessment for frailty followed by a more comprehensive assessment. There are a number of options as to where the initial screening could take place:

- *Secondary care* – this is unlikely to identify those who are not well known to services and the use of a risk stratification tool for older people admitted to secondary care is more likely to be useful. (see below)
- *Primary Care* – given the high number of older people who see their GP annually using GP practices for initial screening is appropriate.
- *Community/Self Report* – this would help to reach those older people not known to services but there are some limitations of self-assessment instruments: they often have lower response rates from the most vulnerable (and hence possibly frail) groups; and the reliability of responses from frail older people, especially on cognitive questions, may be questionable³⁵.

Primary care is an obvious target for the delivery of a pre-screening frailty tool. Over 90% of over 75 year olds see their GP at least once a year. Under the initial General Medical Services Contract offering all patients over 75 an annual health check was a requirement. Since the change to the new contract in 2004 this has not been a requirement and there is not a Quality and Outcomes Framework measure that incorporates a similar (non-disease specific) check. However given the high prevalence of long term conditions in older people is likely to mean that many are seen regularly for disease-specific health checks.

There are at least two possible delivery methods for a primary care based screening tool for frailty:

- 1) Self Assessment –Using a tool that can be posted to relevant patients (i.e. those aged 65 or 70 and over) on a practice register. The responses could then be collated centrally and the more comprehensive assessment arranged for those needing it.
- 2) GP assessment – GPs or other practice staff could complete a tool using patient records, this may not be feasible for patients who visit the practice infrequently.

Once individuals are identified as potentially frail using a screening tool they would then need to undergo a comprehensive assessment, ideally by a multidisciplinary team. The contents and structure of this is not considered here, as there is ongoing work on Integrated Care and single point of assessment in the borough.

Key Messages

- *There are a variety of tools available to identify frail older people, from simple self-assessment screening questionnaires through to complex healthcare professional completed assessments.*
- *Many of the tools described have been shown to identify those at increased risk of hospital admission or mortality.*

Recommendations

- **Consider introduction of a simple self-completed (or completed from basic information held by GP practices) frailty screening tool to identify individuals not known to services.**
- **Selecting a particular tool should be determined by the overall strategy for this group of individuals.**

2.2. Risk Stratification

The section above focused on how to identify frail older people in the community who are not known to health and social care services. This section focuses on frail older people who are already users of services and how to quantify their risk of further health and social care use. Inevitably there is some overlap in the methods used, as any tool that identifies someone as frail, will also identify those at more risk of health and social care use.

Although the aim is to understand the risk of use of both health and social care, the majority of the tools developed focus solely in health care. However given that healthcare use is likely to be associated with a reduction in functional ability and hence increased need for social care these tools may identify those at risk of increased use of social as well as health care.

The starting point for the development of many of these tools was an aim to reduce emergency and avoidable hospital admissions. There is evidence that emergency admission rates in the UK are higher in; older people, areas of deprivation, areas with increased morbidity and chronic disease (on GP registers), urban areas and there is some evidence that admissions are higher in black and minority ethnic populations for some conditions such as asthma^{36, 37, 38}. It has been found that emergency admission rates are 60-90% higher in GP practices serving the most deprived populations compared to those serving the least deprived³⁹. Given that Lewisham has sizeable populations that fall into these higher risk categories it is not surprising that its emergency hospital admission rates are higher than the national average.

In principle, there are several ways to identify individuals who may be at high risk of future admission:

- **Clinical knowledge** – this is widely used in the NHS, but there is little evidence in the area. Although clinicians may be able to identify individuals who are currently high risk they may be less able to identify those who may be at risk in the future.⁴⁰
- **Threshold modelling** – this identifies individuals at high risk using a set of criteria, which may include repeated emergency admissions.
- **Predictive modelling** – this involved entering data into a statistical model which then calculates the risk of future admission for that individual.

There is reasonable agreement that in general predictive models provide the best available technique in identifying those at high risk of future admission.⁴⁰ A number of the most widely used and studied tools are described below.

Case finding Using Repeated Age and Repeat Emergency Admissions

It would seem reasonable to assume those that have had a high number of emergency admissions are at risk of repeat admissions and therefore it would be possible to identify those at risk simply using a number of emergency admissions as a threshold. However a pilot of a model that assumed those aged 65 and over with 2 or more emergency admissions to be at risk showed that this was not accurate in predicting their risk of admission within 12 months.⁴¹ This is because of the “regression to the mean” phenomenon for individuals’ risk of admission. A history of two or more emergency admissions in a year is a risk factor for future admission in elderly patients: in the first year after the index year such patients aged 65 still have admission rates that are 3.4 times higher than those in the general population of the same age. But these rates are still much lower than in the index year. In the year after two emergency admissions, the overall emergency admission rate was reduced by 75% in patients 65, without any intervention.⁴¹ A review of HES data has been suggested that about

a third of over 65 year olds with 2 or more emergency admissions in the last year will be admitted again in the next 12 months³⁶. As well as limiting the use of previous admissions as a predictor of future admissions the regression to mean phenomenon is important when evaluating any interventions aiming to reduce admission rates.

Emergency Admission Risk Likelihood Index (EARLI)

EARLI, typically administered by a GP practice, is a six-item questionnaire used to identify patients aged 75 and over who are at high risk of admission. The six questions included were:

- Do you have heart problems?
- Do you have leg ulcers?
- Can you leave your house without help?
- Do you have memory problems and get confused?
- Would you say the general state of your health is good?

Using the responses patients are categorised as low, moderate or high risk of emergency admission in the next 12 months. The tool correctly identified more than half of those at high or very high risk of admission and 79% of those who were not.⁴² One limitation is that this provides a snapshot view of an individuals risk and does not take into account changes in their health over time unless it is repeated.

Patients at Risk of Re-hospitalisation (PARR) and derivatives

This tool was developed between 2005 and 2007 by The King's Fund on behalf of the Department of Health. It systematically identifies patients (aged 65 and over), who have had an emergency admission and are at high risk of future emergency admissions; it uses Hospital Episodes (HES) data and other variables. The identification algorithms include:

- 1) A "trigger event", this is an emergency hospital admission with a reference diagnosis (ie those where the admission is less likely to be unavoidable and that gives a higher risk of re-admission). (Reference diagnoses make up a fifth to a quarter of all emergency medical admissions)
- 2) Patient variables, these include presence of chronic conditions and demographics.
- 3) Community variables, during development of the model it was noted that admission rates between GP practices varied significantly, up to twenty-fold across England. This, in part due to varying thresholds for admission, is therefore incorporated into the model.
- 4) Hospital variables, similarly there was variation in re-admission rates for reference conditions between hospitals and this is included in the model.

The PARR algorithm and software designed to run it was freely available for use to all PCTs in the UK. Unfortunately the Department of Health have not funded an update to this tool and software, which is now eight years old. A further limitation of PARR is that it requires someone to have had an emergency admission to trigger the tool.

Combined Predictive Model

In order to address the limitation of PARR that it can only be used once an individual has been admitted the Combined Model combined secondary care data with GP electronic records. In addition it aimed to improved the predictive accuracy for very high risk patients and allow all patients to be risk stratified. This risk stratification places all individuals into one of four categories and each category is associated with a staged intervention aim⁴³. (Figure 20)

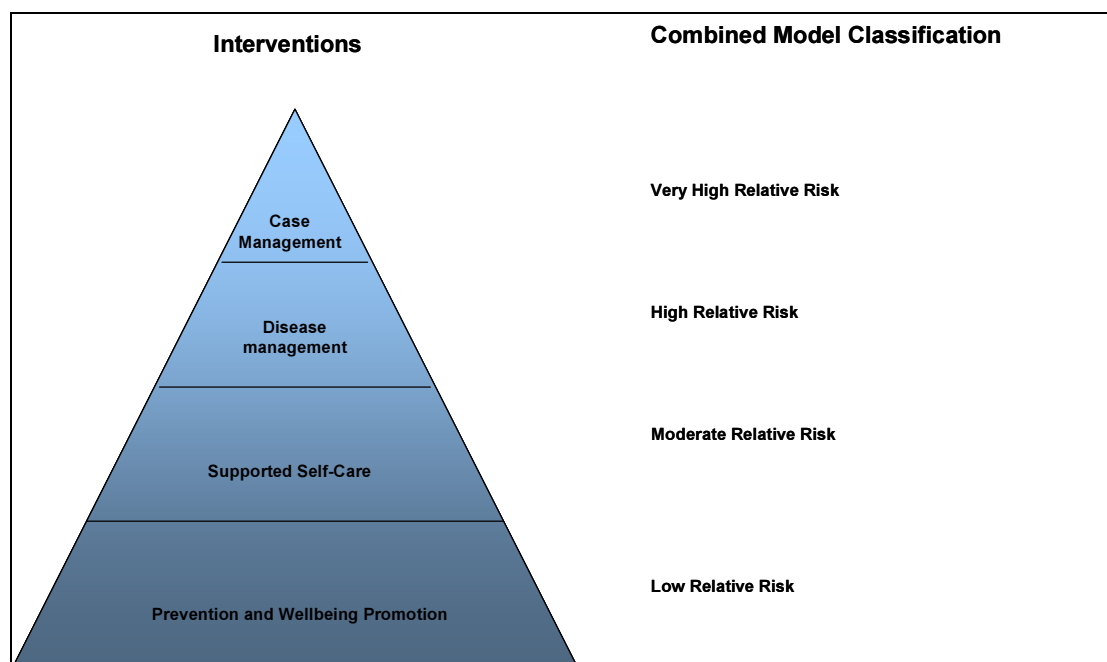


Figure 20 – Classification and Interventions using Combined Predictive Model⁴³

Unlike PARR the Combined Model was not available to download ready for use, as it was anticipated that it would be developed locally. Adding GP data to the tool enables it to be applied to a wider group of patients; however it also brings added complications as the data may not be readily available outside GP Practices and will be less standardised than HES data.

PARR-30

PARR-30 is a predictive model that aims to identify inpatients at risk of re-admission within 30 days of discharge. It is primarily aimed at acute hospital trusts and uses HES data to identify those at risk. The model had a low sensitivity, although this was better amongst some sub groups, it may be that with additional validation work the model will be improved⁴⁴. In England approximately 8% of individuals discharged from hospital are re-admitted within 30 days⁴⁵. Given the low sensitivity and that it aims to identify those at risk of re-admission only in the first 30 days this tool is useful only in a selected population.

Summary Predictor of Key Events (SPOKE)

SPOKe was developed by the Sussex Health Informatics Service; it works by analysing the healthcare history for each resident in Sussex. It is similar to the Combined Model but has been adapted to fit local data availability for Sussex, Kent and Essex. The accuracy of risk stratification is similar to the Combined Model. It has been used predominantly by Community Matrons to prioritise patients for case management and reduce/avoid admissions and historical as well as current scores are available.⁴⁶

United Health UK RISC

RISC was developed by United Health UK for the NHS. It uses information from a variety of sources, including primary and secondary care, to perform a risk assessment for the entire population. It provides both population-wide and individual patient information to facilitate caseload planning and individual case management. A number of PCTs used the tool as part of the Department of Health's Long Term Conditions QIPP (Quality Innovation Productivity and Prevention) Workstream⁴⁷.

Doctor Foster's High Impact User Manager (HUM)

The HUM system was developed in conjunction with Imperial College London and University College London and Dr Foster intelligence. It allows acute hospital trusts and GP practices to access up-to-date information via the web and conduct their own analysis to identify a list of patients who may be or become high-impact users of secondary care. In particular it aims to identify patients with conditions where hospitalisation is at least partially preventable.⁴⁸

Other Models

In addition to those listed there are a number of other models, often developed locally or for use in specific population groups; including:

- **PRISM** is a tool developed for use in Wales. It is applicable to all patients registered with a GP and predicts admission in the next 12 months.³⁶
- **SPARRA and PEONY** (Scottish Patients at Risk of Admission and Re-admission and Predicting Emergency Admissions over the Next Year). These are both Scottish models. SPARRA uses 3 years of linked hospital admission and demographic data and can be applied to individuals aged over 65 who have had an emergency admission in the past 3 years. PEONY can be applied to all patients registered with a GP practice aged over 40 and uses a variety of information included prescribed drugs, number and length of admissions and demographic data⁴⁹.

There are a few other models that were developed as part of a programme to reduce health and social care use amongst frail older people, these are included in the next section.

Models to Predict Social Care Use

Much of the drive to develop tools for risk stratification came from the QIPP agenda. There has been less of a drive to develop similar models to predict social care use. There were some tick-box prediction tools used at individual patient level but the Nuffield Trust model described below represented the first attempt to utilise population level data to identify those at risk of social care use. One of the challenges of using social care data at population level is that there are no ICD-10 equivalent categories and so it can be hard to standardise the data. This makes developing a tool that is accurate across different local areas challenging but should not affect the utility of a tool developed at a local authority/CCG level.

Nuffield Trust's Social Care risk model

In 2009, the Department of Health commissioned the Nuffield Trust to work with a group of Primary Care Trusts and Local Authorities to determine the feasibility of building predictive risk models for social care. Pseudo-anonymised data on a number of variables was used, from health and social care, including inpatient and outpatient episodes and A&E attendances. The tool aimed to predict, within the next twelve months, care home admissions, initiation of at least ten hours of homecare or an increase in social care expenditure of £10,000 a year (in addition three models were compared using £5000, £3000 and £1000 a year increase in spending). The sensitivity of the tool was low, though improved with a lower threshold for the increase in social care expenditure; at a threshold of £1000 the positive predictive value of the tool was 55%. The developers of the tool acknowledge the limitations but do note that those who were classified at high risk were 17 times more likely to have an increase in social care in the following year.⁵⁰

At present the sensitivity of this tool is probably too low to make it useful in identifying patients. However further modifications and, for example the inclusion of primary care data may make it more accurate in the future.

Selecting and Implementing a Tool

Despite the significant number of tools available selecting the most appropriate to use locally is not easy. At present it is not clear whether it is preferable to procure or build a tool at local, regional or national level. Nationally the policy of the Department of Health, despite previously funding the development of two models, is to promote an open market for suppliers of risk tools. The Nuffield Trust has recently published guidance for commissioners in choosing a predictive model.⁵¹ Factors to consider in selecting a tool include:

1. The event it is aiming to predict

The event needs to be undesirable to the patient, significant (probably in financial terms) to health and/or social care, recorded in routine administrative data and preventable. Typically the events used are admissions (unplanned or speciality specific) or increase in social care use. However at a local level it is key that the event the tool predicts is one that fits with the local strategy. For example in Lewisham given the existence of an admission avoidance service and introduction of integrated care would a tool that focused on identifying those at risk of increased social care use be more appropriate?

2. The data required

The majority of the tools use Secondary uses Service (SUS) data from secondary care; in addition others use GP, social care or prescribing data. The tool selected needs to use data that is both available and acceptably accurate locally. The output of any tool is limited by the quality of the data entered. In particular ensuring that Read coding for conditions associated with preventable unplanned admissions is standard across GP practices.

3. *Information Governance and data linkage*

Models that link two sources of data (i.e. SUS and GP) are able to link data using pseudoanonymisation (based, for example, on the NHS number). However if, in addition, links to non-NHS data sources (i.e. social care) are required the linking becomes much more challenging. If the aim locally is to use a tool that combines data sources careful consideration needs to be given to both the data linkage challenges and the information governance implications. The National Information Governance Board for Health and Social Care, in June 2012, published guidelines on the implications of risk stratification activities for the NHS, social care and partner agencies.⁵²

4. *Technical*

The tools already in existence are available in a variety of forms, from algorithms that require local software development to those that are available to download and use without significant local development. There are clear advantages of choosing a tool that can be developed and tailored to the local health and social care economy; however this is likely to incur more costs to implement.

5. *Maintenance*

There are three considerations of maintaining and using a model:

- How often it should be run to generate a list of at risk patients
- How often it should be recalibrated, i.e. altering the weight of the variables within the algorithm to improve accuracy.
- How often/when it should be rebuilt, i.e. adding or removing variables from the algorithm.

The frequency with which each of these needs to be done will depend on the population and the tool, however ensuring that there is local expertise available to be able to perform these tasks is important.

6. *What next?*

The tool is only able to identify a list of people who may be at increased risk of a particular event, be that admission or an increase in their social care use. It is not able to determine which subgroup or individuals should be targeted or which intervention to use. Using the local strategy to determine which group to target should be done before a tool is selected; for example if a decision is made to target the very highest risk individuals with time consuming, costly interventions the tool used has to have a high specificity.

Impactability Models

Although these tools identify people who may be at high risk of unplanned admission/increasing social care use at present they are not able to determine which of those people may be amenable to preventative care. There have been some attempts to refine tools so as to be able to identify the subgroup of individuals who are at high risk and in whom preventative intervention is likely to be successful. Strategies include:

- Excluding those at very high risk (as admissions may be less likely to be preventable and the risk of death prior to intervention is higher).
- Focusing only on ambulatory care sensitive conditions
- Excluding individuals who have been non-compliant with preventative interventions in the past.
- Assessing patients "activation" or willingness to engage in preventative interventions.

- Include patients who have similar characteristics to populations in which preventative interventions have been successful.
- Exclude those who have characteristics that suggest they may be at risk of disengaging with preventative measures.⁵³

Although these tools are at a very early stage in development there are clearly significant potential problems with this approach, particularly in addressing health inequalities in a population.

Key Messages

- *There are a variety of tools available to risk stratify frail older people according to their risk of future hospital admission.*
- *Tools aiming to identify risk of social care admission are not currently well enough developed to be useful.*
- *At present these tools are unable to identify the interventions that would be most effective for those frail older people at risk.*
- *There is not strong evidence to recommend the use of one tool over another (without more detailed information on the intended target for identification and integration, for example targeting the very high risk with a complex intervention would require a highly specific tool , where as a less intense but wider reaching intervention would benefit from a tool with higher sensitivity).*

Recommendations

- **Selecting the most appropriate use for risk stratification locally requires careful consideration to be given to the context in which it will be used.**

Who to Target?

It is clear that there are many tools available to identify or risk stratify frail older people. However a key question remains as to who should be the target, both who should you aim to identify and in the case of risk stratification who should be the target of interventions.

Individuals' risk of future healthcare use varies; this has commonly been represented in the Kaiser pyramid. The pyramid shows that the very high risk group represent a very small proportion of the population but each account for a disproportionately large share of future healthcare use.

Risk segmentation

The Kaiser pyramid can be divided into four segments:

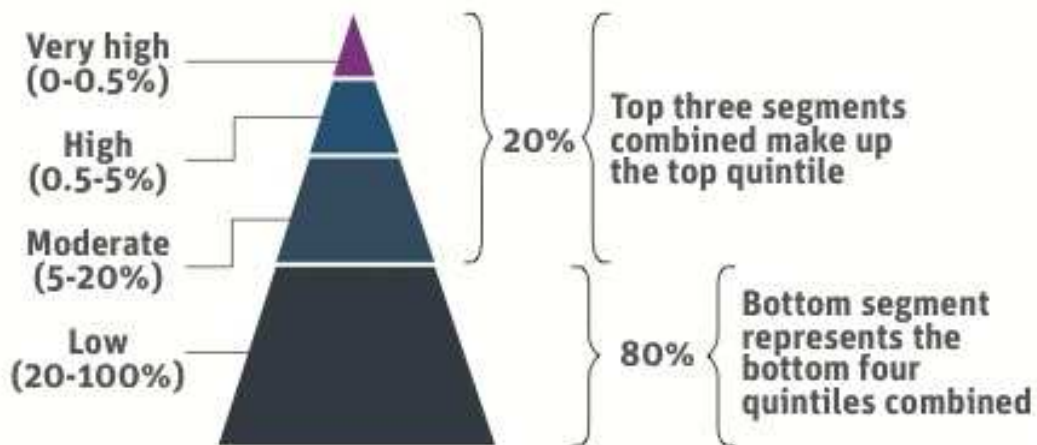


Figure 21 - Kaiser Pyramid of Risk of Future Healthcare Use⁵¹

Risk stratification tools aim to provide information on individual's within a particular population in each of these risk "segments". At strategic service planning level these tools can provide information on the number of these individuals. And for service delivery it can provide details of individuals at each risk level to be targeted with an appropriate intervention.

However in using these tools and in particular in planning interventions based on the outcomes it is important to consider where the greatest impact is on the health service locally; by taking into account both the size of the population and the level of use. Moving down the pyramid, the population size increases so although each individual accounts for a smaller proportion of future utilisation than those in the high-risk category, in aggregate these lower-risk populations will represent a greater proportion of future utilisation because there are far more such people. It is important, therefore, that any intervention be targeted carefully at the right population after having taken account of the expected impact, cost and local feasibility of the intervention. (Figure 22)

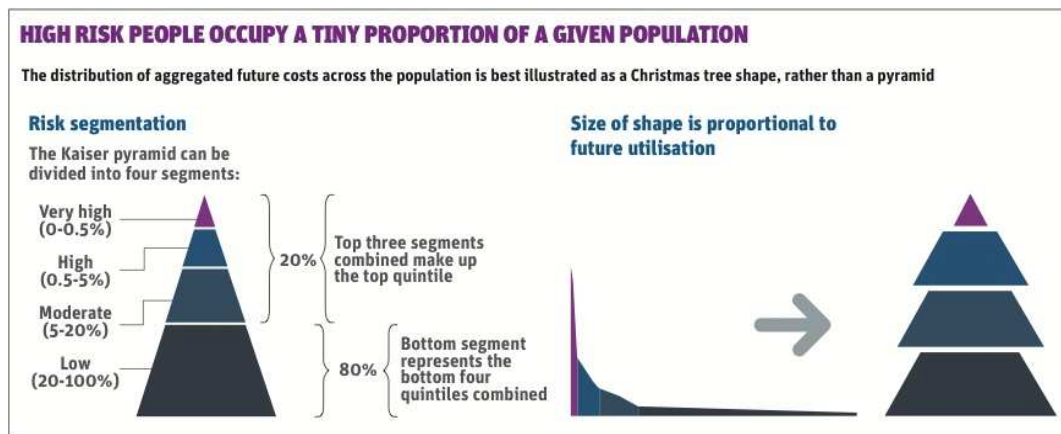


Figure 22 - Risk of Future Healthcare Use and Population Size⁵¹

Prior to starting to decide which tool or intervention to use it is vital to be clear about what it is you want to predict (i.e. early identification of frail older people at risk of falls, hospital admission and deteriorating health and wellbeing rather than predicting health and social care use in those who are already high users of those services). Similarly to maximise the gain in using an identification or risk stratification tool it needs to be embedded in a wider strategy for managing older people. For example in the case of Lewisham this would include:

- Integrated care,
- Long term condition management,
- Falls management,
- And others.

2.3. Approaches to reduce health and social care use

This section initially sought to consider which measures are effective in reducing health and social care use amongst “high-end service users”, i.e. those who are “high risk” using a risk stratification model. However as early identification of the frail elderly became more of a focus this section provides a brief overview of measures that have been found to be effective in reducing hospital admissions in that group and some practical examples of how a tool may be used and integrated at a local level.

2.3.1. Reducing Hospital Admissions

Reducing hospital admissions has been the focus of many interventions over the past few years, on both local and national levels. Understanding which interventions are most effective is challenging for a number of reasons:

- Admission rates are affected by many factors, therefore separating out any impact an intervention has had on admissions locally is difficult.
- Many interventions are complex and multi-faceted, meaning that if there is a reduction in admission rates it can be difficult to identify which element of the intervention was effective. Similarly it may be challenging to reproduce such a complex intervention in a different context.
- For some interventions there is conflicting evidence about its effectiveness. This may be as a result of interventions being subtly different between studies, differing populations with different admission behaviours or as a result in differences inherent in the study designs.

The King’s Fund in 2010 provided an overview of the research evidence on what works in reducing unplanned admissions³⁶. (Figure 23)

Evidence Generally of Little or No Effect	Further Evidence Needed	Evidence Generally of Positive Effect
<ul style="list-style-type: none"> •Pharmacists-based medication reviews •Intermediate care •Community – based case management •Early discharge to hospital at home •Nurse-led interventions pre and post-discharge for patients with COPD 	<ul style="list-style-type: none"> •Increasing GP practice size •Changing out-of-hours primary care arrangements •Telemedicine •Cost-effectiveness of GPs in A&E •Access to social care in A&E •Hospital-based case management •Rehabilitation programmes •Rapid response teams 	<ul style="list-style-type: none"> •Continuity of care with a GP •Hospital at home at as alternative to admission •Assertive case management in mental health •Self-management •Early senior review in A&E •Multidisciplinary interventions and telemonitoring in heart failure •Integration of primary and secondary care •Structured discharge planning •Personalised health care programmes

Figure 23 - Evidence for Interventions to Reduce Hospital Admissions or Re-admissions (adapted from King's Fund Report³⁶)

Self- Management

There is evidence from systemic reviews that self-management is effective in reducing unplanned admissions for long term conditions including asthma and COPD. One study in COPD patients found that providing self-management education to ten patients with (fairly severe) COPD for a year prevented one admission⁵⁴. Self management has also been shown to reduce symptoms and improve quality of life. There have also been some studies that did not find an improvement in admissions when providing a self-management intervention, but the weight of evidence is in favour.

However the extent to which this is applicable to frail older patients is questionable. For example given self management has not been shown to reduce unplanned admissions for every LTC what would the impact be on frail older people without a LTC. Similarly do frail older people with a LTC respond to self management education in the same way as the general population with LTCs?

Continuity of Care with a GP

High continuity of care is associated with lower hospital admissions. A study in Canada that looked specifically at people aged 67 and over found continuity of care with a family doctor reduced the odds of a hospital admission with an ambulatory care sensitive condition⁵⁵ (i.e. one in which a primary care intervention should be able to prevent the admission).

Out of Hours GP Services

A five-fold variation in out-of-hours admission rates has been found between GPs working in the same out-of-hours service with the same population. Follow up qualitative research with those GPs suggested this may be due to lack of confidence, feelings of isolation, aversion to risk and lack of awareness to alternatives to admission.^{56,57}. The factors are modifiable, particularly the lack of awareness of alternatives, though it does raise the question of how many of the alternatives are available out-of-hours.

Telemedicine

The majority of evidence for the use of telemedicine is in diabetes or heart failure, and predominantly from the USA, where it has been shown to reduce hospital admissions. In the UK there is less evidence but two reviews suggest that it may reduce hospital admissions. Automated vital signs monitoring and telephone follow up by nurses appear to be the most effective interventions.³⁹ Again, given the evidence base for the use of telemedicine is in people with particular LTCs it is hard to know if it would be effective in frail older people in general.

Case Management

The initial stage of case management involves the identification of at-risk individuals using a risk stratification model as outlined above. What then follows is variable, particularly when compared internationally; typically case management in the UK is less intensive than the USA; which may include health visitors to visit older people at home. Although there is evidence for case management in some conditions, most notable mental health it is not universal and the Evercare model in frail older people did not reduce hospital admissions (see below). There is some evidence for using patient advocacy case management in frail older people to reduce service use.³⁶

Hospital at Home

Hospital at Home, as an alternative to admission for the older people who are clinically stable, is less expensive and associated with greater levels of satisfaction. However it was also associated with slightly higher levels of subsequent admission.³⁶

Intermediate Care

There is conflicting evidence regarding the use of intermediate care. One review of evidence concluded that it did not reduce admissions.³⁶ However a slightly more recent review of nurse-led units used following discharge from an acute hospital found that it did reduce early re-admissions, but that it was more expensive than inpatient stays.⁵⁸

Integrated Care

There is evidence that integrating primary care and social care reduces admissions, in particular when used in high-risk older people⁵⁹. There is also evidence for the integration of primary and secondary care in reducing admissions. Particularly when used to provide disease management for patients with certain conditions. (Though isolated provision of hospital specialist clinics in primary care is not effective at reducing admissions)

Acute Assessment Units (AAUs)

Whilst there is some evidence that these reduce admissions the numbers of short admissions has been rising considerably, raising the question of whether there has been a reduction in the admission threshold associated with the 4 hour target in A&E and use of AAUs.³⁶

Senior Review in A&E

Availability of a senior doctor (experienced middle-grade/consultant) in A&E to review patients has been shown to reduce admissions.³⁶

Discharge interventions for Reducing Re-admissions

There is strong evidence that structured individualised discharge planning reduces readmission rates (by 15% in randomised controlled trials).⁶⁰ Discharge to hospital at home was associated with an increase in re-admission rates in older patients³⁶.

2.3.2. Examples of Implementation of Frail Older People Identification Tools

Evercare⁶¹

In April 2003 UnitedHealth Europe piloted the Evercare case management model for older people in the UK. Patients were selected on the basis of age (≥ 65) and a history of emergency admissions. Advanced practice nurses then agreed individualised care plans with the patient, the general practitioner, and other staff. And patients were subsequently monitored.

Quantitatively the intervention did not reduce hospital admissions, bed days or mortality in the GP practices in which it was implemented. However the authors note, from qualitative data, that access to case management added a frequency of contact, regular monitoring, psychosocial support, and a range of referral options that had not previously been provided to frail older people.

Waltham Forest Case Finding Service⁶²

Since 2002 Waltham Forest have had a frail older people case finding service. It was established to identify frail older people in the community who may be at risk of increasing dependency on services, to initiate a Single Assessment Process where appropriate and deliver co-ordinated services in the community. They adopted a generalised case finding approach:

- GPs identified all their patients aged 65 and over and made their information available to the programme.
- Frailty self assessment questionnaires were posted to the patients identified above, alongside a letter about the programme from the GP.
- Completed questionnaires are returned to Age UK Waltham Forest, where they are scored and those who identify as potentially frail/with unmet needs undergo a Single Assessment Process, those who do not receive health promotion information and signposting to community services.
- Following assessment in addition to referrals to statutory services people may also be referred to other services such as falls prevention, healthy living, handyperson and home security information.

One clear advantage of this generalised case finding approach is that it means wider aspects of frail older people's lives can be assessed and, if needed, addressed. Although these wider aspects are not purely health issues, they are ones that can have an impact on health and wellbeing. Examples of these wider aspects include: heating or housing repairs, isolation and lack of confidence in using community facilities and income maximisation.

Case Finding & Single Assessment Pathway

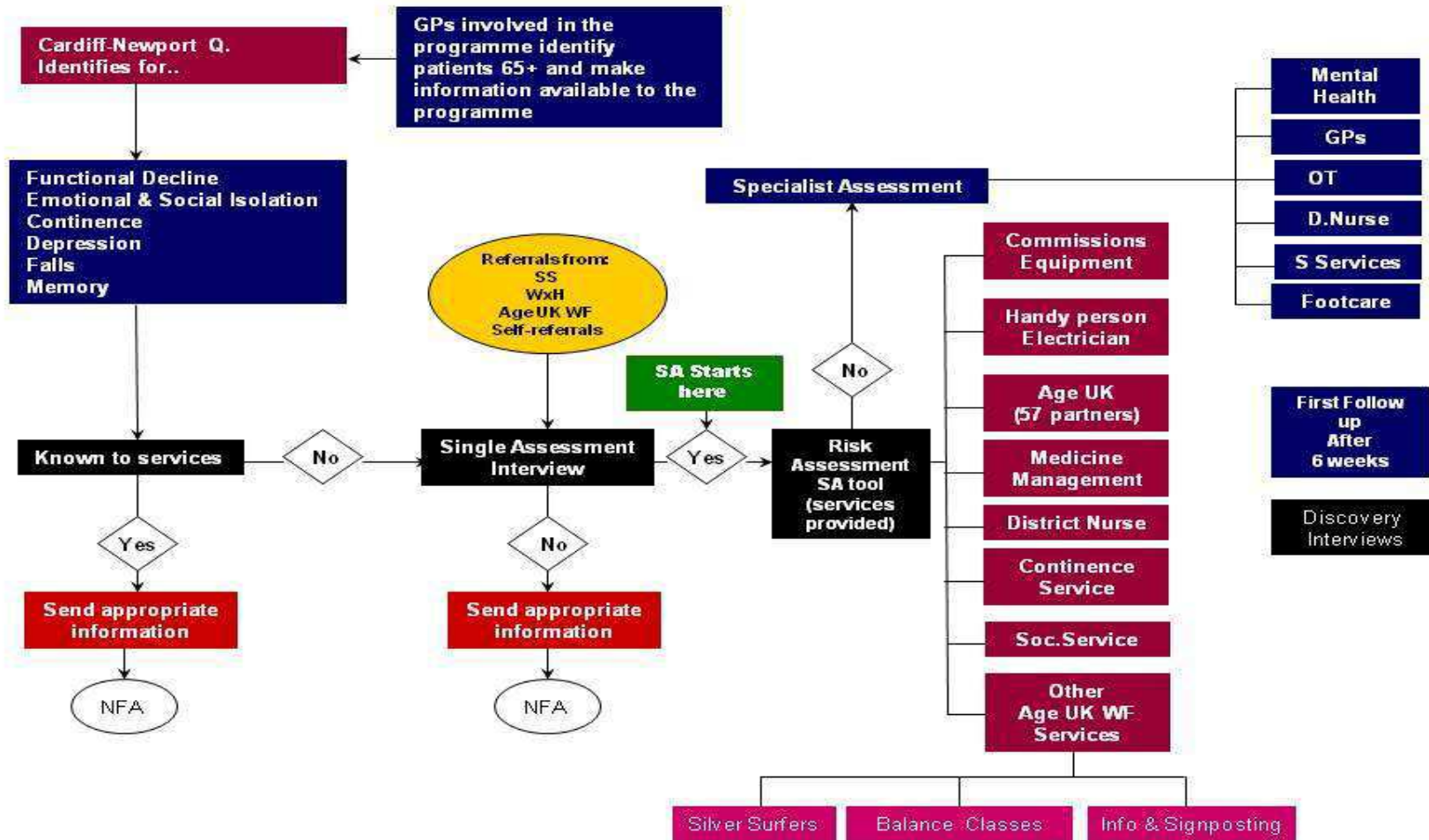


Figure 24 Waltham Forest Care Finding Service Outline

The questionnaire used by Waltham Forest is the Cardiff-Newport self-reporting questionnaire which includes 30 questions covering⁶³:

- Home circumstances and carers
- Recent health
- Present medication
- Physical handicap, mobility
- Fall and falls risk
- Shopping
- Social activities
- Activities of daily living (housework, personal care, dressing, bathing)
- Continence
- Eyesight and hearing
- Independence
- Memory, depression, anxiety
- Present use and perceived need for services
- Changes in past year and present concerns

The Cardiff-Newport questionnaire was originally developed and tested using a randomised trial of 359 GP patients aged 65 and over in Wales in the early 1990s. The questionnaire was validated using a geriatric health visitor as gold standard as a tool for identifying frail older people. It was found to have a sensitivity of 89% and specificity of 78%. Each person who completed the questionnaire was then seen by a nurse, follow up was for 3 years. The response rate was 88%, with younger and more active individuals being less likely to complete the questionnaire. Mortality in the intervention (i.e. questionnaire and nurse appointment) group was significantly lower than the control group. Hospital admissions and long-term residential care were not significantly different⁶⁴.

The Waltham Forest service has reached 45% of all residents over 65 in the borough in its first 11 years (from 2002 to 2011). It had a response rate of 47% to their postal questionnaires and about half of those returning questionnaires were referred for a Single Assessment. Over the first 11 years:

- 5772 questionnaires were completed
- 26% of older people were identified as taking 4 or more medications without them having been reviewed appropriately.
- 6200 risk factors, that were not previously known, were identified
- 300 people who had falls were found
- A further 1000 people at risk of falls were identified
- 1000 people were found to have memory problems
- 140 people were found to have depression
- 1800 people were found to be socially isolated
- 1700 people received services (this included a variety of services)

Of note if a similar service were to be considered in Lewisham, the Waltham Forest service found that the response rate to the questionnaire was lowest amongst BME communities. The service discovered this was because individuals in those communities were unable to read, write or speak English and responses from BME communities have improved since they employed an Asian-speaking Single Assessment Officer.

Waltham Forest is an ethnically-diverse London borough, with people from Pakistan making up the highest proportion of the BAME population, followed by Black Caribbean and black

African. It ranks 13th in the country in terms of Index of Multiple Deprivation. Hospital admissions and falls rates are above the England average for people aged 65 and over in Waltham Forest (comparisons between boroughs are not statistically valid)⁷⁶⁵. Therefore there are similarities between the populations of Lewisham and Waltham Forest, which is useful in considering utilising their case-finding model locally.

Camden: Integrating Care for People with Chronic and Complex Needs⁶⁶

Camden define frail older people, using the Edmonton frailty index (or similar), though it is not clear the mechanism of identification. Frail people with complex needs are placed on a “frailty register”, there are about 280 patients on the register. A weekly MDT between primary care, secondary care, mental health and social care discusses these patients. Prior to this MDT care 86% of days were spent at home by the cohort of patients, following the intervention 95% of days are spent at home.

