Public Document Pack

Health and Wellbeing Board Agenda

Thursday, 3 July 2014
2.00 pm,
Council Chamber,
Civic Suite
Lewisham Town Hall
London SE6 4RU

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

Part 1

Health and Wellbeing Board Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Thursday, 3 July 2014.

Barry Quirk, Chief Executive
Wednesday, 25 June 2014

Mayor Sir Steve Bullock (Chair)	London Borough of Lewisham
Marc Rowland (Vice-Chair)	Lewisham Clinical Commissioning Group
Councillor Chris Best	Community Services, London Borough of Lewisham
Aileen Buckton	Directorate for Community Services, 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
Peter Ramrayka	Voluntary and Community Sector
Dr Danny Ruta	Public Health, London Borough of Lewisham
Brendan Sarsfield	Family Mosaic
Frankie Sulke	Directorate for Children and Young People

MINUTES OF THE HEALTH AND WELLBEING BOARD

Tuesday, 25 March 2014 at 2.00 pm

ATTENDANCE

PRESENT: Mayor Sir Steve Bullock (Chair), Cllr Chris Best (Cabinet Member for Community Services), Aileen Buckton (Executive Director for Community Services, LBL), Dr Danny Ruta (Director of Public Health, LBL), Frankie Sulke (Executive Director for Children and Young People, LBL), Elizabeth Butler (Chair, Lewisham and Greenwich Healthcare Trust), Jane Clegg (Delivery, NHS SE England – South London Area, London Region), Tony Nickson (Director, Voluntary Action Lewisham), Peter Ramrayka (Voluntary and Community Sector), Chris Freed (interim representative of Healthwatch Lewisham), Brendan Sarsfield (Family Mosaic).

IN ATTENDANCE: Cllr Alan Hall, Cllr John Muldoon, Jacky Bourke-White (Chief Executive, Age UK Lewisham and Southwark), Ed Knowles (Service Manager Commissioning and Strategy, CYP, LBL), Carmel Langstaff (Service Manager, Strategy and Policy, Community Services, LBL), Salena Mulhere (Overview and Scrutiny Manager), Sarah Wainer (Head of Strategy, Improvement and Partnerships, Community Services, LBL), Martin Wilkinson (Chief Officer, Lewisham Clinical Commissioning Group), Dr Donal O'Sullivan (Consultant in Public Health Medicine, LBL), Kalyan DasGupta (Clerk to the Board, LBL).

1. Minutes of the last meeting and matters arising

1.1 The Chair welcomed Chris Freed as the interim representative from Healthwatch Lewisham to the Board.

1.2 Apologies were received from Dr Simon Parton (Chair, Lewisham Local Medical Committee).

1.3 The minutes of 28 January 2014 were agreed as an accurate record.

1.4 Matters Arising

1.4.1 Integrated Health and Social Care – Better Care Fund

- Martin Wilkinson clarified that the funding had been transferred from the CCG to the Council in order to create a pooled fund.

- Brendan Sarsfield asked for a response to his request for a Key Performance Indicators (KPI) dashboard alongside information on the financial context.

The following points were raised or highlighted in the discussion:

- The Health and Wellbeing Strategy and Better Care Fund KPIs should be brought together to create a performance management framework. In addition, there are other relevant indicators that could be included, such as those related to Housing.

- Work is already proceeding on KPIs for the Health and Wellbeing Strategy Delivery Plan and twice-yearly routine updates have already been scheduled. Persistent underperformance will also be flagged up, on an exception basis.

- The Children and Young People's Plan has KPIs that are not included in the Health and Wellbeing Strategy and should be reflected in the performance management framework.

- The Board needs to consider all the areas within its remit, which extends beyond the Council. Each partner needs to monitor their own organisation's progress against a single set of indicators.

1.4.2 The Board:

1. Recommended that relevant officers gather and feed back financial information to the Board.

2. Agreed to receive a presentation on a proposal regarding a performance framework at the next meeting.

3. Noted that a draft organogram was being produced and that the final version would be circulated to members on completion.

4. Recommended that officers organise a half-day Away Day session for members to consider all the areas within the Board's remit.

2. Declarations of Interest

Under the item on Emergency Services Review, Cllr Alan Hall, introducing the report, declared an interest as Lewisham's only elected governor on South East London's King's Fund Trust, and Cllr John Muldoon, co-reporting, declared an interest as an elected governor of South London and Maudsley (SLaM) NHS Foundation Trust, representing Lambeth, Southwark and Greenwich.

3. Children and Young People's Health Commissioning Intentions

3.1 Ed Knowles (Service Manager, Commissioning & Strategy, Children and Young People, LBL), presented the report to inform the Board of the health commissioning intentions for children and young people across 2014/15.

3.2 Ed highlighted the following points:

- The 2014/15 children's health commissioning intentions target specific areas of inequality in Lewisham to improve access for children and young people across the Borough.

- Quality and CQUIN schedules will form the backbone of effective performance management with Lewisham's main provider (Lewisham and Greenwich NHS

Trust) to highlight areas of success and where further improvements are needed.

- Partnership working and engagement with children and families will be vital to ensure that service redesign is in line with the needs of the Borough.

3.3 The following points were raised or highlighted in the discussion:

- The choice in relation to delivery would be shaped by what was appropriate. Quality and price are generally considered satisfactory at the moment. All services have performance indicators attached to them for monitoring quality.

- A clear overview and precise targets are essential for proper performance management. Additionally, an educational, preventative approach to acute conditions, such as diabetes, can often avoid the need for service provision altogether.

3.4 The Board thanked the reporter for the presentation and noted the commissioning intentions for children's community health services.

4. South East London Commissioning Strategy Programme Update

4.1 Martin Wilkinson (Chief Officer, Lewisham Clinical Commissioning Group) presented an update on progress on the five-year strategy, highlighting the overarching draft case for change, the emerging strategic opportunities and engagement on these and forthcoming key dates and milestones.

4.2 Martin informed the Board that the full draft case for change, the summary versions and factsheet would all be available via the CCG website for downloading and response and that the link would also be circulated to the Board.

4.3 The following points were raised or highlighted in the discussion:

- There are opportunities in relation to integrating further with community services as described by the vision of "shared standards, local delivery".

- A considerable amount of collaborative work is already underway across the full range of stakeholders. A technical reference group will follow up on how the CCG is working with providers and local authorities, as well as on the financial analyses.

- There should be flexibility when moving to a different model, to prevent standards slipping where performance is currently very good.

- Financial models are being reviewed across the whole of London, and not just in one or two boroughs.

4.4 The Board:

1. Noted the update on the development of the South East London Commissioning Strategy and

2. Noted that the full draft case for change, the summary versions and factsheet would all be available via the CCG website for downloading and response and that the link would also be circulated to the Board.

5. Integrated health and social care - Better Care Fund report

5.1 Sarah Wainer (Head of Strategy, Improvement and Partnership, Community Services, LBL) presented the update on the Better Care Fund (BCF) plan.

5.2 Sarah reported that some of the performance targets were being re-calculated because new technical guidance had been received from the Department of Health. Work would now proceed to assess whether the new targets were realistic, given the targets for efficiency savings.

5.3 Members were asked to note the comments received on the draft plan following its submission to NHS England on 14 February 2014. Sarah informed the Board that further work would be undertaken between the publication of this report and the final submission date to provide the required detail.

5.4 The following points were raised or highlighted in the discussion:

- Lewisham is already performing well in relation to several BCF performance indicators.

