Public Document Pack

Health and Wellbeing Board Agenda

Tuesday, 28 January 2014
2.00 pm,
Committee Room 2 - Civic Suite
Civic Suite
Lewisham Town Hall
London SE6 4RU

For more information contact: Kalyan DasGupta (Tel: 020 8314 8378)

Part 1

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Health and Wellbeing Board
Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Tuesday, 28 January 2014.

Barry Quirk, Chief Executive
Monday, 20 January 2014

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 & Greenwich Healthcare NHS Trust
Jane Clegg	NHS England South London Area
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
Frankie Sulke	Directorate for Children and Young People

Health and Wellbeing Board
Agenda

Tuesday, 19 November 2013
1.00 pm,
Owen Theatre (Centre), University Hospital Lewisham, Lewisham High Street, London SE13
Civic Suite
Lewisham Town Hall
London SE6 4RU

For more information contact: Kalyan DasGupta (Tel: 020 8314 8378)

Part 1

Item **Pages**

1. Minutes of the last meeting and matters arising
The Chair welcomed Brendan Sarsfield as a new member of the Board.

Apologies were received from Dr Simon Parton and Frankie Sulke.

The minutes of 19 September 2013 were agreed as an accurate record.

There were no matters arising.

2. Declarations of Interest
Elizabeth Butler (Chair, Lewisham & Greenwich NHS Trust) explained that as her son has autism she had a non-pecuniary interest in Item 9 ("The 2010 Adult Autism Strategy *Fulfilling and Rewarding Lives* – Evaluating Progress").

3. Health and Wellbeing Board Membership
Carmel Langstaff (Service Manager, Policy and Strategy, Community Services, LBL) updated the Board regarding the now completed process to identify an additional voluntary and community sector representative. Peter Ramrayka of the Indo-Caribbean Organisation secured a majority of the votes at an election held at the Health and Social Care Forum in October.

The Board:

1. Agreed to submit a recommendation to appoint Peter Ramrayka to the Health and Wellbeing Board to full Council in January; and

Agreed to change the date of the next meeting to 28 January 2014, in

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order to facilitate the above submission to full Council prior to the next Health and Wellbeing Board.

4. Frail Older People in Lewisham: Local demography, health and social care use and literature review

Katrina McCormick (Deputy Director of Public Health, LBL) presented the report, with recommendations for action for discussion and approval.

The following points were highlighted in the discussion:

- Danny Ruta felt that successful integration would prevent needs escalating and support people to leave hospital sooner.

- Elizabeth Butler said the focus should be on ensuring people get the right intervention at the right time.

- Brendan Sarsfield asked Board members to consider what non-health services can do to support the identification of frail older people. Danny Ruta explained that the report recommends that further work is undertaken to develop a tool locally that could be used by a range of services. Marc Rowland suggested that existing tools could be utilised.

The Board:

- Noted the content of the review.

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

- Suggested that further consideration be given to developing appropriate identification and risk stratification tools in Lewisham.

5. Older People's Housing in Lewisham

Genevieve Macklin (Head of Strategic Housing, LBL) updated the Board on the Council's Older People's Housing Strategy. The Board was asked to make suggestions for the further development of the strategy and consider how more integrated working between housing, health and social care might achieve better outcomes for older residents.

The following points were highlighted in the presentation and discussion:

- The Council has a number of initiatives (for example Marine Wharf, Chiddingstone and Hazlehurst) to address the undersupply of extra care housing in the borough.

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- The “co-housing” model supports intergenerational living, facilitates entry into the property market and reintroduces the concept of the good neighbour. Community development work provides an important way of connecting communities who will support each other to stay independent.

- The increase in life expectancy is creating a challenge to the existing model of housing provision and will require a different approach.

- Handyman services need to be provided more quickly and be linked to the supply of specialist equipment.

- It was suggested that the Board consider the housing stock, across all types of tenure, and examine how changing needs are identified.

The Board:

- Noted the report; and

Agreed to further discussion at a future Board meeting on the impact of housing on health and well being.

6. CCG Commissioning Strategy

Charles Malcolm-Smith (Head of Strategy & Organisational Development, NHS Lewisham Clinical Commissioning Group) presented Lewisham CCG’s five-year Commissioning Strategy. The strategy sets out the vision and ambition of the CCG and includes an analysis of health needs, the financial situation and the views of the public. It identifies eight strategic priorities that are aligned with Lewisham’s Health & Wellbeing Strategy.

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 the Joint Commissioning Unit.

The Board:

- Noted the contents of the CCG’s Commissioning Strategy, its five- year vision, the case for change and the strategic priorities.

7. Integrated Adult Care Programme

Aileen Buckton, Executive Director for Community Services, LBL, presented the Programme Initiation Document for the Integrated Adult Care Programme and sought agreement on the scope of the programme, the proposed deliverables and the arrangements to take

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this work forward.

Aileen Buckton updated the Board on the status of the bid submitted to the Department of Health to become a Pioneer in health and social care integration. 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.

Aileen Buckton explained that £4.9m is available from the Integration Transformation Fund to support Lewisham's integration programme in 2013-14. In 2014-15, additional monies are proposed and Lewisham's total allocation is expected to be in the region of £5.9m. The specific amount to be transferred to Lewisham for 2015-16 has not yet been announced. The Board was asked to approve the budget for 2013-14. Detailed discussions are currently taking place between the CCG and the Council, and a proposal regarding the 2014-15 budget will be presented to the Health and Wellbeing Board for approval in January.

Next steps include:

- Leads and project groups for each of the proposed workstreams to be established.
- Each workstream to develop a project plan, ensuring that existing projects are aligned under the appropriate workstream.
- The Adult Integration Programme Board (AIPB) to identify critical dependencies to ensure that projects are prioritised appropriately.
- The AIPB to ensure that a robust evaluation framework is in place for the programme.
- A communications plan to be developed.
- Each project group to provide regular progress reports to the AIPB, the Health and Wellbeing Board and other key stakeholder boards.
- Detailed financial modelling will be undertaken as part of the programme.

The following points were highlighted in the discussion:

- The majority of resources from the Integration Transformation Fund (ITF) do not represent new money. ITF funding will be performance-related.
- The approach to integration needs to be understood and reiterated by partners including GPs in order to achieve culture change among professionals and residents.
- The programme needs to establish a whole system approach to achieve sustainable and cost effective change.
- The Government has identified a set of indicators to measure performance. Local measures will be developed to capture

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benefits of the preventative programmes.

- The benefits of healthy living should be publicised for Lewisham's residents through agreed common messages.
- Integration will remain on the Board's agenda for the next 2-3 years.

The Board:

- Agreed the Programme Initiation Document and noted the proposed next steps to take this work forward.

- Secured commitment from member organisations to engage with each workstream as and when necessary.

- Agreed the expenditure schedule to be submitted to NHS England regarding the spend in 2013/14.

- Noted the unsuccessful outcome of the Pioneer bid.

Agreed that the Adult Integration Programme Board would map the structures and strategies in place at the start of the programme.

Please note: In the Autumn Statement, the Integration Transformation Fund was re-named the 'Better Care Fund'.

8. Participatory Budgeting Schemes, North Lewisham Health Improvement Programme - Impact on Behaviour and Health Outcomes

Jane Miller (Deputy Director of Public Health, LBL) presented the report which outlined the contribution that the participatory budgeting schemes have made to improving health outcomes of the overall North Lewisham Health Improvement programme.

NICE guidance states that community engagement can improve health outcomes. Evidence from the five local schemes developed within the North Lewisham Health Improvement Programme demonstrates that allocating funding to community organisations is an effective way of engaging local communities and responding to their different needs. Improved health outcomes included: increased consumption of fruit and vegetables, increased levels of physical activity and improved mental wellbeing. The schemes also raised awareness of alcohol consumption and sign-posted users to the Stop Smoking Service.

As a result of the programme, a rich knowledge base about how to reach communities, raise awareness, change behaviour and improve health outcomes had been developed. In the discussion, members commented that it was important to utilise the knowledge and expertise on participatory budgeting that now exists in Lewisham.

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The Board:

- Noted the effectiveness of participatory budgeting in reaching communities, encouraging behaviour change and improving health outcomes.

- Agreed that the use of participatory budgeting schemes will be considered in the delivery of the Health and Wellbeing Strategy objectives and as part of the delivery of the Integrated Adult Care Programme.

Agreed to ensure that the learning about how to run participatory budgeting schemes effectively will be applied to new schemes.

9. The 2010 Adult Autism Strategy Fulfilling and Rewarding Lives - Evaluating Progress

Corinne Moocarme (Associate Director, Physical Disability, NHS Lewisham Clinical Commissioning Group, Joint Commissioning Unit) presented the report and explained that Directors of Adult Social Services had been requested by the Department of Health to take forward the second self-assessment exercise for the implementation of the Adult Autism Strategy. It is a requirement of this process that submissions are discussed by the local Health and Wellbeing Board by the end of January 2014. The returns will be analysed by the Public Health England learning disabilities observatory. All local responses will be published in full online.

The self-assessment highlights that Lewisham is looking to establish a community that accepts and understands autism and provide an infrastructure that supports adults with Autism/Asperger's syndrome to live fulfilling and rewarding lives. Corinne reported that there had already been several promising and innovative developments in response to the National Strategy. The Joint Commissioning Plan for Adults with Autism may need to be reviewed in light of the self-assessment.

Rita Craft (CLASH) made a brief presentation that outlined the need for specialist housing support for adults with Asperger's Syndrome and autism. CLASH felt that the work of the housing support group had stalled and explained that they had been informed that specialist housing is not available for high-functioning (autistic) adults. Rita argued that housing for autistic people, who are often economically very active, should be part of the Lewisham Housing Strategy.

The following points were highlighted in the discussion:

- The needs of people with autism are very varied and further work is needed to identify a range of appropriate housing options.
- Elizabeth Butler queried the range of opportunities and support

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available in the Borough to support employment of adults with autism. She felt it could not be a “one size fits all” approach as adults with autism had a wide range of different skills and abilities. Corinne referenced an autism-specific apprenticeship scheme at St Thomas’s Hospital, and said that as large employers (health and social care) we should all consider our duties towards inclusivity (especially with regard to apprenticeship schemes). Burgess Autistic Trust is actively working with potential employees to widen the range of job opportunities locally for adults with autism.
- In response to a query from Marc Rowland regarding the role of Primary Care in supporting the implementation of the Autism Strategy, Corinne referred to the recommendations contained in Dr Ratna Ganguly’s report *Autism in Lewisham*, (June 2013). This recommended a review of the needs of children and young people with autism spectrum disorder in transition and a regular audit of the number of people diagnosed with Autism. Corinne said that more work needed to be done to identify what sort of training primary care staff required and how best this could be provided.

The Board:

- Noted the content of the Lewisham Autism Self Assessment Framework and declared its support for local implementation work.

- Agreed that further work should be undertaken to identify a range of specialist housing options and that the housing section of the self-assessment should be expanded to give more detail on the work of the autism and housing project group.

- Agreed to establish a six-monthly cycle of updates to the Board, starting with an update on the Amber-rated indicators/areas of need.

10. Local Government Declaration on Tobacco Control

Jane Miller (Deputy Director of Public Health, LBL) presented the report. She explained the background to the Local Government Declaration on Tobacco Control and sought support for the London Borough of Lewisham to sign the declaration.

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

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vested interests of the tobacco industry
- Monitoring the progress of plans
- Joining the Smokefree Action Coalition.

Lewisham had been invited to attend the Parliamentary launch of the Local Government Declaration on Tobacco Control on 11 December.

The Board:

Agreed that it would be beneficial for the London Borough of Lewisham to sign the Local Government Declaration on Tobacco Control.

11. Fulfilling Lives - A Better Start: Big Lottery Fund bid

Ed Knowles (Service Manager - Commissioning and Strategy, Children and Young People) presented the proposal on the bid. He explained that the *Fulfilling Lives – A Better Start* is a Big Lottery Fund 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.

Lewisham's proposal has been shortlisted and work is now underway to develop the final bid. It proposes intensive activity in four wards: Bellingham, Downham, Evelyn and New Cross. The deadline for applications is 28 February 2014.

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.

The Board was invited to:

- Ensure that its understanding of local needs draws upon the expertise and working practice of partner organizations.

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- 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 of the existing level of investment.

- Attend 'A Better Start', the conference planned for February 2014.

- Provide support around the forthcoming strategy day.

The following points were highlighted in the discussion:

- The bid was welcomed as a positive development and should highlight Lewisham's track record of delivery.

- 4-year-olds are coming into schools with complex needs and evidence of this should be gathered from schools to support the bid.

The Board:

- Agreed to support the bid.

12. Health and Wellbeing Work Programme
Carmel Langstaff highlighted key reports from the upcoming programme for 2014, noting that the entries for May and July would be completed as items were proposed.

The Chair requested that Integration should always appear on the Board's agenda, and even if that is the only item, the meeting should be scheduled around it.

The Board:

- Requested that the work programme be amended to:
    - Ensure that integration is considered at every Health and Wellbeing Board meeting
    - Include an update on housing
    - Include 6-monthly updates on the Adult Autism Strategy.

The meeting ended at 15:10 hrs.

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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
Adrian Botto	Public
Aileen Buckton	Directorate for Community Services, London Borough of Lewisham
Mayor Sir Steve Bullock (Chair)	London Borough of Lewisham
Elizabeth Butler	Lewisham & Greenwich Healthcare NHS Trust
Martin Cheeseman	
Jane Clegg	NHS England South London Area
Rita Craft	Campaign in Lewisham for Autism Spectrum Housing
Kalyan DasGupta (Secretary)	
Mark Drinkwater	Voluntary Action Lewisham
Gunvanti Goding	King's Health Partners
Laura Harper	
Lorna Hughes	Lewisham Clinicial Commissioning Group
Carmel Langstaff	Strategy Improvement & Partnerships, CSD
Miriam Long	Healthwatch Lewisham
Genevieve Macklin	
Charles Malcolm-Smith	Lewisham Clinical Commissioning Group
Susanna Masters	Lewisham Clinical Commissioning Group
Katrina McCormick	Public Health Lewisham

Jane Miller	Public Health, LBL
Corinne Moocarme	
Tony Nickson	Voluntary Action Lewisham
Dr Simon Parton	Lewisham Local Medical Committee
Peter Ramrayka	Voluntary and Community Sector
Marc Rowland (Vice-Chair)	Lewisham Clinical Commissioning Group
Dr Danny Ruta	Public Health, London Borough of Lewisham
O Sandhou	Campaign in Lewisham for Autism Spectrum Housing
Brendan Sarsfield	Family Mosaic (Housing)
Frankie Sulke	Directorate for Children and Young People
Sarah Wainer	Directorate for Community Services, LBL
Martin Wilkinson	Lewisham CCG
William Wynn-Jones	Association of British Health Industries

HEALTH AND WELLBEING BOARD				
Report Title	Declarations of interest			
Contributors	Chief Executive – London Borough of Lewisham		Item No.	2
Class	Part 1	Date:	28 January 2014	

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)

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<tr><td>Report Title</td><td colspan="4">South East London Commissioning Strategy Programme</td></tr>
<tr><td>Contributors</td><td colspan="2">Head of Strategy & Organisational Development, NHS Lewisham Clinical Commissioning Group</td><td>Item No.</td><td>3</td></tr>
<tr><td>Class</td><td>Part 1</td><td>Date: 28 January 2014</td><td colspan="2"></td></tr>
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1. Purpose

1.1 All Clinical Commissioning Groups (CCGs) are expected to produce two year plans and five year strategies. In a context where some strategic change will need to be delivered across CCGs, the six CCGs in south east London are proposing to work together and with NHS England commissioners (specialised services and primary care), as well as developing their individual plans and strategies. This report presents an outline of the programme approach, strategic planning process, and governance arrangements.