Greenwich⁶⁷

Greenwich has recently undertaken a large review of individuals in receipt of homecare and found high levels of hospital admission and cardiovascular disease. They identified a need to optimise use of preventative measures for homecare clients and that a large number of new services had been introduced over the last five years. Hence there was a need to link these services and ensure client-facing groups are aware of and make use of these services. They have introduced a health assessment tool that is able to identify local services that the individual may benefit from. In addition a single referral process for these services is provided. Healthy ageing leads will support social care staff in performing these assessments and referrals.

As this service model was implemented in 2012 there is no evaluation data available. However if a similar model is to be considered in Lewisham understanding any challenges or modifications they experienced during implementation may be helpful.

Key Messages

- *There are a number of models available for how to use identification tools locally.*
- *In all cases the key is to ensure a system-wide approach and design that enables linkage with services that are already in place*

Recommendations

- **Once a clear target population is identified, for example frail older people not known to services a more detailed review of existing programmes, including evaluation and their working context would be valuable.**

Conclusions and Recommendations

The population is ageing as a result of increasing life expectancy, it is not clear whether current rates of ill health and disability will increase or decrease. But there will certainly be a significant increase in the number of older people requiring health and social care in the next ten to twenty years.

Defining frailty is difficult but a lack of resilience in the event of minor stressor events is a key element. A quarter to a half of over 85 year olds in England are frail. Although many frail older people also have disabilities or co- morbidities up to a quarter may not have, which can make identification a challenge. Though this is a challenge that needs to be undertaken given that frailty is clearly associated with poorer health outcomes including an increase in mortality.

There are plenty of tools available to identify frail older people, using a self-filled questionnaire or simple interviews and examinations. Similarly identifying older people at increased risk of hospital admissions is possible through the use of predictive modelling tools. Unlike the identification tools these require more complex data inputs and software to provide meaningful information.

A key question is considering frail older people is which group to target for interventions, those with very high use of services (a small number) or those who are not currently using services but who are frail and hence also at risk of worse outcomes. It may be that the second group could benefit from simple, existing interventions but they do not receive them as they are not known to those who could recommend them.

Recommendations:

(Assuming that frail older people not currently known to health and social care services are a priority as a target)

- *A more detailed review of implementation of frailty identification tools in practice, including their impact, feasibility and comparison to Lewisham of the context in which they implemented. (population factors and existing services including non-statutory)*
- *Mapping of existing services for older people in Lewisham, with a view to considering how these might be incorporated into an identification and referral process.*
- *Trial a simple identification tool in a small area to understand how large the population of unidentified frail older people is.*
- *On the basis of above consider piloting a programme of screening older people for frailty, providing those at risk with a more comprehensive assessment which acts to sign post individuals to existing preventative services.*

Appendix

Examples of the questions included in frailty screening tools:

The Tilburg Frailty Indicator (TFI)

Physical component

Do you feel healthy?

Have you lost a lot of weight recently without wishing to do so?

('A lot' is 6 kg or more during the last six months or 3 kg or more during the last month.)

Do you experience problems in your daily life due to:

Difficulty in walking?

Difficulty with maintaining your balance?

Poor hearing?

Poor vision?

Lack of strength in your hands?

Physical tiredness?

Psychological component

Do you have problems with your memory?

Have you felt down during the last month?

Have you felt nervous or anxious during the last month?

Are you able to cope with problems well?

Social component

Do you live alone?

Do you sometimes wish you had more people around you?

Do you receive enough support from other people?

Scoring:

Question 1: Yes = 0; No = 1

Questions 2-8: No = 0; Yes = 1

Question 9: No = 0; Sometimes = 0; Yes = 1

Questions 10-11: No = 0; Sometimes = 1; Yes = 1

Question 12: No = 1; Yes = 0

Question 13: No = 0; Yes = 1

Question 14: No = 0; Sometimes = 1; Yes = 1

Question 15: Yes = 0; No = 1

The Sherbrooke Postal Questionnaire (SPQ)

1. Do you live alone?
2. Do you take more than three different medications every day?
3. Do you regularly use a cane, a walker or a wheelchair to move about?
4. Do you see well?
5. Do you hear well?
6. Do you have problems with your memory?

Scoring:

Question 1: Yes = 0; No = 1

Questions 2-3: No = 0; Yes = 1

Questions 4-5: Yes = 0; No = 1

Question 6: No = 0; Yes = 1

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HEALTH AND WELLBEING BOARD			
Report Title	Older people's housing in Lewisham		
Contributors	Genevieve Macklin, Head of Strategic Housing	Item No.	5
Class	Part 1	Date:19 November 2013	

1. Purpose

- 1.1. The purpose of this report is to update the board on the Council's strategy to improve Older People's Housing and how this can contribute to the health and well being of Lewisham's older population. The report also summarises the wider connections between housing, health and well being for future consideration. The Board is asked to make suggestions for the further development of the Older People's Housing Strategy and consider how more integrated working between housing, health and social care might achieve better outcomes for our older population.

2. Recommendation/s

Members of the Health and Wellbeing Board are recommended to:

- 2.1. Note the contents of the report; and
- 2.2. Comment on the emerging Older Persons Housing Strategy; and
- 2.3. Consider how older persons housing can best contribute to the integrated care programme; and
- 2.4. Agree to a further discussion at a future Board meeting on the wider connections between housing, health and well being.

3. Policy Context

- 3.1 Lewisham's Health and Wellbeing Strategy recognises that health and well being is influenced by wider social and economic determinants such as housing. It identifies the need to create physical and social environments that encourage healthy habits, choices and actions.
- 3.2 Addressing issues relating to the quality and quantity of housing stock in the borough relates directly to the Council's Sustainable Communities Strategy (clean, green and liveable) and to the Council's corporate priorities (decent homes for all).

3.3 This report will focus on the development of an Older People's Housing Strategy and plans for new build, the key policy documents for this are:

3.4 "Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society" (Department for Communities and Local Government (2008)).

Underpinning the document were three key assumptions:

- That specialist housing for older people should not just mean social housing but all forms of housing in which older people might live;
- That if more older people are to remain in their own homes then this requires the integrated activity of the local authority and the health service; and finally
- That staying in the community means more than just good housing, it means developing communities that 'work well' for older people.

3.5 The Wanless Review, 'Securing Good Care for Older People' analysed clear preference by older people to remain their family home, many older people contemplate a move to alternative accommodation, although few people wish that to be residential care.

3.6 This report should be read in conjunction with the 'Frail Older People in Lewisham Demography and Literature Review' (August 2013).

3.7 National research HAPPI (Housing our Ageing Population: Panel for Innovation), and HAPPI2 (Housing our Ageing Population: Plan for Implementation) identify good practice design elements for housing for older people:

- Space and flexibility
- Daylight in the home and in shared spaces
- Balconies and outdoor space
- Adaptability and 'care ready' design
- Positive use of circulation space
- Shared facilities and 'hubs'
- Plants, trees, and the natural environment
- Energy efficiency and sustainable design
- Storage for belongings and bicycles
- External shared surfaces and 'home zones'

4. Background

4.1. Housing is one of the key determinants of health and well being. Poor housing and homelessness cause or contribute to many preventable diseases and injuries, premature deaths and poor health outcomes. Not only do these impact detrimentally on physical health, mental health and wellbeing, they can also impact on individual achievement including work and school attainment and attendance. Good housing contributes positively towards most of the health and wellbeing indicators.

- 4.2. Joint working is needed to ensure that our housing objectives make an active contribution to improving health and wellbeing. Increased awareness and recognition of the housing agenda for health and vice versa is important amongst housing and health professionals.
- 4.3. By improving housing quality, reducing homelessness and reducing inequality, housing plays a particularly key role in prevention and early intervention to address health and social care needs.
- 4.4. The Council has a number of initiatives to improve the quality and availability of housing in the borough, both in the social rented sector and private sectors. These include a return to active house building to maximise volume and quality of new supply, particularly in the social housing sector, and a particular current focus on improving the standard of specialised housing for older people. In addition the Council has well developed partnerships with other housing providers operating across the borough through which it is able to influence the quantity and quality of housing provision.
- 4.5. Housing affects the health and wellbeing of people of all ages, not just the older population. This report focuses on older people's housing. Further reports can be provided across the full range of housing issues as required by the Board.

5. Older People's Housing Strategy

- 5.1. Our strategy for older people's housing will ensure that there are a range of housing options for older people in Lewisham whether they are: active and pre-retirement; retired, independent and active; more frail and in need of support. We want to help people to maintain their independence for as long as possible and we want people's homes to be:
 - suitable for their changing needs
 - attractive, spacious and well located
 - safe and secure
 - affordable
 - warm in the winter, comfortable in the summer
 - able to maintain and improve people's health and wellbeing
- 5.2. Our Older People's Housing Strategy will take into consideration all available information on where people currently live, the accommodation choices they make, and the other services they access. The strategy will look at the housing needs of all older people within the borough – irrespective of whether a person owns their own property, or rents from the Council, Housing Association or a private landlord.

The strategy will cover:

- Key facts about older people in Lewisham and their housing choices
 - A new model for older people's specialist housing
 - Access to information and advice
 - Aids and adaptations
 - Initiatives to support older people in general needs housing
- 5.3. Key outcomes of the Older People's Strategy which support the aims of the Health and Wellbeing Strategy and the objectives of the Integrated Adult Care Programme are:
- Improved independence
 - Reduction in numbers and duration of hospital admissions
 - Help to stay at home for longer
 - Reduced social isolation
 - Improved Health and Wellbeing
 - Linking people with neighbourhood and community resources
 - Providing Care and Support as and when needed
 - Further developed intermediate support when people are discharged from hospital
- 5.4. To date, the focus has been on gathering intelligence and developing the vision for specialist housing. The Council has run a series of consultation events to engage with older people about the emerging vision for specialist housing, and this has been well received. These events include a specific meeting for Positive Ageing Council members and partners to discuss the main themes of the Older People's Housing Strategy, and short presentations and table discussions at community centres and tea groups from the Positive Ageing Council mailing directory. Officers have also attended Lewisham Pensioners' Forum to discuss the strategy.
- 5.5. The next steps for the development of the strategy are:
- further consultation to better understand the needs and housing aspirations of older people in general needs housing
 - further joint working with partner organisations
 - further developing the interface between health, social care and housing

6. Existing Older People's Housing

- 6.1. Over 90% of older people in Lewisham live in general needs housing, and will continue to do so. National studies show that the majority of older people want to stay in their own homes and express a particular desire to avoid residential care. As a result, the proportion of older people living in specialised housing will continue to be a small proportion of the older population. There is a need to ensure that specialised housing is appropriate and suitable for the older population in the borough. Currently in LBL there is an oversupply of designated

general needs older people's housing, too much use of residential care, and an undersupply of suitable extra care.

- 6.2. In Lewisham there are 1,138 units of Sheltered Housing for Social Rent, of which 483 units are with Lewisham's Housing stock. There are 183 units of sheltered housing for lease.
- 6.3. In addition there are an additional 1,700 units of council and housing associated housing which are designated for older people, but which operate on a general needs model.
- 6.4. There are currently 135 Extra Care Units in the borough, of which 55 are council-owned. The other 80 units are owned and managed by Housing21.
- 6.5. In October 2013 there were 307 older people in residential care placements, with a further 355 older people in nursing care.
- 6.6. The council-owned sheltered and extra care housing requires substantial investment to bring it up to modern standards, and in some cases this may not be achievable. As part of the delivery of the Older People's Housing Strategy, a comprehensive asset strategy will be developed, and initial feasibility is underway.

7. New build extra care in Lewisham

- 7.1. In the short-term the Council wants to take advantage of opportunities to develop well-designed and accessible specialist housing for older people.
- 7.2. The Council is working on a new model for modern extra care housing developments incorporating a mixed dependency model and a strong community focus.
- 7.3. Through these developments, the Council expects to see improved outcomes in the following areas:
 - Improved independence
 - Reduction in numbers and duration of hospital admissions
 - Help to stay at home for longer
 - Reduced social isolation
- 7.4. 189 new units of extra care will be built in the borough by the end of 2016 in three developments, details of which are set out below:

Marine Wharf

- 7.5. In June 2014, a new build extra care scheme is due to complete at Marine Wharf, SE16. This scheme has been developed by Berkeley Homes, who have partnered with Notting Hill Housing Trust. The scheme is made up of 78-units of extra care.

Chiddingstone

- 7.6. Lewisham has been awarded nearly £2.5 million from the Mayor of London's Care and Support Specialised Housing Fund to develop a flagship 51-unit extra care scheme in Lewisham Park by 2016. This funding was administered by the Mayor of London on behalf of the Department of Health. The Council will partner with a registered provider to deliver the scheme, and further details on the procurement and delivery of the scheme will be made available in further updates.

Hazelhurst

- 7.7. Phoenix Community Housing Trust have also been awarded £2.6 million from the same grant funding programme towards the development of a £9.3 million 60-unit extra care scheme on the Hazelhurst site, near Beckenham place park. Phoenix have submitted a bid to the Council for £2.1 million in support of the scheme, which is due to complete by the end of 2016. If successful, this will be funded from section 106 funds set aside for affordable housing projects.

8. Financial implications

- 8.1. The purpose of this report is to request comment and insight in relation to the development of an Older People's Housing Strategy and the new build extra care housing which is being developed in the borough. As such, there are no direct financial implications arising from the report.
- 8.2. The Council's financial commitment to the New Build Programme, set out in 7.6 and 7.7 will be considered as part of the Council's normal budget process, and reported to members at the appropriate stage.

9. Legal & Human Rights implications

- 9.1. The European Convention on Human Rights states in Article 8 that "Everyone has the right to respect for his private and family life, his home and correspondence". The Human Rights Act 1998 incorporates the Convention. Whilst it does not, however, necessarily mean that everyone has an immediate *right* to a home, (because Article 8 is a "qualified" right and therefore is capable in certain circumstances, of being lawfully and legitimately interfered with,) the provision by an Authority of a relevant strategy for older people's housing does engage Article 8 principles.
- 9.2. The Equality Act 2010 (the Act) introduced a new public sector equality duty (the equality duty or the duty). It covers the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

9.3. In summary, the public sector 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.

9.4 Members of the Board are reminded that under Section 195 Health and Social Care Act 2012, health and wellbeing boards are under a duty to encourage integrated working between the persons who arrange for health and social care services in the area.

10. Crime and Disorder Implications

10.1. There are no specific Crime and Disorder implications resulting from this report.

11. Equalities Implications

11.1. An equalities analysis assessment will be carried out to accompany the Older People's Housing Strategy. There are potential equalities implications regarding the consultation process which will be considered.

12. Environmental Implications

12.1. The environmental implications of new build schemes will be taken into consideration.

13. Conclusion

13.1. The board is invited to comment on the proposals included within this report and to make suggestions as to how they would like to contribute to this agenda.

Background Documents

['Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society', Department for Communities and Local Government \(2008\)](#)

['Securing Good Care for Older People: Taking a long-term view', Wanless D \(2006\)](#)

[HAPPI \(Housing our Ageing Population: Panel for Innovation\)](#)

[HAPPI2 \(Housing our Ageing Population: Plan for Implementation\)](#)

If there are any queries on this report please contact **Laura Harper, Housing Strategy Officer, LB Lewisham**, on **020 8314 6096**, or by email at: **laura.harper@lewisham.gov.uk**

HEALTH AND WELLBEING BOARD			
Report Title	Lewisham CCG Strategy		
Contributors	Head of Strategy & Organisational Development, NHS Lewisham Clinical Commissioning Group	Item No.	6
Class	Part 1	Date: 19 November 2013	

1. Purpose

- 1.1 This report presents NHS Lewisham CCG's five year commissioning strategy. The strategy includes the vision and ambition of the CCG, an analysis of population health needs and health outcomes, the financial situation, and public engagement feedback. It identifies eight strategic priorities and their supporting aims that are aligned with Lewisham Health & Wellbeing Strategy.

2. Recommendation/s

Members of the Health and Wellbeing Board are invited to:

- 2.1 Note the contents of the CCG's Commissioning Strategy at Appendix A: its five year vision, the 'case for change', and the strategic priorities.

3. Policy Context

- 3.1 The development of the CCG's strategy has included a 'case for change' exercise encompassing population health needs, health outcomes, public engagement feedback, financial analysis and benchmarking.
- 3.2 The NHS England programme 'A Call to Action' launched in July 2013 complements the development of and engagement on the strategy and its priorities. The Call to Action has highlighted the challenges at a national level facing health and care services in the future and encouraged locally developed five year plans for commissioning.
- 3.3 NHS England's initial response to the Call for Action has highlighted the need for CCG plans to contain quantifiable health outcomes ambitions, to have a focus on health inequalities, to develop detailed two year operating plans, and for strong integrated working and partnership through Health and Wellbeing Boards. The CCG will continue to collaborate on strategic work across the 6 South east

London CCGs where our local priorities and requirements are best served by doing so.

- 3.4 The population health needs analysis was carried out by Lewisham Public Health based on the Joint Strategic Needs Assessment (JSNA).
- 3.5 One of the statutory responsibilities of the CCG is to ensure that health outcomes are improving for local people. This is a key element of the NHS Mandate and will be part of the national assurance process for CCGs. The NHS Health Outcomes Framework includes indicators covering five domains through which outcomes improvements can be assessed.

4. Background

- 4.1 Lewisham CCG has developed a new 5 year commissioning strategy to reflect its establishment as a new organisation and responsibilities for commissioning services for its population. It was approved by the CCG's Governing Body on 3rd October 2013.
- 4.2 The development process has been undertaken to ensure that a comprehensive, agreed strategy is in place for the start of the contracting cycle for 2014/15.
- 4.3 At its meeting in July 2013, the Health and Wellbeing Board received an overview of the strategy which included the outcomes of the population health needs analysis, health outcomes, financial analysis and benchmarking, and identified strategic themes.
- 4.4 Public engagement on the strategy has taken place over a number of phases which are described in Appendix 1 to the Strategy. This has included activities in 2012 and January and July 2013 to comment on the strategic priorities. From September 2013 a further engagement programme (complementing the Call to Action) has focused on the delivery of the strategic priority areas to inform their implementation and QIPP plans.

5. Vision – Better Health, Best Care, Best Value

- 5.1 The CCG's strategy describes the vision and ambition of the CCG based on the framework of 'better health, best care and best value'.
- 5.2 For better health, the ambition is to reduce the gap in key health outcomes between Lewisham and England by 10% over the five year period.
- 5.3 For best care, the ambition is to provide high quality care for everyone which is:

- Proactive and planned, with a focus on early detection, diagnosis and intervention
 - Patient centred, personalised to the individual's preferences and choices and considers the whole person rather than specific health conditions
 - Empowering to the individual to be confident in their management and decision making about their own care, as far as they want and are able to
 - Developing local neighbourhoods and communities to help people and communities to manage their health and wellbeing by finding local solutions.
- 5.4 The vision for best value is to commission more effectively with the most efficient use of resources working with other commissioners.

6. Commissioning Differently – The ‘Case for Change’

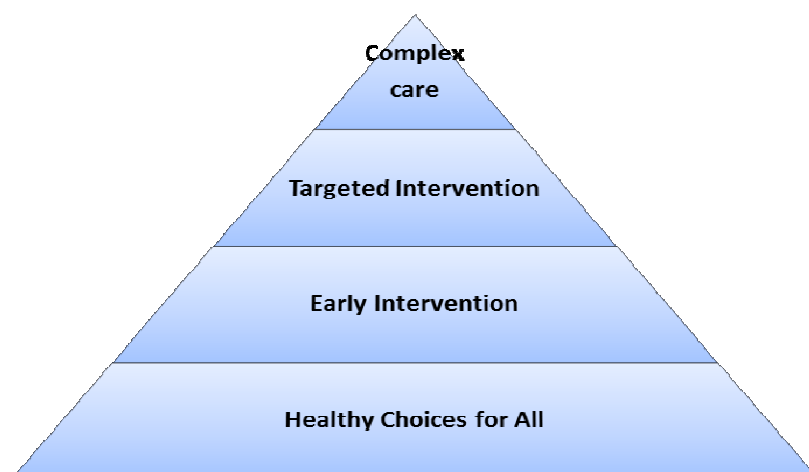
- 6.1 Lewisham's JSNA has identified the changing health needs of the Lewisham population that will increase demand on services, including inequalities, the ageing population, main causes of death and need for health promotion, increasing prevalence of long-term conditions such as diabetes and dementia, a high prevalence of mental health, and high rate of low birthweight babies.
- 6.2 Health outcomes for the Lewisham population have been improving but are still not as good as other similar London boroughs.
- 6.3 Patient and public feedback has highlighted specific areas for improvement such as accessibility and joined up care between local services.
- 6.4 Local primary care, community care and hospital providers will need to work closely together to ensure their services can address their demand and supply challenges.
- 6.5 Without change there will be gap in finances, between resources available and expected expenditure.

7. Transforming Local Services - Strategic Priorities

- 7.1 There are eight strategic priorities grouped around themes of healthy lifestyles and choice, frail and vulnerable people, long-term conditions, and service delivery. The strategy outlines the two year aims for each of them.

Strategic Themes	Strategic Priorities
Healthy Lifestyles and Choice	1. Health and wellbeing – smoking cessation, alcohol abuse, obesity and cancer
	2. Maternity and children’s care in hospital
Frail and Vulnerable People	3. Frail older people (including end of life care)
Long Term Conditions	4. Long Term Conditions – eg COPD, diabetes, CVD, dementia
	5. Mental Health
Deliver Services Differently	6. Primary care development and planned care
	7. Urgent Care
	8. Greater integration of health and social care commissioning

- 7.2 The priorities are aligned with Lewisham’s Health & Wellbeing Strategy, particularly for priority 1, health wellbeing, which will deliver a particular focus on smoking, alcohol abuse, obesity and increased screening and early diagnosis of cancer.
- 7.3 Priority 6, primary care development and planned care, will also be aligned with the South East London Community Based Care (CBC) Programme. This is supporting learning between CCGs and applying a principle of ‘shared standards, local models’.
- 7.4 The greater integration of health and social care commissioning will support all of the other priorities. Its delivery model has been developed in partnership with the Health and Wellbeing Board and is based on four different levels of advice, support and care an individual may receive during their lifetime:



8. Next Steps

- 8.1 The strategy will inform the further development of the CCG's commissioning intentions and QIPP implementation plans for 2014-15. Each strategic priority area is led by a CCG clinician supported by commissioning managers from the CCG and/or borough Joint Commissioning Unit.

9 Financial implications

- 9.1 A financial analysis has been included in the development of the strategy to date and will be incorporated into service planning and commissioning in line with CCG and joint budgets.

10. Legal implications

- 10.1 Members of the Board are reminded that under Section 195 Health and Social Care Act 2012, health and wellbeing boards are under a duty to encourage integrated working between the persons who arrange for health and social care services in the area. This is recognised in the strategic priorities identified in the development process.

11. Crime and Disorder Implications

- 11.1 There are no specific crime and disorder implications arising from this report.

12. Equalities Implications

- 12.1 An equalities analysis of the draft strategic aims and priorities has been undertaken by Lewisham Public Health and is included in the Draft Strategy. It examined the eight strategic priorities and for each one identified potential positive, negative and neutral outcomes. It concludes that overall the strategy will contribute to reducing inequalities, and highlights potential positive outcomes for disadvantaged groups and for those that share protected characteristics. Further work on equality impact assessment will be undertaken as part of the development of the CCG's QIPP plans.

13. Environmental Implications

- 13.1 There are no environmental implications arising from this report.

Background Documents

NHS Commissioning Board Outcomes Benchmarking Support Packs: CCG Level 2012

<http://www.england.nhs.uk/wp-content/uploads/2012/12/ccg-pack-08l.pdf>

Lewisham Health Profile 2012 English Public Health Observatories
<http://www.apho.org.uk/resource/item.aspx?RID=117235>

NHS England: 'The NHS belongs to the people – a
call to action' July 2013 and response October 2013
http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

<http://www.england.nhs.uk/wp-content/uploads/2013/10/david-letter-comm.pdf>

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**NHS LEWISHAM CLINICAL COMMISSIONING GROUP
COMMISSIONING STRATEGY 2013-18**

**A LOCAL HEALTH PLAN
FOR LEWISHAM**

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Approved by	Governing Body
Date Approved	3 rd October 2013
Originator/Author	Head of Strategy & Organisational Development
Responsible Committee	Strategy & Development

INTRODUCTION

NHS Lewisham Clinical Commissioning Group was established on 1 April 2013 and is responsible for commissioning (planning, buying and monitoring) the majority of health services in Lewisham. We are a membership organisation made up of all the GP practices in Lewisham.

This is our five year commissioning strategy for 2014/15 to 2018/19. It is a framework for how we will work over the next five years and has been developed in the context of national requirements to improve health outcomes, significant service and financial challenges facing the NHS and the rising expectations of patients and the public. As a new organisation, clinically led and formed from the membership of all our GP practices it sets out our commitment to the people of Lewisham.

The strategy sets out our purpose, vision, our understanding of the health needs of Lewisham residents and our ambitious plans to improve their health and wellbeing. It explains how we will use our available resources to ensure they receive high quality, safe health services which are good value for money.

The strategy will shape our commissioning priorities and service improvement plans; help us develop our commissioning intentions and annual operating plans over the next five years. It is informed by the experiences and views of our patients and the public, the Lewisham Joint Strategic Needs Assessment and the Lewisham Health and Wellbeing Strategy.

We have a good record of partnership working and the strong relationships with the local authority, health care providers, Healthwatch Lewisham, and voluntary and community organisations will continue to be critical to our success as we deliver these plans.

We will focus on local transformational plans to enable us to develop a sustainable local health service which meets local health needs and which will help us deliver our vision for the best health and best care for Lewisham residents

Dr Marc Rowland



CCG Chair

Martin Wilkinson



Chief Officer

WHO WE ARE

Lewisham CCG took over full responsibility for planning and buying most of the healthcare services for Lewisham residents on 1st April 2013. These services include:

- Hospital care
- Rehabilitation care
- Urgent and emergency care
- Most community health services
- Mental health and learning disability services

Primary care services such as GPs, pharmacists, dentists and opticians and some other specialist services are commissioned by NHS England¹.

Our aim is to secure the best possible health and care services for Lewisham residents in order to reduce health inequalities and improve health outcomes. We will do this by using findings about the health needs of our population² to identify priorities and to make plans for how healthcare can be provided. We have contracts with a range of health service providers that includes NHS and private hospitals and voluntary sector organisations. We monitor how well the services are being delivered to ensure that they are meeting the needs of our patients, that they are safe and of high quality, and that they are providing value for money.

We are overseen by NHS England which makes sure that we have the capacity and capability to commission services successfully and to meet our financial responsibilities.

As a membership organisation, our GP member practices work closely in local or neighbourhood groupings, to discuss common problems that are arising, and to see how local services can be improved and co-ordinated better.

¹ Visit www.england.nhs.uk for more information

² JSNA <http://www.lewishamsna.org.uk/>

GP Practices in Lewisham

● Neighbourhood 1 Practices

- 1 Mornington
- 2 Queens Road
- 3 Kingfisher MC
- 4 Clifton Rise
- 5 New Cross Health Centre
- 6 Grove Medical Centre
- 7 Vesta Road
- 8 Amersham Vale Training Practice
- 9 Deptford Surgery
- 10 Dr Batra Surgery
- 11 Deptford Medical Centre

● Neighbourhood 2 Practices

- 12 Belmont Hill
- 13 Lewisham Medical Centre
- 14 Lee Health Centre
- 15 Morden Hill
- 16 St Johns Medical Centre
- 17 Lee Road
- 18 Brockley Road
- 19 Hilly Fields Medical Centre
- 20 Honor Oak
- 21 Triangle
- 22 Rushey Green
- 23 Woodlands Health Centre
- 24 Nightingale
- 25 Hurley Group Practice

● Neighbourhood 3 Practices

- 26 South Lewisham
- 27 Torridon Road
- 28 Baring Road
- 29 ICO Moorside Clinic
- 30 Downham Family Practice
- 31 Winlaton
- 32 ICO Chinbrook
- 33 Parkview
- 34 ICO Marvels Lane Health Centre
- 35 Muirkirk Road
- 36 ICO Boundfield Road Medical Centre
- 37 Oakview

● Neighbourhood 4 Practices

- 38 Jenner
- 39 Sydenham Green
- 40 Woolstone Medical Centre
- 41 Sydenham Surgery
- 42 Wells Park
- 43 Bellingham Green
- 44 Vale Medical Centre



The GPs in Lewisham have elected seven representatives, including the CCG Chair Dr Marc Rowland, to lead clinical commissioning in Lewisham. As well as spending time

on commissioning, these GPs are still practising clinicians and they work closely with other doctors to share information about the services that people need.

They are members of the CCG's Governing Body, along with two lay members, a nurse and a hospital doctor as well as two senior managers (the CCG's Chief Officer and Finance Director). The Governing Body has responsibility for agreeing commissioning plans, ensuring public funds are spent correctly and for assuring the quality and safety of services the CCG commissions.

1.1 Partnership Working

We work in partnership with other commissioners to meet our goals and to ensure efficient and effective working.

1.1.1 Lewisham Health & Wellbeing Board

The Health & Wellbeing Board is a statutory committee of the London Borough of Lewisham (LBL). Its functions include encouraging integrated working to advance health and wellbeing of the area, and to prepare a joint strategic needs assessment (JSNA) so that the Council and CCG can develop strategies to meet identified needs. The CCG Chair is a member and vice chair of the Health and Wellbeing Board.

1.1.2 Borough Joint Commissioning

The CCG works closely with Lewisham council to jointly commission services for children and young people, learning disability, mental health, physical disabilities and emerging client groups, and older adults services. The unit also includes a team for commissioning, contracting and brokerage for the borough. These arrangements have been established under Section 75 agreements. All of these joint commissioning arrangements sit within the management structures of LBL. The LBL Executive Director of Community Services is a co-opted advisory member of our Governing Body.

1.1.3 Public Health

Lewisham Public Health functions and staff transferred to LBL in April 2013. The CCG's strong working relationship with Public Health has continued with the Director of Public Health also a co-opted advisory member of our Governing Body.

1.1.4 South East London Clinical Commissioning Groups

The six CCGs in South-East London, Lewisham, Lambeth, Southwark, Greenwich, Bexley and Bromley, have established collaborative arrangements to meet their shared and interdependent commissioning responsibilities. These arrangements include lead commissioning arrangements, joint clinical strategy committees, and programme boards

to support implementation of the Trust Special Administrator (TSA) recommendations for the South London Healthcare Trust (SLHT) and Community Based Care (CBC) strategy. These arrangements are supported by a South East London CCG Programme Management Office hosted by Southwark CCG.

2. OUR VISION – BETTER HEALTH, BEST CARE, BEST VALUE

This section describes the difference we aim to make through commissioning to meet the challenges we describe in section 3.

Our mission is visually represented as:



Working together with Lewisham people is at the centre of everything we do.

2.1 OUR AMBITION

Better Health - the Five Year Vision

To reduce the gap in key health outcomes between Lewisham and England by 10% over the five year period

We will determine our success in improving the health of Lewisham people through measures of life expectancy, rates of premature mortality from the three biggest causes of death in Lewisham (cancer, respiratory diseases and cardiovascular disease), infant mortality, patient experience and end of life care.

Using National Health & Social Care Information Centre data, Lewisham Public Health have identified target levels for these key measures through which we will monitor progress towards achieving our vision.

Outcomes	Measures	Current Level	Target 2018
Life Expectancy	Potential years of life lost from causes amenable to healthcare	Females 2110.5 Males 2415.3	Females 2091.1 Males 2409.0
	Life expectancy at birth	Females 81.3 Males 76.7	Females 83.8 Males 79.8
	Disability free life expectancy at age 65	Females 9.01 Males 8.99	Females 9.20 Males 9.11
Causes of death	Under 75 mortality rate from cancer	125.4 deaths per 100,000	104 deaths per 100,000
	Under 75 mortality rate from cardiovascular disease	84.8 deaths per 100,000	54 deaths per 100,000
	Under 75 mortality rate from respiratory disease (bronchitis, emphysema and other COPD)	36.4 deaths per 100,000	31.5 deaths per 100,000
Infant mortality	Neonatal mortality	3.6 per 1000	<i>To be confirmed</i>
	Stillbirths	6.1 per 1000	<i>To be confirmed</i>
Patient experience	People feeling supported to manage their condition	Not yet available ³	Not yet available
End of life care	Proportion who die hospital	58.3%	55.1%
	Proportion who die at home ⁴	20.4%	23.1%

³ This measure is not yet available from the Health & Social Care Information Centre

⁴ Proxy measures pending development of a single measure for preferred place of death

Best Care – the Commissioning Vision

High quality care for everyone

We will determine our success by commissioning services differently, in partnership with other commissioners, to deliver high quality support and care which is:

- Proactive and planned, with a focus on early detection, diagnosis and intervention
- Patient centred, personalised to the individual's preferences and choices and considers the whole person rather than specific health conditions
- Empowering to the individual to be confident in their management and decision making about their own care, as far as they want and are able to
- Developing local neighbourhoods and communities to help people and communities to manage their health and wellbeing by finding local solutions:

Best Value – the Financial Vision

To commissioning more effectively with the most efficient use of resources

We will measure our success by operating within our commissioning budget and demonstrating that we have used the budget effectively, delivering value for money.

The Quality, Innovation, Productivity and Prevention (QIPP) programme is the national initiative that aims to make the NHS work more efficiently so that there are more funds available for treating patients. Delivering a successful QIPP programme in Lewisham will be crucial to ensuring we are using our resources in the most efficient way to enable us to meet our vision for better health and best care.

3. COMMISSIONING DIFFERENTLY – ‘THE CASE FOR CHANGE’

This section explains why we need to work differently with you: the public, other commissioners and providers of care. The challenges outlined provide the ‘case for change’: why we need a new strategic vision to improve the way we commission services. No change will not deliver our vision for better health, best care and best value.

3.1 THE HEALTH NEEDS OF LEWISHAM’S POPULATION

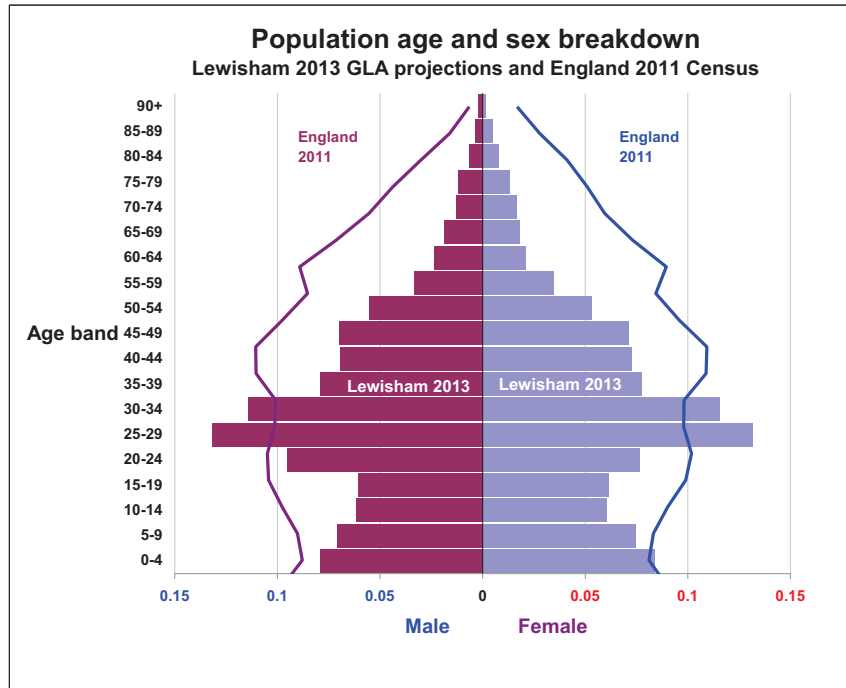
In order to obtain information on the health and wellbeing of the people of Lewisham, we have referred to Lewisham’s Joint Strategic Needs Assessment (JSNA) (<http://www.lewishamjsna.org.uk/>) The JSNA brings together in one place a wealth of information on the health and social care needs of Lewisham’s citizens, complemented by information on the social, environmental and population trends that are likely to impact on people’s health and well-being. The JSNA also includes the community and patient view on local health and social care services.

3.1.1 Population Profile

- **Demography**

The Census in 2011 reported the actual population in Lewisham was 275,900. In 2013 it is estimated to be 284,325. Lewisham has a young population - 25.4% of the population of Lewisham is under the age of twenty.

Population age and sex breakdown Lewisham and England



Source: Census 2011

- **Living alone**

In 2011 census Lewisham had a higher proportion of one person households 34% compared to 30% in England. Nearly nine percent of one person household are aged 65 and over.