- A whole-system approach is required in relation to the £10m available for 2015/16.

- The Better Care Fund is an opportunity to make better use of existing resources.

- The BCF/KPIs will be developed as part of the wider integration programme.

- It was explained that 5 of the 6 metrics have been set by Central Government. The 6th local indicator has been selected by Lewisham ("Proportion of people feeling supported to manage their (long term) condition").

- The Board was also reminded that it had already agreed nine priorities, including Long-Term conditions, the key metric for which had already been provided, ensuring the Board was on track.

5.5 The Board:

1. Noted the report;

2. Agreed that the Chair and Vice Chair of the Health and Wellbeing Board be given responsibility on behalf of the Board for final sign-off of the plan prior to its submission on 4 April and requested that copies also be e-mailed to members in confidence.

3. Agreed that officers would clarify and explain both the Key Performance Indicators (KPIs) and the metrics to a future Board.

4. Recommended that every partner take up a Performance Indicator as a "topic" of work, such as "Housing and Mental Health or "Voluntary Services".

6. Health and Social Care Integration - Co-ordinating the Voluntary and Community Sector response

6.1 Tony Nickson (Director, Voluntary Action Lewisham - VAL) presented the report, along with Jacky Bourke-White (Chief Executive, Age UK Lewisham and Southwark), focusing on some ways in which Lewisham's Voluntary and Community Sector contributes to integrated health and social care in the borough.

6.2 The presentation highlighted the following points:

- Lewisham has about 800 voluntary and community sector organisations, mostly charities, facing increasing expectations.

- VAL has become increasingly involved in co-ordinating voluntary and community sector health and social care work.

- VAL and Age UK are part of a consortium of voluntary and community sector organisations managing the community connections initiative. This preventative project works with vulnerable adults to identify community solutions to their health and care needs.

- Volunteer Centre Lewisham promotes volunteering opportunities for Community Connections, and the Voluntary and Community Sector makes a valuable contribution to the strategic goals of the Health and Wellbeing Strategy and the integration of health and social care.

- New or different ways of doing the work more effectively through collaboration should be explored.

6.3 The following points were raised or highlighted in the discussion:

- Tony Nickson agreed to act as the link between the Health and Social Care Forum (HSCF) and the Health and Wellbeing Board.

- The HSCF has shown that communication is one of the key challenges faced by the sector.

- Aileen noted that 147 people had been supported to date from the Community Connections Project.

- Cllr Best suggested that the Community Connections Project could link Lewisham's Local Assembly programme.

6.4 The Board noted the report.

7. Health Protection Update

7.1 Dr Donal O'Sullivan (Consultant in Public Health Medicine, LBL) submitted the terms of reference for the Health Protection Committee for final approval and presented an update on arrangements and health protection work to date in Lewisham, as well as on key areas of local health protection work as they are included in the Committee's work plan.

7.2 Dr O'Sullivan highlighted the following points:

7.3 In June 2013, Lewisham's Health and Wellbeing Board approved a new local Health Protection Committee (HPC) to oversee the borough's additional mandated duties, with respect to the control of infectious diseases (including healthcare associated infections) in the population.

7.4 A Health Protection Committee has been set up in Lewisham in response to changes in the borough's mandated duties, with respect to the protection of the health of the population.

7.5 The Committee has developed a local workplan, which will be reviewed quarterly and amended in response to changing situations and new information.

7.6 The Health Protection group had already met twice as a committee, amended the Terms of Reference, and taken on board the Borough Resilience Forum recommendations.

7.7 The following points were raised or highlighted in the discussion:

- Peter Ramrayka thanked Donal for the report, and asked how the key information would be communicated to the public.

  Donal responded that information was uploaded onto the JSNA website and also conveyed to patients and/or parents of patients with respiratory disease.

- In response to a question about the location of flu-related information, Donal explained that there is clear national and London-wide guidance on how to manage flu with the help of special incident groups. Any incident remains in an ad hoc arrangement until (or unless) it becomes a major incident. The Director of Public Health would always be a member of the major incident group, and the Health Protection Committee would supervise the process. It would therefore know about these incidents, including incidents of bird flu.

7.8 The Board:

1. Approved the amended terms of reference for the Health Protection Committee, noting in particular the changes to the Terms of Reference to take into account the requirement to link the work of the Borough Resilience Forum with the Health Protection Committee and the Health and Wellbeing Board.

2. Agreed the priorities for action, and subsequent timescales, as detailed in the Committee's local work plan.

3. Agreed the reporting arrangements from the Health Protection Committee to the Health and Wellbeing Board.

4. Agreed that the risks should be reflected in the form of Key Performance Indicators (KPIs) in the appropriate Risk Register.

8. Big Lottery Fulfilling Lives - A Better Start and HeadStart Funding Application

8.1 Ed Knowles (Service Manager Commissioning & Strategy, CYP, LBL) presented a summary of the recent funding application made to the Big Lottery "Fulfilling Lives: A Better Start" investment and the next steps, and also provided Board members with background information on the "Fulfilling Lives: HeadStart" investment. The aims, objectives budgets and milestones of these programmes were explained.

8.2 The following points were raised or highlighted in the discussion:

- Lewisham is the only local authority in the competition for both bids.

- The voluntary-sector organisation Children's Society was in the lead for "Better Start" and VAL has led on governance structures.

- Brendan Sarsfield highlighted the potential for housing associations to promote activity.

- Schools have put together a Transition Curriculum around themes in HeadStart.

8.3 The Board noted the submission of Lewisham's application.

9. Comments of the Children and Young People Select Committee on Early Intervention and Targeted Support

9.1 Frankie Sulke (Executive Director for Children and Young People, LBL) presented the referral, to inform the Board of the comments and views of the Children and Young People Select Committee, arising from discussions held on the officer report entitled Early Interventions and Targeted Support, considered at its meeting on 29 January 2014.

9.2 The following points were highlighted:

9.3 The Children and Young People Select Committee's remit covers all services provided to young people aged under 19, such as education and social services, and includes the provision of health related services for under 19s.

9.4 On 28 January 2014 the Children and Young People Select Committee visited Downderry Children's Centre in order to find out more about the work that Children's Centres carry out around early intervention. On 29 January 2014 the Committee then considered a report entitled Early Intervention and Targeted Support which provided information about changes in early intervention funding, the work of the Early Intervention and Access Service, the development of Payment by Results and the balance between targeted and non-targeted provision.

9.5 During the meeting the Committee noted the important role that Children's Centres play in early intervention and in providing links to public services operating throughout the borough. The Committee felt that there is considerable good work already between health agencies and the Children's Centres. They raised the possibility though for increased use of Children's Centres to deliver services associated with health.

9.6 The Committee particularly recommended that the Health and Wellbeing Board consider whether there is scope to increase the number of outreach immunisation programmes operating in the borough, specifically within Children's Centres, and to increase availability of immunisation for both MMR and MMR 2 in Children's Centres.

9.7 The following points were raised or highlighted in the discussion:

- The key issue is the co-ordination of the work of Early Intervention and Targeted Support.

- Discussions conducted with Children's Centre managers so far had been very encouraging and that GPs would be a logical next stop.

9.8 The Board:

1. Noted the views of the Children and Young People Select Committee as set out above.

2. Agreed that GPs should be a logical next stop for progressing Early Intervention and Targeted Support.

3. Agreed to return to the subject for further consideration at a future meeting.

10. Emergency Services Review

10.1 Cllr Alan Hall, introducing the report, declared an interest as Lewisham's only elected governor on South East London's King's Fund Trust; Cllr John Muldoon, co-reporting, declared an interest as an elected governor of South

London and Maudsley (SLaM) NHS Foundation Trust, representing Lambeth, Southwark and Greenwich.