2. Recommendation/s

Members of the Health and Wellbeing Board are invited to:

2.1 Note the contents of the South East London Commissioning Strategy Programme at Appendix A.

3. Policy Context

3.1 The NHS England programme ‘A Call to Action’ was launched in July 2013. It 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.

3.2 ‘A Call to Action’ has been followed by strategic and operational planning guidance. ‘Everyone Counts: Planning for Patients: 2014/15-2018/19’ that sets out a framework within which commissioners will need to work with providers and partners in local government to develop strong, robust and ambitious five year plans to secure the continuity of sustainable high quality care for all.

3.3 While each CCG is accountable for developing a Strategic, Operational and Financial plan, they may also choose to join with neighbouring CCGs in a larger ‘Unit of Planning’ to aggregate plans, ensure that the strategies align in a holistic way and maximise the value for money from the planning resources and support at their disposal.

4. South East London Commissioning Strategy Programme Overview

4.1 The strategy will build on the six individual CCG-level strategies developed locally. The CCGs will work collaboratively on the elements of the strategy that cannot be addressed at CCG level alone, or where there is common agreement that there is added value in working collectively.

4.2 Other aspects of the programme approach and vision include a focus on improving health and reducing inequalities, working with Health and Wellbeing boards, a commitment to public and patient engagement, delivering local health and integrated care services to ensure safety, quality and sustainability.

4.3 A high level description of the strategy approach was submitted to NHS England on 18 December 2013. A draft strategy needs to be submitted to NHS England by 04 April 2014 and the full strategy by 20 June 2014.

4.4 The governance structure for the strategy programme is shown at page 13 in Appendix A. It incorporates clinical commissioning leadership and alignment with Health and Wellbeing Boards, and involvement of representatives of local authorities and Public Health particularly through the South East London Partnership Group. The programme will also link to local Healthwatch teams in each borough.

8. Next Steps

8.1 The strategic ‘case for change’ is under development which will inform collective elements of the draft 5 year strategy. The draft strategy will be presented to the Board in March 2014.

9 Financial implications

9.1 A financial analysis is being undertaken as part of the strategic case for change.

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 The health needs analysis informing the development of the strategy is based on the local Joint Strategic Needs Analysis and CCG strategy which include the health inequalities implications for Lewisham's population.

13. Environmental Implications

13.1 There are no environmental implications arising from this report.

Background Documents

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

NHS England Strategic and Operational Planning 2014-19, 'Everyone Counts: Planning for Patients 2014/15-2018/19'
http://www.england.nhs.uk/ourwork/sop/

If there are any queries on this report please contact Charles Malcolm-Smith, Head of Strategy & Organisational Development, NHS Lewisham Clinical Commissioning Group, on 020-7206-3246, or by email at: charles.malcolm-smith@nhs.net

South East London Commissioning Strategy Programme - DRAFT

Version 3.0 – 15 January 2014

Introduction

All CCGs are expected to produce two year plans and five year strategies. In a context where some strategic change will need to be delivered across CCGs, the six CCGs in south east London are proposing to work together and with NHS England commissioners (specialised services and primary care), as well as developing their individual plans and strategies.

Building on the successful collaboration of the six south east London CCGs on the community-based care programme, the CCGs and NHS England commissioners, in close partnership with local providers and local authorities, are planning to develop and deliver a new five year commissioner-led, clinically-driven strategy programme across the boroughs. The aim is to address the challenges faced across the south east London health system by working together to deliver local health and integrated care services which meet safety and quality standards consistently and are sustainable in the longer term.

This will complement and build on the very specific work of each CCG with its local authority and other local partners and will address those issues which cannot be addressed by one CCG alone or where the CCGs agree that there is added value from working together.

The South East London Commissioning Strategy Programme will encompass the South East London response to NHS England's requirement to produce a five year strategy.

The purpose of this document is to outline the following aspects of the programme:

- Programme Approach and Vision
- The Strategic Planning Process
- Governance Arrangements

Please note that the contents of this pack are presented only to provide an update on the initiation activities of the South East London Commissioning Strategy Programme. They come from a variety of sources that are still in draft form and represent thinking and discussions that are still in progress.

South East London Commissioning Strategy Programme update

1) Approach and Vision

2) Strategic Planning Process

3) Governance Arrangements

Programme Approach

The approach will have a strong focus on engagement, aiming to co-design with partners, including patients and local people. Initial thinking will be developed and amended through the engagement process.

Key principles for the approach, which are being developed with partners, include:

- Being based on local needs and aspirations, listening to local voices and building on work at borough level, whilst taking into account national and London policies.
- Focusing on improving health and reducing inequalities.
- Employing a strong partnership approach, led by NHS commissioners and involving closely a wide range of local partners, including patients and communities, local authorities and NHS partners, to build agreement on priorities, strategic goals and outcomes.
- Creating solid foundations by ensuring all stakeholders have a common understanding of the scale of the challenge and then a shared vision and ambition for the next five years.
- Being open and transparent throughout the process, from identification of need, to implementation of the strategy.
- Engaging broadly, building on existing borough-level work with wider engagement activity to complement this as appropriate.
- Working with the Health and Wellbeing Board in each borough.

Following these principles, the South East London strategy will build on the six individual CCG-level strategies developed locally with partners. CCGs will work collaboratively on the elements of the strategy that cannot be addressed at CCG level alone, or where there is common agreement that there is added value in working collectively.

Engagement will be undertaken throughout the process, primarily through existing borough-level engagement, but on a wider basis where this is helpful. Initial engagement will include developing the case for change, scope and vision, the ambition of the programme and will move onto priorities and models of care as the programme develops. *(The draft strategy is being initiated before the conclusion of the NHS 'Call to Action' consultation in all boroughs. The work will be reviewed at the completion of this consultation to check alignment).*

In the nature of fast moving, iterative programmes, as the South East London Commissioning Strategy Programme works through the steps above the details of the vision and scope are currently constantly moving to reflect the feedback received at each stage of the engagement. As such, details contained in this pack are likely to evolve in the coming weeks and months as the strategies are finalised.

Programme Vision

Initial emerging themes on which the vision and scope will be based include:

- Engagement throughout to put the public and patient voice and views of other key stakeholders at the heart of strategy design and delivery.
- Co-designing and co-production of a shared strategy to improve the health and wellbeing of individuals and communities in each borough and across south east London, to meet local health and social care needs and to reduce local health inequalities.
- Delivering local health and integrated care services across south east London that consistently meet safety and quality standards and are sustainable.
- To maximise effectiveness of all activities across south east London, the programme takes account of existing or planned initiatives and alignment with overall strategic direction.
- Employing a "bottom up" approach to developing a south east London-wide ‘frame’ for individual CCG’s strategies, while also reflecting the national and London policy context.

South East London Commissioning Strategy Programme update

1) Vision, Scope and Scale of Challenge

2) Strategic Planning Process

3) Governance Arrangements

Introduction

The primary focus of the South East London Commissioning Strategy Programme is the design and implementation of the five year Commissioning Strategy for South East London covering the period 2014/15 to 2018/19.

In addition, with a view to maximising effectiveness of all change activities across South East London, the programme also takes account of other existing or planned initiatives, seeking to ensure alignment with overall strategic direction.

The purpose of this section of the document is to outline the following aspects of the programme:

- The relationship between the 5 Year Strategy and the Operational Planning Process
- A high-level view of the plan for the definition of the South East London 5 Year Strategy

South East London Five Year Strategy

Planning cycle and timetable

The five year strategy design and implementation cycle runs alongside the regular cycle of commissioning operational planning and delivery.

While the development of the CCGs' 2014/15 operational plans will be largely completed in advance of the initial draft strategy, future iterations will be heavily informed by the strategy and the need to deliver benefits as early in the five year cycle as possible.

Stakeholder, patient and public engagement will be built into the plan from the earliest stages of the design of the five year strategy, using existing borough-level and south east London-wide engagement routes.

The South East London Commissioning Strategy Programme will encompass the south east London response to NHS England's requirement to produce a five year strategy covering the period 2014/15 to 2018/19. It is currently at a very early stage, defining its overall scope and delivery approach.

NHS England has set some milestones:

A high level description of the approach is required by 18 December 2013 – this has been delivered.

A draft strategy needs to be submitted to NHS England by 04 April 2014 and the full strategy by 20 June 2014.

The first delivery project within the Commissioning Strategy Programme will focus on the development of the strategy by June 2014. The diagram overleaf shows how this development will be undertaken, in partnership with the programme's stakeholders.

Strategy Development Timetable

South East London Commissioning Strategy Programme update

1) Vision, Scope and Scale of Challenge

2) Strategic Planning Process

3) Governance Arrangements

Introduction

The South East London Commissioning Strategy Programme governance is designed to ensure a partnership approach to design and delivery, while remaining commissioner-led and clinically-driven and ensuring that the needs of local patients remain at the heart of the strategy.

The governance structure has been designed to be consistent with the NHS England Strategic Planning guidelines to support joint commissioning and strategic planning, building on well established collaborative relationships within the six boroughs and NHS England.

The structure will enable effective decision-making and oversight and clear ownership of deliverables and benefits at all stages of the programme. It will operate in an open and transparent manner, and takes account the voices of stakeholders across the South East London community.

The purpose of this section of the document is to outline the following aspects of the governance of the programme:

- Principles
- Structure and high-level memberships
- Key roles and functions
- Arrangements that will be put in place for collaboration and assurance.

Principles

The programme will contain a combination of contributing projects and workstreams at varying points in their lifecycle, each requiring slightly different treatment from a governance and operating perspective. The governance of the programme has been designed to take account of each of these stages:

- **Design –** focusing on envisioning, co-design and strategy development and service specification underpinned by good information and analytics
- **Implementation –** focusing on delivering agreed projects, programmes and service changes
- **Business as Usual (BAU) –** focusing on delivery as part of normal operations, with appropriate assurance and benefits management.

The governance approach is based on a number of overarching principles and assumptions:

- It is based on local needs and aspirations, building on work at a borough level
- Patient safety and quality must be at the heart of decision making
- Programme governance must be open and transparent, with opportunity for challenge by from local authorities, patients and public
- Decisions should take into account patients, carer and community voice
- The roles, responsibilities and accountabilities of the CCGs, NHSE and all partner organisations must be explicitly defined
- There should be clear points of accountability for all deliverables
- Programme governance should provide assurance that the anticipated benefits of the programme will be delivered
- The core programme will be responsible for ensuring that contributing projects and programmes deliver the planned benefits of the programme in line with the programme critical path and overall timetable
- Duplication of effort should be minimised across the health system.

Structure and high-level memberships

Collective Governance and Decision Making

Key advisory and collaborative bodies:
- South East London CCG Stakeholder Reference Group
- South East London Healthwatches
- South East London Health Overview and Scrutiny Committees
- External Clinical Advisory (as appropriate)

Programme Governance

South East London Partnership Group

Chair(s): 1 CCG Chair + Another (local authority/ provider, tbc)
Members: CCG Chairs & COs, Provider CEOs & MDs, local authority CEOs, representation from NTDA, NHSE, LAS, Public Health, LETB, HIN/AHSN

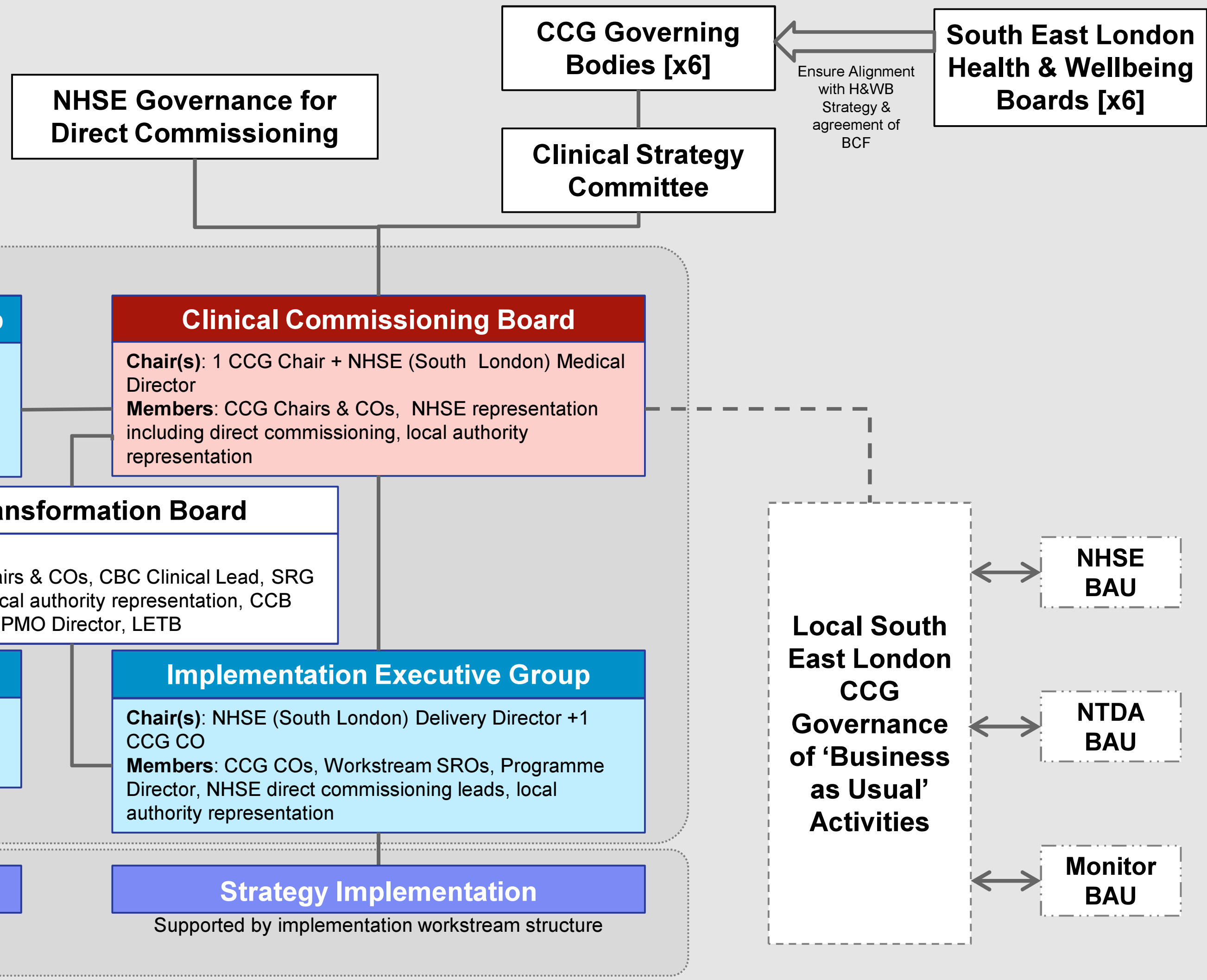
Clinical Executive Group

Chair(s): 1 CCG Chair + 1 secondary care MD
Members: CCG Chairs, Provider MDs, NHSE representation

Clinical Design

Supported by clinical design workstream structure

Programme Design & Implementation



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Notes & Abbreviations
BCF = Better Care Fund
NHSE = NHS England
NTDA = NHS Trust Development Authority
LAS = London Ambulance Service
LETB = Local Education and Training Boards
HIN = Health Innovation Network
AHSN = Academic Health Science Networks
MD = Medical Director, throughout
BAU = 'Business as Usual'
CBC = Community Based Care
SRG = Stakeholder Reference Group
CSC = Clinical Strategy Committee

Last Updated : 11/12/13

Key roles and functions

Key roles and functions within the governance structure are outlined below. The structure reflects initial planning guidance (NHSE, LGA, TDA and Monitor - 04 November 2013) including approach to joint working and units of planning. Structure and membership have been designed to best support the development of the Commissioning Strategy and it is likely that this will need to be revisited at key points in the programme lifecycle – in particular when the programme moves on to a delivery footing.