- **Lone parent household**

In 2011 Lewisham had a higher proportion of lone parent household (11%) compared to London (9%) and England (7%).

- **The projected population for Lewisham**

Over the next 15 years 2013 -2028 it is estimated that the total population will rise by 13%. The greatest percentage increase will be in those aged 65 and over.

There has been a sustained rise in the birth rate in Lewisham for several years, reflecting a similar rise in London and the country as a whole. Much of the rise in births has been in births to mothers who were not born in the UK, the Commonwealth or the EU. Over 50% of all births in Lewisham now occur to women from minority groups.

Lewisham population projected counts by broad age band

Age band	2013	2018	2023	2028	% Change (2013-2028)
0 to 4	22388	23341	23048	22887	2.2%
5 to 19	48795	50606	53780	55418	13.6%
20 to 64	186334	198192	203616	208041	11.6%
65 to 90+	26808	27482	29878	34288	27.9%
Total	284325	299621	310321	320635	12.8%

Source: GLA Population Projections 2012 Round, SHLAA, Borough SYA

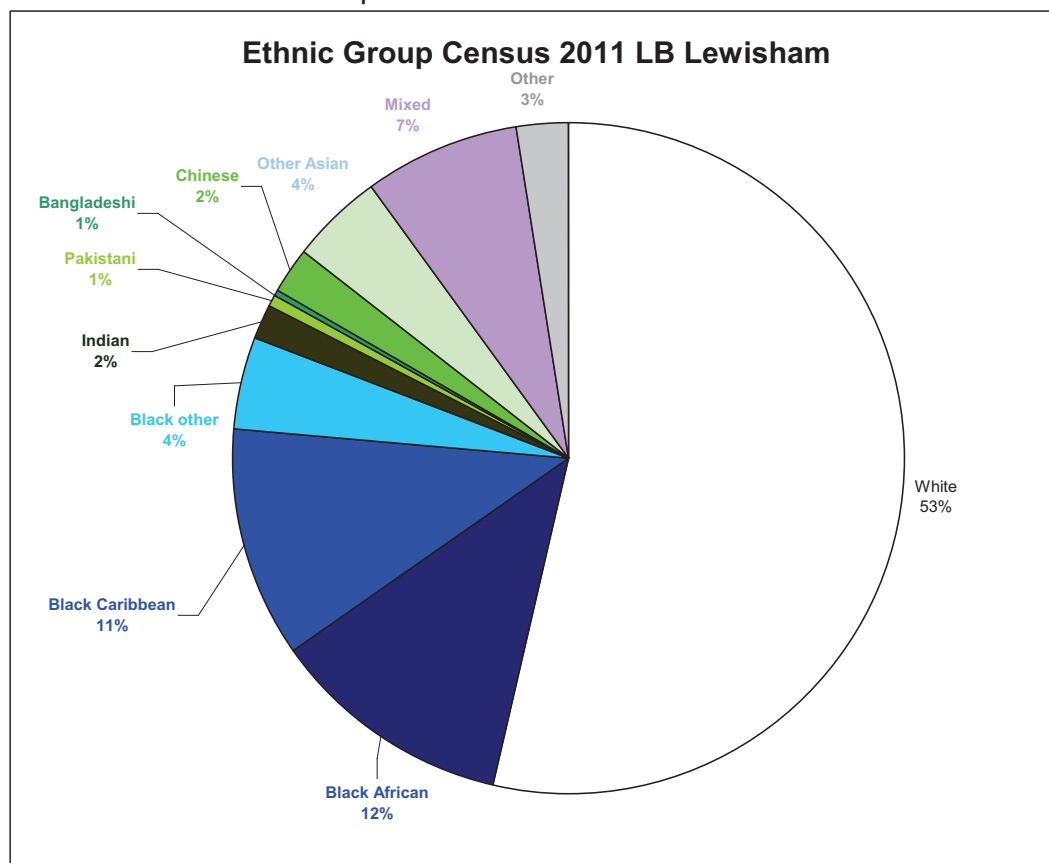
Though the birth rate in Lewisham is expected to plateau and decline towards the latter half of this decade, the population of children, in particular those aged 5 to 14 will continue to rise for the foreseeable future because of the previous rise in births.

In Lewisham the number of residents aged over 65years has been stable or even falling slightly over the last decade, despite an overall growth in the population between 2001 and 2011 of about 11%. However population projections suggest that from about 2015 the number of Lewisham residents over 65 years old will begin to rise. This projected growth is not simply as a result of overall population growth as the proportion of over 65s in the population is also expected to increase. In Lewisham as a whole the proportion of over 65s in the population in 2013 was 9% and is expected to be 11% by 2028. This is because the population is living longer. Nationally the chance of surviving from birth to the age of 85 has more than doubled for men over the last thirty years, from 14% in 1980-1982 to 38% in 2009-11. In Lewisham the life expectancy at birth was 76.7 years for women and 72.3 years for men in 1991-93; in 2008-10 it had increased to 81.3 years and 78.8 years respectively. Similarly life expectancy aged 65 years was 15 years for men and 16.6 years for women in 2000-2002 and increased to 18.4 years and 19.9 years respectively in 2008-10.

- **Ethnicity**

Lewisham is a very ethnically diverse borough, 46.5 % of the population are from Black and Minority Groups (BAME) compared to 40.2% London and 12.5% in England. In 2011 the two largest BAME group were Black African (12%) and Black Caribbean (11%). In the school population the proportion from BAME rises to 77% and over 170 different languages are spoken.

Census 2011 Ethnic Group Breakdown



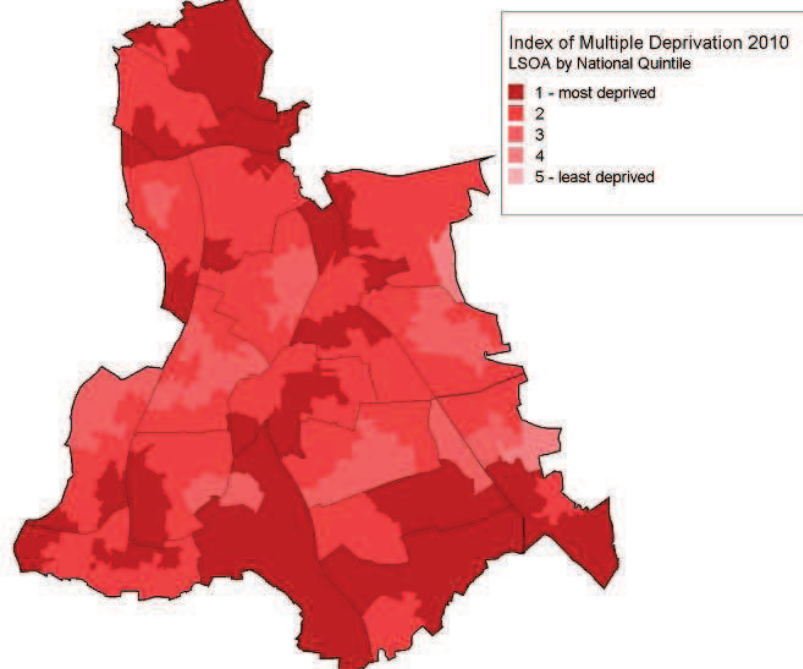
The rates of growth in various ethnic groups means that by 2028 the proportion of population from each group will have changed. This change is most significant in the over 65 age group, where the White population will reduce from 71% in 2013 to 53% in 2028. There is also a projected decline in the proportion of the population from the Black Caribbean group.

- **Deprivation**

Deprivation has increased in Lewisham. The 2010 Index of multiple deprivation (IMD) ranked Lewisham 31st out of the 354 local authorities in England compared to a rank of 39 in 2007. Relative to the rest of the country Lewisham is becoming more deprived.

Evelyn ward in the North of Lewisham is the most deprived ward followed by Bellingham, Downham and Whitefoot (5th) in the South of the borough. Rushey Green in the centre of Lewisham borough ranks as the 4th most deprived borough.

Map of IMD by quintile across Lewisham

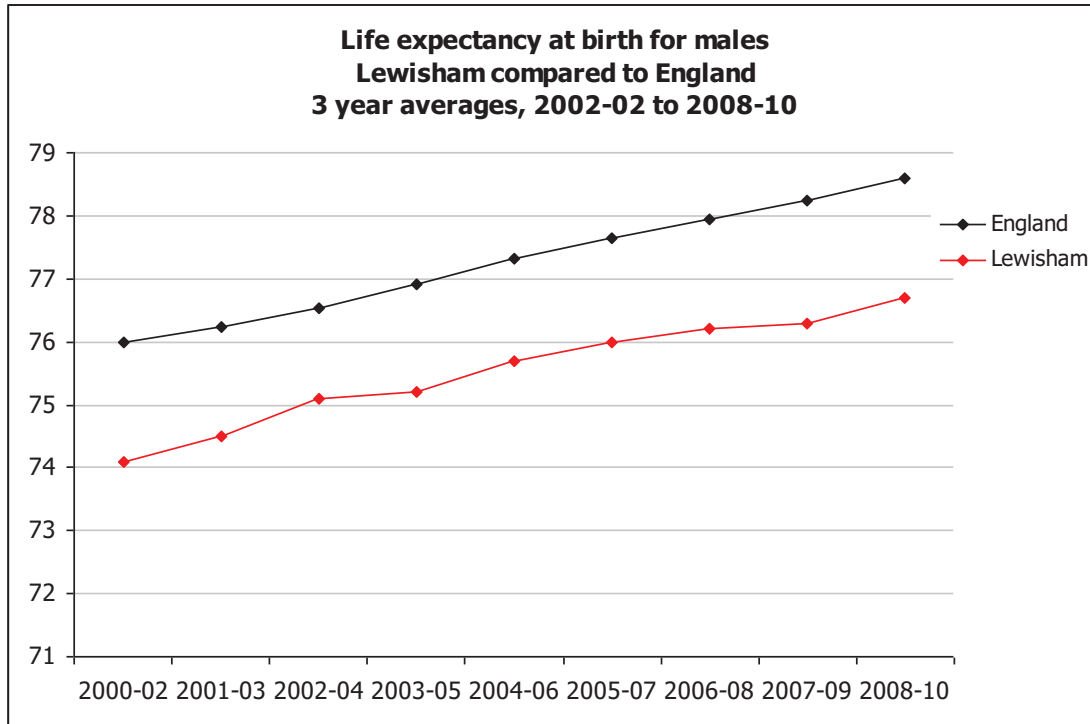


3.1.2 Life Expectancy & Mortality

- **Life Expectancy**

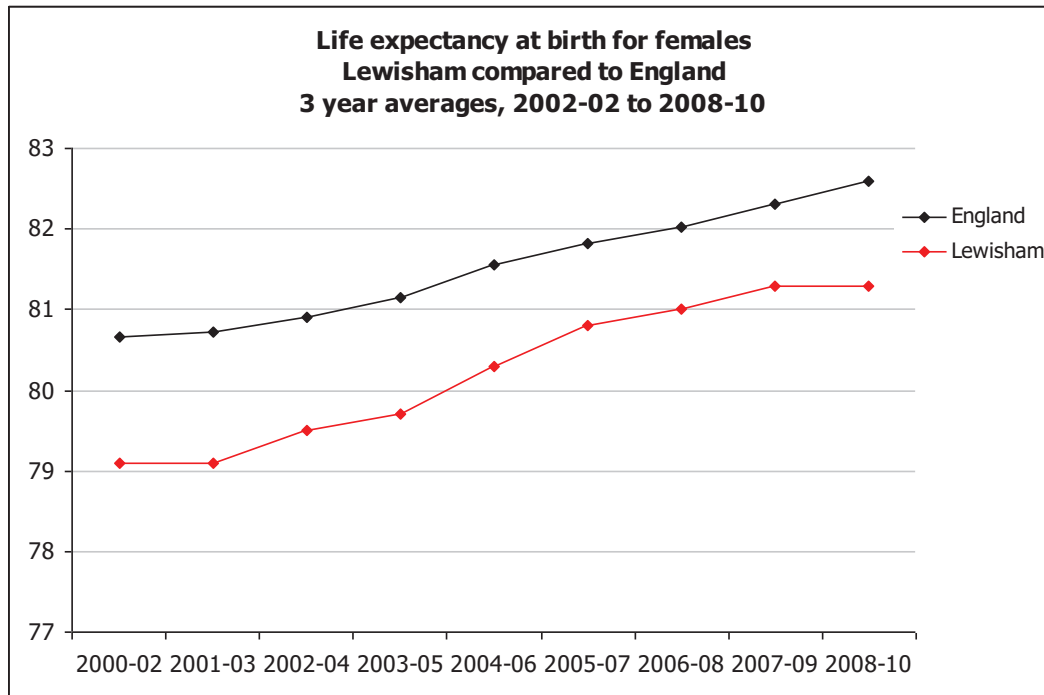
For males, life expectancy rose 2.6 years in England and 2.5 years in Lewisham in this ten year period. However there is a two year difference in the life expectancy for males between England and the Lewisham average.

Life Expectancy at Birth for Males



For males, Lewisham has significantly lower Life Expectancy than England, London and South East Sector. Males in Lewisham Central ward have significantly lower life expectancy than the Lewisham average.

Life Expectancy at birth females



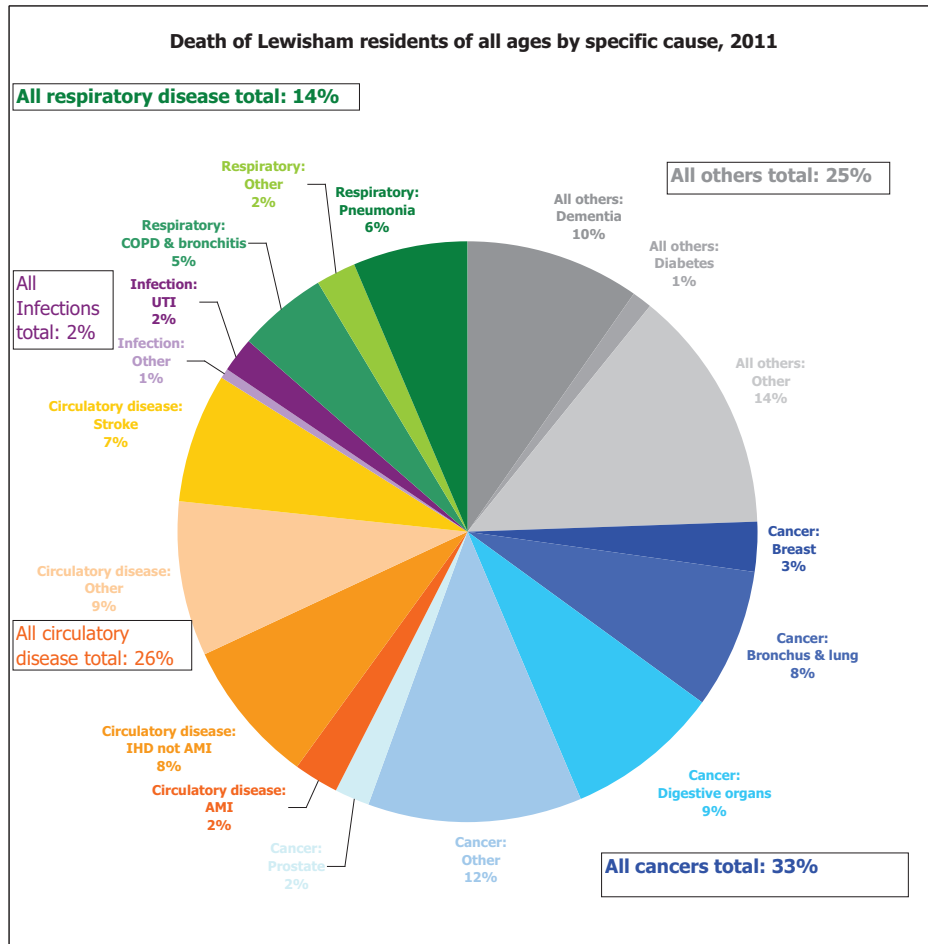
Source: HSCIC Indicator Portal (<https://indicators.ic.uk/webview>)

For females, life expectancy rose 1.9 years in England and 2.2 years in Lewisham in this ten year period. However there is a 1.9 year difference in the life expectancy for females between England and the Lewisham average.

- **Mortality**

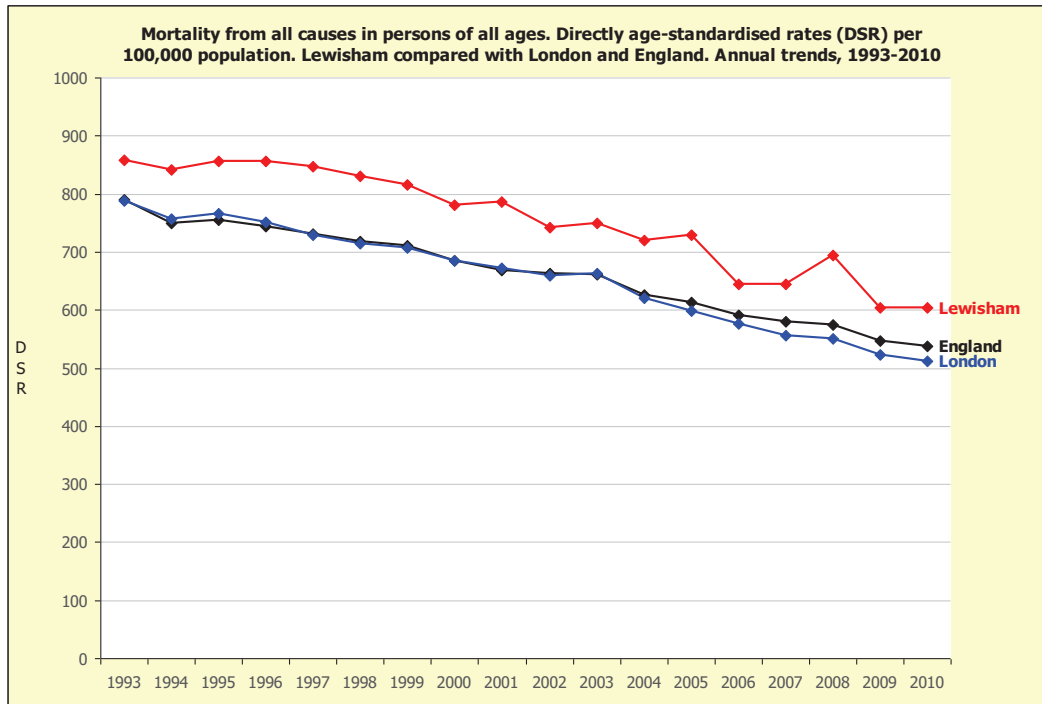
In 2011 there were 1,561 deaths in Lewisham. The main causes of death were cancer (518) 33%, circulatory disease (412) 26% and respiratory (212) 7.4% followed by dementia (152). Over the last couple of years cancer has overtaken cardiovascular disease as the main a cause of death, and cancer deaths are now 33% of all deaths. Deaths from cancer, circulatory disease and respiratory disease are the major contributors to the gap in life expectancy between Lewisham and England for both men and women.

Deaths by cause (percent)



Since 2000 overall the rates of All Cause, all age mortality have been falling in England, London and Lewisham. However rates in Lewisham remain higher than those of England and London.

Mortality from all causes trend 1993-2010



Source: HSCIC Indicator Portal (<https://indicators.ic.nhs.uk/webview/>)

3.1.3 Morbidity

Prevalence models provide estimates of underlying prevalence derived from population statistics and research on the risk factors for different conditions. At any time there will be a significant number of people with undiagnosed disease who are not benefitting from treatment.

A 'long term condition' is a health problem that cannot be cured but can be controlled by medicines or other treatments. Examples include diabetes, heart disease, chronic obstructive pulmonary disease (COPD), dementia, depression, and there are many more.

Research indicates that nearly 20% of people have more than two long-term conditions and this proportion increases steeply with age. In addition for Lewisham there are inequalities in long-term conditions with their prevalence of being 60% higher in social class V versus those in social class I and the prevalence of those with two or more long-term conditions is also higher in more deprived populations.

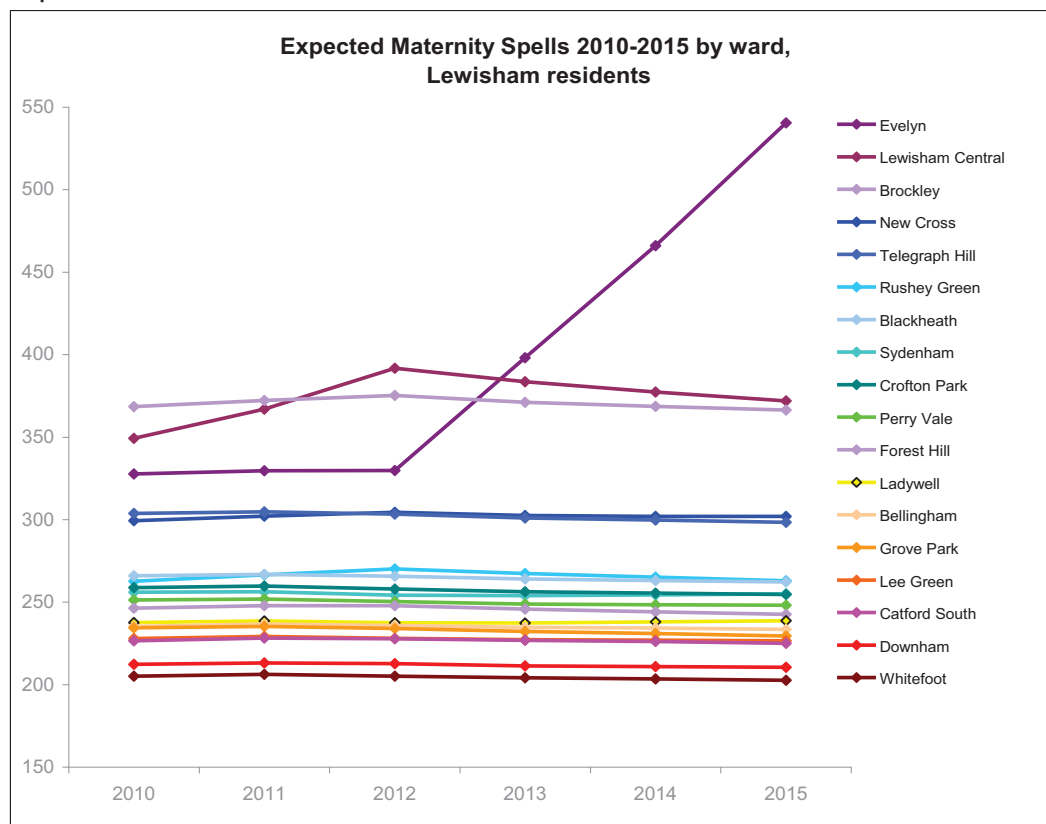
In addition in 2010 there were 1,360 people in Lewisham known to be living with HIV with 30-40% undiagnosed estimated to be approximately 500 people.

People with long-term physical health conditions – the most frequent users of health care services – commonly experience mental health problems such as depression and anxiety, or dementia in the case of older people.

3.1.4 The Health of Children and Young People in Lewisham

The population of children in Lewisham has been increasing due to an increase in the number of births. This is expected to plateau towards the end of decade but new housing developments planned for Lewisham Central mean that there is expected to be an increase in births in that particular ward.

Expected Births to Lewisham Residents

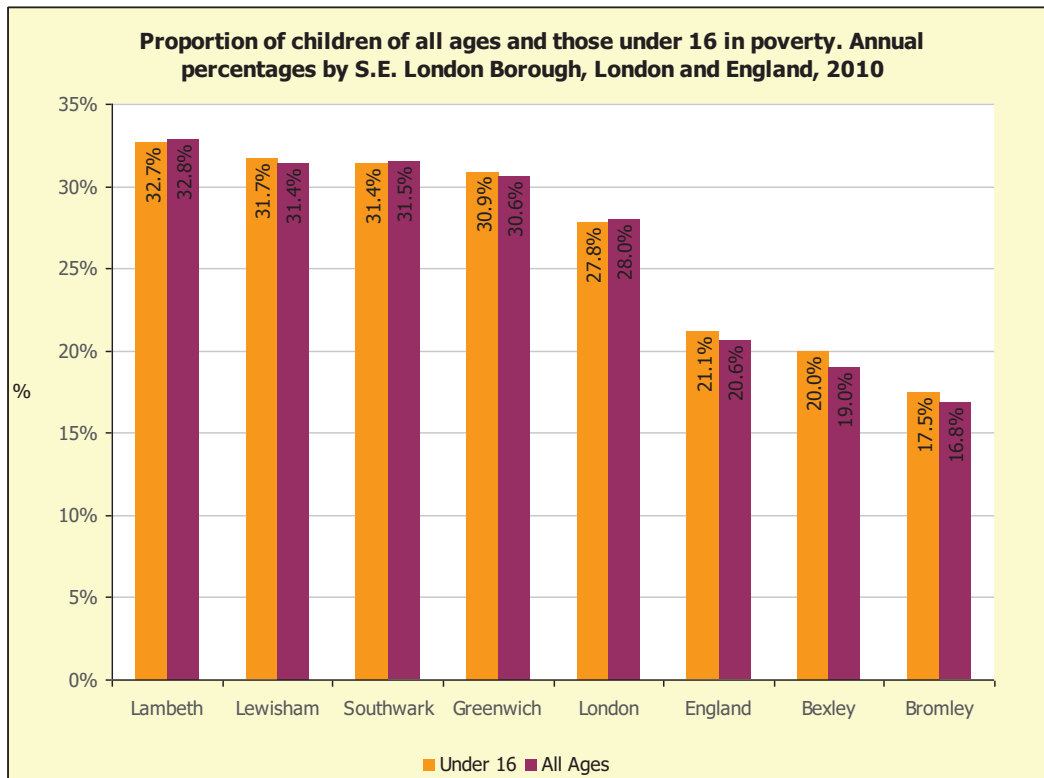


Source: GLA

The huge number of languages spoken in Lewisham and the numbers of adults who do not have English as a first language are well documented. The extent of the impact of this, is however, unclear, particularly in relation to the health of children where the impact may be greater because of the increasing proportion of children born to mothers who themselves were born abroad which may create barriers to accessing health services or expose the children themselves to a different range of health risk factors.

The impact of deprivation on the health and particular mental health of parents has an adverse impact on children. The level of child poverty is significantly worse than the England average. The rate of family homelessness is also worse than the England average.

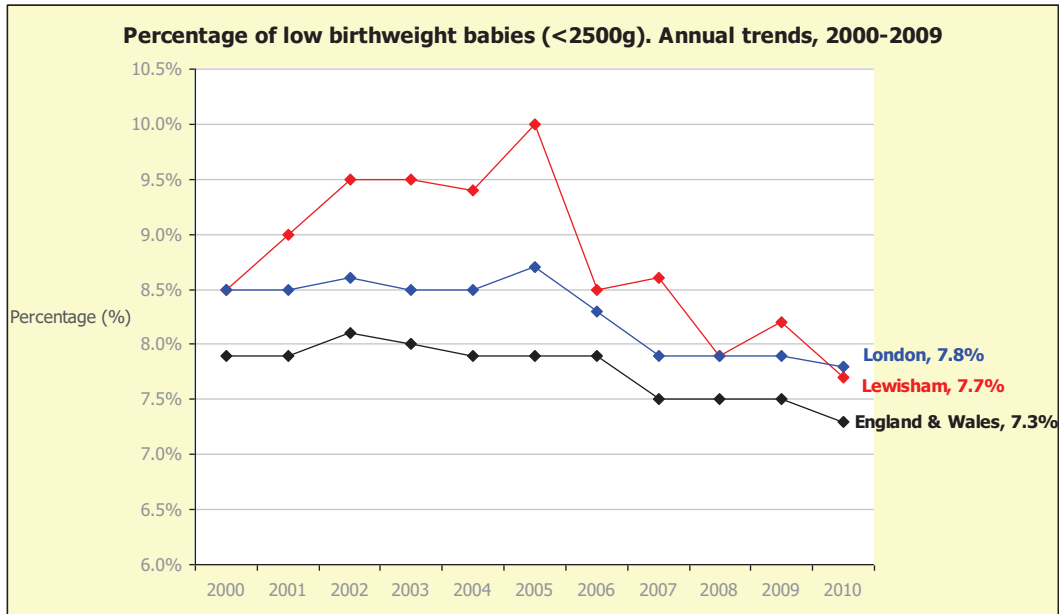
Proportion of children living in Poverty



- **Low Birthweight**

A low birthweight baby is defined as a baby who weighs less than 2.500kg (5 lbs 8oz). Low birthweight is a major determinant of perinatal illness, disability and death and adversely affects babies born into families from a lower socio-economic background. Smoking is the major modifiable risk factor contributing to low birth weight. A concerted programme to reduce low birthweight rates in Lewisham, focussing on increasing the proportion of women seeing a midwife early in pregnancy and on smoking cessation in pregnancy, seems to have had some effect with a change in the local picture and Lewisham's position in relation to England and London as a whole, however low birthweight remains a problem.

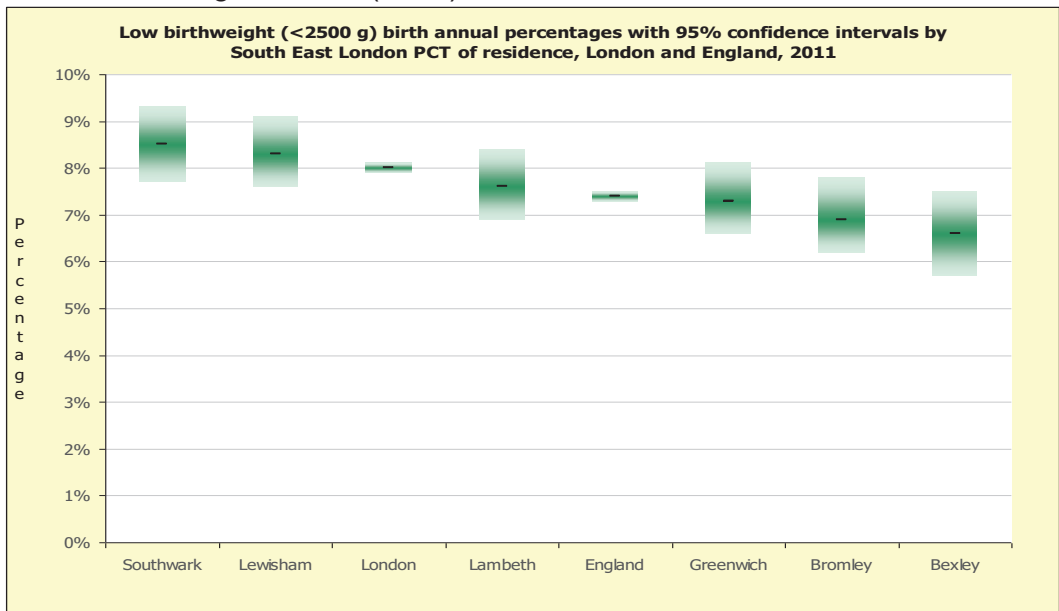
Percentage of Low Birthweight Babies(2000 - 2009)



Source: ONS

Most recent information suggests that the local rate is significantly higher than that of England, though comparable to that of London as a whole.

% Low Birthweight Babies (2011)



Source: ONS

- **Stillbirth rates, Infant and Child Mortality**

In the past, perinatal mortality, and in particular stillbirth rates have been significantly higher in Lewisham than in England and London as a whole. This is no longer the case; the most recent data suggest that local Infant and child mortality rates are similar to the England average. Efforts continue to keep these rates low but continued scrutiny of these important indicators of child health is necessary.

3.1.5 Mental health

Poor mental health has a great social and economic impact. In 2011, 1.1% of the population registered with a Lewisham GP was on an Severe Mental Illness (SMI) register. This equates to 3,423 people. In London the figure is 1% and England 0.8%. The number of people on a Care Programme Approach (CPA) which is a way of coordinating care for those with severe and enduring mental health problems is higher than London at a rate of 9.07 per 1,000 population compared to 7.43 per 1,000 in London.

Most mental disorder begins before adulthood with 50% of lifetime cases of diagnosable mental illnesses beginning by age 14 and 75% of disorders starting by the mid-20s This highlights that interventions for children and adolescents can offer the greatest opportunities for prevention of mental disorder.

Within Lewisham there is variable need, with the southern wards of the borough (Downham, Bellingham and Whitefoot) estimated to have a 25 – 40% higher need for services, in contrast to less deprived wards such as Forest Hill and Catford South that have lower need than the national average.

3.1.6 Health risks

- **Smoking**

Smoking remains the biggest single cause of preventable mortality and morbidity. Tobacco use remains one of our most significant public health challenges and smoking is the single biggest cause of inequalities in death rates between the richest and poorest in our communities. Lewisham is significantly worse than England in smoking attributable mortality, smoking attributable deaths due to heart disease, deaths from lung cancer and COPD, lung cancer registrations and smoking related admissions.

- **Alcohol**

Alcohol related harm is significant and increasing in Lewisham. Alcohol use has a major impact on health, anti-social behaviour, crime and other important social issues, including the well-being and development of children.

Lewisham men are more than twice as likely to die from alcohol related causes compared with women, however the death rate is decreasing for men and increasing for women. Lewisham men have twice the rate of alcohol attributable hospital admissions compared with women, however the rate for women has almost doubled in the past five years, and the rate for men is beginning to level off. Lewisham young women have twice the alcohol specific admission rate compared with young men, whereas in over 18s it is three times as high for men compared with women.

- **Obesity**

Local data sources indicate the prevalence of adult obesity is around 33% in Lewisham compared to 24.2% in England. Lewisham has a high prevalence of childhood obesity: 11.4% of reception children were obese as were 25.0% of children in year 6, significantly higher than the England average for the past three years. Over 40% of 10-11 year olds and nearly a quarter of 4-5 year olds were overweight or obese in 2011/12.

- **Physical Activity**

In 2009 the percentage of the total adult participation in at least 3 days sport and active recreation for at least 30 minutes, was 18.7% in Lewisham compared to 20.3% in London and 22.1% in England

- **Cancer screening uptake 2010-2011**

Uptake of cancer screening in Lewisham is significantly worse than London. This has implications for cancer survival as many women particularly are missing the opportunity for early diagnosis of cancers which may result in better treatment outcomes.

SUMMARY – OUR POPULATION HEALTH CHALLENGES

1. Inequalities	While there are improvements in population health, there are still differences between different part of the borough, for instance life expectancy at birth is rising (now on average 76.6 years for men and 81.3 years for women) but for men in Lewisham Central and for women in Telegraph Hill it is significantly lower than the average. The same is true for all cause mortality rates which have been falling in Lewisham but in Lewisham Central is significantly higher than the Lewisham average.
2. Population	The Lewisham population is projected to grow across all age groups over the next five years. For this period the largest percentage growth rate is in the 20-64 year old age group, and for the period 2013-28 the largest growth will be in the 65-90+ age group. The increasing number of births expected to plateau towards the end of the decade.
3. Cause of Death	Cancer is now the main cause of death (33% of deaths), followed by circulatory disease (26%), respiratory disease (13%) and dementia (10%).
4. Health Promotion	More people smoke than the national average and reducing the number of people in Lewisham who smoke would make a major impact on the key causes of premature death.
5. Long-Term Conditions	There will be increasing numbers of people who have long-term conditions and this will further increase with the ageing population, particularly the likelihood of having more than two conditions. Lewisham’s black and minority ethnic communities are also at greater risk from health conditions such as diabetes, hypertension and stroke. Dementia - with the increasing age of the population the number of dementia cases will rise; prevalence increases particularly in the population older than 65.
6. Mental health	Prevalence of mental illness is high in Lewisham and there are inequalities within the borough: southern wards which are also deprived (such as Downham, Bellingham and Whitefoot) have higher needs for services than some other areas.
7. Birth weight	The percentage of low birthweight babies falling but is still a significantly higher rate than the England average, though it is now comparable to London as a whole.

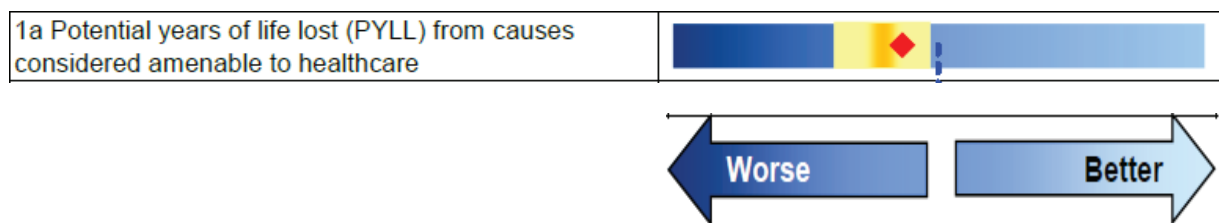
3.2 HEALTH OUTCOMES

Our aim is to improve health outcomes for all of the Lewisham population. Over the last 10 years health outcomes have got better for Lewisham people however compared to other similar London boroughs we have further room to improve. The NHS Health Outcomes Framework provides the mechanism to assess improvements, and these indicators in particular will reflect the priorities of the CCG's strategy:

3.2.1 Potential Years of Life Lost

To ensure that the NHS is held to account for doing all that it can to prevent amenable deaths. Deaths from causes considered 'amenable' to health care are premature deaths that should not occur in the presence of timely and effective health care.