10.2 Cllr Hall thanked all those, including the Executive Directors, who had worked to help produce the report.

10.3 Cllr Hall then presented the report, highlighting the following points:

10.4 The Council's Overview and Scrutiny Committee had completed a review of emergency services in Lewisham in October 2013. The present report was intended to inform the Board of the recommendations and to detail the implications of those recommendations for the Health and Wellbeing Board work programme.

10.5 The HWB has established arrangements for reviewing performance against the Health and Wellbeing Strategy and Adult Integrated Care Programme. These include some of the recommendations of the Emergency Services Review. The inclusion of a review of performance against all the recommendations in the work programme was aimed at ensuring a consistent approach to this activity.

10.6 The following points were raised or highlighted in the discussion:

- In response to a query, Cllr Hall responded that the need for an emergency risk register was likely obviated by the fact that any emergency would be dealt with by all stakeholders and partners acting as one council. Cllr Muldoon added that it may be more useful to first subject the existing indicators to scrutiny, as opposed to necessarily creating new ones.

- Elizabeth Butler urged that, whenever feasible, embedded documents be circulated as attachments in future mailouts, because links are sometimes not capable of being opened by recipients outside of the Council system.

- In response to a query from Brendan Sarsfield about the specific role of Board members, Salena Mulhere (Overview and Scrutiny Manager) clarified the situation as follows:

  The recommendation to the Board was that they agree to include a review of performance, against the relevant recommendations in the emergency services review, within their work programme. Salena highlighted that there are seven recommendations related to health, two related to all public sector organisations, and eight related to housing partners, which are the recommendations that the Board is recommended to monitor performance against. Salena added that relevant officers were aware of the appropriate recommendations for them to review.

- The Chair praised and thanked Overview and Scrutiny for its work and indicated that the next step would be to capture the performance indicators and present them to a future Board.

10.7 The Board

1. Noted the recommendations of the Emergency Services Review and agreed to include a review of performance against the recommendations in the work programme.

2. Agreed that, whenever feasible, embedded documents be circulated as attachments in future mailouts.

3. Recommended that the next step be to capture the Emergency Services performance indicators and present them to a future Board.

11. Health and Wellbeing Board Work Programme report

11.1 Carmel Langstaff (Manager, Strategy and Policy, Community Services, LBL) presented the report, updating members on the establishment of the Work Groups and the appointment of Chris Freed as the chair of Voluntary Action Lewisham (VAL) and the interim representative of Healthwatch Lewisham.

11.2 Carmel then highlighted key reports from the upcoming programme for 2014 for discussion and approval, including items on poverty, mental health, violence (including against girls and women), and the health of those in the Criminal Justice System (including girls and women).

11.3 An item on Performance Management review was added. Other items then proposed included worklessness, housing, and mental health and housing.

The Chair proposed that a search first be carried out for any reports already submitted on the above subjects from the inception of the Shadow Health and Wellbeing Board to the present.

11.4 A suggestion was made about producing a Health and Social Care bulletin.

11.5 Martin Wilkinson (Chief Officer, Lewisham Clinical Commissioning Group) suggested The Independence of Primary Care (or the Critical Nature of Primary Care) as a topic for a future report.

11.6 The following points were raised or highlighted in the discussion:

- With regard to the proposed item on Violence (including against girls and women) above, Frankie Sulke informed the Board that the Children's Safeguarding Board has already been carrying out a considerable amount of work on Female Genital Mutilation (FGM) in Lewisham. Brendan Sarsfield proposed that, since the items for Board business need to adhere to the agreed nine priorities, discussion of Children and Young People and FGM be addressed in a different forum. This was agreed.

- It was stressed that mapping (currently being carried out by Children and Young People) would be an important factor in deciding the future direction of travel for the Board, and Dr Marc Rowland expressed interest in viewing the data already gathered by Dr Danny Ruta.

- The Chair confirmed the Board's request for an Away Day to be organised.

11.7 The Board:

1. Noted the current draft of the work programme;

2. Agreed the additions and amendments discussed, subject to checks;

3. Agreed that a search should first be carried out for any reports already submitted on mental health, worklessness, and housing, from the inception of the Shadow Health and Wellbeing Board to the present, before proceeding with new Board reports on those subjects.

4. Agreed to consider the production of a Health and Social Care bulletin;

5. Agreed that Dr Marc Rowland and Dr Danny Ruta should liaise on the data already gathered by Children and Young People, as part of their mapping exercise, in helping the Board decide the future direction of its travel.

The meeting ended at 16.15 .

HEALTH AND WELLBEING BOARD				
Report Title	Declarations of interest			
Contributors	Chief Executive – London Borough of Lewisham		Item No.	2
Class	Part 1	Date:	3 July 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)

HEALTH AND WELLBEING BOARD				
Report Title	South East London Commissioning Strategy			
Contributors	Head of Strategy & Organisational Development, NHS Lewisham Clinical Commissioning Group		**Item No**	3
Class	Part 1	**Date**	3 July 2014	
Strategic Context	Please see the body of the report			

1. Purpose

1.1 The six Clinical Commissioning Groups (CCGs) in south east London are working together to produce a five year strategy. The Board received progress updates in January and March which covered the programme approach, strategic planning process, and governance arrangements, as well as the overarching draft case for change, the emerging strategic opportunities and establishment of the programme's Clinical Leadership Groups. The draft strategy and its appendices which are included as appendices to this report were approved by the CCG's Governing Body for submission to NHS England on 20 June.

2. Recommendations

Members of the Health and Wellbeing Board are recommended to:

- Note the draft South East London Commissioning Strategy.
- Comment in particular on section 5., which outlines the improvement interventions and which will be the focus for the next stage in the development of the strategy.

3. Strategic Context

3.1 The NHS England strategic and operational planning guidance. 'Everyone Counts: Planning for Patients: 2014/15-2018/19' 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.

3.2 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. Draft Strategy

4.1 The strategy is still being developed, so the document reflects the progress to date, whilst complementing and building on the interventions and priorities set out in the Lewisham CCG 5 year strategic plan.

4.2 The case for change is powerful and the risk of not proceeding with strategic change is that health outcomes will continue to be highly variable, health inequalities will persist and in some cases worsen, and the current healthcare system will become unsustainable.

4.3 The strategy sets out seven priority areas for intervention across south east London:

- primary and community care
- long term conditions - physical and mental health
- children
- maternity services
- cancer
- urgent and emergency care
- planned care

These areas are strongly aligned with both Lewisham's Health and Wellbeing Strategy and the Lewisham CCG strategic priorities.

4.4 Clinical Leadership Groups have led the development of proposed models of care, and the strategy proposes an integrated system model which brings together the individual elements. This is rooted in resilient communities and has as its foundation a primary and community care system which is accessible, proactive, coordinates care and provides continuity of care.

4.5 The document then begins to describe the impact of the strategic change which is proposed. This includes a much greater emphasis on health and wellbeing, on the prevention of ill health and on early detection and early intervention, and therefore a shift of activity and resources to reflect the strategic approach.