In South East London the function of the Strategic Planning Group will be primarily delivered through the Clinical Commissioning Board, supported by South East London Partnership Group and the Implementation Executive Group.

- The **Clinical Strategy Committee (CSC)** is a committee of each CCG Governing Body and provides the point of governance for CCGs for the five year strategy. There will be equivalent point of governance for services directly commissioned by NHSE.
- The programme will be led by the **Clinical Commissioning Board (CCB)**, which will act as the overall programme board. The CCB will be commissioner-led and clinically-driven and will steer and make decisions on the development and delivery of the strategy. Members of the CCB will have the authority to make decisions on the agreed scope of the programme on behalf of their respective organisations. All workstream SROs within the programme will be accountable to the CCB for delivering their agreed share of the benefits of the programme.
- The **South East London Partnership Group** will be the strategic and partnership forum for the programme. The Group will be clinically-led and will frame and shape the commissioning strategy on behalf of the CCB, providing collective system leadership and oversight to the programme. Key programme decisions will require the support of the Partnership Group.
- The **Clinical Executive Group (CEG)** will assist the Partnership Group with oversight of clinical design work by providing assurance and managing interdependencies across the individual clinical leadership groups. It will act as a conduit for the management and escalation of clinical risks.
- **Clinical Leadership Groups (CLGs)** will be responsible for clinical design work, ensuring that this takes into account national and London quality standards, clinical interdependencies, and clinical workforce implications. The groups will ensure that proposed models of care deliver safe and sustainable clinical services; and that clinical redesign projects have plans in place to deliver safe services during transition and change. CLGs will be managed as a clinical workstream and will report to the Clinical Executive Group.
- The **Implementation Executive Group (IEG)** will be the executive group supporting the CCB, providing oversight to planning, implementation, benefits realisation and assurance. The IEG will also steer the mobilisation workstream, and have an ongoing responsibility to make recommendations to the CCB on the optimal structure and scope of the programme.

Collaboration and assurance

The programme will include a number of advisory and collaborative bodies. Links will be established with these groups as appropriate as part of the mobilisation and ongoing delivery.

- **Health and Wellbeing Boards (HWBs)** will provide oversight, advice and input into the programme at borough level, focused on improvement of the health and wellbeing of their local populations, reducing health inequalities, and encouraging joined up working across commissioners.
- **Health Overview and Scrutiny Committees (HOSCs)** will provide local scrutiny and review in line with statutory requirements under the Local Government Act and Health and Social Care Act.
- The programme will link to the **South East London Stakeholder Reference Group** for advice and oversight in relation to engagement on the development of the Commissioning Strategy, in order to ensure that the views of patients, service users, the public and their representatives are heard and acted upon.
- The programme will link to local **Healthwatch** teams in each borough to ensure that proposals developed as part of the Commissioning Strategy take account of the voices of consumers and those who use services local health and social care services.
- An external **Clinical Advisory Group** will be established, if and as required at later stages in the programme, to ensure that any proposed clinical changes are designed in a manner that ensures wide ranging clinical engagement in service design and alignment with national and London-wide quality standards; and that clinical services will be safe and sustainable both during transition and post implementation.

Health and Wellbeing Board			
Report Title	**Developing an Integrated Approach to Public Health in South East London: Establishing an Urban Public Health Collaborative**		
Key Decision	No	Item No.	4
Ward	All		
Contributors	Executive Director for Community Services		
Class	Part 1	Date:	28 January 2014

1. Purpose

1.1 The purpose of this report is to update the Board on the progress made in establishing a public health collaborative across Lambeth, Southwark and Lewisham involving all key partners.

2. Recommendations

Members of the Health and Wellbeing Board are recommended to:

- Note the progress made in the first year of the programme;
- Consider how frequently it would like to receive future updates.

3. Policy Context

3.1 There are profound Public Health challenges facing the local population served by the London Boroughs of Lambeth, Southwark and Lewisham, by King's Health Partners (KHP), Lewisham & Greenwich NHS Trust, Primary Care providers, Clinical Commissioners and other stakeholders. There are also tremendous opportunities for these organisations to work with the local population in South East London to develop and deliver innovative interventions to reduce inequalities and improve the quality of care.

3.2 The South East London Collaborative is committed to co-designing, co-evaluating and co-implementing public health interventions specifically aimed delivering the Health and Wellbeing Strategies of Lambeth, Southwark and Lewisham Health & Wellbeing Boards.

4. Background

4.1 To make a really significant impact in reducing premature mortality and health inequalities in urban populations will require public health academics, practitioners, clinicians, clinical researchers, public servants, policy makers and local communities to work together to co-

design, co-evaluate and co-implement cost-effective complex public health interventions that are innovative and sustainable to scale.

4.2 Over the next five years the aim is to be recognised internationally for our academic and service innovation in Urban Public Health in addressing local and international issues, with a focus on inequalities in health and healthcare delivery, particularly with regard to ethnicity and deprivation. The vision will be delivered through the Urban Public Health Collaborative for South East London that will facilitate the design, evaluation and implementation of complex public health interventions by involving all stakeholders at every stage. The collaborative will provide a unique test bed to develop and test innovative solutions in prevention and management of long term conditions of Public Health importance.

4.3 With an academic base in King's College London, the Collaborative will allow us to:

- Build world class research capacity to develop and evaluate complex public health interventions;
- Provide the education and training opportunities necessary to equip all our local stakeholders with skills to engage in the design, evaluation and implementation of complex public health interventions;
- Provide a forum and resources for partners across Lambeth, Southwark and Lewisham to work together to design, evaluate and then implement large scale complex public health interventions across the populations and communities of South East London;
- Create the world's first Urban Public Health Collaborative on the principles of co-production.

4.4 **Structure and Governance of the Collaborative**

In October 2012, a public health programme office, headed by Professor Charles Wolfe, and supported by the Directors of Public Health for Lambeth and Southwark, and for Lewisham, was established within the School of Medicine, King's College London. Funded for two years by Guy's and St Thomas' Charity (£250,000, 2012-14), the programme office is staffed by a full time programme manager, Dr Gunvanti Goding and part time by Dr Danny Ruta, Director of Public Health for the London Borough of Lewisham.

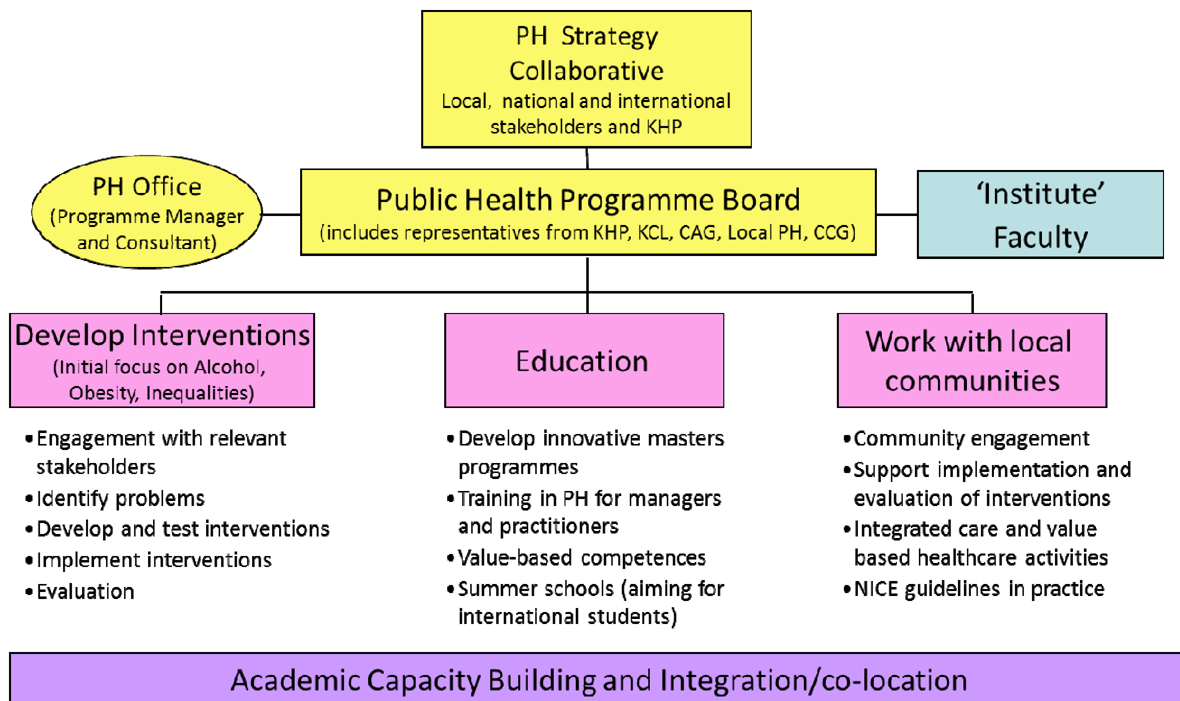
The Public Health Programme Office will support the South East London Public Health Programme Board in the delivery of Public Health Collaborative's strategy with the purpose of developing an integrated approach to public health across South East London. The Programme Board comprises the following members:

Professor Charles Wolfe (Chair), KHP Public Health Lead

Professor John Moxham, KHP Strategy Director
Ms Jill Lockett, KHP Director for Performance & Delivery
Mr Tim Higginson, Chief Executive, Lewisham & Greenwich NHS Trust
Mr Oliver Smith, Director of Strategy and Innovation, Guy's and St Thomas' Charity
Dr Chris Streather, Managing Director, South London Academic Health Science Network
Professor Colin Drummond, Institute of Psychiatry, KCL
Professor Peter Littlejohns, Division of Health and Social Care Research, KCL
Professor Toby Provost, Division of Health and Social Care Research, KCL
Professor Derek Bolton, Institute of Psychiatry, KCL
Dr Ruth Wallis, Director of Public Health, Lambeth and Southwark
Dr Danny Ruta, Consultant for KHP Public Health and Director of Public Health, Lewisham
Dr Gunvanti Goding, KHP Public Health

Four work streams overseen by the Programme Board have been established to: build research capacity; design and evaluate public health interventions; establish a public health education and training programme; and improve public health through community involvement (Figure 1).

Figure 1: Delivering the Public Health Strategy



4.5 The Collaborative was launched in April 2013 with representation from all three Boroughs (Leaders of the Boroughs, and Chairs of Clinical Commissioning Groups and Health & Wellbeing Boards), KHP and its Clinical Academic Groups (CAGs) as well as Public Health England

(PHE). Working relationships with the local partners have been agreed which include informal regular updates with the Chairs of the CCGs and Health & Wellbeing Boards as well as formal presentations twice a year at the meetings to the Boards. This will ensure that research and implementation priorities of the Collaborative are aligned to the three Boroughs' health and wellbeing strategies. Although the CCGs are not specifically represented on the Programme Board as planned, the CCG Chairs felt that such a mechanism will ensure cross-talk and alignment of priorities between the CCG Boards and the Collaborative.

4.6 **Building research capacity**

An Academic Group has been formed which aims to strengthen research capacity in public health by identifying current and future needs. Public Health is central to the recently funded Academic Health Sciences Network (AHSN) for South London and Collaboration for Leadership in Applied Health Research and Care (CLAHRC) and there is clearly a need for close collaboration between researchers, practitioners and communities that requires thought around physical co-location as part of the collaborative. The Academic Group has agreed that KCL and the Collaborative need to develop core Public Health capacity in both early translation public health methodologies (e.g. epidemiology and informatics, health economics and social science of translation) and late translational sciences. In addition, the development of a niche in Public Health intervention is central to the strategy and would make the Collaborative a USP.

The Collaborative now involves several Public Health specialists working part of their time or wholly at KHP and we have made several honorary positions relevant to the Collaborative, e.g. visiting Chairs to Gillian Leng (Deputy Chief Executive at NICE and Director of Health and Social Care) and Kalipso Chalkido (Director of International Programmes) from NICE; senior lectureships to Yvonne Doyle (Director of Public Health for NHS South of England) and Justin Varney (Consultant in Public Health Medicine) from PHE. Other people working closely with the Collaborative through different work streams are Ingrid Wolfe (Paediatrician), Anatole Menon-Johansson (Consultant in GUM/HIV), Marius Terblanche (consultant in Critical Care Medicine) and Marlies Ostermann (Consultant in Nephrology and Critical Care) all from GSTT and Allison Streetly (Deputy Director Healthcare Public Health) from PHE. Space is also available for local authority public health staff to work with academics in KCL and currently two Lewisham public health staff (Alfred Banya and Frances Fuller) are working with King's public health team.

The ways of working of the Collaborative that have been agreed by all groups are outlined in Figure 2. The key is that individual groups work in their current locations and departments in separate organisations and that we have a 'Collaborative space' innovatively designed to maximise the chances of interdisciplinary working. KCL has identified the building Public Health is to be relocated to and there is space for collaborators

from KCL, the Boroughs, CLAHRC, and AHSN along with the CAG members.

4.7 **Designing and evaluating public health interventions**

With a tenet of co-production, the Collaborative will facilitate the development and evaluations of research and intervention bringing together both the public health academic and service professionals. An Interventions Group has been set up to facilitate the co-production of interventions in health priority areas identified by the LSL Health and Wellbeing Boards. The initial focus is on interventions to reduce the harm caused by alcohol, lack of activity/obesity, smoking. Funded evaluations include: alcohol screening training for staff, and improving the uptake of National Institute for Health and Clinical Excellence (NICE) Public Health guidance.

A workshop in March 2013 brought together service and academic practitioners to discuss ways of working together in the spirit of collaboration and co-production of public health interventions. A second workshop is planned on 22nd November 2013 to discuss, plan and co-develop specific proposal(s) for submission to MRC Public Health Intervention Development scheme and NIHR programmes.