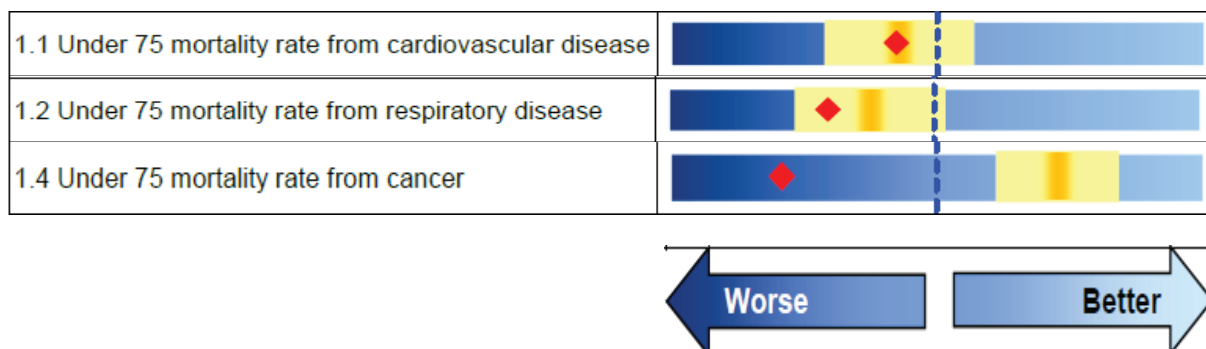
The figures below illustrates Lewisham's current position (red square) in comparison to the England average (blue dotted line), and its ONS cluster (yellow segment).⁵



3.2.2 Premature (under 75) mortality rates

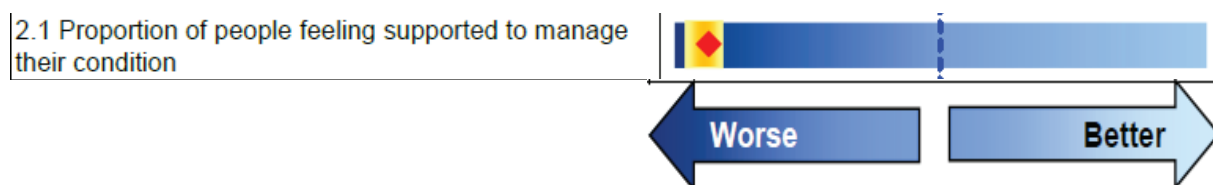
- Cardiovascular disease - To ensure that the NHS is held to account for doing all that it can to prevent deaths in people under 75 suffering from cardiovascular disease.
- Respiratory - To ensure that the NHS is held to account for doing all that it can to prevent deaths in people under 75 suffering from respiratory disease.
- Cancer - To demonstrate that the NHS can make a contribution to improving preventable as well as amenable cancer mortality.

⁵ NHS Commissioning Board Outcomes Benchmarking Support Packs: CCG Level 2012



3.2.3 Long Term Conditions

An assessment of the extent to which those with long-term conditions are able to manage their condition through the quality of the support offered by healthcare providers. The outcome will be proportion of people feeling supported to manage their condition. Lewisham's current position is:



3.2.4 Infant Mortality

The outcome framework will include an indicator that measures how neonatal mortality and stillbirths relates to the outcomes of NHS care during pre-pregnancy, pregnancy, birth and immediately after birth.

Currently available is a measure of infant deaths per 1,000 births. This shows Lewisham comparison with England as follows (the yellow circle being Lewisham and the vertical line the England average)⁶:



⁶ Lewisham Health Profile 2012 English Public Health Observatories

3.3 PUBLIC FEEDBACK

We have collected patient and public feedback from a number of sources, including questionnaires, the PALS service and complaints, and outreach events. A summary of the main messages is:

- The birthing unit at Lewisham is highly praised
- It is important to include patients and carers in care plans
- People have told us that they are not given enough information about medication and other aspects of their care
- Older people can feel disengaged as they are seldom involved in decisions
- Access to primary care varies
- There are positive views of community pharmacy services
- Patients value A&E Service
- People would like to see care joined up

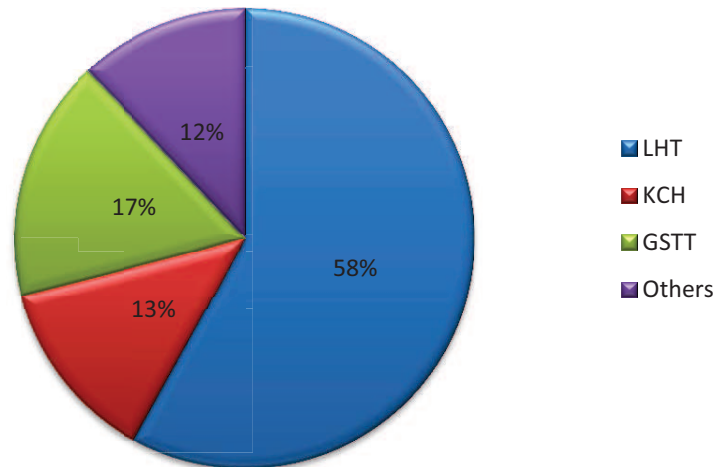
The phases of public engagement activity are described in Appendix 1, including the activities in 2012 and January and July 2013 to comment on the strategic priorities.

From September 2013 a further engagement programme has focused on the delivery of the strategic priority areas which will inform their implementation and QIPP plans following a complete engagement activity and outcomes analysis.

3.4 PROVIDER LANDSCAPE

Our main providers of secondary care services are Lewisham Healthcare NHS Trust (LHT), King's College Hospital NHS Foundation Trust (KCH), and Guy's and St Thomas's NHS Foundation Trust (GSTT). Their approximate share of activity is as follows:

Secondary Care Providers % Activity 2013-14



Our community services provider is also Lewisham Healthcare, and mental health services are provided by the South London and Maudsley NHS Foundation Trust (SLAM).

All our health service providers, public, voluntary and privately owned organisations, are facing challenges to secure sustainable primary, community and acute services.

Health service providers face increasing demand because:

- Health demand overall is increasing – rising rate of people with one or more long-term conditions and an ageing population
- Public expectations - patients using services 24/7 and seeking treatment for minor conditions rather than healthy living and self management
- Medical advances are helping people to live longer but, in line with this, more people can expect to live for some time with a care and support need. The NHS can now treat conditions that previously went undiagnosed or were simply untreatable.

Health services providers face increasing difficulty in providing/supplying services:

- Increasing costs - the cost of providing care is getting more expensive. The NHS now provides a much more extensive and sophisticated range of treatments and procedures

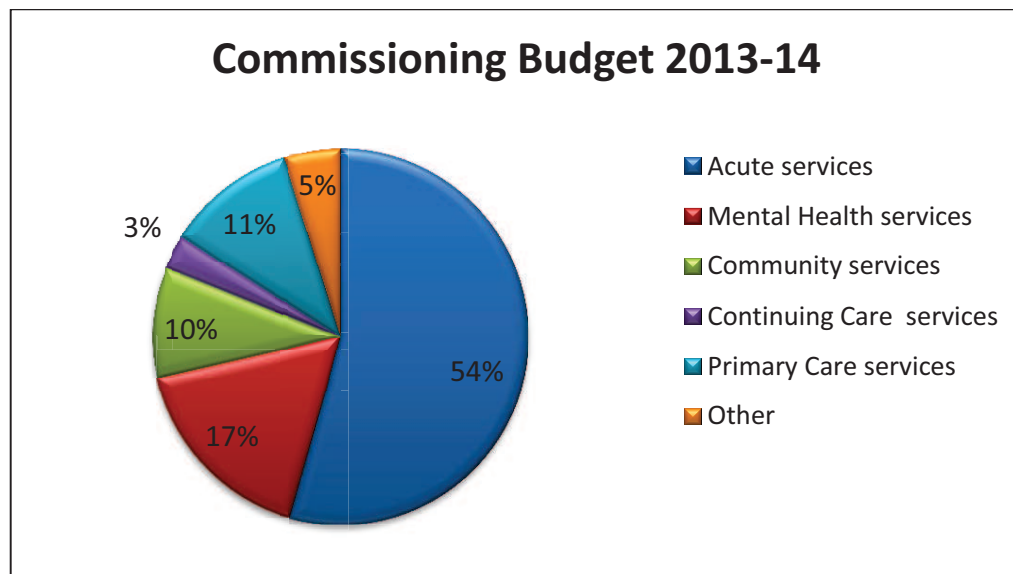
- Greater scrutiny and higher expectations of quality and governance standards. For example workforce standards - the impact of the European Working Time Directive (EWTD) on the hours doctors work and staffing levels.
- Limited financial resources to buy health services - the broad consensus is that for the next decade, the NHS can expect its budget to remain flat in real terms, or to increase with overall GDP growth at best. This represents a dramatic slow-down in spending growth for the NHS.

Locally primary care, community care and hospital providers are considering how they can work together differently to make their services more sustainable.

The outcomes of the Trust Special Administrator (TSA) review of the South London Healthcare NHS Trust will have a further impact on the organisation of local NHS organisations with the planned merger of Lewisham Hospital and the Queen Elizabeth Hospital in Greenwich. We are committed to working together with all local health providers, other commissioners and you, to identify and implement the best configuration of local hospital services which will deliver our strategic aims of 'better health, best care and best value' for Lewisham people.

3.5 FINANCIAL CONTEXT

We currently receive (2013/14) around £365m to commission most of the healthcare services in Lewisham which we allocate as follows:

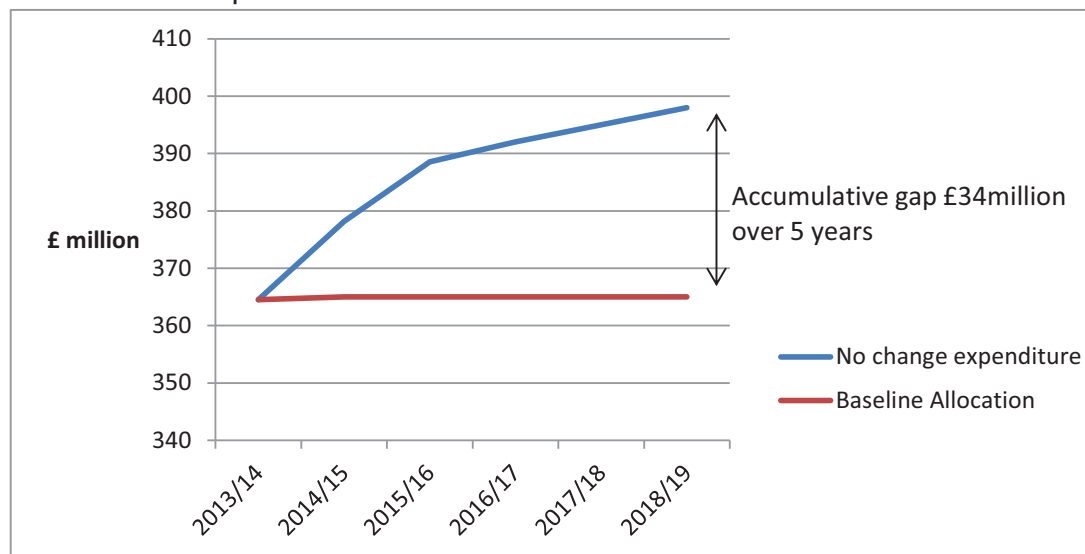


If Lewisham CCG continues to commission in the same way as today it will result in the CCG facing a funding gap between projected spending requirements and resources

available of around £34 million between 2014/15 and 2018/19 (approximately 9% of projected costs in 2018/19). This estimate is made taking into account current expected productivity improvements and the expected annual out-turn expenditure in line with contracts, and assumes that the health budget will remain protected in real terms.

Based on the above assumptions, the expected financial position for the CCG would be an accumulative financial gap of £34m over 5 years. We will be doing further work during autumn 2013 to test and update our current financial assumptions, so that we can be more certain about our future financial position.

Illustration of Expected Financial Position



3.6 NATIONAL REQUIREMENTS

3.6.1 The NHS Constitution

The NHS Constitution requires Government to provide a statement of NHS accountability, describing the principles, values, rights and responsibilities that underpin the NHS:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf

3.6.2 The NHS Mandate

The NHS Mandate sets out the Government’s vision for the NHS and the funding available to achieve this. The first and current mandate to NHS England, sets out objectives based on five priority areas identified by Government following a wide consultation held in 2012 which aims to deliver the ‘*best possible care and treatment for all*’:

NHS Mandate: Priority Areas

- i) Improving standards of care and not just treatment, especially for older people and at the end of people's lives;
- ii) The diagnosis, treatment and care of people with dementia;
- iii) Supporting people with multiple long-term physical and mental health conditions, particularly by embracing opportunities created by technology, and delivering a service that values mental and physical health equally;
- iv) Preventing premature deaths from the biggest killers;
- v) Furthering economic growth, including supporting people with health conditions to remain in or find work

Source: NHS Mandate 2012

The current mandate sets out the strategic direction and objectives for NHS England and other organisations across health and social care for 2013 to 2015. To ensure that the mandate reflects the ongoing developments and scale of the challenges ahead, the mandate is refreshed on an annual basis.

The Government plans to carry forward all the existing objectives of the current mandate and while the impact of a public consultation on the existing mandate is not yet clear, recent challenges and evidence which has emerged over the last 12 months is expected to influence the changes proposed:

- **Patient Care and Safety** – The recommendations proposed following the Francis Inquiry on Mid-Staffordshire NHS Foundation Trust, and the cases of abuse which emerged at Winterbourne View both demonstrate the failings which have occurred within the health and social care system which organisations must learn from. It is anticipated that the revised mandate will aim to transform patient care and safety becoming one of its key priorities.
- **Integrated Care** – The NHS faces significant challenges ahead. The scale of the financial challenge and limited resources available increases this pressure even further. Integrated Care is seen as a key enabler to address these challenges, by bringing health, social care and other organisations to work more closely together so that resources are use more efficiently and effectively. It is anticipated that the Mandate will set the expectation for NHS England to leading the way for better integration of health and social care.
- **Accident and Emergency (A&E) services** – This year has seen the significant pressures placed on A & E services. The increasing demand on these services are symptomatic on longer term pressures on the NHS such as the support

available to stay healthy which creates additional pressures on existing services. NHS England are currently working to develop a plan for vulnerable older people which aims to address this and how to improve out of hospital care. The Government aims to use the refreshed Mandate to outline its ambitions to support this plan.

Conclusion – the case for change

- The changing health needs of the Lewisham population will increase demand on services
- We need to improve our health outcomes
- We need to improve quality and accessibility of local services to all
- The current configuration of health services is not likely to be sustainable
- There will be gap in finances, between resources available and expenditure

More of the same will not address this challenge

This means working with our partners to do things differently

4. TRANSFORMING LOCAL SERVICES

This section describes the changes we plan to make to our commissioning to achieve our vision.

Our commissioning strategy does not sit alone, and we will be working in partnership with other South East London clinical commissioning groups and in particular as members of the Lewisham Health & Wellbeing Board to meet the health needs identified in the JSNA.

4.1 PRIORITIES

We have identified eight strategic priorities that we will focus on to transform services:

Strategic Themes	Strategic Priorities
Healthy Lifestyles and Choice	1. Health and wellbeing – smoking cessation, alcohol abuse, obesity and cancer
	2. Maternity and children’s care in hospital
Frail and Vulnerable People	3. Frail older people (including end of life care)
Long Term Conditions	4. Long Term Conditions – eg COPD, diabetes, CVD, dementia
	5. Mental Health
Deliver Services Differently	6. Primary care development and planned care
	7. Urgent Care
	8. Greater integration of health and social care commissioning

Over the past eighteen months we have asked Lewisham people “what’s important about your health services”, and we have listened to what you told us. Your feedback helped us to set the priorities that will help us to meet our challenges that we have described in our case for change. We call this linkage our ‘golden thread’.

Strategic Priorities	Case for Change Summary
Health promotion – smoking cessation, alcohol abuse, obesity and cancer	<p>This provides long-term benefits in helping to address our health needs challenges such as the main causes of death (cancer, circulatory diseases, respiratory disease) and inequalities between different areas of Lewisham.</p> <p>The NHS Mandate’s objective of <i>‘Preventing people from dying early’</i> includes supporting the earlier diagnosis of illness, particularly through appropriate use of primary care, and tackling risk factors such as high blood pressure and cholesterol. Also focusing on preventing illness, to help people stay in good health – by not smoking, eating healthily, drinking less alcohol, and exercising more.</p>
Maternity and children’s care in hospital	<p>We want to build on the positive public feedback about the maternity unit at Lewisham Hospital and to support the long-term sustainability of our local maternity providers. We also need to address the rates of low birthweight babies.</p> <p>The Mandate’s ambitions for Maternity and Children’s services particularly feature in its objective for <i>‘Ensuring that people have a positive experience of care’</i>. This includes helping to give Children the best start in life and promoting their health and resilience as they grow up through a more joined-up approach to addressing their needs.</p>
Frail older people (including end of life care)	<p>Our health needs analysis has highlighted the increasing numbers of frail elderly people, while public feedback has identified that older people feel disengaged in their care.</p> <p>The Mandate has as one its priority areas <i>‘Improving standards of care and not just treatment, especially for older people and at the end of people’s lives’</i> .</p>
Long Term Conditions – eg COPD, diabetes, CVD, dementia	<p>Long term conditions and dementia rates are increasing and we need to ensure that our local services are able to manage this demand efficiently while providing high quality care which is inclusive of patients and carers in care planning</p> <p>The Mandate’s objective <i>‘Enhancing quality of life for people with long-term conditions’</i> and supporting people with ongoing health problems to live healthily and independently with better control over the care they receive. This includes better involvement of patients and their carers and to manage and make decisions about their own care and treatment and developing the knowledge skills and confidence to manage their own health.</p>

Mental Health	<p>There is a high prevalence of mental health need in Lewisham, and in this area too we have heard feedback about how important it is to include patients and carers in plans</p> <p>Mental health appears in across several of the Mandate's objectives which our strategic priority for Mental Health will aim to address. This includes treating mental and physical health in a coordinated way to support recovery and improving access to services for people with Mental health so that to be on par with physical health.</p>
Primary care development and planned care	<p>The demands on these sectors are increasing with the increasing prevalence of long term conditions and dementia. Public feedback has highlighted that access to primary care varies and with a positive view of the contribution of pharmacies.</p>
Urgent Care	<p>Patients value A&E services but we need to work with the public and providers to develop a local configuration of emergency services that is affordable.</p>
Greater integration of health and social care commissioning	<p>People would like to see care joined up. This will also be essential as our population develops more complex health needs and there is increasing pressure on our services.</p>

4.2 STRATEGIC AIMS

For each of our priorities we have identified the changes we will aim to implement, our key objectives and changes that will be introduced in the next two years. As we progress towards our goals in subsequent years we will refine and add to our plans and the changes we have to introduce.

4.2.1 Health and Wellbeing

Strategic Aims

To contribute to the delivery of the Health and Wellbeing Board's nine priorities with a particular focus on reducing smoking, alcohol abuse, obesity and to increase cancer awareness, screening and early diagnosis.⁷

4.2.2 Maternity and Children's Care in Hospital

Strategic Aims

- To normalise and improve the quality of maternity care to women in Lewisham across the care pathway
- To develop children's integrated care pathways to ensure that children receive excellent care in the appropriate setting.

4.2.3 Frail Older People (Including End of Life Care)

Strategic Aims

- To improve the advice, support and care provided to frail older people so they can continue to live independently;
- As needs change to ensure that there is responsive and appropriate high quality care and support available in a variety of settings including community, extra care and care homes

4.2.4 Long-Term Conditions

Strategic Aims

- To develop integrated care pathways, building on COPD, Heart Failure and Diabetes service redesign work.

⁷ For more information on the Health & Wellbeing Board and strategy priorities see <http://councilmeetings.lewisham.gov.uk/mgCommitteeDetails.aspx?ID=315>

- To provide personalised care, using risk stratification tools to systematically identify people earlier with health issues.
- To provide comprehensive integrated services for people with dementia.
- To improve the patient's and carer's experience by changing culture and behaviours so that the patient is at the centre.
- To enable patients to be better supported to take greater responsibilities, with the opportunity for a healthcare personalised budget.

4.2.5 Mental Health

Strategic Aims

To ensure a mental health service system within which all providers, whether statutory, independent or third sector, through outcome based commissioning focused on seven success criteria:

- I. Health outcomes
- II. Social outcomes
- III. Community safety outcomes
- IV. Treatment choice and service relationship outcomes
- V. Physical health outcomes
- VI. Fair and straightforward access
- VII. Value for money

4.2.6 Primary Care Development and Planned Care

Strategic Aims

- Working with primary care to ensure high quality of care for all by levelling up standards and reducing variations between practices and care for specific communities.
- Working with local providers to ensure optimisation of planned care services by commissioning effectively

4.2.7 Urgent Care

Strategic Aims

- To ensure that the right care is delivered in the right place, at the right time to reduce the requirement for unplanned care, working with providers of urgent care.
- To review, with stakeholders, the current number of different ways Lewisham people access urgent care to enabling us to develop and implement the most appropriate model(s) and configuration of urgent care services

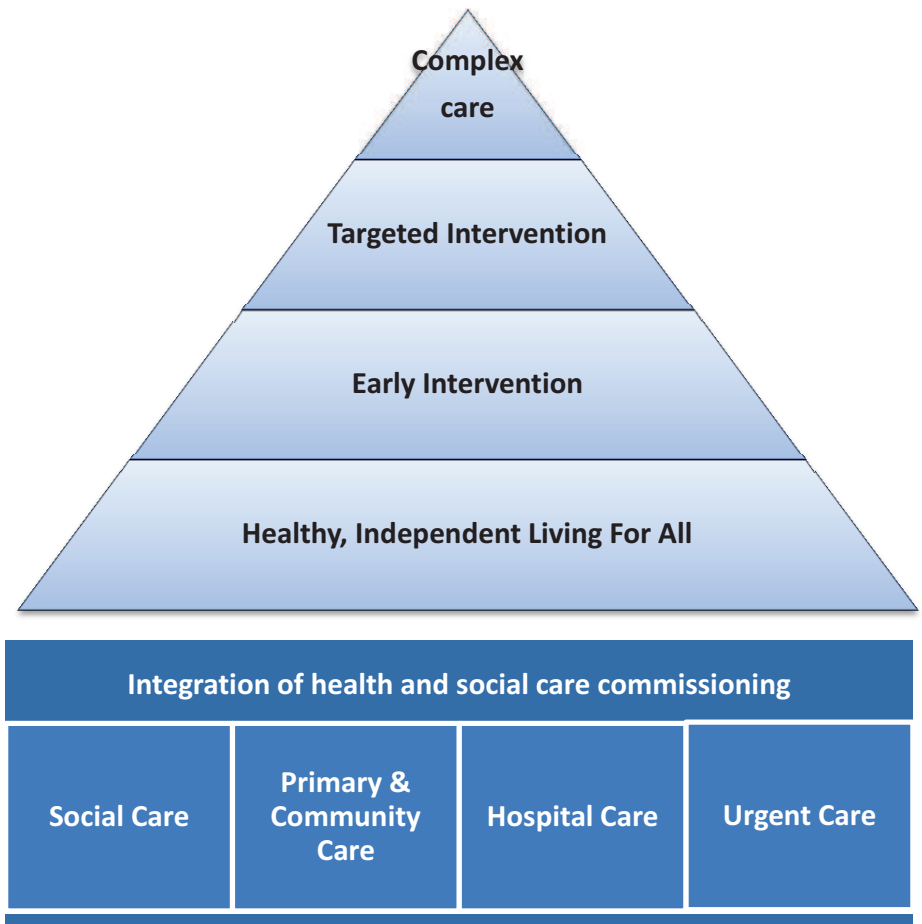
4.2.8 Greater Integration of Health and Social Care Commissioning

Strategic Aims

Greater Integration of health (primary, community and secondary care) and adult social care commissioning - by implementing the Lewisham's integrated delivery model which is based on providing advice, support and care to an individual, recognising that each person's health is unique and dynamic, so will need different levels of advice, support and care from a variety of services during their life time. The delivery of this priority is represented by four levels of advice, support and care:

- Healthy Choices for All – empowering and supporting individuals, families and communities to take action to make healthy lifestyle choices
- Early Intervention - identifying at an early stage when more support is required and providing fast and convenient access to high quality support and advice.
- Targeted Intervention – identifying those specific high risk individuals who would benefit from active intervention to avoid a potential crisis such as an inappropriate admission and re-admissions to hospital.
- Complex Care – coordinating and managing a complex health and social care package in a single care plan which is tailored around the needs of the individual, carer and the family with them at the heart and still in control - 'nothing about me, without me'.

DELIVERY MODEL



CCG PRIORITIES

Long Term Care:

- Long-term conditions (COPD, diabetes, CVD)
- Mental health
- Frail older people

Healthy Choices:

- Maternity
- Health promotion

Provision

5. EQUALITIES ANALYSIS

An equalities analysis of the draft strategic aims and priorities has been undertaken by Lewisham Public Health and is included in Appendix 2. It examined the eight strategic priorities and for each one identified potential positive, negative and neutral outcomes. It concludes that overall the strategy will contribute to reducing inequalities, and highlights potential positive outcomes for disadvantaged groups and for those that share protected characteristics. Further work on equality impact assessment will be undertaken as part of the development of the CCG's QIPP plans.

Appendix 1: Phases of Engagement 2012-13

Engaging on our priorities	
2012	Our outreach programme in 2012 utilised the <i>'Have Your Say'</i> patient survey – presenting outcomes across the borough; asking patients about what they do and don't value in their health service. We attended a series of local meetings and engaged with GP Practice Patient Groups.
January 2013	<p><i>Shaping Your Health Services</i></p> <p>On the 31st January 2013 over 50 Lewisham patients, members of the public, carers and local councillors filled the Lewisham Town Hall Civic Suite. The engagement event was to enable discussions on the Lewisham Clinical Commissioning Groups (LCCG) Strategic Priorities to improve services and patients health.</p> <ul style="list-style-type: none"> • Complete the engagement cycle by ensuring that the CCG feedback to patients: <i>'You Said We Did'</i> • Confirmed that patients were happy with the priorities • Considering good practice, expectations and barriers what patients thought of our plans
Developing a local strategy for Lewisham	
July	<p><i>Lewisham Peoples Day Launch</i></p> <p>Our strategy was launched at Lewisham Peoples Day on Saturday 13th July. Local people were encouraged to comment on the strategy and priorities using questionnaires. LCCG engaged with 120 residents and 73 completed the questionnaires.</p>
September /October	<p>An engagement programme on the draft strategic priorities <i>'We are up for the challenge'</i> was launched on 16th September, incorporating the NHS England <i>'A call to action'</i> national programme launched on 11th July 2013. This has involved:</p> <ul style="list-style-type: none"> • Distributed information on the Strategic Plan to over 4000 individuals utilising partner networks via (Voluntary Action Lewisham, SLAM, Healthwatch, Lewisham Ethnic Minority Partnership) • Created a webpage dedicated to the plan – with an online survey • Provided updates and alerts on Twitter and Face Book • Included 2 updates on GPi • Informed all Practice Participation Groups via Healthwatch • Targeted 12 practices (across the Borough) – using face to face attendance at these practices

To ensure we involved marginalised groups specific face to face activity has taken place with:

- Lewisham Health and Social Care Forum
 - Carers Lewisham
 - St Mungo's Housing
 - Lewisham Park Housing Association
 - 999 Club (homeless/rough sleepers support group)
 - Lewisham Pensioners Day
 - BME Older People's Group
 - Stroke Association
 - Foodbank Lewisham
- **CCG membership:** Engaging with our members at the Membership Forum meetings and on-line
 - **Talking to our stakeholders:** Healthier Communities Select Committee, LCCG Public Engagement Group, Health & Well Being Board, and Local Medical Council.

The survey and stakeholder engagement and face to face activity have used six core questions:

- I. Are we getting the basics right in local health services at the moment?
- II. Do we need to include anything else in order to get these basics right?
- III. How can we support you to stay well?
- IV. What makes it difficult for you to stay well and what can we do differently?
- V. How can health and social care services work better together?
- VI. What do we need to do differently so that people receive joined up care?

Appendix 2: Equality Impact Assessment Scoping Paper

October 2013

Lewisham Public health Team

Introduction

The document is an Equality Impact Assessment of the Lewisham Clinical Commissioning Group (CCG) strategic plan for 2013-18. It is based on the information available at the time of writing, mostly a strategic view of intended changes. Because of the timing of this paper, a detailed review of the evidence and background work underpinning the proposed changes was not possible. Further work in this area may be warranted.

A full assessment of the Lewisham population in relation to the nine statutory protected characteristics (age, disability, sex and gender, pregnancy and maternity, race, religion or belief, gender reassignment, sexual orientation, marriage and civil partnership), plus deprivation was carried out in August 2013 by the Lewisham Public Health team. This assessment formed part of an Equality Impact Assessment of the Lewisham Health and Wellbeing Board's Strategy for the next decade.

This population assessment has been used as the principal source of information on Lewisham's population for this paper and is given in full in annex 1, along with the primary data sources used. Additional information has been taken from CCG papers relating to this strategy. These are listed in annex 2. Statements of fact about the characteristics of various populations are drawn from the above sources but are not individually referenced for ease of reading.

The CCG strategy highlights eight strategic priority areas (listed below). An Equality Impact Assessment of each of these areas is given below.

- Health Promotion
- Maternity and Acute Children
- Frail Older People (including End of Life Care)
- Primary Care Development and Planned Care
- Long-Term Conditions
- Urgent Care
- Mental Health
- Greater Integration of health and Social Care Commissioning

Impact Assessment

Health Promotion

The Health Promotion priority encompasses how Lewisham CCG will support the delivery of the Lewisham Health and Wellbeing Strategy.

As mentioned above, a full Equality Impact Assessment of the Lewisham Health and Wellbeing Strategy for the next decade has already been carried out. Please see this document for more details.

Maternity and Acute Children

Potential Positive Outcomes

1. Lewisham has high rates of low birth weight babies and infant mortality, although both are falling. Changes to maternity services are expected to improve quality of delivery and care across a range of outcomes. These improvements should be of benefit to all those who access these services, regardless of their race, age, sexuality, marital status etc.
2. However there are a number of high risk populations in Lewisham with high rates of complications in pregnancy due to obesity, diabetes, mental health and deprivation. The highest risk of low birth weight is in babies born to mothers of Black African and Black Caribbean ethnicity, to mothers of any Asian ethnic group, and to mothers from deprived areas. High rates of maternal obesity are associated with deprivation and being of Black African Black Caribbean and Pakistani ethnicity. Planned changes to move to an integrated model of service should improve service quality and benefit these groups.

Potential Negative Outcomes

1. Service reconfigurations can often result in higher staff turnover and disruption while changes are being implemented. The proposed changes might therefore reduce service quality as organisational knowledge is lost and (possibly) staff morale is affected in the short term. If services are temporarily disrupted, the high-risk groups identified above are likely to be disproportionately affected by this disruption.
2. Lewisham's birth rate is rising and is expected to continue at a high level for several years before starting to fall. Planned service reconfigurations are to be made within the existing budget even though this includes a national annual growth assumption. This may not be possible and the service might then experience disruption but without the positive outcomes hoped for in the longer term.

Neutral Outcomes

1. The Cochrane review of midwife-led maternity services – the model upon which this service reconfiguration is broadly based – anticipates improvements across the board. Those who are not high-risk in terms of age, ethnicity, deprivation, obesity etc may notice less of a change than those with greater needs.

Frail Older People (including End of Life Care)

Potential Positive Outcomes

1. Although the proposed changes were only defined in broad terms at the time of writing, improvements to services for frail older people are likely to benefit women, since they live longer, have more long term conditions on average than men, are more at risk of common mental illnesses and make greater use of social services.
2. The older population in Lewisham is less ethnically diverse than the younger demographic. Improvements in services for frail elderly people are therefore likely to benefit those of white ethnicity, who make up three quarters of the older population. Over time the proportion of the older population from BME groups will increase as these populations age.
3. Disability increases with age, so improvements to services for frail elderly should be of particular benefit to disabled people.
4. There is a larger older population in the south of the borough compared to the north. The south of Lewisham is also generally deprived. Improvements to services for frail elderly people should therefore benefit these deprived areas.
5. Greater consistency of provision to care homes should benefit older people who are no longer fully independent, especially women, who make greater use of health services.

Potential Negative Outcomes

1. At present Lewisham's elderly population is mostly white. The ethnic diversity of older people in Lewisham will increase as the current population ages. This change in the demographic profile needs to be borne in mind in future service plans, ensuring sensitivity to ethnicity and religion in particular.

Anticipated Neutral Outcomes

1. As long as the proposed changes are delivered sensitively to individual's needs - in terms of the nine protected characteristics plus deprivation - it is difficult to assess (based on outline information on commissioning plans available at the time of writing) how they might disadvantage certain groups.

Primary Care Development and Planned Care

Potential Positive Outcomes

1. Improving standards in primary care across the board, by reducing variation in performance, should most benefit those with significant health needs. These are likely to be older people, those living in deprived areas, those with disabling long term conditions, mothers of young children and young children themselves.
2. Women might benefit from improvements to primary care, given their greater risk of common mental illness, which is commonly identified in a primary care setting. Also women might benefit if improvements led to better management of CVD as the 40% of life expectancy gap in women is due to CVD compared with 32% for men.
3. Where poor primary care performance is associated with deprivation, improvements to primary care should be of particular benefit to those who live with poor health in deprived areas.
4. A desire to maintain local provision of primary care by sustaining local practices should be particularly benefit those with restricted mobility and/or low incomes, such as those living with disabilities, those living in deprived areas, older people and perhaps mothers with young families.
5. A planned move to self management technology might also be of particular benefit to those with restricted mobility. Familiarity with technology might also benefit younger people with long term conditions.
6. Some ethnicities are at greater risk of certain diseases commonly treated in primary care. For example diabetes is more common in Asian and Black populations and obesity is strongly linked to deprivation among those from ethnic minorities. Improvements to primary care should therefore benefit those from ethnic minorities.
7. Improvements to primary care should benefit those who are divorced, separated or widowed, since they tend to have poorer physical and mental health than single people.

Potential Negative Outcomes

1. A planned move to self management through technology might disadvantage those with learning disabilities, people who are less familiar with technology (e.g. some older people) or those with lower levels of education. Careful screening and appropriate alternative methods of care will be needed for those for whom self-care technology is not appropriate.

Potential Neutral Outcomes

1. As long as services are delivered sensitively and appropriately, the proposed changes should not have an impact on people because of their religion or belief, those from the Lesbian, Gay, Bisexual and Transgender (LGBT) community and those in marriages or civil partnerships.

Long-Term Conditions (LTCs)

Potential Positive Outcomes

1. LTCs increase with age, are often disabling, are more prevalent among deprived communities and are in some cases associated with certain ethnicities (e.g. diabetes). A focus on improving integration and quality of care, along with earlier identification should benefit all these groups through delaying/reducing the impact of disease and reducing emergency admissions.
2. A proposed integration with the 3rd sector for dementia care should benefit older people.
3. Women with LTCs are at greater risk of complications in pregnancy. A focus on improved management of LTCs should benefit women and their children.

Potential Negative Outcomes

1. HIV is not considered explicitly in the CCG strategy, however it is a long term condition with a high prevalence in Lewisham. Whilst HIV treatment is commissioned by NHSE rather than the CCG, HIV care and support including specialist nursing and specialist mental health provision is commissioned by the CCG. The burden of HIV falls disproportionately on men who have sex with men (MSM), and Black African communities, where heterosexual men are likely to be diagnosed late. HIV is also a particularly sensitive topic for certain religions. HIV therefore cuts across many of the protected characteristics, most importantly race, sexuality, maternity, gender and religion. The explicit inclusion of HIV among other listed LTCs would help address inequalities in these areas.
2. Obesity is linked to a number of LTCs and associated with deprivation in women and is more common among certain ethnic minorities in Lewisham, such as those of Black African and Black Caribbean descent. This should be considered in the LTC workstream.
3. A planned move to possible personal budgets for care of people with LTCs might, if inappropriately applied, disadvantage those lacking the skills to appropriately manage this. Those with learning difficulties and those with lower educational attainment (linked to deprivation) would be particularly at risk.