5. Next Steps

5.1 There is further work required to develop the models in more detail and to engage widely, then to consider the implications in practice, again with extensive engagement in each borough and across south east London. Feedback from this engagement and involvement will continue to inform development of the strategy. Should any significant service changes be proposed as a result of the further development by the clinicians, patients and local people working on the strategy, then consultation on these would take place in the second half of 2015.

6 Financial implications

6.1 A financial analysis is included as part of the strategic case for change.

7. Legal implications

7.1 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.

8. Crime and Disorder Implications

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

9. Equalities Implications

9.1 An early Equalities Analysis Assessment (EAA) has been commissioned by the strategy programme to ensure that the strategy has considered, from the outset, the potential impact on those protected under the Equality Act 2010 and the additional south east London groups and to ensure that plans for further engagement – locally and more widely – are targeted appropriately to reach local people and communities whose voices are seldom heard.

10. Environmental Implications

10.1 There are no environmental implications arising from this report.

Background Documents

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 you have any difficulty in opening the links above or those within the body of the report, please contact Kalyan DasGupta (kalyan.dasgupta@lewisham.gov.uk; 020 8314 8378), who will assist.

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

South East London Commissioning Strategy Programme

Commissioning Strategy 2014-19

30 May 2014

Version 0.19 – DRAFT (IN DEVELOPMENT)

Contents

Executive Summary

i. Overview

The NHS in South East London is planned by Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark CCGs and NHS England (London). Together we are working in partnership with local authorities, local providers and other key stakeholders to define a five-year Strategy for health and integrated care services across south east London.

The strategy complements and builds on local work and has a particular focus on those areas where improvement can only be delivered by collective action or where there is added value from working together. It seeks to respond to local needs and aspirations, to improve the health of people in south east London, to reduce health inequalities and to deliver a health care system which is clinically and financially sustainable. It also meets the NHS England requirement that all CCGs develop a commissioning strategy and, specifically, the requirement to submit a document for review by NHS England by 20 June 2014.

The approach is commissioner led and clinically driven, and informed by wide engagement with local communities, patients and public.

This document sets out the proposed five year commissioning strategy for South East London, for submission to NHS England on 20 June 2014. It builds on earlier submissions on 20 December 2013 (Headline Strategy, our ‘plan for a plan’) and 04 April 2014 (Draft Strategy).

This document brings together the content of CCG Operating Plans focusing on changes at borough level predominantly over the next two years, with the emerging system-wide components being developed collaboratively by the NHS, local authorities and partners across South East London, which will have a transformational impact over years three to five of the Strategy.

The Strategy and its component parts are still very much a live working document and should be considered in the context of continuing development, testing and iteration.

Executive Summary

ii. Our vision and ambition

A five year NHS Commissioning Strategy for south east London is being developed in partnership with local authorities and local providers led by our clinicians. It builds on the individual strategies of the CCGs, working in partnership with their local authorities and others, is framed by the Health and Wellbeing strategies and focuses on those issues which would be best done together.

Working with partners we are developing a collective vision for the health system in south east London, based on the following themes:

- Supporting people to be more in control of their health and have a greater say in their own care
- Helping people to live independently and know what to do when things go wrong
- Helping communities to support one another
- Making sure primary care services are consistently excellent and with an increased focus on prevention
- Reducing variation in healthcare outcomes and addressing inequalities by raising the standards in our health services to match the best
- Developing joined up care so that people receive the support they need when they need it
- Delivering services that meet the same high quality standards whenever and wherever care is provided
- Spending our money wisely, to deliver better outcomes and avoid waste

iii. The Case for Change in South East London

The vision and ambition reflects the needs of the people of south east London, which are reflected in our case for change:

- The health of south east London's population has improved significantly, but there is much more to do
- The national and London context is changing the way that health and integrated care services are planned and delivered
- Significant developments and opportunities within south east London help us to make a strong and innovative response to the national and London context
- Our health services have many strengths but quality is variable and we have tolerated unacceptable and unwarranted variation in quality for too long
- Commissioners face a challenging financial position, and need to secure the best value out of **the £2.8bn** spent on NHS services
- Our health and social care partners face a similar and interrelated set of challenges supporting the same populations so working together is the best approach.

Executive Summary

iv. How we will measure success of the Strategy

The Strategy is designed to achieve the following over the next five years:

- Improved health for people in south east London, including sustained improvement against the NHS, public health and social care outcomes frameworks within all south east London boroughs, and sustained improvement in life expectancy and particularly healthy life expectancy
- Reduction in health inequalities within all south east London boroughs
- Achievement of London Clinical Standards* across all services where these apply
- All organisations within the health economy to be financially sound and sustainable and to report surplus in 2018/19
- No provider will be subject to enhanced regulatory scrutiny due to performance concerns

v. Our objectives and integrated system model to deliver these

The first two years of the strategy will be delivered by the operational plans of the CCGs; the changes are more locally driven, but will lead us into wider transformation in years three to five.

Seven system objectives have been agreed by the Partnership Group and reflect both local priorities and national framing; and are set out below.

1. Securing additional years of life for those with avoidable and treatable mental and physical health conditions
2. Improving the health related quality of life of people with one or more long-term conditions, including physical and mental health
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community
4. Increasing the proportion of older people living independently at home following discharge from hospital
5. Increasing the number of people having a positive experience of hospital care
6. Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

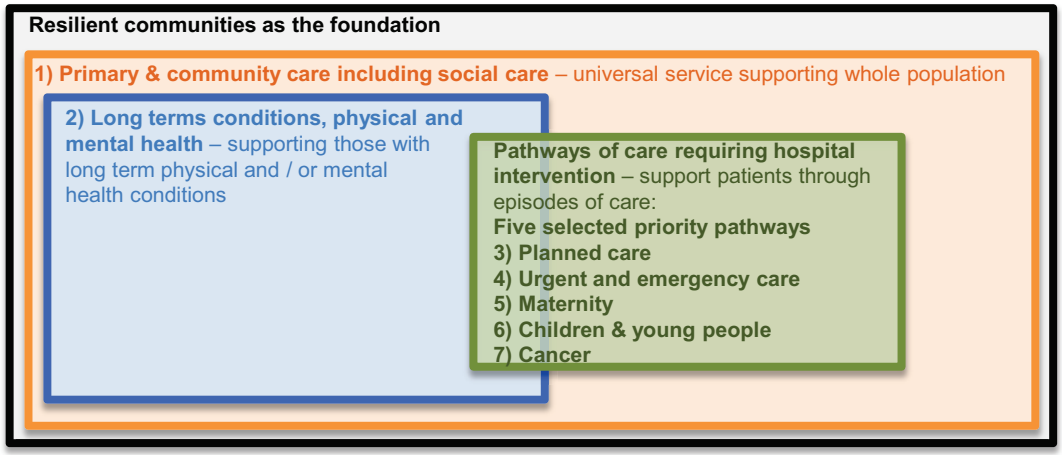
* London quality standards - http://www.londonhp.nhs.uk/wp-content/uploads/2013/03/Model-of-care-standards-FINAL-Feb2013-v1.11.pdf

Executive Summary

v. Our objectives and integrated system model to deliver these (Contd.)

South east London is developing an integrated system model which brings together the different components of the Strategy into a single health system focused on delivering the objectives of the Strategy. The system model sets out the key elements and characteristics of the health and integrated care system that will be in place by the end of year five of the Strategy.