4.8 **Establishing a public health education and training programme**

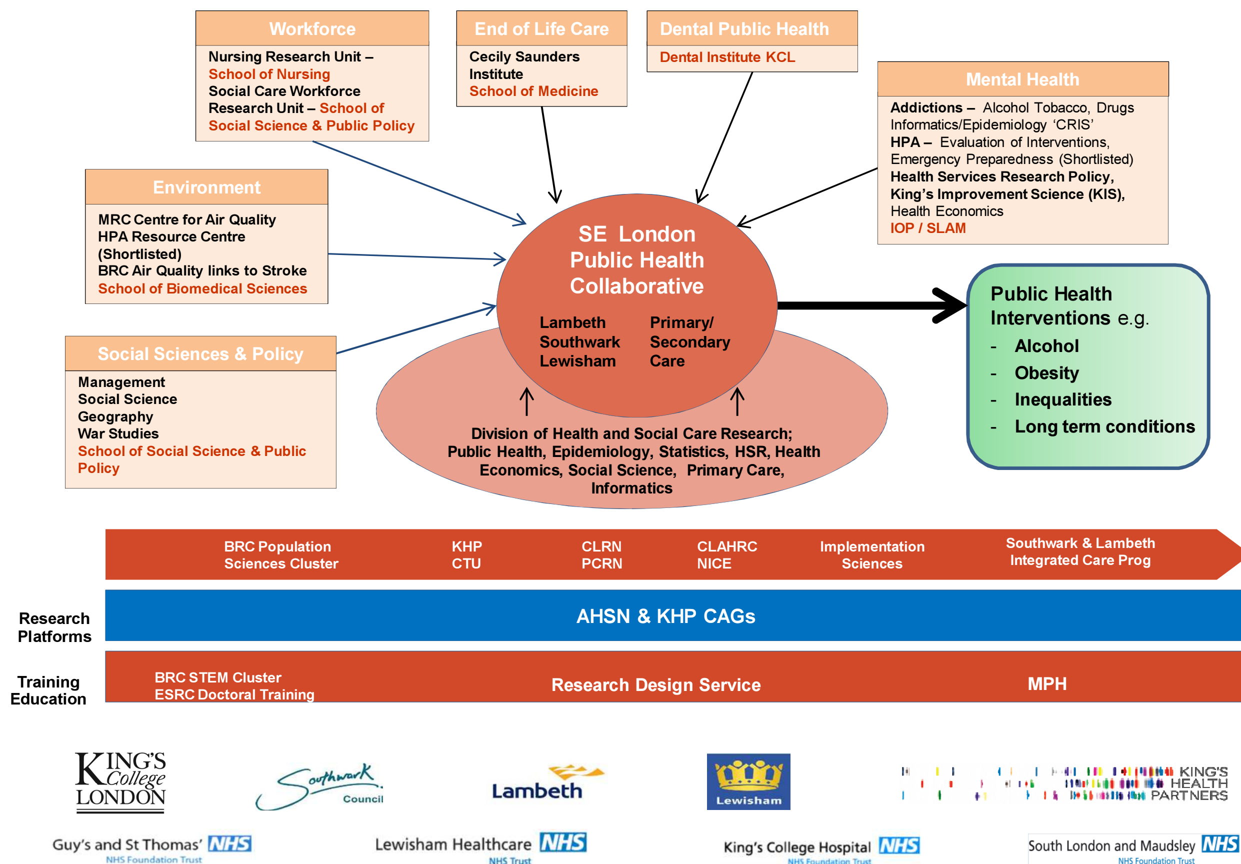
Discussions with CAG leaders and public health service staff have identified a need for opportunities in educational programmes to support the design, implementation and evaluation of complex public health interventions and other key public health knowledge and skills, particularly for local health and social care professionals (managers, doctors and nurses). The Training and Education Group is exploring the development and delivery of a pilot public health education opportunity (PHEO) through a mixture of distance learning as well as face to face peer meetings and supervision. Such PHEOs will equip practitioners to undertake their own public health research as well as quality improvement projects. In collaboration with the Alcohol team a training App is being developed which will teach general health professionals and non-NHS professionals (e.g. social workers, school teachers) how to deliver a brief alcohol intervention. Filming for the App has completed and will be ready for piloting early next year.

4.9 **Improve public health through community involvement**

We have set up a Community Involvement Group to support the development and evaluation of models of community interventions by harnessing community and lay knowledge. The Group includes academic and service providers and citizens' groups, and will provide a forum for working in partnership to achieve improvements across a range of population outcomes as well as reduce inequality and enhance social capital. Funded projects in this area include community engagement in adolescents with Citizens UK.

Meaningful and effective community involvement will require dedicated resources to bring diverse sections of the communities of Lambeth, Southwark and Lewisham together, for example to fund event hire, travel, childcare etc. A number of potential research projects are emerging which will require external funding.

Figure 2: South East London Public Health Collaborative



South East London Public Health Collaborative - Public Health Programme Office
Nov 2013

5. Financial implications

5.1 The cost of engaging in these arrangements (staff time etc) will be met from existing budgets.

5.2 Sharing expertise and learning will give Lewisham better value for money from the research that we undertake or fund, though it won't necessarily reduce the cost of that research.

5.3 Changes in provision made as a result of what we learn will have an impact on the health of residents in the borough in the future but it is

too soon to say what the financial impact of that will be on the cost of health and social care provision.

6. Legal implications

6.1 There are no legal implications arising from this report.

7. Crime and Disorder Implications

7.1 Complex public health interventions are likely to have a positive impact on crime and community safety by enhancing community resilience.

8. Equalities Implications

8.1 All public health interventions will be designed specifically to reduce health inequalities. A co-production / community development approach will underpin all the Collaborative's work; this will ensure a focus on addressing the needs of the most disadvantaged in our communities.

9. Environmental Implications

9.1 It is possible that some of the public health interventions may have a direct, positive impact on the environment.

10. Conclusion

10.1 It is hoped that a successful Urban Public Health Collaborative in South East London will allow us to:

- Build world class research capacity to develop and evaluate complex public health interventions;
- Provide the education and training opportunities necessary to equip all our local stakeholders with skills to engage in the design, evaluation and implementation of complex public health interventions;
- Provide a forum and resources for partners across Lambeth, Southwark and Lewisham to work together to design, evaluate and then implement large scale complex public health interventions across the populations and communities of South East London;
- Create the world's first Urban Public Health Collaborative on the principles of co-production.

Background Documents

Establishing an Urban Public Health Collaborative:
http://www.kcl.ac.uk/medicine/research/divisions/hscr/about/publichealth/index.aspx

If there are any queries on this report please contact Dr Danny Ruta, Director of Public Health, Community Services Directorate, London Borough of Lewisham on 020 8314 9094.

HEALTH AND WELLBEING BOARD				
Report Title	**Integrated Health and Social Care – Better Care Fund (BCF)**			
Contributors	Executive Director for Community Services and Chief Officer, Lewisham Clinical Commissioning Group		Item No.	5
Class	Part 1	Date: 28 January 2013		

1. Purpose

1.1 This report provides members of the Health and Wellbeing Board with background information on the Better Care Fund (formerly known as the Integration Transformation Fund) and seeks agreement on the proposed areas of spend. The report also outlines the required next steps.

2. Recommendations

2.1 Members of the Health and Wellbeing Board are recommended to:

- Note the indicative BCF allocation for Lewisham;
- Agree the proposed areas of BCF spend to enable officers to complete the first draft of BCF template;
- Consider which additional local outcomes measure they wish to select as part of the BCF submission;
- Note the timetable for submission of the draft and final BCF plan;
- Agree that the Executive Director for Community Services, Lewisham Council and the Chief Officer, Lewisham Clinical Commissioning Group be asked to complete the BCF template and submit a first draft to NHS England and the LGA;
- Note that a final draft will be presented to the Health and Wellbeing Board for approval on 25 March 2014, prior to the BCF submission deadline of 4 April 2014.

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 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.

4. Background

4.1 The Better Care Fund was announced as part of the 2013 Spending Round. The document stated that 'the Government will introduce a £3.8 billion pooled budget for health and social care services, shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people'.

4.2 The Government also announced an extra £200m to be transferred from health to social care in 2014/15. The associated guidance states that Councils should use the additional £200m to prepare for the implementation of pooled budgets in April 2015 and to make early progress against the national conditions and the performance measures set out in the locally agreed plan.

4.3 The tables below summarise the elements of the Spending Round announcement on the Fund:

2014/15	**2015/16**
A further £200m transfer from the NHS to adult social care, in addition to the £900m transfer already planned	£3.8bn to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the Fund will be created from:
£1.9bn of NHS funding
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. This will comprise: • £130m Carers' Break funding • £300m CCG reablement funding • £354m capital funding (including £220m Disabled Facilities Grant) • £1.1bn existing transfer from health to adult social care.

4.4 Members are asked to note that £1.9bn of the £3.8bn for 15/16 will be dependent on performance and local areas must set and monitor achievement of national and locally agreed outcomes during 2014/15 as a baseline for 2015/16.

4.5 The indicative allocations for Lewisham are:

2014/15	2015/16
£6.1m	£19.74m plus £1.374m from existing local authority capital

4.6 It is important to note that most of the additional funding that has been announced is not new money. The majority of funding to be transferred from the CCG to the Council is money that is already committed to existing services.

5. Lewisham's Adult Integrated Care Programme (AICP) and proposed use of the Better Care Fund

5.1 The Board will no doubt recall that Lewisham's approach to integration of service delivery focuses on impacting on and influencing the health and social wellbeing of all the borough's residents. This is reflected in the now very well established Children and Young People's Plan and in the recently agreed scope of the Adult Integrated Care Programme.

5.2 Lewisham's Adult Integrated Care Programme has three key strategic objectives:

- Better Health - to make choosing healthy living easier;
- Better Care - to provide the most effective personalised care and support where and when it is most needed;
- Stronger Communities - to build engaged, resilient and self-directing communities.

5.3 The Better Care Fund sits therefore as part of a wider strategy and approach and shapes how resources will be focused specifically on improving integrated services and outcomes for older and disabled residents who are in need of both health and social care services. As the focus of this work is to establish better coordinated and planned care closer to home, it relieves pressure on both acute services and use of emergency/crisis social care services.

5.4 In 14/15 it is proposed that the Fund be used to as follows:

Activity Area	£000's
SCAIT	507
Neighbourhood Teams - Staffing	2,107
Enablement (including Hospital Assessment Social Work Team and Lewisham Intermediate Care)	3,026
Other	50
LBL preparation for 7 day working including domiciliary care	70

work	
Promote Welcome Home support service to facilitate discharge	170
ICT	70
Project management	100
Total	**6,100**

5.5 In 15/16 it is proposed that the Fund be used as follows:

Activity Area	**£000's**
SCAIT	*507*
Neighbourhood Teams - Staffing	*2,145*
Enablement (including Hospital Assessment Social Work Team and Lewisham Intermediate Care)	*2,826*
Other	*50*
LBL preparation for 7 day working inc dom care work	*70*
Promote Welcome Home support service to facilitate discharge	*170*
ICT	*400*
Project management	*100*
Reablement - reviewing all other services to ensure they are effective	
- Reablement Pathway for clients referred to social services	45
- Single point of access	120
- In patient step down facility	653
- Early discharge of COPD patients	249
- Outpatient IV therapy	33
- Heart failure nursing	139
- Clinical assessment services	350
- Safeguarding	120
Carers - Review and improve existing services	776
Older people's services/ frail elderly. Redesign care pathway	10,986
Total sum to be transferred from Health	**19,739**
DFG	613
Capital	762
Total BCF budget	**21,114**

6. Outcomes Framework and Metrics

6.1 As part of the AICP, we have been working to develop a robust Outcomes Framework of measures that we intend to use to demonstrate clearly the level of local ambition for improvement of the Integrated Care Programme and to monitor our progress. This will then be used to monitor and assure the Health and Wellbeing Board that we are on track to deliver the locally agreed level of ambition.

6.2 In submitting our plans to access the BCF, the Outcomes Framework has to include the following five national metrics as a minimum:

National Metrics
• patient / service user experience (ASCOF 3A, NHOF 4) • admissions to residential and care homes (ASCOF 2A) • avoidable emergency admissions (NHOF 3A) • effectiveness of reablement (ASCOF 2E) • delayed transfers of care (ASCOF 2C)

6.3 We are also required to select one of the metrics from the menu below, or agree a local alternative.

Local Metrics
1. Proportion of people feeling supported to manage their (long term) condition (NHOF 2.1) 2. Estimated diagnosis rate for people with dementia (NHOF 2.6i and PH 4.16) 3. Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 / 120 days (NHOF 3.5) 4. Social care-related quality of life (ASCOF 1A and NHOF 2) 5. Proportion of adults in contact with secondary mental health services living independently with or without support *ASCOF 1H and PHOF 1.8) 6. Carer-reported quality of life (ASCOF 1D and NHOF 2.4) 7. Proportion of adult social care users who have as much social contact as they would like (ASCOF 1I) 8. Proportion of adults classified as “inactive” ((PHOF 2.13) 9. Injuries due to falls in people aged 65 and over (PHOF 2.24)

6.4 Each metric will be of equal value for the payment for the performance element of the Better Care Fund.

6.5 This work, of setting baselines and agreeing specific levels of ambition for the metrics, will be discussed by the Adult Integration Programme Board and recommendations presented to the Health and Wellbeing Board at its next meeting.

6.6 The Adult Integration Programme Board will consider a number of factors, when reviewing potential outcomes measures, such as:

- having a clear baseline against which to compare future performance;
- ensuring that the target is achievable, yet challenging enough to incentivise an improvement in integration and improved outcomes for users;
- understanding the long-run trend to ensure that the target does not purely reward improved performance consistent with trend increase; and
- ensuring that any seasonality in performance is taken into account.

6.7 Members of the Health and Wellbeing Board are asked to consider which additional local outcomes measure they wish to select as part of the Better Care Fund submission. To assist in this decision, the following points should be noted:

- Indicator 1 on managing long term conditions is subject to a review and may change;
- Indicators 2, 4, 5 and 6 are on more than one Outcome Framework.
- Most indicators are reported annually, except the carers indicator which is biennial, making interim monitoring difficult, and indicator 5 on mental health adults, which is available quarterly.

7. Accessing the Fund

7.1 To access the fund, Lewisham must complete a “good first draft” of the Better Care Fund template to NHS England and the LGA by 14 February 2014. A final version must be submitted to NHS England as part of the CCG’s Strategic and Operational Plan by 4 April 2014.

7.2 The plan must cover the two years 2014/15 to 2015/16 and set out how the funding will be used locally, subject to the following six national conditions:

- Plans for use of the fund must be jointly agreed and signed off by the Health and Wellbeing Board, and the CCG and Council. In agreeing the plan, CCGs and councils should engage with providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people.

- Local areas must include an explanation of how local adult social care services will be protected.

- Local areas must set out plans for 7-day services to support patients being discharged and prevent unnecessary admissions at weekends.

- Securing better data sharing between health and social care, based on the NHS number.

- Ensuring a joint approach to assessments and care planning.

- Agreement on the impact of changes on the acute sector.

8. Financial implications

8.1 This report describes proposals for use of sums transferred from health. In 2013/14 the transferred sum is £4.89m for which the Health and Wellbeing Board approved expenditure proposals at its November meeting.

8.2 In 2014/15 this increases by £1.14m. As in 2013/14, this will be paid via a S256 agreement. Specific proposals for the use of the total sum are shown above. These build on 2013/14 plans but with some funding applied to the preparation for further integration in 2015/16.