Potential Neutral Outcomes

1. Those who do not suffer from long term conditions - regardless of their age, ethnicity, religion, sexuality, etc - are unlikely to be affected by these changes.

Urgent Care

Possible Positive Outcomes

1. If the proposed changes do deliver savings, as anticipated, this should free resources for other areas of healthcare provision or contribute to required savings. In general terms this could benefit those who make use of these services, as discussed in this paper.
2. Although homeless people and people with drug and alcohol problems are not explicitly covered by the 9 protected characteristics, planned pathways for these groups should help ensure they are not disadvantaged by changes to reduced urgent care provision.

Possible Negative Outcomes

1. The implication of specific pathways for homeless people and people with drug and alcohol problems is that these are heavy users of Urgent Care. If these pathways are unsuccessful then these groups could be disadvantaged by proposed changes.
2. An increased use of telephone triage and other non face-to-face forms of contact may disadvantage people with disabilities (for example those with learning disabilities or who are hearing impaired). Those on low incomes may be unable to afford phone calls, for example if they have run out of credit. Internet access is not universal and some groups, such as some older people, may find remote ways of working more challenging.
3. Similarly, while an increased focus on self-care may be appropriate for many people, this will be more challenging for those with low levels of education (associated with deprivation) and those with learning disabilities.

Possible Neutral Outcomes

1. It is not expected that the proposed changes to urgent care will significantly affect people with regards to religion or belief, the LGBT community and those in marriages or civil partnerships.

Mental Health

Potential Positive Outcomes

1. Mental ill health is more prevalent in certain BME groups, those who identify as Lesbian, Gay or Bisexual, those who are divorced/widowed/separated and those living in deprived areas. There are also very high levels of mental illness amongst those known to the criminal justice system. Expecting providers to demonstrate how they meet the needs of diverse communities will help ensure that those at highest risk of mental illness will be supported to access services.
3. Community based services delivered near to home help support people with poor mental health to recover without requiring initial or further hospital admission.
4. Certain ethnic groups are over-represented in local inpatient services (principally White other and Black Other). Improving the community offer to patients may

prevent escalation of mental illness and reduce over representation in inpatient services.

Potential Negative Outcomes

1. Those with the poorest mental health are most likely to need access to inpatient services. A reduction in inpatient beds may mean that those with the worst mental health wait longer for treatment in an inpatient setting or need to travel further to access inpatient care.

Neutral Outcomes

1. Those who identify as Lesbian, Gay, Bisexual and Transgender (LGBT) are at increased risk of mental illness. It is not clear if the commissioning intentions have any specific impacts for this group over those highlighted above.

Greater Integration of Health and Social Care Commissioning

Possible Positive Outcomes

1. A move towards closer integration of health and social care commissioning, with four proposed levels of support (Healthy Choices for All, Early Intervention, Targeted Intervention and Complex Care) should particularly benefit those whose needs cut across health and social care. For example, older people with LTCs often require social support in addition to health services. Those from deprived communities, certain ethnic minorities, and women (who use more social care) should all benefit.
2. Those of all ages with disabilities also often require health and social care on an ongoing basis. They should benefit from closer integration of commissioning.

Possible Negative Outcomes

1. Targeted intervention will only benefit those who have been identified. The process of identifying those at risk requires careful scrutiny from an inequalities perspective to ensure certain groups are not missed, disadvantaged or marginalised. It would be worth giving consideration to groups not covered by the nine protected characteristics plus deprivation considered here, for example those without recourse to public funds, homeless people and people with drug and alcohol problems. This is a potential area for more detailed work in the future.

Possible Neutral Outcomes

1. People who are not big users of health or social care are unlikely to be much affected by the proposed changes. This applies to healthy people of all ages, ethnicities, sexual orientation and so on.

Conclusion

The conclusion of this study is that, at the strategic level considered here, the proposed changes to services would, on the whole, prove more beneficial than harmful. The changes have clearly been designed with the aim of reducing inequalities.

In broad terms, there are however two areas that give cause for concern.

Firstly, the move towards increased self-management and remote care, either through the use of technology or non face-to-face contact may disadvantage those with certain disabilities, learning disabilities, older people, those with low levels of education and those with low incomes. Alternatives need to be considered for these groups.

Secondly, the interface with HIV care commissioned by NHS England should be reconsidered, particularly because HIV affects several vulnerable groups such as men who have sex with men and those from Black African communities as part of the mental health work.

Because of the timing of this paper, the detailed evidence and background work which has informed the proposed changes has not been considered. In addition, the commissioning intentions are at an early stage and have not yet been translated into service specifications. It would be worth considering how to involve assessment of the impact of proposed changes on inequalities through each stage of the commissioning cycle.

This paper has only considered the impact on the nine protected characteristics plus deprivation. There are other non-statutory characteristics that might be considered on a service-by-service basis, for example the impact of planned changes to Urgent Care on homeless people and people with drug and alcohol problems.

Annex 1: Assessment of Lewisham Population in Relation to the nine protected characteristics plus deprivation

Data Sources

General

Census 2011 (various elements)

Greater London Authority (2012) Population Projections 2012 Round, SHLAA

Office of National Statistics (2011) General Lifestyle Survey

Age

APHO (2012) Health and Wellbeing of Older People's Atlas

Lewisham Joint Strategic Needs Assessment (alcohol, tobacco control, sexual health, mental health, long term support, cancer, immunisations and healthy weight chapters)

Health Equity Audit of the Stop Smoking Service in Lewisham, May 2013

Health Survey for England 2009

Department of Health (2012) Long Term Conditions Compendium of Information

Purdy S, King's Fund (2010) Avoiding hospital admissions What does the research evidence say?

Department of Health (2011) The likely impact of earlier diagnosis of cancer on costs and benefits to the NHS.

NHS Lewisham Health Equity Audit of Breast Cancer Screening 2010

K Robb, S Stubbings, A Ramirez, U Macleod, J Austoker, J Waller, S Hiom and J Wardle (2009) Public awareness of cancer in Britain: a population-based survey of adults (British Journal of Cancer 2009 101(Suppl 2): S18–S23)

Lewisham Public Health Performance Dashboards: Immunisations

Disability

Lewisham Joint Strategic Needs Assessment (alcohol, adults with learning disabilities and healthy weight chapters)

NHS Yorkshire and the Humber (2010) Healthy Ambitions for People with Learning Disabilities

Department of Health (2012) Long Term Conditions Compendium of Information

Child and Maternal Health Observatory (2011) Disability and obesity: The prevalence of obesity in disabled children

Gender

Lewisham Joint Strategic Needs Assessment (alcohol, tobacco control, sexual health, mental health, long term support, cancer, immunisations and healthy weight chapters)

Health and Social Care Information Centre (2013) Statistics on Obesity, Physical Activity and Diet, England.

Department of Health (2012) Long Term Conditions Compendium of Information

Health Equity Audit of the Stop Smoking Service in Lewisham, May 2013

London Health Improvement Board (2011) Alcohol

Hospital Episode Statistics (various years)

Pregnancy/Maternity

Lewisham Joint Strategic Needs Assessment (tobacco control, sexual health, immunisations and healthy weight chapters)

NHS Information Centre (2012) Statistics on Smoking in England

Lewisham Public Health Performance Dashboards: Immunisations

Kelly y et al (2009) Why does birthweight vary among ethnic groups in the UK? Findings from the Millennium Cohort Study

(*J Public Health (2009) 31 (1): 131-137*)

Race

Lewisham Joint Strategic Needs Assessment (alcohol, tobacco control, sexual health, mental health, long term support, cancer and healthy weight chapters)

Health Survey England (2004) (special focus on ethnic minority health)

Hospital Episodes Data (2011)

Selten, J-P, Cantor-Graae, E & Kahn, René S (2007) Migration and Schizophrenia

(*Current Opinion in Psychiatry: March 2007 - Volume 20 - Issue 2 - p 111-115*)

Kelly y et al (2009) Why does birthweight vary among ethnic groups in the UK? Findings from the Millennium Cohort Study

(J Public Health (2009) 31 (1): 131-137)

British Heart Foundation Health Promotion Research Group (2010) Ethnic Differences in Cardiovascular Disease

Diabetes UK (2010) Diabetes in the UK 2010: Key statistics on diabetes

Health Equity Audit of the Stop Smoking Service in Lewisham, May 2013

NHS Lewisham Health Equity Audit of Breast Cancer Screening 2010

K Robb, S Stubbings, A Ramirez, U Macleod, J Austoker, J Waller, S Hiom and J Wardle (2009) Public awareness of cancer in Britain: a population-based survey of adults

(British Journal of Cancer 2009 101(Suppl 2): S18–S23)

Public Health England (2013) HIV Epidemiology in London: 2011 Data

Religion/Belief

Department of Health (2009) Religion or Belief: a practical guide for the NHS

Gender Re-assignment

Department of Health (2007) Reducing health inequalities for lesbian, gay, bisexual and trans people

Gender Identity Research and Education Centre (2011) The Number of Gender Variant People in the UK - Update 2011

Sexual Orientation

Lewisham Joint Strategic Needs Assessment (demography, sexual health and mental health chapters)

Public Health England (2013) HIV Epidemiology in London: 2011 Data

Marriage/Civil Partnership

Derbyshire County Council (2013) Equality Impact Analysis of Health and Wellbeing Strategy

Deprivation

Lewisham Joint Strategic Needs Assessment (alcohol, tobacco control, sexual health, mental health, long term support, cancer and Lewisham profile chapters)

Health Equity Audit of the Stop Smoking Service in Lewisham, May 2013

Characteristics of Lewisham Population

Age

- Lewisham has a relatively young population:
- 25.4% of residents are under 19 (compared to an England average of 25%)
- Children under 5 make up 8% of the population, compared to 6.3% in England
- Only 10.5% of the population are over 65 (compared to an average of 11% for London and 16% for England)
- There is a higher proportion of older residents in the south of the borough (7% of residents of the northern wards of the borough (Evelyn, New Cross and Brockley) are aged 65 years and over compared to 14% in the southern wards of Grove Park, Downham, Sydenham and Catford South). (There is not a similar geographical pattern for younger residents.)
- Lewisham's younger population is more ethnically diverse; 73% of residents aged 65 and over are white, compared to 61% of those aged 16-64 years.

Older People

- Both healthy and disability adjusted life expectancy at age 65 are significantly lower in Lewisham than both the England and London averages.
- The rates of all and emergency admissions for those aged 65 and older are significantly higher in Lewisham than England.
- Lewisham has a directly standardised all cause mortality rate for the over 65s that is significantly worse than England as a whole.
- Health declines with age; 16% of Lewisham residents aged 35-49 report not being in good health compared to 71% of over 85s.
- England-wide figures show that long term conditions become more common with increasing age. Three times as many over 75 year olds report having at least one long term condition compared to those aged 16-44.
- The prevalence and hospital admission rates for COPD (Chronic Obstructive Pulmonary Disease) are higher in Lewisham than in England as a whole. 88% of admissions for COPD are amongst people aged 60 years or over. Similarly rates of admissions for heart failure are higher in Lewisham than England as a whole.
- Emergency readmission rates within 28 days of discharge for residents aged over 75 are significantly worse than England.
- The rates of admission of over 65s to residential and nursing homes in Lewisham was 560 per 100,000 in 2011/12; this is lower than the England average, though

higher than the London average. The rates of over 65s returning home to their usual place of residence following a hospital admission for hip fractures is worse for Lewisham residents than the England average.

- 89% of those aged 65+ in Lewisham discharged to rehabilitation services are still at home 91 days after admission.
- Standardised cancer mortality rates amongst the over 65s are significantly higher in Lewisham than England. However, those for 35-64 year olds are lower than England.
- In 2011/12 70% of over 65s year olds were vaccinated against influenza. This is below both the London and England rates.

Children and Young People

- Obesity amongst children in Lewisham is a significant problem. The prevalence of obesity amongst both 4-5 year old and 10-11 year olds is higher in Lewisham than the England average; 37% of 10-11 year olds are either overweight or obese.
- Lewisham has a high proportion of children and young people from ethnic minorities; national data has shown a higher prevalence of overweight (including obesity) in Black African and Caribbean children.
- England has one of the highest death rates from chronic liver disease, used as a marker for alcohol-related harm, in Western Europe. And importantly for young people it is the only disease in which deaths amongst the under 65s are increasing. Hospital admissions related to alcohol are high and increasing in Lewisham. Binge drinking is more common amongst young people, and there is evidence of a rise in alcohol harm amongst young women in particular (see gender section for further details)
- The earlier children or young people start smoking the greater their risk of developing lung cancer and heart disease later in life. Children who live with parents or siblings who smoke are two to three times more likely to take up smoking. There is evidence that smokers who started at an early age smoke more and are less likely to be able to quit. In Lewisham smokers aged 15-19 using the Stop Smoking Service were less likely to successfully quit than older smokers.
- Rates of mental illness are higher in Lewisham than England and London. Most mental disorder begins before adulthood with 50% of lifetime cases of diagnosable mental illnesses beginning by age 14 and 75% of disorders starting by the mid-20s.
- The under-18 conception rate in Lewisham is significantly higher than rates in both London and England. In Lewisham abortion rates are highest amongst 18 and 19 year old women, and overall the abortion rates in the borough are higher than both London and England.
- Uptake rates of MMR2 and pre school booster vaccination for Lewisham children are amongst the lowest in London. There was an outbreak of Measles in Lewisham in 2008.

Disability

- In 2011 14% of individuals in Lewisham reported having a long-standing health condition or disability that limited their day to day activities. Half of those reported that it limited them “a lot”.
- Individuals with a long standing disability or health condition may be more vulnerable to minor illnesses or accidents. These may also have a greater impact on their wellbeing and ability to live independently in the short or long term.
- Similarly those with a long standing disability or health condition are more likely to require long term care and support.
- The rates of admission for people with COPD and heart failure are higher in Lewisham than the England average.
- Individuals with learning disabilities are more likely to be admitted to hospital than the general population (26% per year and 14% per year respectively). They are also four times more likely to die of preventable causes and are significantly more likely to die under the age of 50.
- Lewisham is currently a pathfinder in a national programme for children with disabilities and special educational needs.
- People with long term conditions are 2 to 3 times more likely to suffer from depression than those in good health. Amongst those with two or more chronic physical conditions, the risk of depression is seven times higher.
- The proportion of people achieving recommended levels of physical activity is lower amongst those with disabilities than the able-bodied. The prevalence of obesity is higher in children with long-term health conditions or disabilities.
- In Lewisham 17% of people accessing alcohol treatment services have a disability.

Sex and Gender

- 15.5% of males living in Lewisham of all ages reported not being in good health, compared to 17.7% of women.
- Emergency admissions for Lewisham residents vary across the borough. Rushey Green and Ladywell have the highest standardised rates for men and Rushey Green and Evelyn for women.
- Men are twice as likely to die from alcohol related harm as women.
- Alcohol harm is an increasing problem amongst women and in particular young women; although alcohol-specific admissions are higher for men than women, over the past few years rates have levelled off in men but continue to rise in women. In the case of under 18s the alcohol-specific admission rates for women are twice those of young men (though in the over 18s the rates for men are three times higher)
- The premature mortality rate for all cancers for men (under 75) in Lewisham was 24% higher than the England-wide rate, the same rate for women in Lewisham was 10% higher than the rate for England.

- Physical activity is higher amongst men than women at all ages. A higher proportion of women than men in England have a healthy⁸ body mass index (BMI) (34% and 39% respectively), but more women are obese than men (26% and 24% respectively) In the case of women (in England) rates of obesity increase with increasing levels of deprivation; this relationship with deprivation is weaker for men.
- In the UK smoking prevalence is slightly higher in men than women and smoking-related mortality is higher amongst men. In Lewisham more women than men seek support to quit smoking through the Stop Smoking Service, but men are more successful in quitting using the service than women.
- Women are more likely to suffer from common mental illnesses than men, though men are twice as likely to suffer from schizophrenia.
- Women have more long term conditions on average than men, particularly with increasing age.
- On the average, women receive more social care services (8.2%) than men (3.6%) in Lewisham, though this is presumably because on average women live longer than men.

Pregnancy and Maternity

- The general fertility rate (number of live births per 1000 women aged 15-44) in Lewisham is higher than the London and England averages. In 2011 the wards with the highest rates were Crofton Park and Rushey Green; Brockley and Telegraph hill had the lowest.
- Abortion rates in Lewisham are higher than the England average and almost half of abortions are performed on women who have had at least one previous abortion. The highest rates of abortion in the borough are for women aged 18-19 years old.
- The low birth weight rate for Lewisham births is higher than the England average, though not significantly different to London. Low birth weight can be associated with some ethnicities, including black Caribbean and black African, alcohol use, smoking and deprivation.
- Smoking by mothers at time of delivery is lower in Lewisham than the UK average.
- Local maternal obesity data show there are more women overweight (31%) or obese (24%) in Lewisham compared with England as a whole (28% and 17%).
- Influenza vaccine rates amongst pregnant women in Lewisham are below the London average.

Race

- Lewisham is an ethnically diverse borough, with only 41.5% of the population describing themselves as white British. The largest BME groups in the borough are black Caribbean and black African.

⁸ BMI between 18.5 and 25

- In Lewisham self reported health at the 2011 Census was worse in white British and black Caribbean residents than other ethnic groups. However, this may simply reflect the age profiles of these ethnic groups.
- Obesity prevalence varies between ethnic groups. In England the prevalence of obesity is higher in women of Black Caribbean, Black African and Pakistani groups compared to the general population.
- In Lewisham the majority of people accessing alcohol treatment services are white British; the Health Survey England in 2004 found that harmful drinking was less prevalent among ethnic minorities, including black Caribbean and Africans.
- There is evidence nationally that some ethnic minorities have a higher prevalence of some mental illnesses, most notably black African and Caribbean men and schizophrenia; it is thought migration and other factors play a part in this association. In Lewisham there are high numbers of admissions amongst people whose ethnicity is reported as black other.
- Smoking prevalence varies between ethnic groups. Taking this into account proportionately fewer black African smokers are using the local Stop Smoking Service.
- Some long term conditions are more prevalent amongst ethnic minority communities, including diabetes and cardiovascular disease.
- There is evidence nationally to suggest that emergency admissions are higher amongst ethnic minority groups.
- Cancer incidence in general is lower amongst ethnic minority groups, although there are some important exceptions. For example, prostate cancer incidence is greater amongst Black African and Black African-Caribbean men.
- Levels of public awareness of early symptoms and signs of cancer have been found to be lower amongst ethnic minority groups. In Lewisham breast cancer screening attendance was lower amongst BME women than white British women.
- Pregnancy rates are 74% higher amongst black ethnic groups than white ones; similarly, abortion rates are higher.
- New diagnoses of HIV are higher amongst black Africans in Lewisham, and Lewisham as a whole has one of the highest prevalences of HIV in England. About a third of new diagnoses of HIV in South East London are in Black Africans.

Religion or Belief

- Christianity is the most widely reported religion in the borough, with 53% of residents identifying themselves as Christian, 6% identify as Muslim and 27% have no religion.
- At the last census rates of self reported poor health were significantly lower than average amongst those with no religion and Hindus and higher than average amongst Christians, Buddhists, and those of “Other Religions”⁹.
- Religious and cultural views can influence attitudes towards reproductive medicine, abortion, contraception, neonatal care and death. They may also determine the

⁹ Excluding Hinduism, Christianity, Buddhism, Islam, Judaism and Sikhism

types of treatment and drugs used, for example blood transfusions, porcine or alcohol-based drugs.

- In Lewisham there are a number of successful health projects run alongside religious groups. For example, the Community Health Improvement Service conduct health drop in sessions in a variety of faith centres, including the Hindu temple. Similarly, services have worked alongside religious groups at key times, such as the Stop Smoking Service at Ramadan.

Gender Reassignment

- There is very limited information on the prevalence of gender reassignment. The most recent estimate suggests that 25 per 100,000 individuals have received treatment for gender variance; 60% of those have undergone transition surgery. The majority (80%) of those undergoing surgery were born male and transitioning to female.
- A national survey of transgender people found that a third of adults had attempted suicide.
- Rates of substance misuse have been found to be higher amongst transgender communities.
- 30% of transgender people have experienced discrimination from healthcare professionals, including with regard to cancer screening.

Sexual Orientation

- There are no accurate statistics available regarding the profile of the lesbian, gay, bisexual and transgender (LGBT) population either in Lewisham, London or Britain as a whole.
- The Greater London Authority based its Sexual Orientation Equality Scheme on an estimate that the lesbian and gay population comprises roughly 10% of the total population.
- At the 2011 census 2% of over 16 year olds were cohabiting with someone of the same sex or were in a civil partnership, this is higher than both the England and London averages (0.9 % and 1.4% respectively).
- There are higher rates of mental illness amongst individuals who describe themselves as lesbian, gay, or bisexual. Young gay men have been found to have a 5 fold increase in the risk of depression compared to heterosexual men. Suicide risk is 12 times higher.
- Men who have sex with men (MSM) are at increased risk of acquiring HIV; just over half of new diagnoses of HIV in 2011 in South East London were in MSM. In London as a whole rates of new HIV infection amongst the MSM community are increasing, despite falling amongst other groups.

Marriage and Civil Partnership

- About half of Lewisham residents over 16 have never been married or in a civil partnership. This is higher than England as a whole.
- A third of over 16s in Lewisham are currently married or in a civil partnership (0.5% in civil partnership)
- 17% of residents (aged 16 and over) have been married or in a civil partnership but are now separated, divorced¹⁰ or widowed¹¹.
- Married people's physical and mental health tends to be better than that of single people. However the health of single people is usually better than that of people who are widowed, separated or divorced.

Deprivation

- Lewisham is the 31st most deprived local authority in England and deprivation is increasing in the borough relative to the rest of the country.
- The highest levels of deprivation are found in Evelyn ward, in the north of the borough and Downham ward, in the south of the borough.
- Deprivation is quantified using the Index of Multiple Deprivation, which takes into account the following components: income, employment, health and disability, education, skills and training, housing and services, crime and the living environment.
- Increased deprivation is associated with worse health and wellbeing outcomes across many domains:
 - In Lewisham alcohol specific admissions are higher amongst residents of more deprived wards. The admission rates in Lewisham central for the period from 2005 to 201 were three times higher than the ward with the lowest rates of alcohol specific admissions.
 - Obesity is higher amongst those from more deprived areas. National figures have shown obesity levels amongst 4-5 year olds in the most deprived areas to be double that of the least deprived.
 - It has been estimated that the need for mental health services is 25-40% higher amongst residents of the least affluent wards in the borough compared to the most affluent.
 - Cancer incidence and mortality are generally higher in deprived groups compared with affluent groups. Although breast cancer has higher incidence in more affluent groups, its mortality is higher in less affluent women.
 - Smoking prevalence is higher amongst those from lower socio-economic groups.

¹⁰ Or were in a civil partnership that has now been legally dissolved

¹¹ Or are the sole surviving partner of a civil partnership

- Additionally, smokers from lower socio-economic groups are more likely to have started earlier, smoke more and find it harder to quit than smokers from higher socio-economic groups.

Annex 2: Additional Data Sources

CCG Papers

Commissioning Intentions, Strategic Priorities [undated]: Powerpoint presentation, supplied on 9/9/13 by Charles Malcolm-Smith

Lewisham CCG Strategy Development Update 6th June 2013

Lewisham CCG Strategy Summary Version 0.4 August 13

Appendix 3: Glossary of Terms

AAS Admission Avoidance Service

A&E Accident and Emergency

AHSN Academic Health Science Network

APMS Alternative Provider Medical Services

AQP Any Qualified Provider

BMA British Medical Association

BME Black and Minority Ethnic

BNF British National Formulary

CAMHS Child and Adolescent Mental Health Services

CAS Central Alert System

C&B Choose & Book

CBT Cognitive Behavioural Therapy

CCG Clinical Commissioning Group

CEMACH Confidential Enquiry into Maternal and Child Health

CIO Chief Information Officer

CIP Cost Improvement Programme

CNST Clinical Negligence Scheme for Trusts

COPD Chronic Obstructive Pulmonary Disease

CRL Capital Resource Limit

CPA Care Programme Approach

CPD Continuing Professional Development

CPR Child Protection Register

CQC Care Quality Commission

CQUIN Commissioning for Quality and Innovation

CRB Criminal Records Bureau

CSU Commissioning Support Unit

CSS Commissioning Support Service

CYPPB Children and Young people Partnership Board

DAT Drug Action Team

DGH District General Hospital

DH or **DoH** Department of Health

E&D Equality and Diversity

EDS (NHS) Equality Delivery System

EI Early Intervention

EIA Equality Impact Assessment

EMIS Practice Information System

ENT Ear, Nose and Throat

EPP Expert Patient Programme

EPR Electronic Patient Record

EPS Electronic Prescription Service

EWTD European Working-Time Directive

FCE Finished Consultant Episode

FHS Family Health Services

FIMS Financial Information

Management System

FOI Freedom of Information

FOT Forecast Outturn

FT Foundation Trust

GP General Practitioner

GPI General Practitioner Interactive

GPSI or **GPwSI** General Practitioner with a special interest

GSTT Guy's & St. Thomas's NHS Foundation Trust

HCA Health Care Assistant

HCAIs Healthcare Acquired Infections

HIA Health Impact Assessment

HRG4 Healthcare Resource Group version 4

HTA Health Technology Assessment

HV Health Visitors
HWB Health and Wellbeing Board

Staphylococcus Aureus
MSK Musculoskeletal

IAPT Improving Access to Psychological Therapies (programme)
ICO Integrated Care Organisation
ICP Integrated Care Pathway
ICT Information and Communication Technology
ICU Intensive Care Unit
I&E Income and Expenditure
IG Information Governance
IM&T Information Management and Technology
IST Intensive Support Team

NCAS National Clinical Assessment Service Programme
NCB National commissioning Board
NTDA National Trust Development Authority
NHS National Health Service
NHS SBS NHS Shared Business Services
NHS CB NHS Commissioning Board
NHSLA NHS Litigation Authority

JHWS Joint Health and Wellbeing Strategy
JSNA Joint Strategic Needs Assessment

OD Organisational Development
ONS Office for National Statistics
OOH Out of Hours
OP Outpatient Assessment
OSC (local authority) Overview and Scrutiny Committee

KPI key Performance Indicator

PALS Patient Advice and Liaison Service
PBMA Programme Budgeting and Marginal Analysis
PbR Payment by Results
PHE Public Health England
PHO Public Health Observatory
PI Performance Indicator
PMS Personal Medical Services
PNA Pharmaceutical Needs Assessment
POD Point of Access
PPA Prescription Pricing Authority
PPE Patient and Public Engagement
PPG Patient Participation Group
PPI Patient and Public Involvement
PROM Patient-Reported Outcome Measure

LA Local Authority
LES Local Enhanced Services
LHNT Lewisham Healthcare NHS Trust
LIFT Local Improvement Finance Trust
LINKs Local Involvement Networks
LMC Local Medical Committee
LSP Local Strategic Partnership
LTC Long-Term Conditions

MCATS Musculoskeletal Community Assessment and Treatment Service
MFF Market Forces Factor
MMR Measles, Mumps, Rubella (vaccination)
MRI Magnetic Resonance Imaging
MRSA Methicillin-Resistant

QA Quality Assurance
QALY Quality-Adjusted Life Year
QIPP Quality Innovation Productivity
and Prevention
QMAS Quality Management and
Analysis System
QOF Quality and Outcomes Framework

RO Responsible Officer
RRL Revenue Resource Limited
RTT Referral to Treatment

SBS (NHS) Shared Business Services
SFI Standing Financial Instructions
SLA Service Level Agreement
SLaM South London and Maudsley
Mental Health Foundation Trust
SMR Standardised Mortality Ratio

SO Standing Order
SUS Secondary User Services

TIA Trans Ischaemic Attack- Stroke
Indicator
TDA – Trust Development Authority
TSA – Trust Special Administrator

UCC Urgent Care Centre

VFM Value for Money
VPR Virtual Patient Record

WIC Walk in Centre
WTD Working-Time Directive
WTR Working Time Regulations

HEALTH AND WELLBEING BOARD			
Report Title	Integrated Adult Care Programme		
Contributors	Head of Strategy, Improvement and Partnerships, Community Services and Corporate Director, NHS Lewisham Clinical Commissioning Group	Item No. 7	
Class	Part 1	Date:19 November 2013	

1. Purpose

- 1.1 This report presents Members of the Health and Wellbeing Board with the Programme Initiation Document for the Integrated Adult Care Programme (Annex 1) and seeks agreement from them on the scope of the programme, the proposed deliverables and the arrangements to take this work forward.
- 1.2 The report also seeks agreement from Members to submit to NHS England the attached details on integration expenditure for 13/14 (Annex 2).
- 1.3 This report also informs Members of the outcome of the Pioneer bid.

2. Recommendations

- 2.1 Members of the Health and Wellbeing Board (H&WB) are recommended to:
 - Agree the Programme Initiation Document (Annex 1) which defines the programme, sets out the business case and outlines the project organisation and governance;
 - Agree the proposed workstreams and secure commitment from organisations represented on the Health and Wellbeing Board to engage with each workstream as and when necessary;
 - Note the proposed next steps to take this work forward;
 - Agree that the expenditure schedule (Annex 2) be submitted to NHS England; and
 - Note the unsuccessful outcome of the Pioneer bid.

3. Policy Context

- 3.1 The activity of the Health and Wellbeing Board is focused on delivering the strategic vision for Lewisham as established in *Shaping our Future – Lewisham’s Sustainable Community Strategy* and in Lewisham’s Health and Wellbeing Strategy.
- 3.2 The work of the Board directly contributes to *Shaping our Future’s* priority outcome which states that communities in Lewisham should be *Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing.*
- 3.3 The Health and Social Care Act 2012 requires the Health and Wellbeing Board to encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area. The timetable for the implementation of the Act is attached as Appendix A of the Integrated Care Programme PID.

4. Integrated Adult Care Programme

- 4.1 In response to the Government’s stated ambition to make joined up and coordinated health and social care the norm by 2018, Members of the Health and Wellbeing Board (HWB) agreed to increase the scale and pace of integrated working across health and social care in Lewisham.
- 4.2 The integrated care programme builds on the work undertaken to date which has focused on integrating services that support those with the most complex needs and, in particular, their access to health and social care services and their experience of admission into and out of the acute sector.
- 4.3 Building on this initial phase, the vision for integrated care, as articulated in the attached Programme Initiation Document (PID), see Annex 1, is for a population-based approach, covering all adults in Lewisham. It will include the frail and vulnerable, working age and older people, people with Long Term Conditions and /or mental health problems, people with learning disabilities, as well as the wider adult community. Although this programme’s focus is on the integration of adult services, it will align with the ongoing integration of children’s health, care and other services which are well established and being continually improved as set out in Lewisham’s Children and Young People’s Plan.
- 4.4 It is a whole system approach covering most services and activities for adults across the health and care sector, including Public Health and working with Housing. It will embrace the opportunities and flexibility that can be delivered through the voluntary, community and private

sectors. It will be aligned with universal services such as employment and leisure.

- 4.5 The PID provides more detail on the programme which seeks a step change in the way services are delivered, in patient experience and in performance and outcomes.

5. Next Steps

5.1 Development Stage:

- Officers will establish project leads and project groups for each of the proposed workstreams.
- Each project lead will ensure that where activity is already taking place, and where other groups exist, as part of the delivery of the Health and Wellbeing Strategy objectives this work is aligned under the appropriate workstream to avoid any duplication.
- The AIPB will identify critical dependencies to ensure that projects are prioritised appropriately.
- The AIPB will ensure that a robust evaluation framework is in place for the programme.
- A communications plan will be developed so that the aims and objectives of the integrated programme are well understood and so that all stakeholders can contribute to the development and delivery of the programme.

5.2 Planning and Implementation Stage:

- Each project group will develop its own workplan to achieve the agreed deliverables, ensuring the actions are co-produced with key stakeholders.
- Each project group will provide regular progress reports to the AIPB, the Health and Wellbeing Board and other key stakeholder boards.
- The workstream focussed on resources will undertake detailed financial modelling.
- Evaluation of completed projects will be used to inform the development of the programme.

6. Pioneer – Expression of Interest

- 6.1 In June 2013, Lewisham submitted an expression of interest in becoming a Pioneer in health and social care integration to the Department of Health. The National Partners informed the Council at the end of October that Lewisham's bid was not included in the final selection but stated that they hoped that Lewisham would continue to benefit in some way from the wider programme of support planned. Although unsuccessful, Lewisham has been invited to take part in a learning community for integrated care and support incorporating both

pioneers and other localities to capture and spread information, skills and ideas.

- 6.2 In providing feedback, the National Partners recognised the good work already underway, particularly in community development and the involvement of the voluntary sector, and cited the bid's strong preventive component. They also recognised the good governance that is in place for the programme. However Lewisham's plans for communicating its proposals for integration more widely did not come across strongly enough.

7. Funding to Support Integration

- 7.1 In May 2013, the Department of Health issued directions concerning the 13/14 transfer of funds to support integration from the NHS to local authorities. These funds must be used to support adult social care services which also have a health benefit. The use of the funding must be agreed with the CCG and approved by the Health and Wellbeing Board before being submitted for final approval by NHS England.
- 7.2 The amount for transfer from the NHS to the Council for 13/14 is £4.9m. Annex B of this report provides details on the expenditure that has taken place on integration in 13/14. This expenditure schedule has been agreed with the CCG. The £4.9m has primarily been allocated against expenditure on the integrated neighbourhood model and on enablement. Both these areas have been recognised by partners in Lewisham as having a positive effect on the whole system.
- 7.3 Subject to agreement by the Health and Wellbeing Board, it is proposed that the expenditure schedule is submitted to NHS England to enable the monies to be transferred.
- 7.4 In 14/15, additional monies are proposed for transfer from the CCGs to local authorities and Lewisham's total allocation is expected to be in the region of £5.9m (£1m more than 2013/14). More recently, in the spending round for 2015/16, the Government announced funding of £3.8 billion for health and social care through the Integration Transformation Fund (ITF). This overall amount takes into account monies already announced for 13/14 and 14/15. Again, the specific amount to be transferred to Lewisham for 15/16 has not yet been announced. A detailed plan for the use of Lewisham's 14/15 and 15/16 allocations has to be submitted to NHS England by 15 February 2014. Detailed discussions are currently taking place between the CCG and the Council and proposed areas of spend will be presented to the Health and Wellbeing Board for approval in January.

8. Financial Implications

- 8.1 There are no specific financial implications arising from this report. All current activity to progress the development of the programme will be

provided from existing resources within the CCG and the Council or from the funding that is to be transferred from the CCG to the Council. Until the individual workstreams are fully established and the individual project plans drawn up it is not possible to say precisely what additional programme management resources are needed. Any requests for such resources will be considered by the Adult Integrated Programme Board.

9. Legal Implications

- 9.1 As part of their statutory functions, Members are required to encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area and to encourage persons who arrange for the provision of health-related services in its area to work closely with the Health and Wellbeing Board.

10. Crime and Disorder Implications

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

11. Equalities Implications

- 11.1 There are no specific equalities implications arising from this report or its recommendations. However, addressing health inequalities is a key element of the programme.

12. Environmental Implications

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

13. Conclusion

- 13.1 Officers will take forward on the integration programme and establish as soon as possible the groups that will progress the individual workstreams. Further reports will be presented at appropriate intervals to the Health and Wellbeing Board.

If there are any queries on this report please contact **Sarah Wainer, Head of Strategy, Improvement and Partnerships** on 020 8314 9611 or **Susanna Masters, Corporate Director NHS Lewisham Clinical Commissioning Group** on 020 3049 3216.



Lewisham

Clinical Commissioning Group



Lewisham

ANNEX 1

Programme Initiation Document

Integrated Adult Care

Programme

Location	Lewisham
Programme:	Integrated adult care programme
Programme Managers:	Susanna Masters LCCG/Sarah Wainer LBL
Senior Responsible Officer:	Martin Wilkinson LCCG/Aileen Buckton LBL
PID Version Number: 1	Date: 19 November 2013

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1. Programme Summary & Background

In May 2013, the Government announced its ambition to make joined up and co-ordinated health and social care the norm by 2018.

In response to the Government's stated direction of travel, and in the context of rising demands and budgetary pressures across sectors, Lewisham's Health and Wellbeing Board has recognised that the pace and scale of integration across health and social care has to increase in order to improve the user experience and outcomes for all adults, to maximise the use of resources (reducing duplication and streamlining processes) and to achieve the significant savings that are required across the partnership.