- The Integrated System Model has at its foundation the recognition that we must and can strengthen the resilience of our local communities. This is the core business of each borough's Health and Wellbeing Board and the partners who have developed this strategy have agreed to ensure that they fully support this work.
- Primary and community care services are the cornerstone of health and social care and 90% of NHS contacts are provided in the community. South east London will deliver these services through 24 **Locality Care Networks** which will bring together GP practices with wider primary care and community services to support their communities and people.
- Those people with long term physical and / or mental health conditions will be able to access services through integrated teams which bring together social care and wider local authority services, NHS funded services and the voluntary sector.
- For people who are most ill and require NHS care provided in hospitals, it is essential that the different parts of the system are well connected as patients experience joined-up care across organisational boundaries. In addition to primary and community care and long term conditions, physical and mental health, the Strategy focuses on a further five priority pathways which support people across hospital and community settings. This strategy does not seek to address each and every pathway that patients need but focuses on those pathways that require coordinated approaches across our SEL boroughs and the different parts of the NHS system.



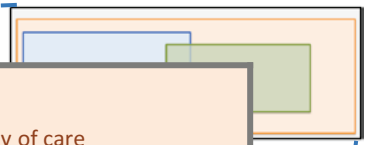
- The integrated model is underpinned by the eight characteristics of our integrated system, which are to:
  1. Build resilient communities
  2. Promote health and wellbeing
  3. Provide accessible & easy to navigate services
  4. Join up services from different agencies & disciplines
  5. Deliver early diagnosis & intervention
  6. Raise the quality of services to the same high standard
  7. Support people to manage their own health & wellbeing
  8. Achieve improved outcomes for all residents

Executive Summary

vi. Key improvement interventions

The seven strategic interventions that make up the system model are being developed by Clinical Leadership Groups. The interventions were prioritised by the Partnership Group and other key stakeholders, in order to achieve the greatest impact on improving outcomes and reducing inequalities, whilst addressing variation in quality and experience of patients' care. The groups' outputs are in the early stages of definition and testing and will be further developed after the next submission of the Strategy on 20 June.

The key focus of each intervention is set out below.



EMERGING CONTENT– SUBJECT TO FURTHER REVISION / DEVELOPMENT

1. Primary and community care	• Provided at scale by 24 locality care networks supporting whole populations • Universal service covering the whole population 'cradle to grave' • The changes to primary care will focus on four high impact areas: Access, Proactive care, Coordinated care, Continuity of care
2. Long term conditions for physical and mental health	• Those with long term physical and / or mental health conditions will be supported with segmentation into three categories • Locality care networks will play a lead role at all stages • There will be a consistent focus on: reablement (not just the prevention of deterioration, but returning people to better health); coordinated care and care planning; and supporting self management
3. Planned care	• Pre-treatment and diagnosis: standardised and multidisciplinary approaches; clear care plans; hubs and 'one-stop-shops' where appropriate; diagnostics delivered once in right place at right time; senior opinion early in the pathway; more treatment in the community where appropriate • Treatment: delivered in the most productive and efficient way through standardisation; delivery at appropriate scale; specialty focus on specific areas; movement towards day case procedures - when safe; review current use of outpatient model • Post treatment: As much at home / in the community as possible; 7 day a week transfers to community; early planning throughout pathway • Close collaboration between primary, secondary, social care and social services throughout.
4. Urgent & emergency care	• Rapid access model: home ward + sub acute specialist response (co-located with hospital, emphasis on specialist gerontology/elderly/mental health) • UCC co-located with A&E and out of hours – minor illness, injuries and burns with diagnostics and prescribing • Admit to hospital to 'do and discharge' • Services meeting London Quality Standards
5. Maternity	• Single point of contact – to inform newly pregnant women of their options and choices • Promotion of normalised birth: incl. home birth for multips; birth centres for low risk primips • Continuity of care through a 'midwifery led' model with improved/extended consultant cover • Assessing for women's toxic stress during pregnancy • Services meeting London Quality Standards and other maternity quality standards
6. Children	• Collective focus on the child including, 'every contact counts' • Improved Access – 'no wrong door' • CAMHS/Psychological support • Integrated step-down from hospital designed around child • Services meeting London Quality Standards
7. Cancer	• Saving lives and improving outcomes through prevention and earlier detection, diagnosis and intervention. Reducing variation in care, supporting people and their carers living with cancer as a long term condition and improved end of life care.

Executive Summary

vii. Impact of model

We will measure the impact of delivering our integrated system model by looking at:

- Delivery of the NHS outcomes (which are also our system objectives for the Strategy) and other key outcomes for south east London
- Changes in patient activity across our system
- Changes in the investment and ongoing costs to deliver health and integrated care services.

The impact of delivering the model will be across three key areas:

- Through a much greater emphasis on health and wellbeing, prevention and early intervention we will drive improved health outcomes and reduced health inequalities for our population that enable people to live longer and live healthier lives for longer
- Building on a foundation of community resilience and greater self-care there will be a significant shift of activity and resource from services focusing on late response in secondary care to primary, community and social care, and services enabling self-care. The transformation of our universal primary and community services provided through Locality Care Networks, and the transformation of how we support those with long term physical and mental health conditions will be key to this
- Through delivering consistently high standards of care across all services we will improve patient experience and clinical outcomes and reduce variation for our patients. We will re-shape services to create centres of excellence supporting networks of care. This will require significant one-off investment and will change patterns of spend on local services.

The first two years of the Strategy will be delivered through the Operating Plans of the six CCGs. Years three to five build on those foundations to deliver system transformation, driven by our seven priority interventions. The current stage of development of the Strategy is therefore a combination of a shared vision, detailed plans for years one and two, and an emerging view of the impact of years three to five

Executive Summary

viii. Supporting strategies

When the strategic opportunities and scope of the Clinical Leadership Groups were agreed, it was acknowledged that there would be some overlap and interplay between the groups and further that there would be a need for cross-cutting supporting strategies to enable the delivery of interventions defined through the groups.

Supporting strategies will be a fundamental part of the development of the strategy after the 20 June NHS England submission and successful implementation of any resulting system changes. Clinical Leadership Group workshops and the Partnership Group stakeholder meetings have identified a number of common supporting strategies. Initially, four priority strategies will be developed, which are detailed below.

Priority Supporting Strategy	Overview
IT and Information	To drive a consistent and accessible approach to IT and information across all providers including: • Shared definitions and standards • Sharing of patient data and health information across providers • Use of a virtual patient record
Workforce	To develop a new workforce model that meets the needs of an increasingly community based model of prevention and care including: • Use of multi-disciplinary teams, at the right time in the right place • 24/7 care with an appropriate range of skills • Addressing recruitment and retention issues • Supporting cultural and behavioural change to reflect the emphasis on public health and self care
Commissioning Models	To develop innovative approaches to commissioning and contracting that incentivise the right behaviours across the system, including: • Commissioning and providing for outcomes • Development of incentives and contractual levers for change, including quality improvement • Effective co-commissioning to reduce complexity and ensure consistency of approach.
Communications and Engagement	To develop the existing Communications and Engagement workstream to support all aspects of the programme over the coming months including: • Coordination of local and south east London-wide engagement on the strategy, including potential impacts on the health system • Communication with stakeholders, patients, local people and staff • Development of proposals for campaign approach to engage patients and local people in the strategy and management of their own health
Estates	To an Estates workstream with particular focus on: • Supporting Locality Care Networks through enabling the bringing together of staff and services • Promoting co-location of services where appropriate • Establishing primary care estate for the 21st Century.