8.3 From 2015/16 arrangements will change. The transferred sum increases (to £19.74m locally) and will be managed through a S75 arrangement in a pooled budget which will also contain two sources of funding currently paid direct to the Council : disabled facilities grant and adult social care capital grant. The total sum, now known as the Better Care Fund, is the minimum for pooling but both the CCG and the Council can pool greater amounts if they choose.

8.4 These arrangements are intended to improve performance on a range of indicators and retention of part of the transferred sum will be dependent on this improvement. The sum transferred from health is presented in the Council's financial settlement as new funding but members should note that the majority is not increased funding to the system; increases in funding to the Council are matched by equivalent reductions in funding to the CCG.

8.5 Specific plans for the 2015/16 financial year have not yet been developed. However given the requirement for adult social care to contribute to savings of £22m (to the Council's overall £85m savings target), and for the CCG to deliver savings of £25m by March 2016 and thereafter in the region of £10m per annum, the plans will need to support the largest possible contributions to these savings. The Better Care Fund can be used to maintain services that would otherwise need to be reduced or ended, and part will need to be used in this way.

Further, part will need to be used to prepare for implementation of the Care Bill.

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.

9.2 The legal framework under which the NHS is transferring funds to the Authority is S256 of the National Health Service Act 2006 (the Act). The paying NHS body must be satisfied that the payment secures an effective use of public funds. This is usually managed through a Memorandum of Understanding which is likely to be agreed with the CCG.

9.3 Where there is an integration of services and or joint funding, then this is dealt with under an agreement under S 75 of the Act which sets out the governance arrangements for the delivery of services, and where relevant any delegation of functions from one party to another and the respective budget contributions of the local authority and the CCG in relation to the services.

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.

12. Environmental Implications

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

13. Conclusion

13.1 Officers will continue to develop the BCF plan and submit a first draft to NHS England and the LGA by 14 February 2014. A further report and final draft of the BCF plan will be presented to the Health and Wellbeing Board for approval in March, prior to its submission on 4 April.

If there are any queries on this report please contact Sarah Wainer, Head or Strategy, Improvement and Partnerships, Community Services Directorate, Lewisham Council, on 020 8314 9611 or by email sarah.wainer@lewisham.gov.uk.

Health and Wellbeing Board				
Report Title	**Update on Public Health Budget Spending Plans for 2014-15**			
Key Decision	Yes	Item No.	6	
Ward	All			
Contributors	Executive Director for Community Services (and others if appropriate)			
Class	Part 1	Date:	28th January 2014	

1. Purpose

1.1 The purpose of this report is to update the Health and Wellbeing Board on the Public Health budget allocation and proposed expenditure for 2014-15, and to seek support from the Board on proposed recommendations to Mayor and Cabinet for the allocation on additional investment for 2014-15.

2. Recommendation/s

The Board is recommended to:

2.1 Note the successful transfer of a wide range of Public Health responsibilities to the Council, together with a ring fenced budget.

2.2 Note the outcome of a review of contracts and cost pressures for 2014-15, and an intention to undertake a comprehensive contract review in the coming financial year.

2.3 Support the proposed recommendations to Mayor and Cabinet for the allocation of £200k of additional investment in the school age nursing service in 2014-15, and support the council's continued funding of free swimming.

3. Policy Context

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

4. Background

4.1 Lewisham public health functions transferred from the NHS to the London Borough of Lewisham in April 2013. The budget allocation from

the Department of Health was £19,541,000 for 2013/14, and £20,088,100 for 2014/15. Along with all public health staff, over 70 contracts were 'novated' across from the NHS to the Local Authority with a year extension until March 2014. These contracts were primarily NHS contracts, and although a small number were terminated, the remainder were extended to enable a smooth continuation of service delivery through and beyond the transition. The public health budget allows the Council to deliver a comprehensive range of mandatory and discretionary public health functions.

4.2 Public health mandatory functions include:

- Access to sexual health services
- National Child Measurement Programme
- NHS Health Check Programme
- Local health protection plan
- Public health advice to NHS commissioners/CCG

4.3 Public health discretionary functions include:

- Tobacco control and Stop Smoking Services
- Alcohol and drug misuse services
- Public health services for children and young people aged 5-19
- Interventions to tackle obesity such as community lifestyle and weight management services
- Locally-led nutrition initiatives
- Increasing levels of physical activity in the local population
- Public mental health services
- Dental public health services
- Accident injury prevention
- Local initiatives on workplace health
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- Behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- Public health aspects of promotion of community safety, violence prevention and response
- Public health aspects of local initiatives to tackle social exclusion

5. Budget spending plans for 2014/15

5.1 The focus of the public health transfer so far has been keeping 'business as usual' and this is consistent with the situation with public health teams across the country. The second year will be the time to "challenge and innovate". Nevertheless, the public health transfer has provided scope for a review of contracts. At the same time certain cost pressures have come to light, primarily prescribing costs which are now the responsibility of the Council.

5.2 The intention is that a more comprehensive contract review will be undertaken in the coming financial year and will include a consideration of alternative service providers, especially for the larger value contracts.

5.3 As a result of the contract review, and after accounting for cost pressures, £400k unallocated from the 2014-15 public health budget has been identified for investment in 2014-15. After reviewing all public health priorities against the Health and Wellbeing Strategy and with regard to the JSNA, a proposal to continue free swimming for children and adults over 60 years was considered and agreed by the Council as part of the 2014-15 budget process. It is further recommended that £200k is invested in the expansion of the School Age Nursing Service, subject to cost pressures, as part of the implementation of the national school age nursing strategy and the healthy child programme.

6. Financial implications

6.1 This report seeks approval for two additional commitments from the Public Health budget in 2014/15.

6.2 The first, £200K to support free swimming, has been considered and agreed by the Council as part of the 2014/15 budget process.

6.3 The second, £200k for the School Age Nursing Service, is a new proposal and increases the Council's overall net expenditure.

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

7. Legal implications

7.1 There are no legal implications arising from this report.

8. Crime and Disorder Implications

8.1 The recommended investments are likely to have a positive impact on crime and community safety by enhancing community resilience.

9. Equalities Implications

9.1 Both interventions will be designed specifically to reduce health inequalities. Free swimming, by removing the cost barrier, and universal access to school nurses will ensure a focus on addressing the needs of the most disadvantaged in our communities.

10. Environmental Implications

10.1 It is possible that some of the actions delivered may have a direct, positive impact on the environment.

11. Conclusion

11.1 Public health responsibilities have been successfully transferred to the Council in a way that has not destabilised existing services, has accommodated cost pressures, permitted some scope for reviewing contracts, and identified £400k for investment in key public health priority areas.

Background Documents

The Health and Wellbeing Strategy and supporting JSNA evidence may be found on www.lewishamjsna.org.uk

If there are any queries on this report please contact **Dr Danny Ruta**, **Director of Public Health**, 020 8314 ext 4909.

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1. Purpose

This report provides members of the Health and Wellbeing Board with a short update on the progress against the priority outcomes of Lewisham's Health and Wellbeing Strategy.

2. Recommendation

The Board is recommended to:

- note the progress made to date; and
- agree to receive another report from the Health and Wellbeing Strategy Group following their detailed review of each area of activity.

3. Policy Context

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.

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*.

In line with *Shaping our future*, the Health and Wellbeing Board has developed a ten year Health and Wellbeing Strategy. The Strategy sets out the improvements and changes that the Board, in partnership with others, will focus on to achieve our vision of "achieving a healthier and happier future for all".

The Strategy outlines the key health and wellbeing challenges that people in Lewisham face, as well as the assets, skills and services that are available locally to support people to stay healthy and be happier.

The Strategy sets three overarching aims:

- To improve health – by providing a wide range of support and opportunities to help adults and children to keep fit and healthy and reduce preventable ill health.
- To improve care – by ensuring that services and support are of high quality and accessible to all those who need them so that they can regain their best health and wellbeing and maintain their independence for as long as possible.
- To improve efficiency – by improving the way services are delivered; streamlining pathways; integrating services so ensuring that services provide good quality and value for money.

4. Background

Lewisham's Health and Wellbeing Strategy sets out the priority outcomes to be achieved by 2023. The supporting three year delivery plan, describing the key actions required, was published in September 2013.

The task for ensuring delivery of the action plan and for reporting on progress to the Health and Wellbeing Board was delegated to the Health and Wellbeing Delivery Group, chaired by the Director of Public Health. The Group has been tasked with regularly reviewing and refreshing the delivery plan, and ensuring that all actions are owned and reflected in all partners' strategic priorities.

5. Progress to date

The Delivery Group has undertaken an initial assessment of all actions within the three year delivery plan.

The plan details the activity being undertaken and planned for completion by March 2014. The Group has carried out a RAG rating and, of the 88 delivery actions agreed by the Board for delivery by end of March 2014, 75% (66) were rated Green, 20% (18) were rated Amber and 5% (4) were rated Red.

The Green rating has been given to all areas of activity that have been completed as required, e.g. Action- To improve staff skills on infant feeding by delivering training and audit staff skills: Progress - 26 Health Visitors and Midwives attended 2 day breastfeeding management training this year. Also 65 of the Health visiting team attended Baby Friendly training.

The Amber rating has been given to those areas of activity where action is being taken but where it has not yet been completed, where some activity has taken place but on a smaller scale than anticipated or where the scope of the activity is not as wide as desired. E.g. Action - To provide all practices with rapid HIV tests: Progress - Currently minimal uptake of rapid tests by practices. This is due to infrastructure issues. The Delivery Group will be

working with those responsible for delivery to establish what needs to be done to ensure the objective is achieved.

Four areas of activity have been rated as Red. This is where activity has been delayed and has not met the agreed timescale, is in hand but it is not clear that the action will be completed by March, or has not yet begun. E.g. Action - To promote images of 'Smokefree' and align local communications to national campaign on Smokefree: Progress – Communications strategy still under development. The four red ratings relate to the three following priority areas: reducing alcohol harm; preventing the uptake of smoking; and improving mental health and wellbeing. That is not to say that activity in these areas has not taken place but that some key actions, such as finalising the Smokefree communication strategy and the wider adoption of alcohol policies, have not progressed as planned.

At its next meeting, the Delivery Group will be asking those responsible for those actions rated red to provide reports on the reasons for the delay or non-delivery. The Group will seek to agree on remedial action. Where barriers continue to exist or where solutions cannot be found, the Group will highlight these in its report to the Health and Wellbeing Board.

6. Financial implications

There are no specific financial implications to the report. The majority of the work to support the Health and Wellbeing Delivery Plan is funded from the ring-fenced 2013/14 Public Health Grant.

However, failure to meet the health and wellbeing strategic objectives highlighted above within a timely fashion, particularly in relation to immunisations, reducing alcohol harm, smoking and mental health, could result in additional financial burdens being placed upon health and social care services in the short, medium and long term.

7. Legal implications

The Health & Wellbeing Board has a statutory obligation to develop and implement a Health and Wellbeing Strategy.

8. Crime and Disorder Implications

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

9. Equalities Implications

All interventions will be designed specifically to reduce health inequalities. A co-production / community development approach underpins all the strategic priorities; this will ensure a focus on addressing the needs of the most disadvantaged in our communities.

10. Environmental Implications

It is possible that some of the actions delivered, such as those on smoking cessation, may have a direct, positive impact on the environment.

11. Conclusion

Good progress is being made in delivering the Lewisham Health and Wellbeing Strategy. A continued focus needs to be made by the Board, the Health and Wellbeing Strategy Delivery Group and its relevant sub-groups, to performance manage and monitor delivery of the plan in 2014/15.

Background Documents

The Health and Wellbeing Strategy and supporting JSNA evidence may be found on www.lewishamjsna.org.uk

If there are any queries on this report please contact Dr Danny Ruta, Director of Public Health, 020 8314 9094 or by email danny.ruta@lewisham.gov.uk

HEALTH AND WELLBEING BOARD				
Report Title	Sexual Health Update			
Contributors	Ruth Hutt		Item No.	8
Class	Part 1 / Part 2	Date: 28 January 2014		

1. Purpose

1.1. The Purpose of this report is to provide an overview of sexual health in Lewisham, the current commissioning arrangements and the development of the tri-borough (Lewisham, Lambeth and Southwark) Sexual Health Strategy.

2. Recommendation/s

2.1. Members of the Health and Wellbeing Board are recommended to:

- Note the contents on the report.
- Contribute to the consultation on the Sexual Health Strategy.

3. Policy Context

3.1. From April 2013 Local Authorities took over the responsibility for commissioning sexual health services from Primary Care Trusts - *'Local Authorities will become responsible for commissioning comprehensive open-access accessible and confidential contraception and sexually transmitted infections (STIs) testing and treatment services, for the benefit of all persons of all ages present in the area*[1].

3.2. Commissioning of abortion, sterilisation and HIV care and support services is the responsibility of clinical commissioning groups.

3.3. Improving sexual health is identified as one of the 9 priorities of Lewisham's Health and Wellbeing Strategy. A summary of local sexual health needs is available on the Lewisham JSNA website http://www.lewishamjsna.org.uk/home/priority-outcomes/sexual-health

3.4. This paper supports the Sustainable Community Strategy principles of narrowing the gap in outcomes for citizens and delivering together efficiently, effectively and equitably – ensuring that all citizens have

[1] Public health in local government factsheet. Department of Health, 20 December 2011.

appropriate access to and choice of high-quality local services. It also links to the priority “Healthy, active and enjoyable”

4. Background

4.1. The neighbouring boroughs of Lambeth and Southwark have similar sexual health issues. A tri-borough commissioning arrangement was developed across the 3 boroughs post April 2013, which has ensured that the overview for all sexual health commissioning (including the services which are the responsibility of the CCGs) is held together and economies of scale can be achieved working with providers and across populations.

4.2. The governance of the new arrangements is overseen by a tri-borough commissioning board which includes representation from all 3 boroughs and CCGs. Each borough then has its own internal governance arrangements to their respective Health and Wellbeing Boards.

4.3. A new sexual health strategy is currently being developed to inform commissioning plans and service developments across the 3 boroughs. A needs assessment is currently being finalised which will inform the strategy.

4.4. London Councils Leaders made a decision in 2013 to commission a Londonwide HIV Prevention Programme which all boroughs will contribute to on a pro-rata basis based on their local HIV prevalence.

5. Acute Sexually Transmitted Infections

5.1. Lewisham has high levels of sexual health need. Diagnosis of acute sexually transmitted infections (STIs) has been rising over time following a similar trend across London and neighbouring boroughs. Rates of re-infection within 12 months are higher than nationally, and highest in 15-24 year olds. Thirty-five percent of men presenting to Genito-Urinary Medicine (GUM) clinics with an STI are men who have sex with men (MSM). Rates of gonorrhoea and syphilis are particularly high in this group. Over 80% of gonorrhoea and syphilis infections diagnosed in GUM clinics are in MSM.

5.2. In the 15-24 year old age group 9% of those tested for Chlamydia have the infection. Lewisham has one of the most successful Chlamydia screening programmes in the country. High rates of diagnosis are in part a reflection of high levels of screening activity as Chlamydia infection often has no symptoms.

6. HIV

6.1. Between 2007 and 2012 the number of people living with HIV in Lewisham has increased by 30%. The diagnosed prevalence rate is

7.9 per 1,000 (1509 individuals) the 8th highest in London (London rate is 5.5 per 1,000). Lambeth and Southwark have the highest rates of 14.4 and 12.2 per 1,000 respectively. HIV rates are increasing mainly as a result of people living longer with HIV infection.