This programme builds on the work undertaken to date. Health and social care partners in Lewisham have already taken steps to integrate services in a number of areas:

- a) bringing district nurses into the Advice and Information Team (the first point of contact for most callers enquiring about health and social care support);
- b) integrating the Council's reablement and Lewisham Healthcare Trust's intermediate care team to create a single enablement service to support people to maintain or regain their health and independence. This service is designed to help people avoid unnecessary hospital admissions or readmissions and reduce the need for costly high level health and care services. It is particularly focused at present on people who are new to social care and those being discharged from hospital;
- c) bringing together a number of different disciplines into a single team working within the four GP neighbourhood clusters. These teams have undertaken a risk stratification of the GP's adult population to identify those who would benefit from early intervention work. The teams also include a community development worker who will link users to networks and opportunities within their local areas to support and improve their health and wellbeing.

This programme will add value by bringing together:

- various strands of activity that are underway or that are planned;
- data, research and information;
- knowledge of good practice and innovation;
- knowledge of common barriers to integration;
- common enablers that support the delivery of coherent integrated services
- monitoring of outcomes e.g. on quality and patient experience
- evaluation;
- financial information, modelling and monitoring.

This Programme Initiation Document sets out the high level aims and deliverables for the programme. It also outlines the proposed workstreams that will be established to undertake more detailed work on, amongst other things, identifying the existing use of resources and where future efficiencies can be made, establishing and monitoring success measures and developing the required enablers. More detail on the proposed workstreams is set out at section 4.

Although this programme's focus is on the integration of adult services, it will align with the ongoing integration of children's health, care and other services as set out in Lewisham's Children and Young People's Plan.

2. Programme Definition

Programme Objectives

The primary aims of this programme are to improve health and care and reduce health inequalities by increasing self help and independence, creating a culture of self responsibility, prevention and early intervention and providing affordable high quality advice, care and support close to, or in, people's own homes.

The specific desired outcomes for the programme are:

A positive experience within a health and wellbeing context for all adults in Lewisham – by enabling people to be connected to their communities and through the promotion of self help, to be in control of their health and wellbeing.

Better health and wellbeing outcomes and reduced health inequalities – seeing significant improvements in the outcomes as set out in national frameworks for public health, CCG and ASC.

High quality and safe services provided to Lewisham residents – provided by a professional and flexible workforce, robust joint contract monitoring and improved recording and sharing of information.

Sustainable, high quality and cost effective health and care systems - by reducing and shifting demand for complex health and care services to existing and new preventative and early intervention opportunities, by innovative commissioning which can respond flexibly to meet people's individual requirements and circumstances.

The delivery of financial efficiencies to enable partners to reflect reducing resource allocations.

The provision of 7 day services; better data sharing and joint approaches to case management as set out by the national conditions for the Integration Transformation Fund.

To develop success measures for the programme we will establish baseline data which will include:

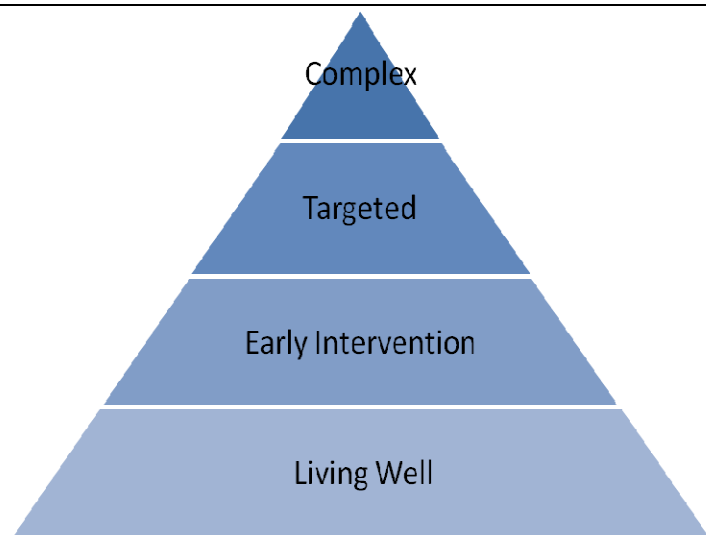
Impact indicators: non elective admissions, urgent care attendance, length of stay in acute and MH hospitals, readmission rates, entries into residential/nursing care, number and packages of domiciliary care, personal budgets, direct payments.

Operational metrics: , number of assessments and reviews, reablement cases.

Financial metrics: total system cost, unit cost, cost per user, benchmarking.

Programme Deliverables

The programme has identified a triangle of need shown below:



Across the four levels , the programme will deliver:

Living Well – active and engaged communities (Level 1)

- Easy and clear access to high quality, personalised information
- Clear communication using consistent messages and integrated campaigns raise awareness and encourage people to take action themselves
- Activities and opportunities available locally to promote and support health and well being
- Effective advice and support (including advice on benefits entitlement) to promote living well
- Stronger community networks working effectively to support people to live well and stay healthy

Early Intervention – Level 2

- Professionals and voluntary sector workers have knowledge and confidence to empower and signpost effectively
- Shared tool for risk stratification to identify those most at risk
- Systems and processes in place to enable safe sharing of information on individuals - individuals tell their story only once
- Rapid delivery and installation of equipment, housing adaptations and other assistive technology
- Proactive and consistent management of health and wellbeing by professionals and voluntary sector workers
- Effective self management of long term conditions
- Strong community networks working effectively to identify and support individuals and carers that require additional help.

Recovery and Regaining Independence – Levels 2 & 3

- Co-ordinated services that are able to respond quickly to unexpected deterioration and other health or care emergencies or crises
- Rapid delivery and installation of equipment, technology and housing adaptations
- Effective support within appropriate settings to enable people to recover
- Effective links to community and neighbourhood support e.g. social network to maintain recovery and independence
- Ongoing effective support to maintain independence
- Professionals provide support to individuals and carers to enable them to exercise

choice and control in relation to their health and wellbeing.

Positive Experience of More Complex Care and Support – Levels 3 & 4

- A co-produced and jointly agreed single assessment
- A jointly produced, agreed and fully implemented care plan
- A single co-produced health and social care record
- Key pathways are coordinated across health and social care e.g. dementia, falls
- Single reviews undertaken by trusted reviewer on behalf of health and social care whenever possible
- Effective allocation of statutory resources to meet needs.

Programme Scope

The programme is ambitious and builds on earlier integration work, increasing the scale and pace.

It is a **population-based approach**, covering all adults in Lewisham. It includes the frail and vulnerable, older people, people with long term conditions and /or mental health problems, people with learning disabilities, carers, as well as the wider adult community. It does not include the under 18 population of Lewisham.

It is a **whole system approach** covering most services and activities across the health and care sector, including public health. It will embrace opportunities and flexibility that can be delivered through the voluntary, community and private sectors. It will be aligned with universal services such as Supporting People, housing, employment, adult education, culture and leisure.

A range of services such as housing fall outside of the scope of the integrated care programme. These services will form critical interdependences to the programme. It is a strategic programme that seeks a step change in the way services are delivered, in patient and service user experience and in performance and outcomes.

Programme Constraints

(a) Legislative Changes

The Care Bill requires the promotion of integration of care and support with local authorities, health and housing services and other service providers to ensure the best outcomes are achieved for the individual. The Bill introduces a number of statutory requirements in relation to the provision of health and care. The timetable is attached at Appendix A.

(b) Commissioning

The constraints are those which apply nationally and limit the flexibility in relation to local commissioning arrangements. Ideally the programme would seek to move away from the national payment by results tariff and towards local risk sharing and incentive agreements so enabling more effective joint management of integration at the local level.

(c) Financial

Development and implementation of detailed proposals will need to be completed within existing resources; these are reducing overall. Further, the complexity of disaggregating budgets to establish pooled budgets may constrain the speed and scale of the integration programme. Estimates of the financial benefits of integration are constrained by the limited nature of the current evidence base.

(d) Accommodation

The co-location of services will inevitably be constrained by the limitations of the existing building stock.

Programme Assumptions

1. Operational Assumptions

The early development of Lewisham's integrated adult care programme has been informed by the evidence and learning from international, national and local research and evaluations including:

The King's Fund Reports:

- 'Transforming our Health Care System' highlights ten priorities for CCG commissioners to transform health care (2013)
- Exploring the system wide costs of falls in older people in Torbay (August 2013)
- Report to the Department of Health and NHS Future Forum from The King's Fund and Nuffield Trust - Integrated care for patients and populations: Improving outcomes by working together (2012)
- Where next for the NHS reforms – The case for Integrated care (2011)
- Integrated Care – What is it? Does it Work? What does it mean for the NHS? (2011)
- Integrating Health and Social care in Torbay (March 2011)
- Avoiding hospital Admissions: What does the research evidence say? (December 2010)

Nuffield Trust

- Commissioning Integrated Care in a Liberated NHS (September 2011)
- Evaluation of the first year of the Inner North West London Integrated Care Pilot (May 2013)

McKinsey & Company

- Understanding patient's needs and risk – a key to a better NHS (June 2013)
- What it takes to make integrated care work (May 2013)
- Local modelling of the Lewisham health and social care system

The overall conclusion of the current available evidence is that there is no single 'best practice' model of integrated care. What matters most is that the delivery model is focused on how care can be better provided around the needs of individuals, especially where this care is being given by a number of different professionals and organisations.

The research has highlighted, however, that there are organisational barriers to successful integration. Lewisham's approach to integrated delivery attempts to address proactively the most frequently cited barriers by having:

- Clear joint governance arrangements and sufficient project management support – the PID sets out the proposed governance arrangements and the role of the Health and Wellbeing Board;
- Involvement of front line staff - a 'bottom-up' approach – the PID describes how the project's proposals are already well grounded in the current and future operational work with provider organisations at a neighbourhood level;
- Engagement of the local communities - the health and social care Joint Public Engagement Group, which includes representation from the voluntary sector, will oversee this work.
- Development of the workforce - it is recognised in the PID that both the provider and commissioning workforce need to develop a common language and culture change which promotes a person centred approach and enables independence, choice and self

help;

- Effective way of sharing information across agencies to implement shared approach to risk stratification, care planning and a single care record;
- Robust commissioning supported by a clear contractual framework which aligns incentives to sustaining and supporting the integrated approach.

2. Financial Assumptions

Reviews by The King's Fund and the Nuffield Trust conclude that significant benefits can arise from the integration of health and social care services where these are targeted at those client groups for whom care is currently poorly co-ordinated. High level modelling of the current costs of Lewisham's health and social care systems information indicates potential net savings of between £7.5million and £15 million which could be achieved as a result of applying the evidence from best practice in Integrated care, assuming a re-investment of 10% of savings (McKinsey & Company - May 2013).

Also local evaluation of the North Lewisham Health Improvement Programme demonstrated that by raising awareness and changing behaviour about smoking, healthy eating and exercise in a community had 'a return of investment of a ratio of 1.8:1 to 3.0:1'.

Research has indicated also that there are wider financial benefits of investing in specialist housing for vulnerable and older people. The research by Frontier Economic (September 2010) examined the annual benefit from the provision of specialist housing to the different sectors and estimated that for an older person the savings in health were about £1,500 per person and a similar level of savings for social care. This would indicate a further saving of about £5 million per annum with the effective provision of specialist housing vulnerable and older people (assuming a frail older population of 1500 people in Lewisham).

As part of the resource workstream, officers will consider what resources will be necessary to undertake more detailed financial modelling to assess the potential total financial efficiencies overall, by different organisation, the time frame and the level of investment required.

Programme Interfaces

A number of areas, organisations and strategies will need to align with the work of the integration programme. These include:

- NHS England – primary care commissioning including GPs, pharmacies and opticians
- Housing –to ensure that the Integration Care Programme is underpinned by an effective housing strategy, particularly in relation to specialist housing for vulnerable and older people. The programme will align with Supporting People to ensure the best use of housing related support resources
- Pathways redesign and implementation - such as GP referral pathways.
- Healthwatch/public engagement – to engage fully with individuals and local communities on all aspects of the programme.
- Community and Cultural Development – to contribute to the development of flexible opportunities, activities and support which gives people choice and control in maintaining/regaining their health and wellbeing.
- Other key groups e.g. Urgent Care Board which includes the LAS and NHS 111.

Each project board will identify the specific interfaces that are required to ensure achievement of the deliverables assigned to that workstream..

3. Business Case

There is a strong driver for integration nationally. In May 2013, the Government and other key national players launched 'Integrated Care and Support: our shared commitment'. This document stated that major change was needed by "...building a system of integrated care for every person in England. It means care and support built around the needs of the individual, their carers and family and that gets the most out of every penny we spend.' The announcement included:

- An ambition to make joined up and coordinated health and social care the norm by 2018.
- The development of the first ever agreed definition of good integrated care and support – developed by the National Voices.
- The identification of ten new 'pioneer' areas around the country which will be looking for the innovative practical approaches needed to achieve changes as quickly as possible.
- The development of new measures of peoples' experience of joined up care and support so change can be evaluated.

In response to the Government's invite, at the end of June, Lewisham submitted an expression of interest in becoming a Pioneer in health and social care integration. Both the Council and the CCG face challenging financial targets to achieve over the coming years combined with increased demand from a population with increased and specific needs. Both had already taken action to integrate in some areas, recognising the benefits in integrating services by reducing duplication in management and functions, improving outcomes for service users and improving performance.

In the expression of interest, Lewisham highlighted the commitment of the Health and Wellbeing Board to increase the scale and pace of integrating working, building on

- a basis of knowledge of what has worked to date and what has not;
- a local understanding of the cultural and organisational changes that are needed to bring different disciplines together; and
- Our experience of the action required to resolve issues and break down barriers

The submission set out in detail the work that has taken place to date in redeveloping the "intermediate tier" of care, and the establishment of multi-disciplinary teams around the GP neighbourhood clusters.

Although the Pioneer bid was unsuccessful, the Health and Wellbeing Board has already demonstrated its commitment to a more ambitious model based on the four different levels of advice, support and care any individual may receive during their life time:

1. **Living Well** – empowering and supporting individuals, families and communities to take action to make healthy lifestyle choices and to engage in activities that maintain and improve their physical and mental well-being and to maintain their independence, by providing relevant advice and assistance on issues such as not smoking, eating healthy, drinking less alcohol and exercising more.

It is estimated that this cohort is about 80% of the total population and accounts for less than 30% of total spend across health and social care (ref: Inner North West London Integrated Care Pilot - May 2013)

2. **Early Intervention** - identifying at an early stage when more support is required and providing fast and convenient access to high quality support and advice. For example,

when an individual or family is finding it less easy to manage alone without additional assistance, such that a little bit of help now will prevent more work later. In health this means systematically detecting and intervening earlier on health issues – for example, prescribing statins to reduce cholesterol and taking measures to reduce high blood pressure. It is estimated that this cohort is about 15% of the total population and accounts for over 30% of total spend across health and social care (ref: Inner North West London Integrated Care Pilot - May 2013)

3. **Targeted Intervention** – identifying those specific high risk individuals who would benefit from active intervention to avoid a potential crisis such as an inappropriate admission and re-admissions to hospital. The aim is to mitigate risk through proactive intervention. It is estimated that this cohort is about 4.5% of the total population and accounts for 29% of total spend across health and social care (ref: Inner North West London Integrated Care Pilot - May 2013)
4. **Complex Care** – coordinating and managing a complex health and social care package in a single care plan which is tailored around the needs of the individual, carer and the family with them at the heart and still in control - ‘nothing about me, without me’. For example, the care package to support a person choosing to die at home. Often it is these complex cases that fall through the cracks of a non-integrated care system. It is estimated that this cohort is about 0.5% of the total population and accounts for 11% of total spend across health and social care (ref: Inner North West London Integrated Care Pilot - May 2013)

In taking forward the programme, the focus will be on the co-ordination of services around the user and on the integration of care, not of organisations. This will require breaking down organisational boundaries, achieving culture change across the whole system, improving information sharing, and ensuring care is properly coordinated across all settings.

4. Project Organisation & Governance

Lewisham's adult integration programme will require the involvement of different commissioning and provider organisations, from both the statutory and non statutory sector, working together in new ways.

Poor governance arrangements are one of the most frequently cited organisational barriers to successful integration so it will be vitally important to the success of this programme that robust governance arrangements are in place to oversee the delivery and evaluation of this complex work programme.

The following Boards will ensure effective governance of the programme:

- Health and Well Being Board
- Adults Integration Programme Board (AIPB)
- Individual Project Boards for each workstream

The Health and Wellbeing Board will be the overarching body that monitors the progress of the programme. To ensure that the progress of each individual workstream is more regularly assessed, the Health and Wellbeing Board has agreed to the establishment of an Adults Integration Programme Board (AIPB). This Board will ensure robust plans and delivery mechanisms are in place for each workstream) and that regular progress reports are presented to the Health and Wellbeing Board.

It is proposed that the AIPB sits alongside, and work closely with, the existing Health and Wellbeing Delivery Group, the Adult Joint Strategic Commissioning Group and the Joint Public Engagement Group .

The AIPB will be accountable to the Health and Wellbeing Board for the delivery and evaluation of the Adult Integrated Care Programme. It will have specific responsibility to:

- Oversee the implementation, monitoring and evaluation of the agreed work programme as outlined in the Programme Initiation Document (PID);
- Coordinate the plans for the use of the Integrated Transformational Funds
- Develop and recommend the local framework for commissioning of health care and social care;
- Identify further opportunities to develop a transformational agenda to improve the health and wellbeing of the population of Lewisham.

Initial members of the AIPB are:

- Marc Rowland, Chair NHS Lewisham Clinical Commissioning Group
- Martin Wilkinson, Chief Officer, NHS Lewisham Clinical Commissioning Group
- Aileen Buckton, Executive Director for Community Services, Lewisham Council
- Claire Champion, Director of Nursing and Clinical Services, Lewisham and Greenwich Healthcare Trust
- Peter Stachniewski, Head of Financial Services, Lewisham Council
- Danny Ruta, Director of Public Health Lewisham Council
- Genevieve Macklin, Head of Strategic Housing, Lewisham Council.

This membership will be reviewed regularly and additional members from Community Development and South London and Maudsley NHS Trust will be invited to join the board

when appropriate.

The board itself will be supported by a small operational group, led initially by Sarah Wainer (Head of Strategy, Improvement and Partnerships) and Susanna Masters (Corporate Director NHS Lewisham Clinical Commissioning Group) who will ensure progress is being made in all workstreams and that regular reports are provided to the programme board and to the Health and Wellbeing Board.

The governance for the programme will also include the Neighbourhood Connection Groups which provide direct involvement and engagement in the programme at a neighbourhood level.

Each of the agreed workstreams will have a project group which will report into the programme board. Each project group will develop its own workplan to achieve the stated outcomes. Part of this work will involve engaging service users and residents in the co-production of new approaches. The project leads will also ensure that where activity is also taking place and being taken forward by existing groups as part of the delivery of the Health and Wellbeing Strategy objectives this work is aligned to the appropriate workstream to avoid duplication. The initial workstreams to be set up are:

Workstream 1 –health and wellbeing campaigns; health and self help promotion; co-ordination and access to information and signposting for all including self funders; initial advice and support; links to community opportunities and activities.

Workstream 2 –the development of effective systems and processes for early and targeted interventions, including enablement, telecare, equipment, enablement, respite, admission avoidance and hospital discharge.

Workstream 3 – the development of single assessments, including risk stratification, joint care plans, joint reviews, direct payments, personal budgets, personalised health budgets and the development of a single health and care record.

Workstream 4 – the review of key pathways across health and social care from initial contact to ongoing care –dementia, falls, COPD, Heart Failure and Diabetes.

Workstream 5 – workforce development, new delivery models and culture change covering brief interventions, knowledge and confidence to empower and signpost effectively; proactive management of health and wellbeing.

Workstream 6 – ICT including information sharing protocols, integrated systems, joint records; digital interface.

Workstream 7 – community development, the Communities That Care initiative, neighbourhood networks.

Workstream 8 – commissioning and market development, resource management including the achievement of savings, quality and safety assurance.

Workstream 9 – interface with housing and supported accommodation.

Workstream 10 – programme support covering sources of programme funding; financial modelling and forecasting; risk management, programme consultations and communications and governance.

5. Programme Communication Plan

The integration of health and care is a complex programme requiring action across many areas and adoption by key stakeholders of the programme's aims and objectives. As recognised by the Pioneer panel, Lewisham needs to consider how it will communicate its proposals for integration more widely. Any plan must ensure there is a wide understanding of the benefits of integration and of the desired outcomes for residents. Therefore a key element of the programme will be the development of an overarching communications plan. This will be undertaken by the project group responsible for Workstream 10.

The communication plan will also set out when reports will be presented to the Health and Wellbeing Board, other key partnership groups and relevant scrutiny committees.

6. Programme Finances

As part of the programme we will review the budgets supporting those services included in its scope enabling them to contribute to the required Council and QIPP savings.

For the Council, the 2013/14 budgets are: Adult Social Care £81m, Public Health £15.6m, Investment Fund £0.742m.

For the CCG, the 2013/14 budget of £336m includes the total budget for healthcare excluding budgets specifically for under 18 year olds. This includes all care settings and care categories. As integrated work is progressed further analysis of Council and NHS spend will take place in order to accurately assess the relevant baselines and future expenditure.

The Government is supporting the integration of Health and Social Care by transferring resources from the NHS to local authorities. These funds must be used to support adult social care services which also have a health benefit. Subject to agreement by the CCG and by the Health and Wellbeing Board, the Council will receive £4.9m in 2013/14 to promote integrated working. In 14/15, a further £1m is expected to be transferred which will increase the total additional resource to in the region of £6m.

In the spending round for 2015/16, the Government announced further funding of £3.8 billion for health and social care through the Integration Transformation Fund (ITF). This overall amount takes into account monies already announced for 13/14 and 14/15. Again, the specific amount to be transferred to Lewisham for 15/16 has not yet been announced. A detailed plan for the use of Lewisham's 14/15 and 15/16 allocations has to be submitted to NHS England by 15 February 2014. Detailed discussions are currently taking place between the CCG and the Council and proposed areas of spend will be presented to the Health and Wellbeing Board for approval in January.

Programme Expenditure

Currently, work on the integrated programme will be taken forward by existing staff across the CCG and the Council. Until the individual workstreams are fully established and the individual workplans drawn up it is not possible to say precisely what additional programme management resources are needed. Any requests for such resources will be considered by the Adult Integrated Programme Board.

7. Programme Plan – Key Milestones

KEY MILESTONES	Start	Finish
Development Stage:		
AIPB established	November 2013	November 2013
Health and Wellbeing Board agree Programme Initiation Document	19 November 2013	19 November 2013
Workstreams established:		
• Initial workstream meetings take place	December 2013	December 2013
• Workstream plans developed	December 2013	January 2014
• Workstream plans approved by AIPB	January 2014	January 2014
Evaluation framework developed	January 2014	January 2014
Health and Wellbeing Board agree plans for the Integration Transformation Fund 2014/15 and 2015/16.	21 January 2014	21 January 2014
Planning and Implementation Stage:		
Initial efficiencies identified	December 2013	January 2014
Approved plans phase 2 implemented	January 2014	March 2015
Detailed financial modelling	February 2014	September 2014
Approved plans phase 3 implemented	April 2015	March 2016

8. Programme Quality Assurance & Performance Indicators

Mechanisms will be established under Workstream 10 to ensure the programme delivers against agreed plans and milestones and to an agreed standard. The controls will include regular project lead reports to the AIPB, monthly updates and exception reports against workplans.

As mentioned earlier, baseline data will be collected in order to establish success measures and set performance indicators. This will include indicators for non elective admissions, urgent care attendance, length of stay in acute and MH hospitals; readmission rates; entries into residential/nursing care; number and packages of domiciliary care, personal budgets, direct payments. Financial impact indicators will also be established.

The programme will follow the principles and methodology set out in *Managing Successful Programmes*.

9. Programme Risks

A Risk Register will be produced for the overall programme and individual risk registers will be developed for each workstream. The Risk Register will be regularly monitored by the AIPB.

A number of areas have already been identified which present possible risks to the programme.

Achievement of financial efficiencies – the timetable to achieve the required efficiencies is challenging and needs to be aligned with the timetables and targets for the local government savings and the CCG's QIPP programmes. Research has indicated that it requires long term sustained multi-organisational focus to achieve maximum efficiencies. Also the levels of financial benefits stated within the PID are based on the best available evidence of good practice, but remain at this point theoretical to Lewisham.

Resources – there may be insufficient resources to invest in new delivery models, new approaches or to build capacity or capability. In addition, the staffing resource may be inadequate to realise the full potential of the programme.

IT Systems, Processes and Governance - systems for effective information sharing across organisations may be difficult due to technical difficulties, governance/confidential issues and/or investment.

Workforce Capacity and Capability – a different culture and relationship with the users of services and a different way of working across organisations is required. This will require buy in from all organisations involved and commitment from staff. Also the programme will seek to develop generic workers working across health and social care.

Action Research – it may be difficult to evaluate the specific improvements in quality, patient experience, health outcomes and finance as a result of the programme, due to the interrelated nature of this programme which interfaces with wider health and social care changes eg Dilnott,

Cross Organisation commitment to the Integration agenda – is needed to maintain long term sustained multi-organisational focus to achieve maximum efficiencies, despite wider national policy changes and local acute configuration changes. The AIPB will need to be mindful that a gap between the strategic direction of the programme and the operational delivery may emerge. Lewisham and the CCG officers will require the capacity and capability to plan and implement the programme effectively, ensuring it remains focussed on delivering improved outcomes. Strong relationships will be important to withstand the changes and to manage competing priorities. There is a risk that relationships are not currently sufficiently well developed to support this.

Approaches to risk – implementing the Integrated Care Programme will involve the development of new delivery models that will require new approaches to managing risk within and across organisations.

10. Equalities Impact Assessment

The equality impact for each workstream will be considered by each project board and where necessary equality impact assessments will be undertaken. This activity will be monitored by the AIPB.

11. Environmental Impact

The environmental impact for each workstream will be considered by each project board and reported to the AIPB.

12. Health & Safety

No Health and Safety issues have been identified in this initial start up phase of the programme.

13. Programme Evaluation

The AIPB will ensure that an appropriate evaluation framework is developed and implemented for each workstream. This will involve reviews at the end of each project, at the end of the programme and following the closure of the programme. The AIPB's oversight of the evaluation will enable the effective transfer of learning across workstreams

The challenges of evaluating specific improvements in quality, patient experience, health outcomes and finance as a result of the programme have been highlighted as a key risk.

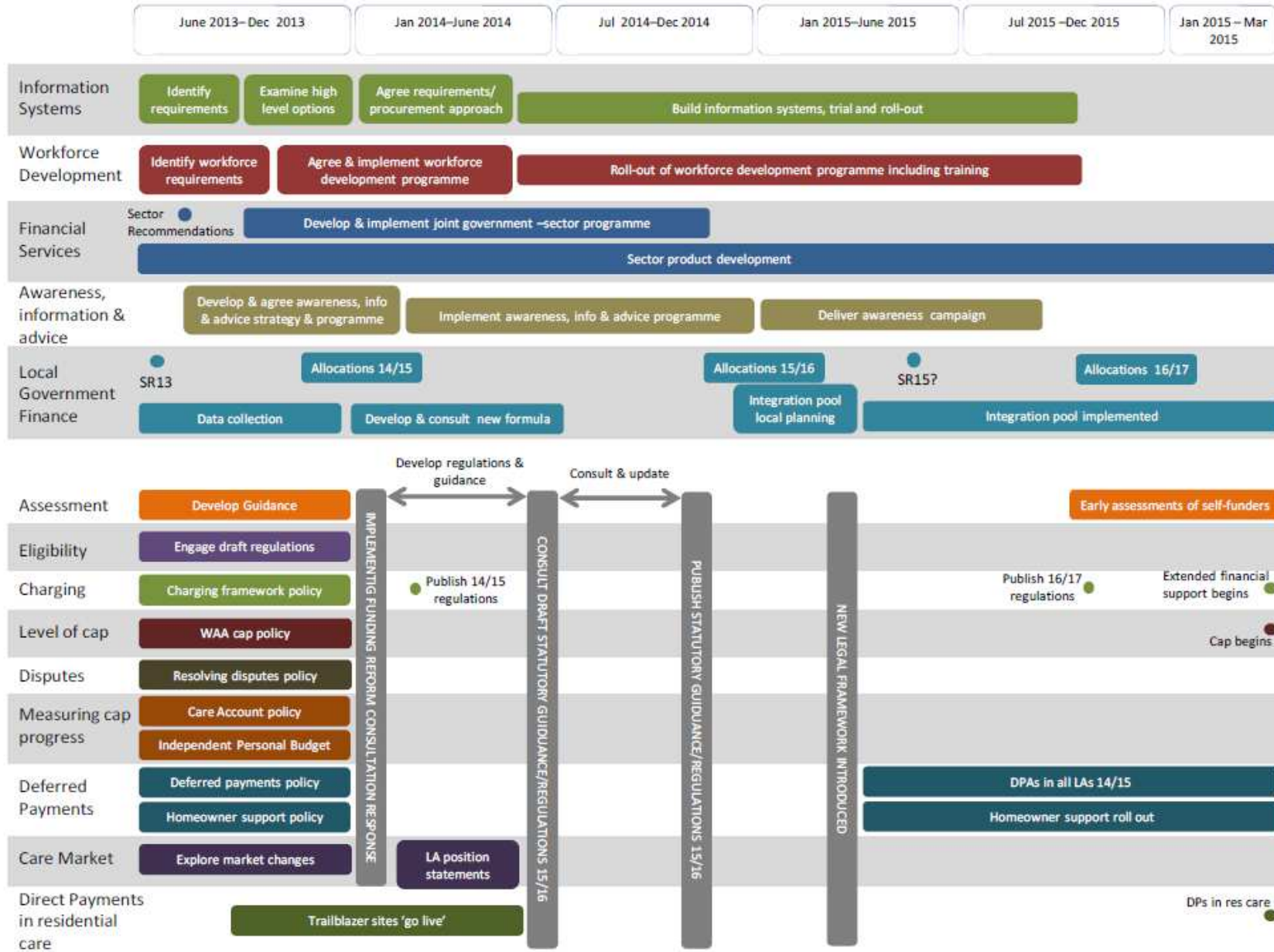
The costs of evaluation will be met from within the total budgets described in paragraph 6 above.

Annex 2

Summary

Area	Description	2013/14 allocation
SCAIT	This team is the first point of contact for the public and is focused on the prevention agenda, which will be strengthened further when it is integrated with health staff from the community nursing team.	507,918
Neighbourhood Teams – Staffing and IT Neighbourhood Teams - IT	Neighbourhood teams - health and social care staff have been aligned to 4 neighbourhoods that are coterminous with the GP Practices. The focus within the neighbourhoods is 'the team around the user'; a multidisciplinary approach to provide the best service for users to support them through ill health and prevent social isolation that can lead to ill health and a dependency on care services. Neighbourhood IT - staff from health and social care will be co located. Mobile IT is key to the success of the neighbourhood teams alongside the development of joint IT assessment systems.	1,381,435 27,700
Enablement inc HAST and LINC	Enablement- this is a merger of Reablement and Lewisham's intermediate care team with a focus on the prevention of dependency on long term care and promoting self care. HAST is a hospital discharge team that assess people on the hospital wards and directs users onto the correct pathway, whether it be enablement or long term care. It interfaces with both health and social care. All staff are now aligned to wards to enable a more proactive approach to case management.	3,026,164
Other		29,200
		<u>4,972,417</u>

Appendix A



Agenda Item 8

HEALTH AND WELLBEING BOARD			
Report Title	Participatory Budgeting Schemes, North Lewisham Health Improvement Programme – Impact on Behaviour and Health Outcomes		
Contributors	Director of Public Health	Item No.	8
Class	Part 1	Date:	19.11.13

1. Summary

- 1.1 It was agreed at the September meeting of the Board, as a result of the presentation of the evaluation of the North Lewisham Health Improvement Programme that, as a next step, a report on Participatory Budgeting (PB) would come to a future meeting.
- 1.2 This report provides both qualitative and quantitative information about the impact of the PB, which has been running as an integral part of the programme.
- 1.3 PB processes can be defined by geographical area (whether that's neighbourhood or larger) or by theme. This means engaging residents and community groups representative of all parts of the community to discuss and vote on spending priorities, make spending proposals, and vote on them, as well giving local people a role in the scrutiny and monitoring of the process and results to inform subsequent PB decisions.
- 1.4 The recent NICE Guidance (2008) emphasises the importance of involving communities in priority setting, funding decisions, designing, delivering, improving and managing health related projects and activities.
- 1.5 Lewisham has a track record of using PB and was the first in the country to use it to allocate funding to improve health.
- 1.6 There have been 5 participatory budgeting schemes (one per year since 2008) within the North Lewisham Health Improvement Programme. The groups deliver a variety of healthy living activities to meet the priorities for the funding: increased consumption of fruit and vegetables, increased levels of physical activity, improved mental wellbeing, support to people to stop smoking and raised awareness of alcohol consumption.
- 1.7 Healthy eating and physical activity activities funded by PB were particularly successful in raising awareness and encouraging behaviour change, not only among participants but also their families.

- 1.8 There were a range of impacts on mental health and well being, including increased self esteem and achievement, less social isolation and improved family relationships.
- 1.9 There were also improvements for people in managing their long term conditions and an increase in the numbers of people quitting smoking.
- 1.10 Allocating funding to community organisations has been demonstrated as an ideal way to reach and respond to the needs of different communities.
- 1.11 Projects were most effective:
 - when they were grounded in an understanding of types of activities and support that local communities were likely to want;
 - when they receive advice, training and development from public health specialists;
 - when they have opportunities to network with each other.

2. Purpose

- 2.1 This report outlines the contribution that the participatory budgeting schemes have made to improving health outcomes as part of the North Lewisham Health Improvement Programme, with a view to informing the development of the Delivery Plans for the Health and Wellbeing Strategy and the Integration of Health and Care at a local level.

3. Recommendations

- 3.1 To note the effectiveness of participatory budgeting in reaching communities, encouraging behaviour change and improving health outcomes.
- 3.2 To agree that the use of participatory budgeting schemes are considered in the delivery of the Health and Wellbeing Strategy objectives and as part of the delivery of the Integrated Adult Care Programme.
- 3.3 To ensure that the learning about how to run participatory budgeting schemes effectively is applied to new schemes.

4. Policy Context

- 4.1 The activity of the Health and Wellbeing Board is focused on delivering the strategic vision for Lewisham as established in *Shaping our Future* – Lewisham’s Sustainable Community Strategy and in Lewisham’s Health and Wellbeing Strategy.

- 4.2 The work of the Board directly contributes to *Shaping our Future's* priority outcome which states that communities in Lewisham should be Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing.
- 4.3 Community development has been a central plank of the World Health Organisation's strategy for improving health and reducing health inequalities since the early 1980s. The World Health Organisation (WHO) linked community development to health by stating that 'the aim of community development is that of achieving personal, collective and social change, all of which is usually associated with improved health status.' As a means of reducing health inequalities, the WHO considers the empowerment of both individuals and communities to be essential (WHO 1997).
- 4.4 The recent NICE Guidance (2008) emphasises the importance of involving communities in priority setting, funding decisions, designing, delivering, improving and managing health related projects and activities.
- 4.3 The previous, Labour government promoted participatory budgeting through the The Local Government and Public Involvement in Health Act. It provided both an incentive and an opportunity for local authorities to adopt PB including the "duty to involve" citizens in decisions which affect them. The current Government is promoting the big society agenda which encourages development of talent, innovation and enterprise to deliver social change.
- 4.4 PB was first developed in Brazil in the 1980s as part of a larger effort to establish democracy and citizen participation. A growing number of European municipalities in France, Germany, Italy, Spain, Portugal and the UK have adopted different models of PB to suit their circumstances.
- 4.5 PB is 'a process of democratic deliberation that directly involves local people in making decisions on the spending and priorities for a defined public budget'.
- 4.6 PB processes can be defined by geographical area (whether that's neighbourhood or larger) or by theme. This means engaging residents and community groups representative of all parts of the community to discuss and vote on spending priorities, make spending proposals, and vote on them, as well giving local people a role in the scrutiny and monitoring of the process and results to inform subsequent PB decisions. PB aims to increase transparency, accountability, understanding and social inclusion in local government affairs¹.

¹ The PB Unit – A project of the charity Church Action on Poverty based in Manchester
<http://www.participatorybudgeting.org.uk/about>

- 4.7 The London Borough of Lewisham, together with key stakeholders, has used the participatory budgeting process on a number of occasions over the past six years to allocate small grants to community groups, often on a ward basis.
- 4.8 Lewisham, through the North Lewisham Health Improvement Programme, was the first in the country to use participatory budgeting to reduce health inequalities and improve health outcomes and was commended by DH, Communities for Health programme for doing so in 2008.
- 4.9 More recently Well London Bellingham has used participatory budgeting and this approach has been adopted across the Well London programme by other boroughs such as Tower Hamlets, following Bellingham's example.