Executive Summary

ix. Programme approach and governance

Our approach to delivery of the Programme

Our approach to delivering the Programme focuses on partnership, engagement, and clinical leadership, and is reflected in our governance and decision-making structure, including:

- The key decision making body, the **Clinical Commissioning Board**, which brings together commissioners from CCGs, NHS England and Local Authorities and also includes Patient and Public voices as well as Healthwatch representation
- The key partner forum, the **Partnership Group**, which brings together a wide range of senior clinicians and managers from commissioners (including Local Authorities), providers and advisory bodies and also includes Patient and Public voices
- The **Clinical Executive Group**, which provides leadership, challenge and assurance to the individual clinical leadership groups and manages interdependencies across groups
- **Clinical Leadership Groups,** which are clinically led working groups consisting of senior experts drawn from across commissioners, NHS providers, social care, and public health, as well as Patient and Public voices and Healthwatch representation.

Executive Summary

x. Our work to date

In our work to date:

- Over 100 clinicians, 50 patient and public voices, senior management and clinical commissioners from all 6 CCGs, NHSE primary care and specialised teams, six Local Authorities including CEOs, Public Health and social care, members of the voluntary sector, 6 Healthwatches, and the chief executives, medical and nursing directors from local providers have all engaged in planning, discussion, design, challenge and learning over the last 6 months
- An Case for Change has been developed for south east London, on which we have sought further engagement and which has been used as a basis to set the priority areas of focus for the Strategy
- An overarching integrated service model has been developed and all CCG GP member practices have adopted a new and consistent approach to working together in locality care networks.
- New models of service delivery have been designed by Clinical Leadership Groups – clinically led design groups – for primary and community care, long term conditions, planned care, urgent and emergency care, maternity, children and young people, and cancer
- These have been developed at speed and now need to be tested, refined and the detailed planning to implement need to be put in place.

This 20 June submission of the Strategy sets out the vision, model, and emerging transformational impact of delivering an integrated system model of health and social care across south east London. In doing so the Strategy sets out how we will deliver improved health outcomes and reduced health inequalities whilst addressing unwarranted variation in quality and experience and setting the local health system on a sustainable footing.

Executive Summary

xi. Further development after 20 June 2014

Beyond 20 June 2014 our work will be focused on:

- Continued development and delivery of key elements of the strategy, with a particular emphasis on primary and community care and long term conditions
- July to December 2014 and beyond – Work to develop proposed interventions and impacts at an institutional and community level with engagement on the Strategy and implications as they develop
- 2015 – Options for implementation, where appropriate and any business case for significant service change (if required) and potential consultation (if required)

During the next phase of the Strategy from 20 June we will:

- Engage with stakeholders and wider public on emerging strategy including the integrated system model
- Identify potential implications of the proposed integrated system model on communities, institutions and organisations
- Develop financial and economic models to test the likely impact of service models being developed by Clinical Leadership Groups
- Develop draft detailed roadmaps for each Clinical Leadership Group
- Undertake capacity modelling on the existing system and proposed integrated system model
- Establish priority supporting strategies
- Start to engage on the implications of the proposed integrated system model

Our expectation is that at the end of the strategy implementation we will have transformed our health system to deliver better outcomes for public and patients in south east London, doing so in a way that is sustainable for future generations.

Executive Summary

xii. Implementation work already underway

We understand the urgency to change services and significant work is already underway that will deliver foundational elements of the Strategy during years one and two. Collaboration on the Strategy follows a principle of 'shared standards, local delivery'. This means CCGs working together at the right scale: at borough, cross-borough or south east London level. CCG operating plans set out a series of bold changes that will be delivered in years one and two of the Strategy. Some examples of significant work already being implemented are as follows:

- **Development of wider primary care, provided at scale** South east London CCGs are already working to transform local primary and community care:
  - The six boroughs have developed a model under which services will be provided at scale by 24 locality care networks supporting whole populations. This builds on the current pathfinder programme for developing new models of primary care under which there have been 12 applications, each with geographical coherence, with a coverage of more than 750,000 registered patients
  - Southwark CCG have been granted £950k from the Prime Minister's Challenge fund to provide extended access to primary care through neighbourhood working, supporting the implementation of the CCG's Primary and Community Care strategy
  - Lewisham CCG has transformed its Diabetes Pathway through enhancing diagnosis across Primary Care, including 'Peer2Peer support' which involves a dedicated clinical lead supporting practices by providing hands on in-practice advice and guidance
- **Developing a modern model of integrated care** There has been significant progress to date in the development of integrated care, delivered through south east London's Community Based Care programme. In addition to developing plans with local authorities under the Better Care Fund, CCGs have also achieved a number of other key milestones:
  - The development and scaling of the Southwark and Lambeth Integrated Care Programme (SLIC)
  - Greenwich achieving national pathfinder status for Integrated Care
- **Improving and enhancing local urgent and emergency care** Locally driven work to improve urgent and emergency care including the redesign of Guys and St Thomas Emergency Department and Urgent Care Centre (UCC) in Lambeth and the successful transition of the 111 service to London Ambulance Service and subsequent achievement of all targets.
- **Transforming specialised services** The development of new cancer treatment centres at Guys Hospital and a cancer treatment centre at Queen Mary's Hospital Sidcup
- **Building resilient communities** South east London's CCGs are working with local authorities through Health and Wellbeing Strategies, to build and develop **resilient communities**, for example through the award winning Lambeth Living Well Collaborative
- **Partnership working across south east London** The Programme has 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 providers. Our Partnership Group provides a strong and collective transformational leadership of the Strategy, with a shared recognition across all members of the scale of the challenge and also the level of organisational and cultural change needed.

Executive Summary

xiii. Risks

We know there are risks to both the development and the implementation of the Strategy. Our key implementation risks are set out below. We understand and are mitigating them. We also recognise that the risk if we do not act, is much greater.

Title	Risk	Impact	Mitigations
Insufficient Impact of Change	• When implemented the impact of the strategy is insufficient to meet the need and ambition	• Improvements in outcomes are not met • Quality remains variable • System is unsustainable	• Collective modelling work and triangulation of strategies and plans across south east London
Insufficient investment to deliver the change	• There is insufficient investment available to deliver the scale of change at the pace required	• Improvements in outcomes are not met • Quality remains variable • System is unsustainable	• Detailed planning and modelling to quantify investment needed and when • Use of non-recurrent funds to pump prime change • Including investment requirements in financial modelling
Financial Sustainability of Health System	• New service models in primary care and community services do not deliver reduced demand for hospital care or hospital capacity does not reduce in line with demand	• Increased system costs through duplication of services and low productivity leading to poor patient and staff experience • Quality remains variable • System is unsustainable	• Clinical Executive Group and Partnership Group review integrated system model and all draft service models as a whole to ensure that any proposed changes to the health system are effectively balanced. • Impact of areas of early implementation (primary and community care, integrated care) reviewed in models as the develop.
Information Systems	• Lack of integrated or interoperable information systems undermines ability to integrate services across the health system in South East London	• Duplication of system, process or information, resulting in poorer patient experience, poor quality of services across integrated pathways and additional cost	• Information Systems to identify and support improvements required to mitigate.
Workforce	• Workforce requirements of new models of services cannot be met in a timely fashion	• Skills not available in right location to support new models of care • Insufficient capacity in system to support cultural change required to drive new behaviours	• Workforce strategy, with input from LETB to identify workforce impacts of proposed changes and develop plans for resolution

Introduction (1 / 2)

- Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark CCGs, working with NHS England as co-commissioner, are working in partnership with local authorities, local providers and other key stakeholders to define a five-year Strategy for health and integrated care services across south east London. The approach is commissioner led and clinically driven, and informed by wide engagement with local communities, patients and public.