6.2. In Lewisham, historically there have been more new infections diagnosed through heterosexually acquired infection mainly among the Black African population. In 2011 this changed and there were more new infections diagnosed through sex between men.

6.3. Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality. It is a critical component of the Public Health Outcomes Framework and monitoring is essential to evaluate the success of expanded HIV testing.

6.4. In Lewisham between 2009 and 2011, 52% of HIV diagnoses were made at a late stage of infection compared to 50% (95% CI 49-51) in England. 32% of men who have sex with men (MSM) and 69% of heterosexuals men were diagnosed late.

6.5 Lewisham was the first London borough to introduce HIV testing as part of the new patient check, undertaken by GPs, in line with the Chief Medical Officer's guidance.

7. Teenage Pregnancy

7.1. Annual teenage pregnancy rates are available up until 2011. The rate has been falling in Lewisham in line with London and national trends, although the first quarter of 2013 does show an increase (mirrored in London and England). The actual numbers have also dropped significantly over the same time period. The proportion of conceptions leading to abortion has remained relatively stable at 53-55%.

Teenage Pregnancy Statistics 2007-2011 (ONS)

Lewisham trend	2007	2008	2009	2010	2011
Number of conceptions	311	296	235	198	184
Rate/1,000 females aged 15-17 (using ONS population)	70.8	68.8	55.6	48.6	39.9

7.2. Up until 2009 schools were offered sex and relationships education (SRE) sessions delivered by the local sexual health service. When this provision was decommissioned there was a drop in clinic attendances amongst young people. The SRE provision has been effective in forming a bridge between the schools and the clinics and made young people aware of where they could go to get support and advice even if

they were not currently sexually active. In the summer term of 2013 secondary schools were offered the opportunity to get free SRE input into years 8 and 9 delivered jointly with the sexual health and school nursing team. The focus of these sessions was on 'Staying Safe' and in particular highlighting the risks of sexual exploitation, acceptable relationship boundaries and how to access services. Sustaining input into sessions such as these now forms part of the school age nursing strategy.

8. Abortion

8.1. Abortion rates have been falling in Lewisham as well the neighbouring boroughs, whilst remaining relatively stable in London and England. Despite this abortion rates in Lewisham are amongst the highest in the country. In 2012, with Lewisham being the 2nd highest in London and England after Barking and Dagenham. Lewisham has the highest under 18 abortion rate in England and rates are particularly high in black women.

8.2. All three boroughs have high rates of repeat termination. Repeat abortion rates are highest in Lewisham (47%), followed by Southwark (46%) and Lambeth (44%). This compares to 37% in London. In women under 25 years old, 37% in Lewisham and 33% in Lambeth and Southwark attended for a repeat abortion in 2012. This compares to 27% in London.

9. Local Services:

9.1. Sexual health services are currently delivered in a broad range of settings including:

- GP practices (contraception, STI & HIV testing and treatment)
- Pharmacies (emergency contraception, condoms)
- Hospitals (GUM and HIV clinics)
- Sexual health clinics (contraception and STI testing and treatment)
- Online (chlamydia and gonorrhoea screening, condom card registration for access to free condoms)

9.2. Lewisham has 4 sexual health clinics across the borough at Downham Health and Leisure Centre, Sydenham Green Health Centre, Rushey Green and the Waldron. Full GUM services including complex STI treatment and special clinics for men who have sex with men are now available at the Waldron. HIV services are provided at the Lewisham Hospital site at the Alexis clinic. In addition to this Lewisham residents can access GUM and HIV services outside of the borough. Most GUM activity currently occurs at Kings Hospital, Guys and St Thomas's Hospital and Chelsea and Westminster NHS Trust.

9.3. In addition to this youth services, libraries and some pharmacies distribute condoms through the pan-London Condom Card Scheme (Come Correct). Condoms are also available to those at high risk of HIV infection through the Safer Partnership (which is partnership of voluntary sector organisations). Lewisham Healthcare NHS Trust sexual health service also provides sex and relationships education in local schools and run a clinic at Lewisham College.

10. Strategy Development

10.1. A needs assessment and service mapping has underpinned the development of the LSL Sexual Health Strategy. A first draft of this document is expected to be completed in late January. A period of consultation with service users, local residents, providers and commissioners (including local authority and clinical commissioning groups) will occur following its publication.

10.2. The Strategy will focus on providing a stepped care approach to sexual health, including health promotion and prevention of sexual ill health, self management, improving access to services which screen for STIs through provision online, in primary care (GPs and pharmacies), and in other settings. The Strategy will also address gaps in the current provision of services to some vulnerable groups including those with mental health problems, those affected by substance misuse, those with learning difficulties and with cultural barriers which prevent them from accessing services.

10.3. Sexual health services are predominately demand led. The focus of commissioning has been on the delivery of testing and treatment services rather than prevention of sexual 'ill health' and promotion of good sexual health. Escalating costs and new outbreaks associated with changing sexual practices requires a new approach to the commissioning of sexual health services.

11. Financial implications

11.1. The London Borough of Lewisham has a sexual health budget of £6.99M for sexual health services (2013/14). The majority (£5.86M) of this is invested in sexual health clinics and GUM services. This excludes the abortion service and HIV care and support services commissioned by the CCG.

11.2. Sexual health services are funded through the Public Health Grant which is ring fenced for at least two years (2013/14 and 2014/15).

11.3. The cost of services can all be met from the agreed 2013/14 budget. Expenditure against contracts whose value is dependent on volume is being monitored closely.

12. Legal implications

12.1. A legal agreement between the 3 boroughs of Lewisham, Lambeth and Southwark underpins the sexual health commissioning arrangement with Lambeth Council as lead commissioning organisation. This sets out amongst other things the governance arrangements between the three Councils, the terms of reference of the Commissioning Board which will have a representative of each Council and provision for decisions by unanimity, the agreed contribution by each Council to the costs of the administration of the commissioning of the services, staffing arrangements, and indemnity and insurance provision.

12.2. A section 75 agreement between Lewisham CCG and Lewisham Council underpins the contracting arrangements with Lewisham and Greenwich Trust.

12.3. 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."

13. Crime and Disorder Implications

None.

14. Equalities Implications

14.1. Sexual health need is disproportionally higher in those from certain BME groups specifically Black African and Caribbean, those identifying as gay or bisexual, those from the most deprived areas and young people (under 25).

14.2. Sexual health services are commissioned to help reduce these inequalities, informed by the needs assessment, which considers different population groups and this will be further addressed through the LSL Sexual Health Strategy.

14.3. An Equality Analysis Assessment (EAA) will be carried out as part of the strategy development.

15. Environmental Implications

None

16. Conclusion

16.1. Sexual health remains a priority for Lewisham. The new Strategy will provide opportunities for innovation in service delivery and help redress the balance between prevention and sexual health services.

16.2. More emphasis on healthy sexual relationships is required, particularly for young men, but also young women. Most of the emphasis to date has been on STI screening and treatment for males and more work on behaviour models would be useful to encourage a more healthy approach to sexual relationships.

16.3. The completed LSL Sexual Health Strategy will be presented to the Board in July 2014.

If there are any queries on this report please contact ***Ruth Hutt, Consultant in Public Health***, on ***020 8314 7610,*** *or by email at:* ***ruth.hutt@lewisham.gov.uk***