5. Background

- 5.1 This report provides both qualitative and quantitative information about the impact of the PB, which has been running as an integral part of the programme.
 - 5.2 PB plays a key role in the delivery of the programme, but has been complemented by a number of other projects using a community development approach such as the CVD and Cancer Healthy Communities Collaboratives.
 - 5.3 The participatory budgeting approach to allocating funds to groups to improve health and wellbeing was a different way of working between community groups and statutory agencies. The North Lewisham Health Improvement Programme stakeholders saw it as a positive way of involving local people in making decisions. The learning from the evaluation of Evelyn Chooses Health Fund (ECHF), commissioned by Public Health, has informed the development of subsequent participatory budgeting rounds (Deptford/New Cross Choose Health).
 - 5.4 The external evaluation explored what impact ECHF had on the project participants, the projects and considered how the projects and fund were delivered, including what worked well or less well. As part of this qualitative evaluation, 47 in-depth interviews were undertaken with a range of participants, including the project lead and Steering Group, project workers and participants in the activities delivered under the Fund.
 - 5.5 The later PB rounds collected more quantitative data as part of the monitoring and evaluation of the reach and impact, however the views
-

of participants and these views are illustrated from quotes within this report.

- 5.6 The ECHF was part of the Communities for Health Programme, launched by the Department of Health, with the aim of piloting approaches to working with the most deprived communities to tackle health inequalities by bringing together Local Authorities, the NHS and the community and voluntary sector.
- 5.7 The ECHF was intended to deliver interventions that would support individuals in making lifestyle changes in relation to smoking, eating and physical activity, using a community development approach². Of the £100,000 granted half was committed to paying for the post of a project lead from Voluntary Action Lewisham. The remaining £50,000 was made available, through a participatory budgeting process, as grants to voluntary and community organisations. The PCT added funding from investment in the North Lewisham Plan, to bring the sum up to £70,000 to be allocated overall.
- 5.8 There have been 5 participatory budgeting schemes, one per year since 2008. The groups deliver a variety of healthy living activities to meet the priorities for the funding: increased consumption of fruit and vegetables, increased levels of physical activity, improved mental wellbeing, support to people to stop smoking and raised awareness of alcohol consumption. Some groups' activities directly meet the priorities; they directly raise awareness of health issues by putting on nutrition workshops, healthier cooking skills, exercise classes, dance classes or walking groups. Other projects use an indirect approach to engage and encourage clients to live more active lifestyles, uptake of fruit and vegetables or to improve mental wellbeing by encouraging people to participate in gardening, creative arts, days out or sewing classes.
- 5.9 The participatory budgeting process in North Lewisham has worked as follows:
- Community groups are invited to apply for up to £5000 to deliver activities that are targeted at lifestyle behaviour change; improving healthy eating, increased physical activity, improved mental well-being and raising awareness on risks from smoking and alcohol harm. Groups are reached and supported throughout the application process by the North Lewisham Health Improvement Officer, employed by Lewisham and Greenwich Healthcare Trust (the Community Health Improvement Service) and the 170 Health Project worker who supports the Deptford/New Cross Health Forum. Posters and leaflets publicising the fund are distributed in community centres, organisations, park notice boards and outreach at

² Evaluation of the Evelyn Chooses Health Fund, November 2008

events, assembly meetings and forums held in Evelyn and New Cross wards.

- Before the fund allocation event, a 2 hour informal presentation skills workshop is organised and delivered in order to prepare projects for the participatory budgeting process. The workshop covers the following: discussion of experience in giving presentations, getting your message across, impact of verbal and non verbal communication, exercises to calm nerves, what to cover in your presentation in the time allocated, 2 minute practice run through of presentations and group feedback.
- There were 42 applications received for the Deptford / New Cross Choose Health 2011 funding. Thirty proposals met the set criteria and were shortlisted by a panel of stakeholders. They were then invited to the Participatory Budgeting event held in December 2010, whereby every group which applied for funding voted for each application by a scored rating system. The successful funded groups were invited to voluntarily give a portion of their budget through a give back process. This sum was then allocated to the group/s that were voted for, but did not receive funding due to the available budget being exhausted. A total of 16 projects were allocated funding from the £70,000 available. Six of these groups had never received funding through the North Lewisham Health Improvement Programme before.

6. Impact on Behaviour Change and Health Outcomes

- 6.1 Evidence of the impact on behaviour change and health outcomes has been drawn from the external evaluation of Evelyn Chooses Health and monitoring reports of the subsequent participatory budgeting rounds, including quantitative data about communities reached and behaviour change and qualitative information from quotes from participants.
- 6.2 The table below summaries the key information. More detailed information from each round is summarised in Appendix 1, attached to this report.

PB Scheme	No. of groups funded	No. of people reached	No. reporting behaviour change	Cost of grants
Evelyn Chooses Health 2008	25	Not known	Not known	£70,000
Deptford New Cross Choose Health 2009	16	691	290/464 - Physical activity 133/377 - Mental well being	£70,000
Deptford New Cross Choose Health 2010	18	960	293/422- Healthy eating 220- Physical activity 208 -Mental well being	£70,000
Deptford New Cross	16	464	129/169 - Healthy	£70,000

Choose Health 2011			eating 199/251-Physical activity 24/71-Smoking 280/320-Mental well being	
Deptford New Cross Choose Health 2012	19	667	231- Physical activity 205- Mental well being	£70,000

7. Impact on healthy eating and physical activity

- 7.1 Healthy eating and physical activity activities funded by PB were particularly successful in raising awareness and encouraging behaviour change. The external evaluation of the first PB fund, Evelyn Chooses Health, demonstrated that participants in ECHF projects reported increased awareness and understanding of, and motivation to improve, health and well being, especially through changes in physical activity and healthier eating habits. Improved physical health, including maintained or increased fitness and energy, weight loss, a sense of physical well-being were identified as outcomes.
- 7.2 Projects also had an impact on participants' families through a new emphasis on health and well-being by, for example, cooking healthier meals, and managing what children ate more actively. Participants also influenced family members to become more involved in physical exercise.
- 7.3 Quantitative monitoring information from subsequent rounds confirms this picture with 69% in 2010 and 76% in 2011 reporting eating more healthily as a result of the activities in which they have participated. This is also confirmed from participants' feedback from which examples are listed below:
- *"I've learnt a lot about eating the healthy foods from the pictures on the wall and I never realised salt was a problem, because where I come from we always put lots of salt on our food."*
 - *"Maggi cubes have how much salt? I am taking that packet back as soon as we leave here" and "I didn't know how unhealthy I was because of the way I see food and exercise".*
 - *"The girls really enjoy your groups and 'A' said today that she is eating more since your groups"* (Novo Women's Project – working with women who have had or still have a drug dependency and often need to gain weight).
 - *"Her interactive teaching style and creative methods go down well with our students, who are often hard to engage. Sessions often go on longer than scheduled, because the young people are asking so many questions."* (Food Skills Ltd – working with young people to teach cooking skills).

- *"Thanks for the menu. We haven't tried them all but the ones we have been very easy to do and tasty." (The Light House Project).*
- *"The course has inspired me to go on and cook for myself a lot more" and "my little girl is going to get more soups made by me. I enjoyed the course very much, it was inspiring".*
- *"I've learnt so much over the last few weeks. It has enabled me to eat a better balanced diet and also to look at increasing my weight in a healthier way. I will miss my chocolate though!"*
- *"I have lost almost 2 stone without dieting. All I have done is change my plate size and using less oil".*
- *"The pick and eat workshop helped my children to be together and enjoy and have fun in harvesting and research for new recipes on the internet. It was very inspirational to be there with 3 generations of my family. We were very delighted with the quality of herbs and vegetables in the garden".*
- *"I actually think my grand daughter believed [potatoes] came out of a bag in a supermarket. I took her right round the supermarket once I found out she was interested... it's educating my grand daughter that not everything comes out of a packet" (Participant, 60+).*
- *"Before I came here I used to eat five pieces of toast for breakfast now I have two and no butter".*

8. The Impact on Physical Activity:

8.1 Similarly to healthy eating, quantitative monitoring information from subsequent rounds confirms the picture outlined by the external evaluation regarding increases in physical activity reported by 63% of participants in 2009 and 79% in 2011. This is also confirmed from participants' feedback from which examples are listed below:

- *"It has helped me feel better and helped me to lose weight - 6 kg
"Glad that my waist measurement is reducing."*
- *"I realised the more I walk... [it's still] painful, but the more I'm active, the better it is. I have less pain" (Participant, aged 58).*
- *"I have been getting off the bus and walking earlier than my stop."*
- *"This has been a really positive experience and has helped me to get out of the house more often."*
- *"I can run for a bus, I feel more confident and upbeat."*

- *"More toned, less breathlessness."*
- *"Less tired."*
- *"My goal has been weight loss; I found the advice and exercise movements at Soca aerobics great and things that I could continue to do at home in addition to my exercise workouts on DVD."*
- *"It helped to loosen stiff joints and muscles."*
- *"I am walking a lot more and doing more exercise."*
- *"Aches and pains subsiding."*
- *"Feeling fitter."*
- *"Happy with my weight loss."*

9 Impact on Mental Wellbeing

- 9.1 The evaluation of ECHF outlined the impact on mental wellbeing. Participants reported increased confidence and self-esteem and a sense of achievement, which were particularly important for those who had lost confidence and self-esteem as a result of having been out of work due to caring responsibilities or health, as well as for participants who had been socially isolated prior to involvement in ECHF activity.
- 9.2 Participants with mental health problems reported improvements in depression and anxiety, although those with severe mental and physical health problems had in some instances been limited in their participation of ECHF activities, and significantly, these participants do not appear to have been enthused by the activities and support on offer.
- 9.3 Family relationships were improved for participants who felt calmer and had more energy as a result of improved physical health, and who felt were more able to play with their children as result.
- 9.4 This impact continued to be demonstrated in subsequent PB rounds from the quantitative monitoring data and whereby participants claimed that the programmes had increased their confidence to socialise with others and feel good about themselves. In 2009, 35% of participants identified improved mental wellbeing and in 2011 87% did so. Examples of participants' feedback included below:
- *"It has boosted my confidence and I have interacted well within the group and I have really enjoyed myself."*
 - *"This has been a really positive experience and has helped me to get out of the house more often."*

- “It made [me] feel good... someone can see something in you. It’s always good to hear good stuff about yourself... you remember it” (Participant, aged 18).
- “As soon as that door is open, I’m in. It’s a world for me... it makes me feel like I’m like everybody else. I can’t explain what it means to me..... it’s a new life” (Participant, aged 60).
- “I was in two minds whether I should come but I am glad I got out of the house.”
- “I didn't know I could write, I am enjoying this.”
- “It would be good to keep meeting like this, I feel good.”
- “Didn't realise there was so much happening in the local area, I must tell my neighbour.”
- “I didn't know writing and storytelling could help me feel good about myself.”
- "Love the social aspect of meeting like minded people and making new friends."
- "It has boosted my confidence and I have interacted well within the group and I have really enjoyed myself."
- "Reducing my medication and fewer visits to my GP."
- "It was good to talk to other people and see that I'm not alone in feeling the way I do."
- "I really love coming here - if I didn't come here I would just go to sleep all day."

10 Impact on the Management of Long Term Conditions

10.1 More effective management of chronic health problems like back pain and diabetes, were identified as outcomes of ECHF projects. Participants with severe pain and mobility difficulties reported how becoming more physically active had helped them to manage their conditions, with what they described as life changing effects.

10.2 In exceptional cases, participation in ECHF projects was felt to help in reducing harmful behaviour amongst people with drug and alcohol dependency by providing a diversionary activity.

11. Sustainability and Rolling Out Learning

- 11.1 The programme has developed a rich knowledge base about how to reach communities, raise awareness, change behaviour and improve health outcomes. The innovative nature of the programme allowed projects to try new and different ways of working and there are many practical examples of what works and what does not work that can inform similar health improvement programmes and projects.
- 11.2 Allocating funding to community organisations has been demonstrated as an ideal way to reach and respond to the needs of different communities. Small grants programmes have been effective at raising awareness about health and in changing the lifestyle behaviour of not only their participants, but also their friends and families.
- 11.3 Projects were most effective:
- when they were grounded in an understanding of types of activities and support that local communities were likely to want.
 - when they receive advice, training and development from public health specialists
 - when they have opportunities to network with each other;
- 11.4 The ECHF evaluation emphasised that outcomes appeared to be sustainable for three sets of participants:
- those who had completed skills focused courses and who felt that not only would they retain the knowledge and skills gained on the course, but they would be able to build on them in the future;
 - those who had undertaken activity based courses, which had resulted in outcomes including increased confidence, self esteem, and new friendships, which they felt able to sustain for themselves;
 - those who had been involved in projects delivering nutrition and exercise classes, and who felt that they had sufficient motivation to, and strategies for, implementing lessons learned.
- 11.5 The size of the PB fund can vary. It needs to be big enough to reach a variety of community groups and will depend on the size of the population to be reached. The cost of the north Lewisham PB fund was £70,000 per annum and funded an average of 19 community groups and reached an average of 696 people per year at a cost of £100 per beneficiary.
- 11.6 In order for the PB process to be effective it needs to have additional infrastructure support:
- Co-ordination and administration - including publicity, organising the PB event, processing the grants and invoices and obtaining monitoring information;

- Outreach and capacity development – support application process and organising training, development and networking of groups.
- 11.7 The cost for this would be proportionate to the size of the fund, but is likely to be from 30-50% of the fund depending on the level of support provided.
- 12. Financial implications**
- 12.1 There are no specific financial implications arising from this report or its recommendations.
- 13. Legal implications**
- 13.1 There are no specific legal implications arising from this report or its recommendations.
- 14. Crime and Disorder Implications**
- 14.1 There are no specific crime and disorder implications arising from this report or its recommendations.
- 15. Equalities Implications**
- 15.1 This approach is recognised as an effective way to reduce health inequalities and specific groups can be targeted if it is clear that they are not being reached. For example, the later north Lewisham PB funds successfully targeted groups with physical and learning disabilities through providing additional support and outreach, following evaluation of previous funds where it was clear that these groups were missed.
- 16. Environmental implications**
- 16.1 There are no specific environmental implications arising from this report or its recommendations.

If there are any queries on this report please contact **Jane Miller, Deputy Director of Public Health** on 020 8314 9058.

North Lewisham Programme Participatory Budgeting Projects & Activities

Funding Stream	Activities	Methodology	Target Groups	Outcome	Measures							Reasons for success
	HEALTHY EATING STOP SMOKING PHYSICAL ACTIVITY MENTAL WELLBEING				Indicators	No of Groups funded	Total No's reached	No reporting behaviour change	Gender % M F	volunteers, referrals & awareness	Cost	Source of evidence
Evelyn Chooses Health Fund Round						25	NA				100000	
	Health Awareness	Awareness and parallel activity sessions, small group size structured classes, experiential learning	Children, young people, parents, adult carers, older and retired people, and those with long term illness	Increased community capacity, awareness and understanding of health issues; Increased motivation to engage and participate; behaviour lifestyle change,	Activity attendance, No of sessions completed		NA	NA	NA	NA		Participants reported a range of positive behavioural change outcomes in mental wellbeing and other Health and social measures. These outcomes were sometimes felt to be sustainable where participants felt that they had gained sufficient learning, motivation and access to resources to support them carry on. N:lew ph team\North Lewisham Health Improvement Plan 2011\Evaluation\NLP Evaluation Evidence
	Healthy Eating	Cookery taster classes, nutrition advice, ready meals for those socially isolated	Children, young people, parents, adult carers, older and retired people, homeless	Increased diet and nutrition awareness. Increased fruit and Vegetable consumption, improved cooking skills	Activity attendance, No of sessions completed		NA	NA	NA	NA		
	Physical Activity	Keep fit classes, organised sport sessions, walking, gardening	Children, young people, parents, adult carers, older and retired people, and those with long term illness	Increase in no's of those physical activity, Increased awareness of the benefits of exercise	Activity attendance, No of sessions completed		NA	NA	NA	NA		
Deptford NewCross Choose Health Round 1 - 2009						16	691		21	79	70000	
	Healthy Eating	Grow your own community garden activities, Nutrition workshops and advise, Healthy eating cookery taster	General community, (NEETS) Not in employment or education, Children and parents	Increased diet and nutrition awareness. Increased fruit and Vegetable consumption, improved cooking skills	Workshop and information attendance, self reported behaviour from project reports		NA	NA	NA	NA		Community grounded activities such as workshops were used in the design and delivery of most interventions. This enabled the maintainance of a high levels of participation and contributed to the development of a sustainable healthy behaviour actions through increased awareness and the adoption of healthy lifestyles.
	Stop Smoking	Brief intervention training of workers & volunteers; general awareness and campaigns	Adult Smokers				NA	NA	NA	NA		
	Physical Activity	Chair exercises, Tai Chi, Aerobics, creative dancing	General population, older adults, womens specific activities for Vietnamese,	Increased physical activity levels	Activity attendance, No of sessions completed		464	290	NA	NA	NA	
Mental Wellbeing	Relief support for carers through monthly Wellbeing sessions, relaxation and massage	Carers, older people, long term illness, refugees and assylum seekers	Increased participation and inclusion	Activity attendance, No of sessions completed, self reported behaviour change		377	133	NA	NA	NA		
Deptford						18	960		23.7	76.3	70000	

NewCross Choose Health Round 2 - 2010	Healthy Eating	Supplementary Saturday school Healthy eating and cookery taster sessions, Nutrition workshops and advise	Children, older people, Homeless,	Increased diet and nutrition awareness. Increased fruit and Vegetable consumption, improved cooking skills	Workshop and information attendance, self reported behaviour from project reports		422	293	NA	NA	NA		A membership register was set up to track people's buying patterns, send alerts on available and new products, planned information sessions and stalls. Establishment of regular deliveries to corporate customers & schools
	Stop Smoking	Brief intervention training of workers & volunteers; general awareness and	Adult Smokers				NA	NA	NA	NA	NA		Source:- N:\lew ph team\North Lewisham Health Improvement Plan 2011\NXG Food Coop\Building Healthier
	Physical Activity	Weekly exercise - Exercise buddies, Walking, Dance aerobics, sailing courses	older adults, Carers, people with special needs, Afghan & Cenntral asian communities	Increased physical activity levels	Activity attendance, No of sessions completed		NA	220	NA	NA	NA		
	Mental Wellbeing	Guided self help, Counselling and Cognitive therapy,	General population, older adults, Carers	Increased no of people reporting wellbeing improvements			NA	208	NA	NA	NA		N:\lew ph team\North Lewisham Health Improvement Plan 2011\Needs & Impact Assessments
Deptford						16	464		43	57		70000	
NewCross Choose Health Round 3 - 2011	Healthy Eating	Resource lifestyle packs, Healthy eating and cookery taster sessions, Nutrition workshops and advise	Children, older people, Homeless,	Increased diet and nutrition awareness. Increased fruit and Vegetable consumption, improved cooking skills	Workshop and information attendance, self reported behaviour from project reports		169	129	NA	NA	NA		
	Stop Smoking	Brief intervention training of workers & volunteers; general awareness and	Adult Smokers	No. of smokers referred to SSS; no. quitting smoking	No quitting from Quit Manager		71	24	NA	NA	NA		
	Physical Activity	Chair exercises, Tai Chi, Aerobics, creative dancing	Womens specific activies for the Vietnamese community, General population, older adults	Increased physical activity levels, Increased participation	No's of people attending information sessions and workshops		251	199	NA	NA	NA		N:\lew ph team\North Lewisham Health Improvement Plan 2011\170 Community Project\Physical Activity commissioning
	Mental Wellbeing	Cognitive behaviour, Laughter and massage and Remniscence theapy sessions	Women with drug abuse history, General population, older adults, Carers	Increased no of people reporting wellbeing improvements	No's of people attending information sessions and workshops		320	280	NA	NA	NA	NA	
Deptford						19	667		29	71		70000	

Healthy Eating	Nutrition information and advice workshops, cookery demonstration sessions	Children, older people, Homeless,	Increased diet and nutrition awareness. Increased fruit and Vegetable consumption, improved cooking skills	Workshop and information attendance, self reported behaviour from project reports		201	NA	NA	NA	NA		Activities and delivery targeted at different groups, weekdays for unemployed and retired, Evening and Weekends for students and those in employment Increased support from service providers and local lead agencies (CD4H, IAPT, VAL, LINKs, 170CP) enabled wider theme coverage and awareness information
Stop Smoking	Brief intervention training of workers & volunteers; general awareness and campaigns	Adult Smokers	No. of smokers referred to SSS; no. quitting smoking	No quitting from Quit Manager		NA	NA	NA	NA	NA		Brief intervention training for groups in receipt of funding was made mandatory
Physical Activity	Chair exercises, Tai Chi, Aerobics, creative dancing	General population, older adults, womens specific activies for Vietnamese,	Increased physical activity levels, Increased participation	No's of people attending information sessions and workshops		NA		NA	NA	NA	231	
Mental Wellbeing	Cognitive behaviour, Laughter, massage and Remniscence therapy sessions, singing, arts and craft activities	longterm conditions, General population, older adults, Carers	Increased no of people reporting wellbeing improvements	No's of people attending information sessions and workshops		NA		NA	NA	NA	205	DNXCH2011 End of Project Report: N:\lew ph team\North Lewisham Health Improvement Plan 2011\Evaluation\NLP Evaluation Evidence
Alcohol awareness	Mandatory workshops delivered to funded groups and wider community, informaiton sharing	General public, service providers for at risk groups	Increased number of groups aware of safe alchol consumption levels	Attendance records, end of project reporting	22	NA	NA	NA	NA	NA		

HEALTH AND WELLBEING BOARD			
Report Title	Autism Self Assessment Framework The 2010 Adult Autism Strategy <i>Fulfilling and Rewarding Lives – Evaluating Progress</i>		
Contributors	Corinne Moocarme – Joint Commissioning	Item No. 9	
Class	Part 1	Date: 19 November 2013	

1. Purpose

- 1.1 Directors of Adult Social Services were requested by the Department of Health to take forward the second self-assessment exercise for the implementation of the Adult Autism Strategy.
- 1.2 It is a requirement of this process that submissions are discussed by the Local Health and Wellbeing Board by the end of January 2014.

2. Recommendations

- 2.1 It is recommended that the Health and Wellbeing Board:
 - Discuss and note the content of the Lewisham Autism Self Assessment Framework.
 - Support local implementation work.
 - Determine if further planning/health needs assessment is required to support implementation of the strategy.

3. Policy Context

- 3.1 The Autism Act 2009 was the first legislation designed to address the needs of Adults on the Autism Spectrum. It placed a duty on the Secretary of State to prepare and publish a Strategy for improving the provision of relevant services to meet the needs of this client group. It also required the Secretary of State to issue Guidance to Local Authorities and to NHS bodies and Foundation Trusts about the exercise of their functions concerned with the provision of these services.
- 3.2 Subsequently, “*Fulfilling and Rewarding Lives – Strategy for Adults with Autism in England*” was published by the Department of Health in March 2010. This was followed by Implementing “*Fulfilling and Rewarding Lives*”, *Statutory Guidance for Local Authorities and NHS Organisations to Support Implementation of the Autism Strategy*” in December of the same year.
- 3.3 The Strategy set out the key areas for local and national work and focused on laying the foundations for change which involved raising awareness of autism, particularly across public services; increasing the availability and consistency of diagnosis; taking steps to make services more accessible for adults with autism, personalisation across all services and looking directly at the challenges faced by adults with autism in getting into work and keeping a job, as part of the wider goal of achieving full employment.
- 3.4 The activity of the Health and Wellbeing Board is focused on delivering the strategic vision for Lewisham as established in *Shaping*

our Future – Lewisham’s Sustainable Community Strategy and in Lewisham’s Health and Wellbeing Strategy.

- 3.5 The work of the Board directly contributes to *Shaping our Future’s* priority outcome which states that communities in Lewisham should be *Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing.*

4. **Background**

- 4.1 As a response to “*Implementing Fulfilling and Rewarding Lives*”, Lewisham PCT identified development funding to support local implementation.
- 4.2 Prior to the Strategy, Lewisham had conducted an Autism Needs Analysis (March 2009). This focused on adults (over 18) in Lewisham who had an Autistic Spectrum Disorder but did not have a learning disability. This established a baseline on prevalence and the needs of this group. Key needs identified for Lewisham were Practical Life Skills, Further Education, Employment and Housing.
- 4.3 To identify what was currently provided in Lewisham a Process Mapping Event was held on the 31st March 2010. The event was well attended by Service users and Service providers from both statutory and Third Sector organisations. Key themes to emerge from the Process Mapping Event were:
- a) Diagnosis
 - b) Training/Awareness Raising
 - c) Information and Support
 - d) Advocacy
- 4.4 These events supported the Joint Commissioning Team to undertake a gap analysis between what was required and what was already available, and from this, develop a coherent Commissioning Plan for this client group.
- 4.5 Following the stakeholder engagement events noted above, Lewisham recognised that services needed to be developed to improve equity of access for diagnosis in adulthood, and to provide information and support for people with ASD both before and after diagnosis. This mirrored two of the priorities identified in the National Strategy.
- 4.6 In response to the issue of diagnostic equity, South London and Maudsley Mental Health Trust was commissioned to deliver a secondary care ASD diagnostic service. This began operating in June 2011.
- 4.7 A specification for a Lewisham Information, Advice and Support Service for Adults with Autism was developed (in consultation with key stakeholders and service users during 2011). The four main outcomes expected from the service were:
- Information Development
 - Facilitate Peer Support
 - Support in decision making and accessing generic services
 - Provide an advisory function on autism for health and social care professionals.

- 4.8 Procurement took place in accordance with the London Borough of Lewisham procurement procedures and following a robust tender evaluation process, it was agreed to award the a 3 year contract to Burgess Autistic Trust.
- 4.9 To meet the requirements of the Strategy with regards to raising awareness of Autism, in early 2012 Lewisham commissioned Endersby Training to deliver Autism awareness training to a wide range of staff across the London Borough of Lewisham. To date training has been delivered to over 150 staff across health and social care with more training planned for 2013/14.

5.0 Self Assessment Framework

5.1 Review of the Strategy

The Department of Health is currently leading a formal review of progress against the Strategy. This is an opportunity for Government to assess whether the objectives of the Strategy remain fundamentally the right ones, to be assured of the progress that is being achieved by Local Authorities and the NHS, and consider what should happen to continue to make progress and what barriers could be resolved. The investigative stage of the Review will last until the end of October and the Strategy will be revised as necessary by March 2014.

5.2 The Self-Assessment Exercise

5.2.1. This exercise builds on the first self assessment exercise which looked at what progress had been made since February 2012. This was based around the self-assessment framework which the Department of Health launched in April 2011 to support localities with the delivery of the Adult Autism Strategy and the statutory guidance for health and social care which was issued in December 2010. The individual returns received and related reports from February 2012 can be found at www.improvinghealthandlives.org.uk/projects/autsaf2011.

5.2.2 The purpose of the self assessment is to:

- assist Local Authorities and their partners in assessing progress in implementing the 2010 Adult Autism Strategy;
- see how much progress has been made since the baseline survey, as at February 2012;
- provide evidence of examples of good progress made that can be shared and of remaining challenges.

5.2.3 The list of questions was more focused than last time but should still enable a comparison with results from the 2012 exercise. For some questions there was a RAG rating system with scoring criteria for that question. If a question is scored Red or Amber, respondents were asked to say what was stopping progress and for Green scores there was an opportunity to say what actions have enabled progress.

5.2.4 There were 17 questions in total that attracted a RAG rating. Lewisham rated itself Green on 6 questions and Amber on the remaining 11. There were no red ratings. Some of the main areas rated Amber requiring further work to progress were:

- The inclusion of Autism in the local Joint Strategic Needs Assessment.
- Improving the data collected regarding numbers of adults with Autism in the Borough.

- The level of information about local support in the area being accessible to people with Autism.
- Promotion of employment of people on the Autism Strategy
- Specific identification of adults with autism in the local housing strategy.

5.2.5 During September 2013 the Lewisham Self Assessment Framework was shared with key stakeholders and agreed by the Adult Joint Strategic Commissioning Group. It was also validated by a group of people with Autism. It was submitted online on the 30th September (in line with deadline) and a copy of the full submission plus a summary of the RAG ratings is attached.

6. Next Steps

- 6.1 The data fill has remained open to allow modifications arising from the Health and Wellbeing Board discussion to be made to RAG rated or yes/no questions.
- 6.2 The returns will be analysed by the Public Health England learning disabilities observatory. All local responses will be published in full online.
- 6.3 The Joint Commissioning Plan for Adults with Autism may need refreshing in line with gaps in provision identified in the SAF and during the Health and Wellbeing Board discussion.

7. Financial implications

- 7.1 None at this stage. There is no funding allocated specifically to meeting the requirements of the Autism Strategy or supporting developments/expansion of services, other than that which is assigned to South London and Maudsley for the Secondary Care ASD Diagnostic Service and to Burgess Autistic Trust for the provision of the Information, Advice and Support Service. Both of these services are funded by NHS Lewisham Clinical Commissioning Group. Any funding/resource implications of a refreshed Commissioning Plan will need to be considered by the London Borough of Lewisham and the Clinical Commissioning Group.

8. Legal implications

- 8.1 There are no legal implications arising from this report.

9. Crime and Disorder Implications

- 9.1 There are no Crime and Disorder Act implications arising from this report.

10. Equalities Implications

- 10.1 The Equality Act 2010 (the Act) brings together all previous equality legislation in England, Scotland and Wales. The Act includes a new public sector equality duty (the equality duty or the duty), replacing the separate duties relating to race, disability and gender equality. The duty came into force on 6 April 2011. The new duty 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.

- 10.2 In summary, the Council must, in the exercise of its functions, have due regard to the need to:
- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
 - advance equality of opportunity between people who share a protected characteristic and those who do not.
 - foster good relations between people who share a protected characteristic and those who do not.
- 10.3 The tender process for the Information, Advice and Support Service included evaluating potential providers and ensuring that adequate equal opportunities policies and procedures were in place. Burgess Autistic Trust is required to demonstrate diversity in providing a service that matches the culture, race, gender and disability of service users living in Lewisham.
- 10.4 The equalities implications of subsequent revisions to the Adults with Autism Commissioning Plan will be considered prior to implementation.

11. Environmental Implications

- 11.1 There are no environmental implications arising from this report.

12. Conclusions

- 12.1 Lewisham is looking to establish a community that accepts and understands autism and which has an infrastructure that provides opportunities for adults with Autism/Asperger's syndrome to live fulfilling and rewarding lives.
- 12.2 There have been several exciting and innovative developments in response to the National Strategy. The Self Assessment Framework is an opportunity for the Health and Wellbeing Board to recognise achievements, take stock of our current position and agree next steps.

If there are any queries on this report, please contact Corinne Moocarme, Joint Commissioning Team on 020 8314 3342. corinne.moocarme@nhs.net

Background Documents

Fulfilling and Rewarding Lives

<https://www.gov.uk/.../fulfilling-and-rewarding-lives-the-strategy-for-adults-with-autism-in-england>

Autism Needs Analysis – London Borough of Lewisham

The needs of adults with an Autism Spectrum Disorder (particularly Asperger syndrome)
Sadie King, Policy Officer, Strategy and Policy, Directorate for Community Services.
March 2009

Self Assessment Frameworks submitted in 2011

www.improvinghealthandlives.org.uk/projects/autsaf2011

Self Assessment Frameworks submitted in 2013

www.improvinghealthandlives.org.uk/projects/autism2013



Autism Self Evaluation

Local authority area

1. How many Clinical Commissioning Groups do you need to work with to implement the Adult Autism Strategy in your local authority area?

1

Comment

2. Are you working with other local authorities to implement part or all of the priorities of the strategy?

- Yes
 No

If yes, how are you doing this?

Planning

3. Do you have a named joint commissioner/senior manager of responsible for services for adults with autism?

- Yes
 No

If yes, what are their responsibilities and who do they report to? Please provide their name and contact details.

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Reports to:
Dee Carlin, Head of Joint Commissioning
dee.carlin@nhs.net
0208 314 7103

Corinne Moocarme has lead responsibility to work with key stakeholders to develop a Commissioning Plan for clients with Asperger's Syndrome and Autism Spectrum Disorder. This includes service development, service re-design, workforce training/development and engaging with specific projects/depts for the Council and CCG including Housing and Public Health.

4. Is Autism included in the local JSNA?

- Red
 Amber
 Green

Comment

Autism is not a specific client group category in the JSNA. The Director of Public Health has commissioned a report to advise how recording systems might need to change across health and social care to better capture specific diagnoses.

5. Have you started to collect data on people with a diagnosis of autism?

- Red
 Amber
 Green

Comment

Both the SLAM Diagnostic Clinic and the Lewisham Information Advice and Support Service are required to collect information on diagnosis as part of their Key Performance Indicators.

6. Do you collect data on the number of people with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any)?

- Yes
 No

If yes, what is

the total number of people?

the number who are also identified as having a learning disability?

the number who are identified as also having mental health problems?

Comment

7. Does your commissioning plan reflect local data and needs of people with autism?

- Yes
 No

If yes, how is this demonstrated?

The Lewisham Joint Commissioning Workplan identifies the importance of continuing to ensure that commissioned services meet the needs of local people with autism.

8. What data collection sources do you use?

- Red
 Red/Amber
 Amber
 Amber/Green
 Green

Comment

*We have made a start in collecting data and plan to progress.
We are able to access data held by:
Autism Diagnostic Clinic
Lewisham Information, Advice and Support Service
Campaign for Lewisham Autism Spectrum Housing (CLASH)
EMIS (Medical Information System) used to elicit READ codes used by GPs
Integrated Adult Services (IAS) Social Care User Records System*

9. Is your local Clinical Commissioning Group or Clinical Commissioning Groups (including the Support Service) engaged in the planning and implementation of the strategy in your local area?

- Red
 Amber
 Green

Comment

The lead officer has presented both requirements and recommendations of the Autism Strategy to a number of audiences, including what was previously the Primary Care Trust. The Chief Operating Officer, Lewisham CCG is a point of continuity between the then PCT and the current CCG and is fully appraised on these. The CCG are represented on the Health and Wellbeing Board, and therefore will be part of the November Health and Wellbeing Board where Autism will be discussed.

10. How have you and your partners engaged people with autism and their carers in planning?

- Red
 Amber
 Green

Please give an example to demonstrate your score.

Carers of young adults with Autism have been engaged in the Lewisham Housing and Autism Joint Project Group. The Lewisham Information Advice and Support Service are required to collect qualitative and quantitative data from service users around emerging needs and service gaps.

11. Have reasonable adjustments been made to everyday services to improve access and support for people with autism?

- Red
 Amber
 Green

Please give an example.

Autism Awareness Training has been provided to our SCAIT (Social Care Access and Information Team) as well as information about autism specific services in the Borough, so that they can support clients trying to access adult social care services for the first time.

As part of the Housing and Disability Group, carers of young adults with autism have been involved in the re-design of the form to be completed when applying for re-housing on medical grounds.

12. Do you have a Transition process in place from Children's social services to Adult social services?

- Yes
 No

If yes, please give brief details of whether this is automatic or requires a parental request, the mechanism and any restrictions on who it applies to.

This is an automatic, internal process between Children's and Adults Services. There are no restrictions providing the child is known to Children's Social Care.

13. Does your planning consider the particular needs of older people with Autism?

- Red
 Amber
 Green

Comment

An analysis of the service being delivered by Lewisham's Autism partners (SLaM and BAT) suggests that the people accessing the current diagnostic and support services are in the main, younger adults living at home with their parents. The issue of accessibility of services by older adults will be discussed in the next round of contract monitoring meetings.

All services commissioned for adults with Autism are available to anyone with ASD aged 18 plus. Training on Autism Awareness has been offered across a wide range of health and the wider council statutory service providers, this would have included staff supporting older adults.

Training

14. Have you got a multi-agency autism training plan?

- Yes
 No

15. Is autism awareness training being/been made available to all staff working in health and social care?

- Red
 Amber
 Green

Comment: Specify whether Self-Advocates with autism are included in the design of training and/or whether they have a role as trainers. If the latter specify whether face-to-face or on video/other recorded media.

Video recorded material featuring adults with autism is included in the training. We are looking to develop further training in conjunction with the Lewisham Information, Advice and Support Service which will include Service Users in the design and delivery.

16. Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?

- Red
 Amber
 Green

Comments

A series of introduction to Autism Specific Conditions half day workshops were commissioned in Lewisham during 2012. A wide range of professionals were invited to attend including: Police, Social Workers, Hostel Workers, Care Workers, Leisure Industry, Housing Organisations, Disability Workers, Management and other staff working for the London Borough of Lewisham.

Earlier in 2012, staff with responsibility for statutory assessments - mainly Social Workers and Occupational Therapists were invited to attend a more in-depth course and encouraged to share stories, share good practice and seek solutions in working with clients with autism. This course was repeated for health staff (mainly health visitors) during the early part of 2013.