- This approach is reflected in the programme's governance and delivery structure, which includes the following key groups:

  - The key decision making body, the SEL **Clinical Commissioning Board**, which brings together commissioners from CCGs, NHS England and Local Authorities and also includes Patient and Public voices as well as Healthwatch representation.
  - The key partner forum, the SEL **Partnership Group**, which brings together a wide range of senior clinicians and managers from commissioners (including Local Authorities), providers and advisory bodies and also includes Patient and Public voice.
  - The SEL **Clinical Executive Group**, provides overall clinical leadership, challenge and assurance to the individual clinical leadership groups and manages interdependencies across the programme and helps build consensus across SEL. The group brings together senior clinicians from commissioners and providers as well as Patient and Public voices and Healthwatch representation.
  - SEL **Clinical Leadership Groups,** which are clinically led working groups consisting of senior experts drawn from across commissioners, NHS providers, social care, and public health, as well as Patient and Public voices and Healthwatch representation.

- This document sets out the headlines of the emerging five year commissioning strategy for South East London, for submission to NHS England on 20 June 2014. It brings together CCG Operating Plans focusing on changes at borough level predominantly over the next two years, with the emerging system-wide components being developed collaboratively by the NHS, local authorities and partners across South East London, which will have a transformational impact over years three to five of the Strategy.

Introduction (2 / 2)

This document sets out:

1. Overarching system **vision**
2. Latest **case for change** at headline level
3. The overarching **success criteria** against which the programme will be measured
4. The **integrated system model** setting out key elements and characteristics of the future health and integrated care system
5. The system level **improvement interventions** that will deliver the components of the Strategy
6. An initial view of **system impact** of the Strategy and the specific impacts of key improvement interventions
7. The **supporting strategies** needed to enable the improvement interventions to be delivered
8. Details of **implementation** and key changes already underway
9. Our **approach** to delivering the Strategy
10. An overview of the **programme governance** structure and processes for development of the Strategy
11. A summary of **high-level risks** to delivery of the strategy

The link between each of these sections and the summary Plan on a Page, including headline content, is set out overleaf. This document steps through each of the above sections. Appendix A then sets out individual Plans on a Page for south east London CCGs, and where available for NHS England Direct Commissioning service lines.

X = relevant section of this document

South East London

Plan on a page – and how segments of the plan link to the sections of this document

1 System Vision

In south east London we spend £2.3billion in the NHS. Over the next five years we aim to achieve much better outcomes than we do now by:

- Supporting people to be more in control of their health and have a greater say in their own care
- Helping people to live independently and know what to do when things go wrong
- Helping communities to support one another
- Closing the inequalities gap between worst health outcomes and our best
- Making sure primary care services are consistently excellent and with an increased focus on prevention
- Reducing variation in healthcare outcomes by raising the standards in our health services to match the best
- Developing joined up care so that people receive the support they need when they need it
- Delivering services that meet the same high quality standards whenever and wherever care is provided
- Spending our money wisely, to deliver better outcomes and avoid waste.

3 Success criteria

- Improved health for people in south east London, including sustained improvement against the NHS, public health and social care outcomes frameworks within all south east London boroughs, and sustained improvement in life expectancy and healthy life expectancy
- Reduction in health inequalities across south east London, to be measured through an agreed reduction in inequalities across life expectancy and healthy life expectancy within all south east London boroughs
- Achievement of London Clinical Standards
- All organisations within the health economy report surplus in 18/19
- No provider under enhanced regulatory scrutiny due to performance concerns

6 System-level objectives and system impact

System objective 1 - Securing additional years of life those with treatable mental and physical health conditions

System objective 2 - Improving the health related quality of life of people with one or more long-term condition, including mental health conditions

System objective 3 - Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital

System objective 4 - Increasing the proportion of older people living independently at home following discharge from hospital

System objective 5 - Increasing the number of people having a positive experience of hospital care

System objective 6 - Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community

System objective 7 - Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

Under development - Impact on other key measures such as population outcomes and public health measures

Integrated system model for south east London 4 5

Resilient communities as the foundation

1) Primary & community care including social care – universal service supporting whole population

2) Long terms conditions, physical and mental health – supporting those with long term physical and / or mental health conditions

Pathways of care requiring hospital intervention – support patients through episodes of care:
Five selected priority pathways
3) Planned care
4) Urgent and emergency care
5) Maternity
6) Children & young people
7) Cancer

System characteristics

- Build resilient communities
- Promote health and wellbeing
- Provide accessible & easy to navigate services
- Join up services from different agencies &disciplines
- Deliver early diagnosis & intervention
- Raise the quality of services to the same high standard
- Support people to manage their own health & wellbeing

Supporting Strategies 7

Priority supporting (enabling) changes that have been identified as critical to enable the delivery of the key improvement interventions, including:

- IT and information
- Workforce
- Commissioning models
- Communications
- Estates

8 Building on the strengths of work already underway

Including:
- Primary and community care
- Integrated care
- Partnership working
- Building resilient communities

9 Approach

- Plan for development of the Strategy to 20 June 2014
- Roadmap for ongoing development and delivery of the Strategy
- Approach to engagement
- Equality impact assessment built into approach

10 Governance

- CCG plans and strategies governed through local arrangements
- Governance of collective strategic change through Clinical Commissioning Board, South East London Partnership Group and supporting bodies

11 High level risks

Risks to the development & implementation of the Strategy are outlined in section 11.
Top risks to delivery are:
B1. Insufficient impact of change
B2. Insufficient investment to deliver the change
B3. Service change not fully implemented

2 Case for Change

Developing the System Vision for south east London

- The system vision sets out what the south east London health system will look like in five years time. This will be supported by underpinning vision statements for each system intervention within the Strategy
- The system vision also reflects the six transformational models / characteristics of a high quality and sustainable system set out in the NHS Vision of '*High quality care for all, now and for future generations*.'
- Appendix C provides additional detail of the system vision and shows how this ties back to the the themes included within the vision statements for each south east London CCG.

Further post 20 June submission

- The system vision will continue to be developed and will be updated as a result of wider consultation and engagement with key stakeholder groups
- Vision statements for each system intervention will be further tested and developed

Vision for south east London and for CCGs

The problem we are trying to solve: Our health outcomes in south east London are not as good as they should be:

- Too many people live with preventable ill health or die too early
- The outcomes from care in our health services vary significantly and high quality care is not available all the time
- We don't treat people early enough to have the best results
- People's experience of care is very variable and can be much better
- Patients tell us that their care is not joined up between different services
- The money to pay for the NHS is limited and need is continually increasing
- Every one of us pays for the NHS and we have a responsibility to spend this money well.

The longer we leave these problems, the worse they will get. We all need to change what we do and how we do it.

Our collective vision for the South East London: In south east London we spend £2.3billion in the NHS. Over the next five years we aim to achieve much better outcomes than we do now by:

- Supporting people to be more in control of their health and have a greater say in their own care
- Helping people to live independently and know what to do when things go wrong
- Helping communities to support one another
- Making sure primary care services are consistently excellent and with an increased focus on prevention
- Reducing variation in healthcare outcomes and addressing inequalities by raising the standards in our health services to match the best
- Developing joined up care so that people receive the support they need when they need it
- Delivering services that meet the same high quality standards whenever and wherever care is provided
- Spending our money wisely, to deliver better outcomes and avoid waste.