Appendix 1

Figure 1 Acute STIs in LSL 2009- 2012

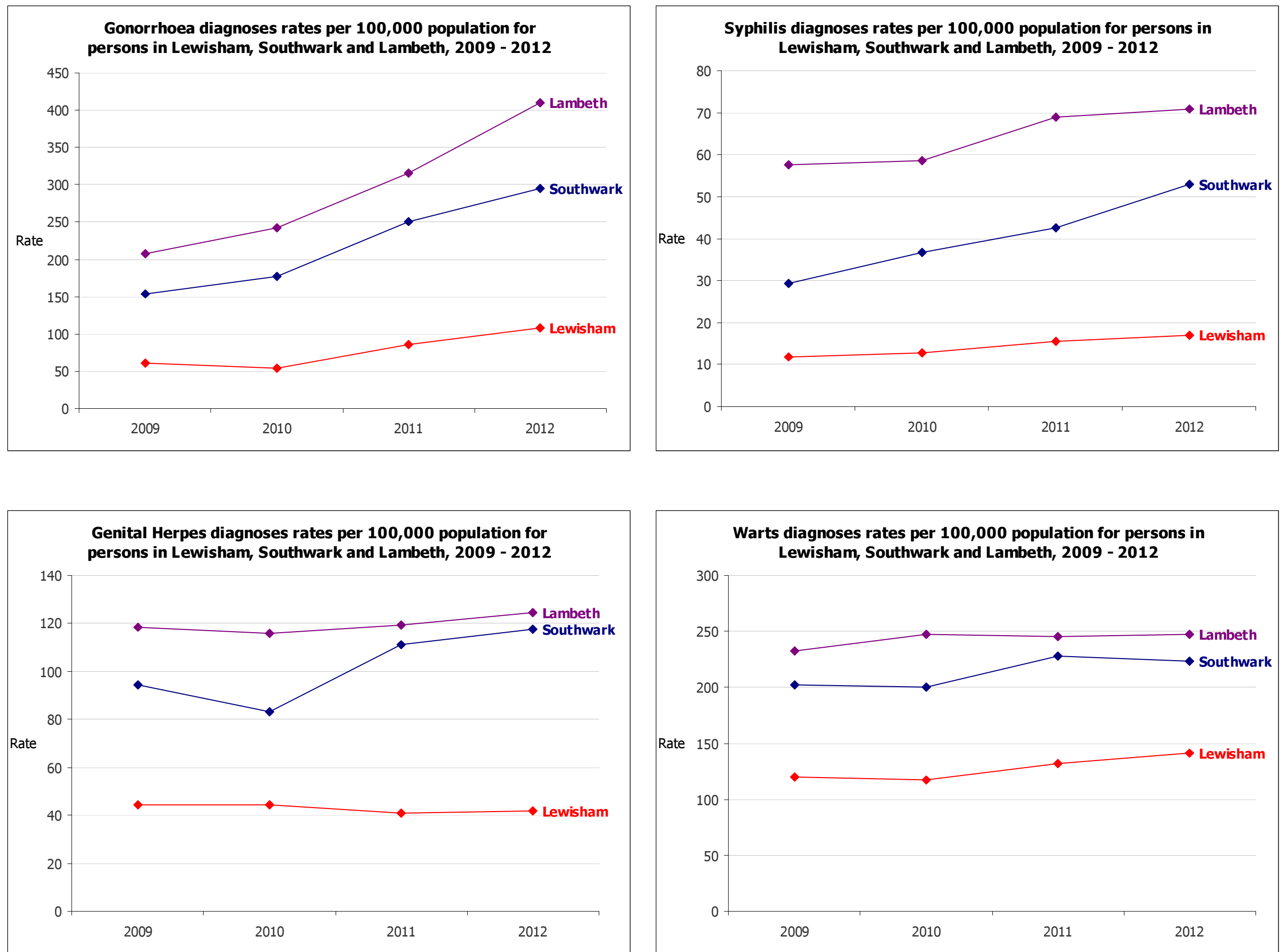


Figure 2 Teenage Pregnancy Rates LSL, London and England

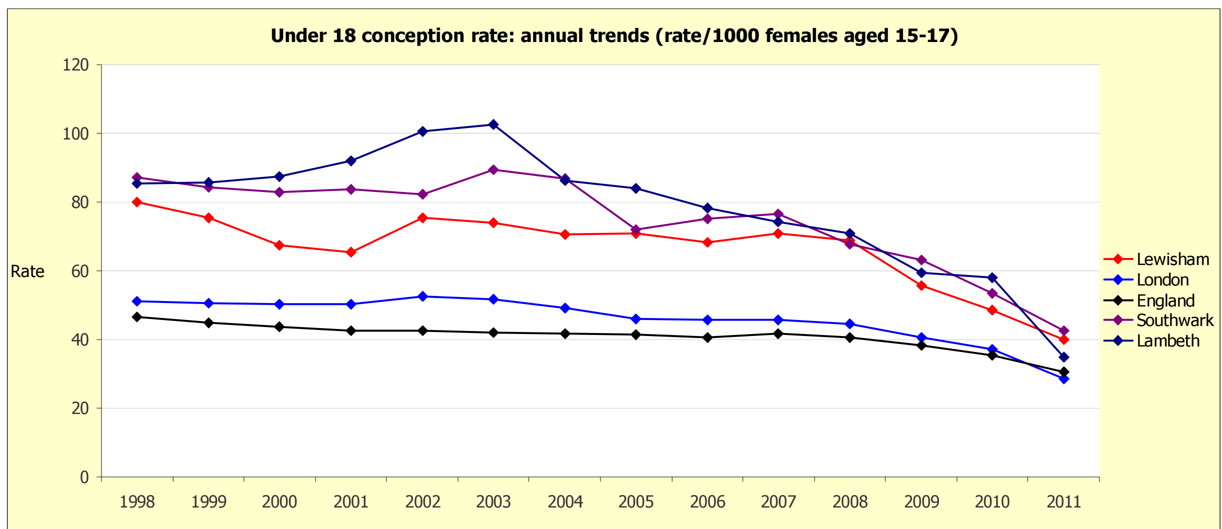


Figure 3 Abortion Rates LSL, London and England

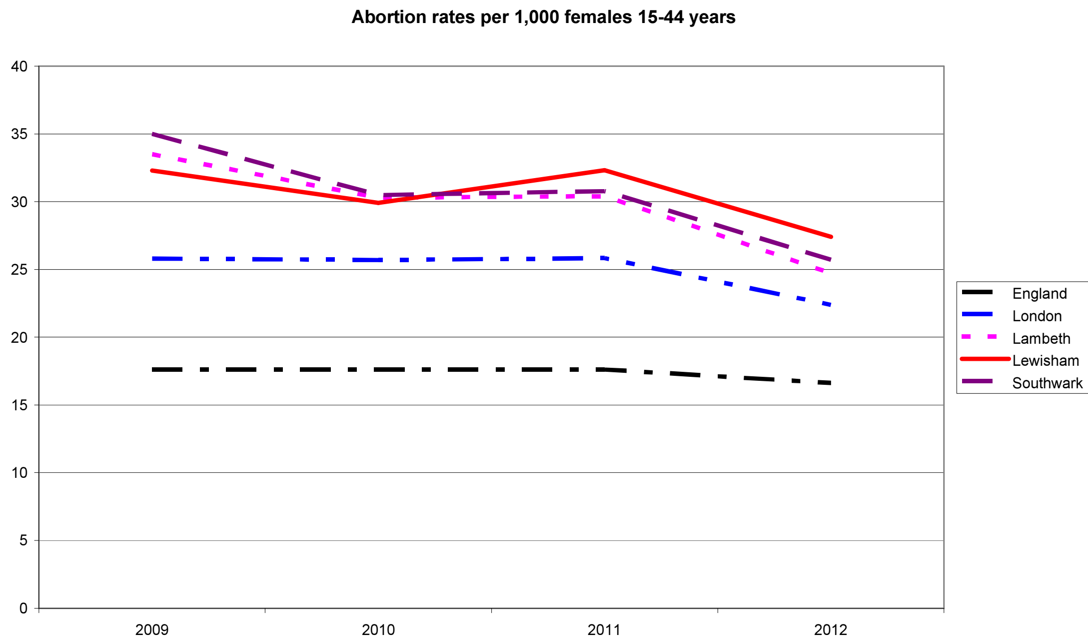
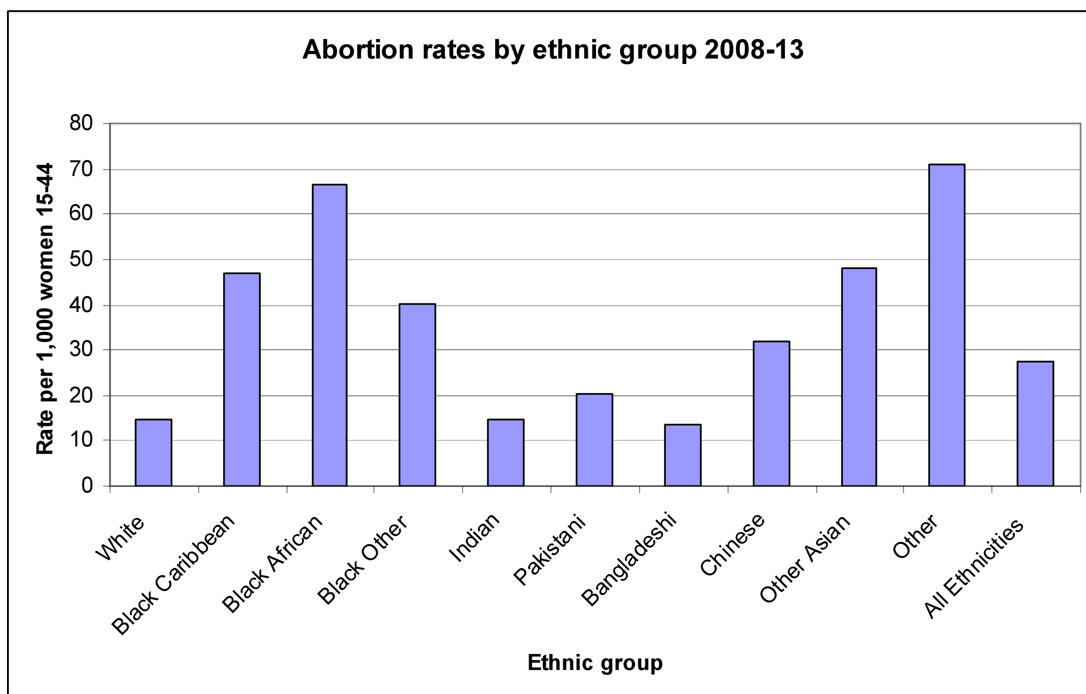


Figure 4 Abortion Rates by Ethnic Group



HEALTH AND WELLBEING BOARD				
Report Title	Joint Health and Social Care Self-Assessment Framework 2012/13 (Learning Disabilities)			
Contributors	Head of Joint Commissioning		Item No.	9
Class	Part 1	Date: 28 January 2014		

1. Purpose

1.1 This report summarises the findings of the Lewisham Joint Health and Social Care Self-Assessment for members of the Health and Wellbeing Board.

2. Recommendations

Members of the Health and Wellbeing Board are requested to:

2.1 Agree the action plan as set out in Appendix 2.

3. Policy Context

3.1 The Lewisham Joint Health and Social Care Learning Disability Self-Assessment (referenced in this report as 'the LD SAF') forms part of a national data collection exercise managed through the Learning Disabilities Health Observatory 'Improving Health and Lives'. Local Partnership Board Areas were required to report retrospectively on 2012/13 activity. The overall context of the LD SAF remains the need to improve the health and life chances of people with learning disabilities. Concerns around poor health care have been highlighted in a number of reports notably 'Death by Indifference' (2007), '6 Lives' (2009) and 'Transforming Care; a national response to Winterbourne View' (2012). Issues relating to citizenship and inclusion have also been highlighted in reports, notably 'Valuing People Now' (2009) and more recently are reflected in the draft Care Bill.

3.2 The LD SAF also intersects with other national frameworks including the Adult Social Care Outcomes Framework 2013-14, the Public Health Outcomes Framework 2013-2016, the Health Equalities Framework (HEF) and the National Health Service Outcomes Framework 2013-14.

3.3 The Lewisham LD SAF submission reflects and supports Lewisham's Sustainable Community Strategy particularly the strategic objective 'healthy, active and enjoyable'.

3.4 It also reflects the Health and Wellbeing Strategy priorities of 'improving mental health and wellbeing' and 'delaying and reducing the need for long term support'.

4. Background

4.1 The Joint Health and Social Care Learning Disability Self-Assessment Framework (LD SAF) replaced two previous documents, the LD Partnership Board Self-Assessment Framework and the Learning Disability Health Self-Assessment.

4.2 The 2012/13 LD SAF required the collection and collation of information from a number of information sources including specific data, evidence statements from both the Council and the Clinical Commissioning Group, and also the personal experiences of people with a learning disability and their families. Measures explored the success with which specialist services and universal services supported the needs and aspirations of people with a learning disability. A particular area of enquiry was the application of 'reasonable adjustments' to ensure access, for example through the use of accessible information.

4.3 Specific areas of data collection were Healthcare delivery, Inclusion and Where I Live / Accommodation, Quality/ Mental Capacity Act & Deprivation of Liberty, and Transition. The Learning Disabilities Health Observatory advised that they would themselves extract data pertaining to 'where I live/ accommodation' from the Adult Social Care Combined Activity Returns.

4.4 The self-assessment measures were presented as three specific sections: Section A - Staying Healthy; Section B – Being Safe; and Section C; Living Well. There were twenty seven measures in total (Appendix 1). Guidance was highly specific to support a consistent national grading process. A statement of up to 1000 characters was allowed to evidence each measure, along with the option to include an anonymised 'Real Life Story'.

4.5 Information was gathered from a large number of key partners both within the Public Sector and the Third Sector. The submission was co-ordinated by Adult Joint Commissioning and the process overseen by the Head of Joint Commissioning for NHS Lewisham CCG and the Council and the Chief Accountable Officer for the Lewisham Clinical Commissioning Group.

4.6 The LD SAF was submitted to the Learning Disabilities Health Observatory, hosted by Public Health England, on 6 December 2013. In previous years, there has been a process of interrogation and validation of the LD SAF. However, there is no formal validation planned for the 2012/13 LD SAF. The Learning Disabilities Observatory has advised that an abridged version of the data will be

given to local area teams for quality assurance purposes. The full data and final reports are expected to be published in March 2014.

4.7 Officers have nevertheless set out as Appendix 2 an action plan to begin to address what are the key areas for improvement as a result of the SAF analysis. This will be amended following further discussion with key stakeholders and review of the Observatory's March report.

4.8 The widespread nature of the LD SAF, and what it is required to report on, cuts across all statutory and third sector provider services. Therefore 'ownership' of the return is often considered as an LD issue, though most of what is being examined is not within the LD 'portfolio'. It is a complex return for a client group that is low in number. Experience of co-ordinating data and evidence for the report itself, and implementing any actions arising from it is often low on the agenda of partners' competing priorities. The identification of a high profile LD 'Champion' would assist in managing a higher priority for this work in the future.

5. Key Findings

5.1 This section sets out some of the key findings of the LD SAF which officers consider may be of specific interest to the Board. The return format itself is lengthy and is contained within a web based electronic submission thus making it inaccessible and not reader friendly enough to attach to this report.

On a general note, data integrity for the LD SAF return remains an issue as it has in previous years. The SAF requests both health and social care data in a way that is not generally collected for this client group. Also, while there are some specific registers which do note people's LD 'diagnostic', those registers are not 'cross referable'. Whilst some data could be extracted from the health Quality Outcome Framework (QOF), several indicator sets for health conditions could not. A manual count of known cases was undertaken wherever possible to provide a valid submission figure. This is not a Lewisham specific issue. However, data aside, there is much positive activity relating to supporting people with a learning disability in the borough.

Data

5.2 Demographics

5.2.1 534 children aged 0-17 have a learning disability in Lewisham.

5.2.2 859 adults aged 18 and over are known to have a learning disability in Lewisham.

5.3 Healthcare Data

5.3.1 Many people with learning disabilities also have other health needs. For example, 28.5% of people in Lewisham known to the CCG have a BMI (body mass index) recorded in the obese range. Over 10% of people with LD have asthma, and over 10% are known to have diabetes.

5.3.2 General health screening has been improved through the use of Health Action Plans: almost 50% of people with LD have a plan. However only 31% received a GP Annual Health Checks (validated by the DES) in 2012/13 [this percentage is higher than that reported in the LD SAF following updated NHSE data January 2014].

5.3.3 With regard to specialist cancer screening, a figure could only be obtained for cervical screening. This figure demonstrates that less than 27% of 'eligible' women with a learning disability attended cervical screening. A 'special needs' mammography service is available at Kings College Hospital and many Lewisham women with a learning disability benefit. However, the actual breast screening numbers for this client group could not be identified. Bowel cancer screening figures for LD could not be captured. Some of this under recording of activity is reflected by an inconsistent 'flagging' of learning disabled people on GP and hospital systems. This should improve in 2014.

5.3.4 Acute and Specialist Care figures were reported from Lewisham and Greenwich NHS Trust and from Kings College Hospital NHS Foundation Trust. Taking into consideration the inconsistent 'flagging' of patients who have a learning disability, it is difficult to ensure robust figures for total numbers of attendances. However, a manual count of attendances by the Safeguarding Leads using the hospital database has indicated that 5 people with learning disabilities attended A&E more than three times between April 2012 and March 2013.

5.3.5 With regard to Winterbourne View in-patient related data seven people were admitted once or more to both mental health and learning disability care between in 2012/13. Of those in both mental health and learning disability in patient beds on 31st March 2013, four people had been continuously in a placement for more than two years. The care of each person continues to be reviewed in line with the Winterbourne protocol.

5.4 Inclusion/ where I live and accommodation Data

5.4.1 The data for this section is equivalent to that recorded by the NHS Information Centre NASCIS Online analytic processor service based on Adult Social Care Combined Activity Returns.

5.4.2 Lewisham has strong indicators demonstrating progress towards independent living for people with learning disabilities. Over 10% of adults in receipt of social care services are in paid employment, which is higher than the England and comparator borough average, and 80%

of people live in settled accommodation, a definition which excludes registered residential or nursing care.

5.5 Service Quality Data

The LD SAF reports that there is consistent recording relating to the management of safeguarding concerns 'internally' and across all partners and provider services. Of all adult safeguarding concerns raised and investigated in 2012/13, 36% were escalated for further investigation. Over 75% of front-line support and clinical staff have accessed training in Deprivation of Liberty Safeguards and Mental Capacity Act.

5.6 Transition

Of the total school age population of 42,164 pupils, 269 children with a learning disability receive additional assistance in school because of Special Educational Needs, combined with a further descriptor of moderate, severe, or profound learning disability. Many of these children, particularly those with higher needs, will continue to require additional care into their adult lives. Therefore effective 'transition' planning through good quality integrated Education, Health and Care Plans, is key to supporting this group as adults.

Self-assessment Measures

5.7 Appendix 1 of this report sets out the RAG (Red Amber Green) ratings at a glance for the full set of self-assessment measures. Detail is outlined in the paragraphs below.

5.8 Section A - Staying Healthy

5.8.1 Section A examined how well primary care, community care, acute clinical settings and also criminal justice settings are meeting the needs of people with learning disabilities. In order to score highly, universal services needed to demonstrate consistent examples of reasonable adjustments and active analysis of information contributing to service planning.

5.8.2 Five of the nine measures relating to health were self-assessed as red due to either a lack of available information, issues with multiple recording systems that could not produce the required data or a range of aspects within a single measure that could not all be demonstrated according to the strict assessment criteria.

5.8.3 Without full availability of screening data for people with learning disabilities it is not possible to tell whether they are proportionally underrepresented compared with the full eligible population. However the lack of complete data obscures the whole story and there are many instances of good practice to be evidenced, for example the

establishment of an LD hospital liaison nurse at Lewisham Hospital, health promotion and disease prevention through Health Action Plans and service user involvement through the Good Health Group.

5.8.4 One illustrative story highlighting good collaborative working:

'Ms T' is on a palliative care pathway and has an LD specific syndrome that causes swallowing difficulties. She is prescribed a wide range of medications on a daily basis, therefore it is essential that swallow safety is effectively balanced with the need for these medications. Close collaboration between the Community Pharmacy Team, LD Speech and Language Therapy (SaLT) and Ms T's GP has been central to ensuring that her medication has been taken in the safest possible way for her. SaLT have further collaborated with the Lewisham Community pharmacy team to ensure that, for people with identified swallow risks, medications generally are given in the safest available form, and in a medium that does not affect the medication's efficacy. This has led to an adjustment in pharmacy procedure and contributed to overall service improvement.

5.9 Section B – Being Safe

5.9.1 Section B considered how effectively all health and social care commissioners oversee care review, contract compliance, equalities, safeguarding and complaints. In order to score highly, comprehensive coverage and continuous improvement needed to be evidenced.

5.9.2 Six of the nine measures in this section were self-assessed as green. Three were rated as amber where the information available could not evidence the exact outcomes as set out in the guidance. A consistent area of good practice is the ways in which service providers involve individuals with learning disabilities and their families in the recruitment of staff, improving service planning and the quality of delivery. Of particular note is the extent to which contract compliance is regularly monitored, and evidence of safeguarding as a priority across all agencies.

5.9.3 One illustrative story highlighting the involvement of people with a learning disability:

The 'All Star Trainers' is a group of 13 trainers all of whom have a learning disability. They deliver training to social care staff in Lewisham (e.g. courses on Epilepsy, Diabetes Awareness, Mental Capacity, Person Centred Awareness and Supporting Independence). They also deliver sessions to students on the Nursing and Social Work degree courses at Southbank University, again on a wide range of topic areas relating to good working practices across health and social care.

5.10 Section C – Living Well

5.10.1 Section C focussed on community engagement across a number of different areas, the majority of which relate to universal service provision. It also covered specialist areas of transitions for young people, involvement in service planning and carers support. In order to score highly, evidence was required of the ways in which people with learning disabilities engage locally in the public sphere and how they and their carers are consulted around improvements.

5.10.2 Seven of the nine measures were self-assessed as green. Three were assessed as amber where not all details of the measure could be met. Arts, sports, transport and amenities were included, demonstrating how they enable access for people with learning disabilities as full citizens of the borough. Community inclusion, citizenship and access to employment all demonstrate how Lewisham is working to reduce social isolation and how people engage with their community through both learning disability specific groups and also universal services.

5.10.3 One illustrative story highlighting citizenship and inclusion:

'Ms S' loves dancing. She used to attend classes in one of the day centres, but then support staff helped her to choose line dancing classes which were part of a programme of activities delivered by Leisure Services at local leisure centres. She loved them before, but she loves them even more now they are held at Glass Mill and everyone knows it. 'Ms S' will tell everyone, 'It's Wednesday, I go dancing!" Her support staff said that 'what is really nice is that the tutor helps her to get the moves right, and understands when she needs to sit down or remove herself from the group. The other participants also help her and it is nice to see this sense of community from the group.