Following excellent feedback on the above courses - London Borough of Lewisham Training Department have commissioned the same company to ensure there is a "rolling programme" of autism awareness training.

A service user recently attended the Lewisham "First Aid for Mental Health" training and commented that Autism should have got a mention during this training.

17. Have Clinical Commissioning Group(s) been involved in the development of workforce planning and are general practitioners and primary care practitioners engaged included in the training agenda?

- Yes
 No

Please comment further on any developments and challenges.

The Autism Awareness Training mentioned above was offered to all GPs and Practice Staff. Unfortunately, this group of staff were not well represented and we need to look again about how the training is promoted and methods of delivery that will make it more attractive to primary care staff.

18. Have local Criminal Justice services engaged in the training agenda?

- Yes
 No

Please comment further on any developments and challenges.

The training was offered to the Police and Probation Service and 25% of total attendees were from one of these staffing groups.

Diagnosis led by the local NHS Commissioner

19. Have you got an established local diagnostic pathway?

- Red
 Amber
 Green

Please provide further comment.

The Lewisham Autism Spectrum Disorder Clinic is commissioned from South London and Maudsley (SLAM) Trust. Referrals are managed via the Community Mental Health Team.

20. If you have got an established local diagnostic pathway, when was the pathway put in place?

Month (Numerical, e.g. January 01)

6

Year (Four figures, e.g. 2013)

2011

Comment

21. How long is the average wait for referral to diagnostic services?

Please report the total number of weeks

13

Comment

13 weeks from referral to initial assessment

22. How many people have completed the pathway in the last year?

72

Comment

40 during 2012
32 to date in 2013

23. Has the local Clinical Commissioning Group(s)/support services taken the lead in developing the pathway?

- Yes
 No

Comment

The pathway was set up before the implementation of the CCG. It has been led by the Joint Commissioning Team who works across health and social care.

24. How would you describe the local diagnostic pathway, ie Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service?

- a. Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis
 b. Specialist autism specific service

Please comment further

The diagnostic clinic is integrated with the Community Mental Health Teams. Following diagnosis, clients are referred to the Information, Advice and Support Service for follow up and ongoing support.

25. In your local diagnostic path does a diagnosis of autism automatically trigger an offer of a Community Care Assessment?

- Yes
 No

Please comment, i.e. if not who receives notification from diagnosticians when someone has received a diagnosis?

Community Mental Health Service and GP. Clients are given information regarding the Information, Advice and Support Service and encouraged to self-refer.

26. What post-diagnostic support (in a wider personalisation perspective, not just assuming statutory services), is available to people diagnosed?

The Lewisham Information, Advice and Support Service is able to facilitate peer support groups, support to access employment/further education and support in managing an ASD diagnosis for service users and their carers.

Care and support

27. Of those adults who were assessed as being eligible for adult social care services and are in receipt of a personal care budget, how many people have a diagnosis of Autism both with a co-occurring learning disability and without?

a. Number of adults assessed as being eligible for adult social care services and in receipt of a personal budget

3141

b. Number of those reported in 27a. who have a diagnosis of Autism but not learning disability

c. Number of those reported in 27a. who have both a diagnosis of Autism AND Learning Disability

Comment

Overall number of Self Directed Support during 2012/13 was 3141 out of 5659 clients.

28. Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide range of local services?

Yes

No

If yes, please give details

Lewisham Information, Advice and Support Service commissioned from Burgess Autistic Trust.

29. Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?

Yes

No

If yes, please give details

Social Care Access and Information Team (SCAIT)

30. Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?

Red

Amber

Green

Comment

Mental Health Advocates have not identified the need for an autism specific course to date.

Many of the team of "Generic" advocates working with service users with a Learning Disability have had specific autism awareness training. Further training can be accessed as required.

31. Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an advocate?

- Red
 Amber
 Green

Comment

There is open referral to Learning Disability Advocacy Support which would extend to those clients with Autism without a Learning Disability.

32. Can people with autism access support if they are non Fair Access Criteria eligible or not eligible for statutory services?

- Yes
 No

Provide an example of the type of support that is available in your area.

Lewisham Information, Advice and Support Service (as referenced above)

33. How would you assess the level of information about local support in your area being accessible to people with autism?

- Red
 Amber
 Green

Comment

This is an area considered in the recent report on Autism in Lewisham produced by Lewisham Public Health. One recommendation is that Autism Champions are identified across health and social care to support their colleagues and to keep up to date on what services are available in the Borough.

Housing & Accommodation

34. Does your local housing strategy specifically identify Autism?

- Red
 Amber
 Green

Comment

It is not specifically mentioned. The Lewisham Housing Strategy expires in 2014 and will be renewed as soon as more about the future of the housing stock is known. Consideration as to the content/scope of the new strategy will take place then.

Employment

35. How have you promoted in your area the employment of people on the Autistic Spectrum?

- Red
 Amber
 Green

Comment

Lewisham Links Employment Project supports employment for adults with Learning Disability. Lewisham Information, Advice and Support Service supports people into mainstream community services, employment opportunities, leisure and learning etc.

36. Do transition processes to adult services have an employment focus?

- Red
 Amber
 Green

Comment

Employment options are considered within the transition process. There are a number of schemes in the borough aimed specifically at supporting employment for young people aged 16-25 with learning difficulties or learning disabilities, including those on the autistic spectrum. These schemes include the provision of training for work readiness, support with job searching and job applications, job coaching, through to fully funded work placements of up to 52 weeks.

Criminal Justice System (CJS)

37. Are the CJS engaging with you as a key partner in your planning for adults with autism?

- Red
 Amber
 Green

Comment

Lewisham Information, Advice and Support Service have not had any engagement with the Police or Probation Service to date but plan to do so in the future.

The CJS are engaged with Lewisham Crime Reduction and Supporting People Team but are not currently engaged on any discrete pieces of work around autism.

Optional Self-advocate stories

Self-advocate stories.

Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one). In the comment box provide the story.

Self-advocate story one

Question number

Comment

Self-advocate story two

Question number

Comment

Self-advocate story three

Question number

Comment

Self-advocate story four

Question number

Comment

Self-advocate story five

Question number

Comment

This marks the end of principal data collection.

Can you confirm that the two requirements for the process to be complete have been met?

a. Have you inspected the pdf output to ensure that the answers recorded on the system match what you intended to enter?

Yes

b. Has the response for your Local Authority area been agreed by the Autism Partnership Board or equivalent group, and the ratings validated by people who have autism, as requested in the [ministerial letter](#) of 5th August 2013?

Yes

The data set used for report-writing purposes will be taken from the system on 30th September 2013.

The data fill will remain open after that for two reasons:

1. to allow entry of the dates on which Health and Well Being Boards discuss the submission and
2. to allow modifications arising from this discussion to be made to RAG rated or yes/no questions.

Please note modifications to comment text or additional stories entered after this point will not be used in the final report.

What was the date of the meeting of the Health and Well Being Board that this was discussed?

Please enter in the following format: 01/01/2014 for the 1st January 2014.

Day

Month

Year

Autism Self Assessment – RAG Ratings

		Question No
Is Autism included in the local JSNA?	Amber	4
Have you started to collect data on people with a diagnosis of autism?	Green	5
What data collection sources do you use?	Amber	8
Is your local CCG engaged in the planning and implementation of the strategy in your local area?	Amber	9
How have you and your partners engaged people with autism and their carers in planning?	Amber	10
Have reasonable adjustments been made to everyday services to improve access and support for people with autism?	Amber	11
Does your planning consider the needs of older people with autism?	Amber	13
Is autism awareness training being/been made available to all staff working in health and social care?	Green	15
Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?	Green	16
Have you got an established local diagnostic pathway?	Green	19
Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?	Amber	30

Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews or safeguarding processes have access to an advocate?	Green	31
How would you assess the level of information about local support in you area being accessible to people with autism?	Amber	33
Does your local housing strategy specifically identify Autism?	Amber	34
How have you promoted in your area the employment of people on the Autistic Spectrum?	Amber	35
Do transition processes to adult services have an employment focus?	Green	36
Are the CJS engaging with you as a key partner in your planning for adults with autism?	Amber	37

Agenda Item 10

HEALTH AND WELLBEING BOARD			
Report Title	Local Government Declaration on Tobacco Control		
Contributors	Director of Public Health	Item No.	
		10	
Class	Part 1	Date:	
		19.11.13	

1. Summary

- 1.1 Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking is a priority outcome of the Health and Wellbeing Strategy. A report outlining progress in relation to this priority was presented to the Health and Wellbeing Board in September. The importance of addressing this challenge in Lewisham was recognised by Board members.
- 1.2 This paper asks the Health and Wellbeing Board to support the London Borough of Lewisham signing up to the Local Government Declaration on Tobacco Control.
- 1.3 The Declaration commits the Council to:
 - Reducing smoking prevalence and health inequalities
 - Developing plans with partners and local communities
 - Participating in local and regional networks
 - Supporting Government action at national level
 - Protecting tobacco control work from the commercial and vested interests of the tobacco industry
 - Monitoring the progress of our plans
 - Joining the Smokefree Action Coalition.
- 1.4 A number of councils have already signed the declaration across England. The Parliamentary launch of the Local Government Declaration on Tobacco Control is on Wednesday 11th December and Lewisham has been invited to attend. The Declaration and the invitation to sign the Declaration are attached as appendices to this report.

2. Purpose

- 2.1 The purpose of this paper is to outline the Local Government Declaration on Tobacco Control and to seek support for the London Borough of Lewisham to sign the declaration.

3. Recommendation

- 3.1 Members of the Health and Wellbeing Board are recommended to agree that it would be beneficial for the London Borough of Lewisham to sign the Local Government Declaration on Tobacco Control.

4. Policy Context

- 4.1 Reducing smoking prevalence was identified in 'Healthy Lives, Healthy People: A Public Health Strategy for England', (which informed the Health and Social Care Act 2012) and as an indicator in the Public Health Outcomes Framework, which sets out a vision for public health, desired outcomes and the indicators to measure improvement.
- 4.2 From 1st April 2013, the public health function has been transferred from the National Health Service to local authorities. Each top tier and unitary authority has its own Health and Wellbeing Board and a Director of Public Health, and these local authorities are responsible for commissioning stop smoking and other relevant services.
- 4.3 The Framework Convention on Tobacco Control (FCTC)¹ is the world's first public health treaty, negotiated through the World Health Organisation. It has been ratified by more than 170 countries, including the UK. Key provisions include support for: price and tax measures to reduce the demand for tobacco products; public protection from exposure to tobacco smoke; regulation of the contents of tobacco products; controlling tobacco advertising, promotion and sponsorship; measures to reduce tobacco dependence and promote cessation; tackle illicit trade in tobacco products; and end sales to children. Article 5.3 commits parties to protecting their public health policies from the commercial and vested interests of the tobacco industry and the UK has explicitly committed to live up to this obligation in chapter 10 of the Tobacco Control Plan for England.
- 4.4 Smoking is one of the nine priority outcomes, identified in the Health and Wellbeing Strategy for Lewisham. Reducing smoking is a priority for the Board this year, along with reducing alcohol consumption and obesity.
- 4.5 The Lewisham Children and Young People's Plan 2012-15 identifies the importance of intervening early to reduce the numbers of children and young people starting smoking focus.
- 4.6 The activity of the Health and Wellbeing Board is focused on delivering the strategic vision for Lewisham as established in *Shaping our Future – Lewisham's Sustainable Community Strategy* and in Lewisham's Health and Wellbeing Strategy.
- 3.2 The work of the Board directly contributes to *Shaping our Future's* priority outcome which states that communities in Lewisham should be *Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing*.

5. Background

- 5.1 Smoking is the primary cause of preventable morbidity and premature death. Tobacco kills over 80,000 people in England every year, more people each year than obesity, alcohol, road accidents and illegal drug use put together.

¹ World Health Organisation, *Framework Convention on Tobacco Control*,
http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf (Accessed 11th April 2013)

- 5.2 Compared to England, Lewisham had significantly more smoking attributable deaths in 2008-10 and hospital admissions in 2010/11.
- 5.3 Currently about 20% of people over 18 smoke in England and about 22% of people smoke in Lewisham (approximately 43,000 smokers). This has fallen since a peak in the 1940s, but shows signs of levelling off more recently. Two thirds of smokers want to stop.
- 5.4 Thousands of children also suffer harm as a result of smoking. Not only are 17,000 children under the age of five admitted to hospital every year as a result of passive smoking but Cancer Research UK also estimate that 430 children in England start smoking every day. Two thirds of smokers start before the age of 18, and across the UK more than 200,000 children aged between 11 and 15 start to smoke every year, even though it is illegal to sell cigarettes to anyone below the age of 18.
- 5.5 Two thirds of smokers say they began to smoke before they were legally old enough to buy cigarettes.² Research shows that by the age of 20, four fifths of smokers regret they ever started. Growing up around smoke puts children at a major health disadvantage in life. Children exposed to tobacco smoke are at much greater risk of cot death, meningitis, lung infections and ear disease, resulting in around 10,000 hospital admissions each year.³
- 5.6 Although smoking has fallen from 40% to 20% since 1980, there has been little change within our poorest communities and smoking is responsible for half the difference in life expectancy between the richest and poorest.
- 5.7 Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities. About half of all smokers in England work in routine and manual occupations. Workers in manual and routine jobs are twice as likely to smoke as those in managerial and professional roles. The poorer and more disadvantaged you are, the more likely you are to smoke and as a result to suffer smoking-related disease. Ill-health caused by smoking is therefore much more common amongst the poorest and most disadvantaged in society.
- 5.8 Smoking rates are also higher among particular ethnic groups, the prevalence rate among Afro-Caribbean men is 37% and among Bangladeshi men it is 36%.⁴
- 5.9 The annual cost of smoking to the UK national economy has been estimated at £13.7 billion. A smoker consuming a pack of twenty cigarettes a day will spend around £2,500 a year on their habit. Based on 2009 prices, poorer smokers proportionately spend five times as much of their weekly household budget on smoking than do richer smokers. If poorer smokers quit they are more likely to spend the money they save in their local communities.⁵

² Office for National Statistics, *General Lifestyle Survey 2011, Chapter 1 Smoking*, <http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2011/rpt-chapter-1.html> (Accessed 11th April 2013)

³ *Smoking: Children*, <http://www.ash.org.uk/localtoolkit/docs/cldr-briefings/Children.pdf> (Accessed 11th April 2013)

⁴ ASH, *Smoking Statistics Who Smokes and How Much*, http://www.ash.org.uk/files/documents/ASH_106.pdf (Accessed 11th April 2013)

⁵ ASH, *The Economics of Tobacco*, http://www.ash.org.uk/files/documents/ASH_121.pdf (Accessed 11th April 2013)

- 5.10 Reducing smoking prevalence and preventing the uptake of smoking among young people remains a challenge in Lewisham.

6. The Local Government Declaration on Tobacco Control

6.1 In May, Newcastle City Council passed a declaration setting out our commitment to tackle the harm smoking causes our communities. This has become known as the Local Government Declaration on Tobacco Control and been endorsed by, among others, the Public Health Minister, Chief Medical Officer and Public Health England. Since then many other councils from across the country have joined Newcastle in signing the declaration.

6.2 Councillor Nick Forbes, Leader of Newcastle City Council, has invited Lewisham Council to sign up to the Declaration.

6.3 The Parliamentary launch of the Local Government Declaration on Tobacco Control is on Wednesday 11th December and Lewisham has been invited to attend.

6.4 The Declaration commits local authorities to take concerted action to protect their communities from the harm tobacco causes. It has been developed to provide a very visible opportunity for local government to:

- publically acknowledge the significant challenge facing us;
- voluntarily demonstrate a commitment to take action;
- publish a statement of its dedication to protect local communities from the harm caused by smoking.

6.5 The Declaration includes a specific and important commitment to protect health policy from the influence of the tobacco industry. Neil Forbes, Newcastle City Council Leader states that:

'This is an obligation already placed on local authorities through the World Health Organisation treaty on tobacco, however the Declaration reminds us of our obligations and restates our commitment.'

6.6 Neil Forbes also emphasises that the Declaration is about taking effective action against threats from the tobacco industry:

'In the past there have been examples of local councils allowing tobacco companies inappropriate access through, for example, their funding of city academies, museums and smoking shelters on council property. This summer representatives of a British American Tobacco subsidiary contacted councils across England, almost certainly yours too, to speak to local councils about their tobacco harm reduction strategies. It is also true that almost all local government pension schemes in England have some investment in tobacco companies. I share the frustrations of many in public health regarding these investments, however our fiduciary duties makes effective action difficult. The greatest threat from the tobacco manufacturers comes not from investments by our pension fund managers but from their influence on our health policy.'

6.7 Signing the Declaration would commit the Council to the following actions:

- To act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- To develop plans with our partners and local communities to address the causes and impacts of tobacco use, according to our local priorities and secure maximum benefit for our communities;
- To participate in local and regional networks for support;
- To monitor the progress of our plans against our commitments and publish the results;
- To join the Smokefree Action Coalition;
- To protect our tobacco control strategies from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- To support the Government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities.

7. Financial Implications

- 7.1 Any activity undertaken to deliver the commitment as set out in the Declaration will be found from existing resources.

8. Legal Implications

- 8.1 There are no legal implications resulting from signing this declaration.

9. Crime and Disorder Implications

- 9.1 Activity to support the commitments included in the Declaration will seek to reduce illicit sales of tobacco and associated criminal gang activity.

10. Equalities Implications

- 10.1 This declaration will contribute to a reduction in smoking. Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities.

11. Environmental Implications

- 11.1 The main environmental implications from smoking are smoking litter (estimated at 40% of all litter) and indoor pollution, leading to passive smoking. Reducing smoking prevalence would lead to a decrease in both indoor pollution and outdoor smoking litter.

If there are any queries on this report please contact **Jane Miller, Deputy Director of Public Health** on 020 8314 9058.



23 October 2013

Our reference: NF/KC/AS

Dear

Local Government Declaration on Tobacco Control

In May Newcastle City Council passed a declaration setting out our commitment to tackle the harm smoking causes our communities. This has become known as the Local Government Declaration on Tobacco Control and been endorsed by, among others, the Public Health Minister, Chief Medical Officer and Public Health England. I'd like to invite your council to join us and sign up to the Declaration.

The Declaration commits councils to:

- Reduce smoking prevalence and health inequalities
- Develop plans with partners and local communities
- Participate in local and regional networks
- Support Government action at national level
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Monitor the progress of our plans
- Join the Smokefree Action Coalition

Many of you may already have seen media coverage or attended a briefing about the Declaration. If you are not already planning to do so then I would like to invite you to join us and sign-up. Councils representing all the major parties have already taken a lead and signed up to the Declaration including Salford City Council, Warwickshire County Council and Bath & North East Somerset Council. I am keen that other councils have the opportunity to get involved ahead of a formal launch in early December in Parliament.

Tobacco remains the single greatest cause of preventable deaths in England – killing over 80,000 people every year, more people each year than obesity, alcohol, road accidents and illegal drug use put together.

Thousands of children also suffer harm as a result of smoking. Not only are 17,000 children under the age of five admitted to hospital every year as a result of passive smoking but cancer Research UK also estimate that 430 children in England start smoking every day.

Although smoking has fallen from 40% to 20% since 1980 there has been little change within our poorest communities and smoking is responsible for half the difference in life expectancy between the richest and poorest. There can be no doubt that, in the context of our public health responsibilities, smoking is the greatest challenge facing us today.

In response, this declaration has been developed to provide a very visible opportunity for local government: to publically acknowledge the significant challenge facing us; to voluntarily demonstrate a commitment to take action; and to publish a statement of our dedication to protect local communities from the harm caused by smoking.

The Declaration includes a specific and important commitment to protect health policy from the influence of the tobacco industry. This is an obligation already placed on local authorities through the World Health Organisation treaty on tobacco – however the Declaration reminds us of our obligations and restates our commitment.

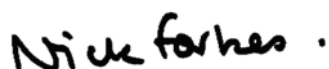
The threat is a real one. In the past there have been examples of local councils allowing tobacco companies inappropriate access through, for example, their funding of city academies, museums and smoking shelters on council property. This summer representatives of a British American Tobacco subsidiary contacted councils across England, almost certainly yours too, to speak to local councils about their tobacco harm reduction strategies.

It is also true that almost all local government pension schemes in England have some investment in tobacco companies. I share the frustrations of many in public health regarding these investments, however our fiduciary duties makes effective action difficult. The greatest threat from the tobacco manufacturers comes not from investments by our pension fund managers but from their influence on our health policy. This Declaration is about taking effective action against real threats.

I have attached a copy of the declaration for you to look at along with some additional information, which should answer any initial questions that you may have. Formal launch of the declaration will take place at the House of Commons on Wednesday 11 December, where the Health Minister and some of the councils who have already signed-up will be available to discuss why they considered it so important to give their support to this initiative.

If you would like any further information or details about the declaration or the launch event please do not hesitate to contact Hazel Cheeseman at Action on Smoking & Health at hazel.cheeseman@ash.org.uk or on 020 7404 0242; or Karen Christon at karen.christon@newcastle.gov.uk or on 0191 211 5024.

Yours sincerely



Councillor Nick Forbes
Leader of Newcastle City Council

Local Government Declaration on Tobacco Control

We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

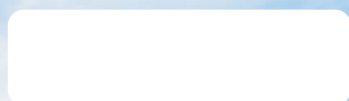
As local leaders in public health we welcome the:

- Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Commitment by the government to live up to its obligations as a party to the World Health Organization's Framework Convention on Tobacco Control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and
- Endorsement of this declaration by the Department of Health, Public Health England and professional bodies.

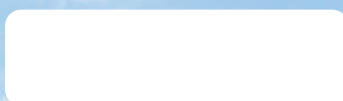
We commit our Council from this dateto:

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use;
- Participate in local and regional networks for support;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities;
- Protect our tobacco control work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Monitor the progress of our plans against our commitments and publish the results; and
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reduce the harm caused by tobacco.

Signatories



Leader of Council



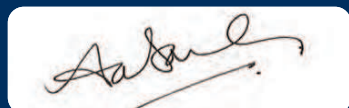
Chief Executive



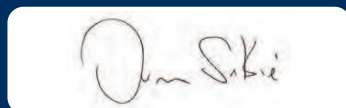
Director of Public Health

Endorsed by

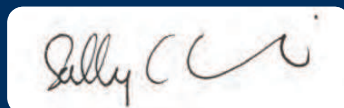
Anna Soubry, Public Health Minister,
Department of Health



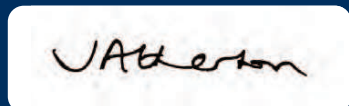
Duncan Selbie, Chief Executive,
Public Health England



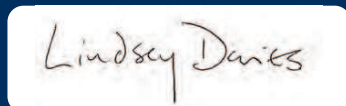
Professor Dame Sally Davies, Chief Medical
Officer, Department of Health



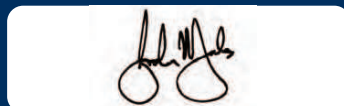
Dr Janet Atherton, President, Association
of Directors of Public Health



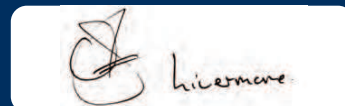
Dr Lindsey Davies, President, UK Faculty
of Public Health



Graham Jukes, Chief Executive, Chartered
Institute of Environmental Health



Leon Livermore, Chief Executive, Trading
Standards Institute





A Better Start

A bid for between £30 - £50million over 10 years, to achieve:

•A **step change** in outcomes for 0-3 year olds and their families, specifically in the areas of:

- Diet and nutrition
- Speech and communication
- Social and emotional wellbeing

•A **system change** that provides the evidence for early intervention and preventative activity and results in communities empowered to support parents-to-be, parents, young families and their children

•A commensurate **reduction** in the need for reactive or remedial interventions from statutory organisations



The developing child and toxic stress

Lewisham's bid is through to the final 15. It proposes intensive activity in four wards: Bellingham, Downham, Evelyn and New Cross.

Although the outcomes for 0-3 year olds are pre-eminent, the successful bid needs to focus on the health, wellbeing and preparedness of parents and future parents as well as the environment in which parents and young families operate.

http://developingchild.harvard.edu/resources/multimedia/videos/theory_of_change/



Our proposal

Improving outcomes for children is everyone's business.

In Lewisham, we have made significant advances in the way organisations work together to improve outcomes. We can now work alongside all our communities so that they recognise the crucial role they play in supporting families and young people.

Investment will:

- provide support and skills to parents-to-be
- develop community resources and expertise
- encourage healthy, safe and supporting environments
- tailor healthcare and other local services, including early years providers, so that they respond early and in a way that best meets the needs of the child and the carers



A Better Start

Work now underway to develop the final bid:

- Designing a portfolio of interventions and programmes
- Mapping local investment in 0-3 year olds
- Engaging the local community in designing and planning the investment
- Engaging wider stakeholders to ensure that activity complements what already exists and operates holistically
- Trialling some interventions now – our 'early adopters'

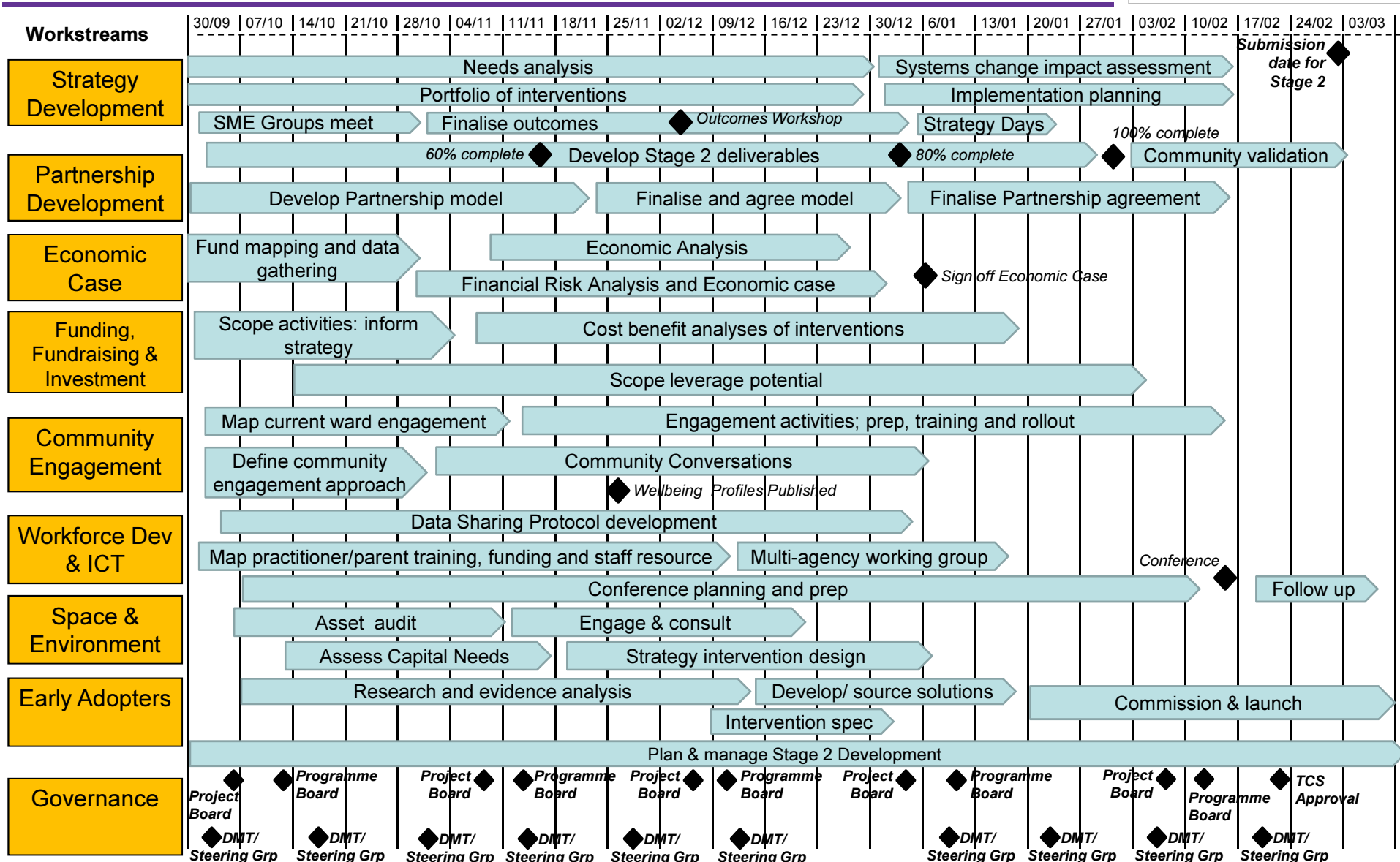
Deadline for applications – 28 February 2014

A Better Start for Lewisham Plan

We are here



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What do we need to demonstrate

- That we have strong **partnership working** and **senior commitment** from across a range of agencies and groups who are partners in the project – we need to demonstrate this both in how we work together through the development process as well as the inputs to the bids
- That we have an in-depth understanding of local needs and that our proposed interventions will be **community-based** and **meet local needs**
- That our interventions are **scientific** (unproven but based on scientific evidence) **or evidence-based** (proven)
- interventions are **located within the community** and will respond to **local needs**
- That our interventions are **congruous with local policy** of all partners – they will fit with, and improve, existing provision
- That our approach is **outcomes-based** and will fit with the outcomes desired by A Better Start
- That we have **clear delivery plans** in place, have secured suitable resources and infrastructure for delivery, and our approach will be **feasible** and **sustainable**
- That we have identified and secured other **sources of funding**
- That, if successful, we will be able to work with the evaluator to define what works well where, including how we will **estimate and measure our reach** to people in different ethnic, racial, socio-economic, gender, sexual orientation, and age categories.



What our partnership can do

- Ensure that our understanding of local needs, draws upon the expertise and working practice of partner organisations
- Consider whether there are innovative, evidence-based interventions that could be expanded in these four wards
- Participate in the resource mapping exercise so that we have a clear understanding as to the existing level of investment
- Attend our 'A Better Start' conference in February 2014
- Support around the forthcoming 'Strategy day'

Agenda Item 12

HEALTH AND WELLBEING BOARD			
Report Title	Health and Wellbeing Board Work Programme		
Contributors	Service Manager – Strategy, Directorate for Community Services	Item No.	12
Class	Part 1	Date: 19 November 2013	

1. Purpose

- 1.1 This report presents the Health and Wellbeing Board with a draft work programme (included as Appendix 1) for discussion and approval.

2. Recommendations

- 2.1 Members of the Health and Wellbeing Board are invited to:

- note the current draft of the work programme and consider whether amends or additions are necessary;
- approve the work programme;
- agree that the work programme will be considered as a standing item at each meeting of the Health and Wellbeing Board.

3. Policy context

- 3.1 The activity of the Health and Wellbeing Board is focussed on delivering the strategic vision for Lewisham as established in *Shaping our Future* – Lewisham’s Sustainable Community Strategy and in Lewisham’s Health and Wellbeing Strategy.
- 3.2 The work of the Board directly contributes to Shaping our future’s priority outcome that communities in Lewisham should be Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing.

4. Work programme

- 4.1 The work programme will be a key document for the Health and Wellbeing Board. It will allow the Board to schedule activity, reports and presentations across the year. It will also provide members of the public and wider stakeholders with a clear picture of the Board's planned activity.
- 4.2 The draft work programme (see Appendix 1), includes some of the key items which the Board will need to consider over the course of 2013/14. This includes the Board's statutory functions in regard to the Joint Strategic Needs Assessment, the Pharmaceutical Needs Assessment and the Health and Wellbeing Strategy.
- 4.3 It is proposed that the work programme is reviewed as a standing item at each meeting of the Board. This will allow members of the Board to add, amend or reschedule items as necessary.
- 4.4 In adding items to the work programme, the Board should specify the information and analysis required in the report, so that report authors are clear as to what is required. The Health and Wellbeing Board Agenda Planning Group may also propose items for inclusion on the work programme, and will seek approval for their inclusion from the Board.
- 4.5 Upon agreement of the work programme, the Health and Wellbeing Agenda Planning group will commission the necessary reports and activities.

5. Financial implications

- 5.1 There are no specific financial implications arising from this report or its recommendations.

6. Legal implications

- 6.1 The Board's statutory functions are broadly set out in paragraph 4.2.
- 6.2 The Equality Act 2010 (the Act) introduced a new public sector equality duty (the equality duty or the duty). It covers the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.
- 6.3 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.
- 6.4 The duty continues to be a “have regard duty”, and the weight to be attached to it is a matter for the Mayor, bearing in mind the issues of relevance and proportionality. It is not an absolute requirement to eliminate unlawful discrimination, advance equality of opportunity or foster good relations.
- 6.5 The Equality and Human Rights Commission has recently issued Technical Guidance on the Public Sector Equality Duty and statutory guidance entitled “Equality Act 2010 Services, Public Functions & Associations Statutory Code of Practice”. The Council must have regard to the statutory code in so far as it relates to the duty and attention is drawn to Chapter 11 which deals particularly with the equality duty. The Technical Guidance also covers what public authorities should do to meet the duty. This includes steps that are legally required, as well as recommended actions. The guidance does not have statutory force but nonetheless regard should be had to it, as failure to do so without compelling reason would be of evidential value. The statutory code and the technical guidance can be found at: <http://www.equalityhumanrights.com/legal-and-policy/equalityact/equality-act-codes-of-practice-and-technical-guidance/>
- 6.6 The Equality and Human Rights Commission (EHRC) has previously issued five guides for public authorities in England giving advice on the equality duty:
1. The essential guide to the public sector equality duty
 2. Meeting the equality duty in policy and decision-making
 3. Engagement and the equality duty
 4. Equality objectives and the equality duty
 5. Equality information and the equality duty
- 6.7 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. Further information and resources are available at: <http://www.equalityhumanrights.com/advice-and-guidance/publicsector-equality-duty/guidance-on-the-equality-duty/>
- 6.8 Members of the Board are reminded that under Section 195 Health and Social Care Act 2012, health and wellbeing boards are under a duty to encourage integrated working between the persons who arrange for health and social care services in the area.

7. Equalities implications

7.1 There are no specific equalities implications arising from this report or its recommendations.

8. Crime and disorder implications

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

9. Environmental implications

9.1 here are no specific environmental implications arising from this report or its recommendations.

Background documents

None

If there are any queries on this report please contact Carmel Langstaff, Service Manager – Strategy, Community Services, London Borough of Lewisham on 0208 314 9579 or by e-mail at carmel.langstaff@lewisham.gov.uk

Health and Wellbeing Board – Work Programme

Meeting date	Agenda Planning		Report Deadline		Agenda Publication		Minutes drafted by	
21 Jan 2014	Date TBC		Fri 3 Jan		Mon 13 Jan		Fri 3 Jan	
Agenda item	Report Title	Deferred?	Key decision or information	Part 1 or Part 2	Lead Organisation(s)	Author(s) / Presenter	Previous report pathway & date	Next report pathway & date
1	Update on progress against Health and Wellbeing Strategy Delivery Plan			Part 1	Delivery Group	Jane Miller / Danny Ruta		
	Integrated Adult Care Programme				Delivery Group	Sarah Wainer / Susanna Masters		
3	Learning Disabilities – Self Assessment			Part 1	LBL	Heather Hughes		
4	Public Health Budget	From 19 Nov		Part 1	LBL	Danny Ruta		
5	Sexual Health Strategy and associated spend			Part 1	CCG	Ruth Hutt		
6	Food Poverty			Part 1	LBL:	Danny Ruta		

7	Update on Health Protection			Part 1	LBL	Brid Nicholson		
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8	Healthwatch update			Part 1	Healthwatch	Healthwatch Chair		
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Meeting date	Agenda Planning		Report Deadline		Agenda Publication		Minutes drafted by	
25 March 2014	Date TBC		Fri 7 March		Mon 17 March		Fri 7 March	
Agenda item	Report Title	Deferred?	Key decision or information	Part 1 or Part 2	Lead Organisation(s)	Author(s) / Presenter	Previous report pathway & date	Next report pathway & date
1	Annual Public Health Report			Part 1	CCG / LBL	Danny Ruta		
2	Integrated Adult Care Programme			Part 1	LBL	Sarah Wainer / Susanna Masters		

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Meeting date	Agenda Planning		Report Deadline		Agenda Publication		Minutes drafted by	
23 Sept 2014	Date TBC		Fri 5 Sept		Mon 15 Sept		Fri 5 Sept	
Agenda item	Report Title	Deferred?	Key decision or information	Part 1 or Part 2	Lead Organisation(s)	Author(s) / Presenter	Previous report pathway & date	Next report pathway & date
1	Revised Pharmaceutical Needs Assessment for HWB approval			Part 1	PHE	Katrina McCormick / Danny Ruta		
2	Integrated Adult Care Programme			Part 1	LBL	Sarah Wainer / Susanna Masters		