6. Financial implications

6.1 There are no specific financial implications arising from this report

7. Legal implications

7.1 There are no specific legal implications arising from this report. However, the LD SAF offers a snapshot of the extent of integrated working between health and social care services to support people with a learning disability who are the responsibility of Lewisham which Health and Wellbeing Boards have a duty to encourage under Section 195 of the Health and Social care Act 2012.

8. Crime and Disorder Implications

8.1 There are no specific crime and disorder implications arising from this report. However, the Health and Wellbeing Board's attention is drawn to the section 5.6.1 where it is reported that Section A – Staying Healthy also considers support for people with a learning disability in the criminal justice system. The LD SAF full report referenced the

renewed focus on offender health and the integrated working between multi-agency specialists, as part of the Liaison and Diversion service.

9. Equalities Implications

9.1 The reality that people with a learning disability have inequitable access to health services has been well evidences in many reports. In particular, the Government Ombudsman in '6 Lives' highlighted the extent to which health providers "failed to (also) live up to human rights principles, especially those of dignity and equality" (p8) and also highlighted a number of avoidable deaths relating to the poor quality of care received. 'Valuing People Now' (2009) highlighted the extent to which people with a learning disability still remained excluded from many of the rights of citizens in terms of their own home, choosing who they lived with, employment, accessing generic services and other areas that many citizens take for granted.

9.2 People with a learning disability are also at risk of double discrimination because of their learning disability specifically, but also language barriers related to ethnicity, challenging behaviour, poor communication and a general lack of expectation of achievement by those who care for them in any setting.

9.3 In addition to general disability measures, some specific measures need to be adopted to support access and integration such as double appointment times, accessible and easy read information. The LD SAF seeks to evaluate the extent to which such measures are generally adopted by local services to promote and support equality of inclusion. The LD SAF (measure B7) considered whether an EIA or EAA have been conducted for housing, care, and support strategies relating to the population as a whole and for people with learning disabilities. An EAA is not required specifically for this Self-Assessment.

9.4 All people with a learning disability have the protected characteristic of a disability defined as 'a person who has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities'. Lewisham has been able to evidence in the LD SAF the extent to which it has considered reasonable adjustments for its citizens with a learning disability in a wide range of generic mainstream services such as sports and leisure, arts and culture, transport and general amenities and also primary and secondary health services.

10. Environmental Implications

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

11. Conclusion

11.1 Despite some of the issues that have arisen with data collection across multiple sites, the Joint Health and Social Care Self-Assessment Learning Disabilities Framework (LD SAF) serves as a reference point for the extent to which people with learning disabilities are able to benefit from services across health, social care and in the community as a whole.

11.2 In Lewisham it has highlighted good practice, both in specialist and universal services. These include safeguarding, employment and community inclusion across a number of areas. It has also highlighted aspects that require improvement. These include the consistent recording of Learning Disability status by healthcare professionals, an extension of Health Action Plans and Annual Health Checks to all and an improvement in the management of data relating the diagnosis and health conditions of people with learning disabilities for both adults and children.

11.3 The anticipated outcome is that data management will improve for subsequent annual LD SAF exercises and that Lewisham will continue to be able to evidence the ways in which the health and life chances of people with learning disabilities continue to improve. These outcomes would be strengthened by the identification of a Learning Disability Champion who would promote the work required to strengthen these key areas.

Background Documents

Full information about the background to Joint Health and Social Care Self Assessment (Public Health England) and guidance for all measures can be found at:

http://www.improvinghealthandlives.org.uk/projects/hscldsaf

If there are any queries on this report please contact*:*

Keri Landau, Interim Joint Commissioning Manager, Community Services on 020 8698 8133 or by email at Keri.landau2@lewisham.gov.uk

Appendix 1
Joint Health and Social Care Self Assessment Framework (LD SAF)
Lewisham 2012/13 RAG rating summary

JHSCSAF SELF ASSESSMENT 2012/13	**RATING**
Section A – Staying Healthy	
A1. LD QOF register in primary care	RED
A2. Screening (general health)	AMBER
A3. Annual Health Checks& Registers	RED
A4. Health Action Plans	RED
A5. Screening (cervical, breast, bowel)	RED
A6. Primary Care Communication of LD status to other healthcare providers	RED
A7. LD liaison function in acute setting	AMBER
A8. NHS commissioned primary and community care	AMBER
A9. Offender Health & Criminal Justice	AMBER
Section B – Being Safe	
B1. Regular Care Review	AMBER
B2. Contract Compliance Assurance	GREEN
B3. Monitor Compliance Framework for Foundation Trusts	AMBER
B4. Safeguarding of people with LD in all provided services & support	GREEN
B5. Training and Recruitment - Involvement	GREEN
B6. Staff recruitment (providers) based on compassion, dignity and respect	GREEN
B7. Local Authority Strategies (support, housing, care) have EIA addressing needs of people with LD	AMBER
B8. Providers change practice as a result of feedback from complaints	GREEN
B9. Mental Capacity Act & Deprivation of Liberty	GREEN
Section C – Living Well	
C1. Effective Joint Working	GREEN
C2. Local Amenities and Transport	GREEN
C3. Arts and Culture	GREEN
C4. Sports and Leisure	GREEN
C5. Supporting People with LD into and in employment	GREEN
C6. Effective Transitions for young people	AMBER
C7. Community Inclusion and Citizenship	GREEN
C8. LD& family carer involvement in service planning and decision making	AMBER
C9. Family carers	GREEN

Appendix 2

Learning Disability Self Assessment 2012/13 Preliminary Action Plan

Theme	Detail	Timescale	Lead	ref.
	• Identify LD Champion	Sep 2014		
Transition	• Numbers with complex/profound learning disability 0-13/14-17 • Numbers with autism & learning disability 0-13/14-17 • Numbers receiving additional assistance in school because of LD and Autistic Spectrum Disorder	March 2014	CYP	2.1/2.2 3.1/3.2 58
Screening	• Number of eligible population with LD who had mammographic screening • Number of eligible population with LD who had bowel screening	June 2014 - for 2013/14 LD SAF	KCH - breast GSTT -bowel	5.3/5.4 &A5 6.3/6.4 & A5
Wider Health	• Number of people with LD & epilepsy	March 2014	LGHT	14
Health Action Plans	• Increase number of people with Health Action Plan who live with family	March 2014	LD Nursing	18.2
Acute	• Frequent A&E attendees (Ensure people are identified and support plan put in place/ actions to address health needs)	June 2014	LGHT/ Community LD Team	24.1/24.2
Health Registers	• LD/downs QOF register validation • AHC register validation	March 2014 (to identify lead)	CCG	A1/A3
	• Improve communication between LD Community Team and GP practices		LD Nursing	A4
LD Status	• Primary care to flag LD status in referrals • LD patients alerted to Safeguarding Lead in Lewisham Hospital	-- Jan 2014 (in place)	CCG	A6
Care review	• Continue to ensure 90% of social care and health clients reviewed annually	ongoing	ASC	B1
Carers	• Review number of registered LD carers	Jan 2014	ASC & CYP	C9

Agenda Item 10

HEALTH AND WELLBEING BOARD				
Report Title	**Healthwatch Performance Review**			
Contributors			Item No.	10
Class	Part 1	Date: 28 January 2014		

1. Purpose

1.1 This report presents Members of the Health and Wellbeing Board with an update on the performance of Healthwatch.

2. Recommendation

2.1 Members of the Health and Wellbeing Board (H&WB) are recommended to:

- Note the progress against agreed targets and action taken to improve performance.

3. Policy Context

3.1 The Health and Social Care Act (2012) introduced significant changes to the provision of advice, signposting and advocacy within health and care settings. Healthwatch England was established in October 2012 to provide a national consumer champion for users of health and care services. Healthwatch England has significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

3.2 From April 2013, local authorities were required to establish a local Healthwatch organisation to:

- signpost people to local health and social care services
- collect and analyse the experiences that people have of local care to help shape local services
- feed views and any recommendations to Healthwatch England to act on at a national level.

The local Healthwatch organisations replaced Local Involvement Networks (LINks).

3.3 The Council is committed to improving the health and wellbeing of citizens in Lewisham. Healthwatch will support the Council to deliver the following key objectives of *Shaping our Future – Lewisham's Sustainable Community Strategy*:

- '*Healthy, active and enjoyable – where people can actively participate in maintaining and improving their health and wellbeing'.*
- '*Empowered and responsible – where people can be actively involved in their local area and contribute to supportive communities.'*

4. Background

4.1 The tender process for the local Healthwatch service was undertaken in November and December 2012. Voluntary Action Lewisham (VAL) was awarded the contract in February 2013. The contract to deliver Lewisham Healthwatch commenced in April 2013.

4.2 Voluntary Action Lewisham's proposal evidenced the organisation's experience of planning and delivering a broad range of community projects in Lewisham. The bid demonstrated VAL's extensive experience of delivering projects that involve signposting, advice, information and engagement. VAL addressed all the method statements satisfactorily with robust evidence provided throughout.

5. Performance Review

5.1 A performance monitoring framework was established at the start of the contract. It was agreed that formal reviews of Lewisham Healthwatch would take place on a quarterly basis starting at the end of the second quarter.

5.2 The Lewisham Healthwatch Project Manager has met with the contract manager for Lewisham on a regular basis since the contract commenced. Lewisham Healthwatch has reported key challenges during this period. It has been difficult to establish the planned governance arrangements. The Chair for the project board resigned in October 2013 and the position is still vacant. Lewisham Healthwatch has also encountered issues regarding the recruitment and retention of staff.

5.3 Lewisham Healthwatch provided an assessment of progress against the nine agreed outcomes at the initial performance review in December 2013. The self assessment reported progress in a range of areas. Lewisham Healthwatch has established a presence in the borough through a website, a launch event and a promotional leaflet. The project has engaged a range of community groups and identified target areas in which to focus its work. A community engagement initiative has been developed in collaboration with the Home Library Service. Lewisham Healthwatch has recruited and trained 16 volunteers and three youth champions.

5.4 The self assessment highlighted limited progress towards achieving a number of the agreed outcomes. Although key promotional tools have

been established i.e. a website and printed material, a strategic approach to planning marketing activity has not been developed. Community engagement activity has been limited in scope to date. Although training on undertaking ‘enter and view’ visits has been completed, no visits have been completed to date. Lewisham Healthwatch has identified the need to develop robust systems to gather and use evidence and recognises that governance for improvement.

5.5 The Local Government Association has set up a regional network to support the development of local Healthwatch organisations. From attendance at network events it is evident that other Healthwatch organisations have encountered similar issues to those experienced by Lewisham Healthwatch.

6. Next Steps

6.1 An improvement plan for Lewisham Healthwatch has been agreed. Over the next quarter, Lewisham Healthwatch will:

- Address governance issues by appointing a chair and establishing a reference group
- Develop a strategic approach to marketing and communications
- Develop clear priorities that reflect the role of Healthwatch in representing the consumer voice to influence service improvement and commissioning
- Develop a volunteer action plan
- Plan its approach to implementing ‘enter and view’ visits
- Demonstrate a robust approach to reporting concerns based on sound evidence and research and use this to present reports to commissioners and influence change

6.2 Since the performance review in December 2013, Lewisham Healthwatch has recruited three members of staff and has established a reference group.

7. Financial Implications

7.1 The contract value for Voluntary Action Lewisham to deliver Lewisham Healthwatch is based on a pricing schedule of £299,510 over two years (£145,605 in year one and £153,905 in year two).

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

8. Legal Implications

8.1 The Health and Social Care Act 2012 requires local authorities to establish a local Healthwatch service.

9. Equalities Implications

9.1 The Council's equalities objectives formed part of the criteria used in the tender evaluation and are detailed in the contract documentation.

9.2 Lewisham Healthwatch will reduce inequalities through the targeted engagement of groups who are seldom heard or hard to reach.

10. Environmental Implications

10.1 The Council's environmental objectives formed part of the criteria used in the tender evaluation and are detailed in the contract documentation.

11. Crime and disorder implications

11.1 There are no crime and disorder implications.

12. Conclusion

12.1 Further reports will be presented at appropriate intervals to the Health and Wellbeing Board.

If there are any queries on this report please contact Carmel Langstaff, Service Manager – Strategy and Policy, Community Services on 020 8314 9579.

Agenda Item 11

HEALTH AND WELLBEING BOARD				
Report Title	Health and Wellbeing Board Work Programme			
Contributors	Service Manager – Strategy, Directorate for Community Services		Item No.	11
Class	Part 1	Date: 28 January 2014		

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;

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 inLewisham'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 2014/15. 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	
25 Mar 2014	**Date TBC**		**Fri 7 March**		**Mon 14 March**		**Fri 4 April**	
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	LBL	A and P: Danny Ruta		
2	**Integrated Adult Care Programme**			Part 1	LBL	A and P: Sarah Wainer / Susanna Masters	AIPB	
3	**Update on Health Protection**	Moved from 28 Jan		Part 1	LBL	A and P: Brid Nicholson		
4	**Emergency Services Review**			Part 1	LBL	A and P: Sarah Wainer	Overview & Scrutiny	
5	**Big Lottery Fund Fulfilling Lives bid: Update**			Part 1	LBL	A and P: Warwick Tompsett		
6	**Housing Strategy and Public Health**			Part 1	LBL	A and P: Jane Miller		

Meeting date	Agenda Planning		Report Deadline		Agenda Publication		Minutes drafted by	
20 May 2014	Date TBC		Fri 2 May		Fri 9 May		Fri 30 May	
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 in relation to Autism Strategy**		Information	Part 1	LBL / CCG	A and P: Corinne Moocarme	ASCG	
2	**Integrated Adult Care Programme**			Part 1	LBL	A and P: Sarah Wainer / Susanna Masters	AIPB	
3	**Healthwatch Annual Report**			Part 1	LBL	A and P: Carmel Langstaff		

Meeting date	**Agenda Planning**		**Report Deadline**		**Agenda Publication**		**Minutes drafted by**	
22 Jul 2014	**Date TBC**		**Fri 4 Jul**		**Mon 11 Jul**		**Fri 31 Jul**	
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	**Integrated Adult Care Programme**			Part 1	LBL	A and P: Sarah Wainer / Susanna Masters	AIPB	

Meeting date	**Agenda Planning**		**Report Deadline**		**Agenda Publication**		**Minutes drafted by**	
23 Sep 2014	**Date TBC**		**Fri 5 Sept**		**Mon 12 Sept**		**Fri 3 Oct**	
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	A and P: Sarah Wainer / Susanna Masters	AIPB	

Meeting date	Agenda Planning		Report Deadline		Agenda Publication		Minutes drafted by	
25 Nov 2014	**Date TBC**		**Fri 7 Nov**		**Fri 14 Nov**		**Fri 5 Dec**	
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	**Integrated Adult Care Programme**			Part 1	LBL	A and P: Sarah Wainer / Susanna Masters	AIPB	

Meeting date	Agenda Planning		Report Deadline		Agenda Publication		Minutes drafted by	
Jan 2015	**Date TBC**		**TBC**		**TBC**		**TBC**	
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	**Integrated Adult Care Programme**			Part 1	LBL	A and P: Sarah Wainer / Susanna Masters	AIPB	