Introduction to the Case for Change

- The Case for Change is south east London's assessment of the current state of the health system, covering: population health needs; quality and performance of local health and integrated care services across the six boroughs; key national and local context; the scale of the financial challenge that needs to be addressed; and key strategic context for our partner organisations.
- The content included in this document is a headline version of our full Case for Change (supported by summary technical and plain English versions), on which local engagement is currently taking place across all six CCGs. These documents are available on the following link, which is replicated across the websites of each of our six CCGs: http://www.southwarkccg.nhs.uk/get-involved/our-projects-and-events/improving-south-east-london%27s-health-services-together/how-to-get-involved/Pages/default.aspx

- The Case for Change has been developed from a number of inputs and sources including:
  - Local Joint Strategic Needs Assessments for each of the six boroughs
  - Commissioning for Value packs provided to each CCG
  - NHSE London Data Packs provided to each CCG and to the South East London Strategic Planning Group
  - Input from Public Health Departments across each of the six boroughs in south east London
  - Stakeholder feedback from our partners across local authorities, local providers, CCGs, our AHSN and LETB, and other key stakeholder organisations
  - Public and patient feedback.

Further development post 20 June submission

- The Case for Change will be updated in September 2014, in line with the next major iteration of the Strategy
- Key areas which will be updated as soon as further information available:
  - Specialised Commissioning – strategic context and scale of financial challenge
  - Primary Care Commissioning – strategic context and scale of financial challenge

The health of south east London's population has improved significantly, but there is much more to do (1 / 3)

South east London has extremes of deprivation and wealth. A high proportion of the 1.67m population live in areas that are amongst the most deprived fifth (quintile) in England, while a smaller proportion live in the most affluent fifth (quintile) in England[1].

The population of south east London is highly mobile. In Southwark and Lambeth, the equivalent of roughly half the current population has moved in or out over a five year period. Even in Bexley, the borough which has the most settled population, the equivalent of roughly a quarter of the current population has moved in and out over a five year period[2].

Premature mortality and differences in life expectancy are both significant issues. There is a difference in life expectancy between the most and least deprived wards of 8.7 years for women and 9.3 years for men. About 11,000 people died prematurely across south east London over the period 2009 to 2011, with four boroughs being classified in the "worst" category for premature mortality outcomes in England[3].

There are large and growing numbers of children living in south east London. Child poverty and obesity are significant challenges.

- Four out of six boroughs are bottom quartile for percentage of children in poverty, with an area average of 27.8% versus national median of 17.1%. The average for CCGs in the top quartile is 10.5%[3]
- Childhood obesity levels in south east London (for year 6 – 10/11 year old pupils) are consistently higher than the London average and significantly above the England average, with levels ranging from 17.3% to 26%. Five out of six boroughs are in the bottom quartile[4]
- Nationally 1 in 10 children and young people aged 5 - 16 suffer from a diagnosable mental health disorder - that is around three children in every class[5]
- Helping our children to get the best start in life (through early interventions and prevention, including access to maternity services, delivering the Healthy Child Programme in full, safeguarding, and support for parents) is critical to our children thriving in childhood and into adult life, especially those from disadvantaged backgrounds.

There are higher proportions of older people living in outer boroughs of south east London. Inner south east London has also experienced an increase in conditions associated with older people through increased life expectancy.

- Bexley (with 6.6% of males and 9.3% of females aged over 75) and Bromley (6.9% of males and 9.7% of females aged over 75) have relatively high proportions of older people compared with other boroughs[3]
- Inner south east London boroughs have also experienced an increase in burden of conditions associated with older people, as a result of increased life expectancy (for example in Lambeth, men now live 5 years longer than in 1995 and women 2.7 years) [3].

[1] IMD 2010, http://data.gov.uk/dataset/index-of-multiple-deprivation, [2] Population mobility based on Census 2011 - ONS Migration Indicators Tool, Mid 2012 data, http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-320124 [3] Public Health England [4] Childhood Obesity Rates 2012/13 - HSCIC, National Child Measurement Programme [5] http://www.youngminds.org.uk/training_services/policy/mental_health_statistics

The health of south east London's population has improved significantly, but there is much more to do (2 / 3)

The biggest causes of premature mortality are cardiovascular diseases, cancers and respiratory diseases. Mortality rates for these diseases have decreased significantly over recent years, but rates continue to be considerably above London average

- Cardiovascular disease: Under 75 deaths from cardiovascular disease in south east London have declined steeply and are now in line with the London average though still slightly above the national average. This masks significant variation between the boroughs, with Greenwich having the highest directly standardised rate at 70 per 100,000 in 2012 compared to Bromley with the lowest at 43. If south east London reduced premature deaths from cardiovascular disease to the levels of the best quartile boroughs in England this would lead to a reduction of 245 premature deaths[1]
- Cancer: Whilst there have been some improvements across the six boroughs prevalence is still above London average. If south east London reduced premature cancer mortality to the levels of the best quartile boroughs in England this would lead to a reduction of 164 premature deaths[2]
- Respiratory diseases: Deaths from chronic obstructive pulmonary disorder across south east London are significantly higher than the national average, driven by high instances in the inner London boroughs. If south east London reduced chronic obstructive pulmonary disorder mortality to the levels of the best boroughs in England this would lead to a reduction of 211 premature deaths[3].

Mental health continues to place the highest burden of morbidity in this part of London.

- A 2011 study identified that in south east London all mental health disorders were associated with substantially lower life expectancy compared to National statistics: between 8.0 and 14.6 years lost for men and between 9.8 to 17.5 years lost for women, depending on the specific disorder[4]
- Nationally, three in four people with common mental health problems receive no treatment, and even for psychotic disorders this figure is nearly 1 in 3. People with severe mental illness are in some cases 3 or 4 times more likely to die prematurely from the 'big killer' diseases, when compared to the population as a whole[5].

[1] Premature deaths from cardiovascular diseases 1993 – 2012 HSCIC Indicator Portal, [2] Cancer Mortality (1993 – 2012) - HSCIC Indicator Portal
[3] Deaths from Chronic Obstructive Pulmonary Disorder (COPD) 1993-2012HSCIC Indicator Portal, [4] Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Care Case Register in London, Chang et al, 2011, http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0019590,
[5] 'Achieving Parity of Esteem between Mental and Physical Health' Norman Lamb MP, Care Services Minister, June 19th 2013 - https://www.gov.uk/government/speeches/achieving-parity-of-esteem-between-mental-and-physical-health

The health of south east London's population has improved significantly, but there is much more to do (3 / 3)

A number of other health issues have been identified as a 'high burden' of ill health across south east London.

- Alcohol-related diseases: there are above average admission rates for alcohol attributable diseases, and an increase in mortality rates. If south east London reduced premature alcohol specific mortality to the levels of the best quartile boroughs in England this would lead to a reduction of 26 premature deaths[1]
- Sexual health: there are the highest levels of HIV and STIs in the country in inner south east London, with a concentration amongst gay men and black African populations for HIV
- Older People: there is a continuing rise in the numbers of people with dementia in south east London, and only about half of the predicted number of current patients are diagnosed and included on GP dementia registers. Older people tend to have multi-morbidities. National estimates are that 12% of people over 65 will have three or more long term conditions, 34% two or more and 67% one long term condition; 2% of patients with chronic disease account for 30% of unplanned hospital admissions, 80% of GP consultations and 70-80% spend is on people with long term conditions[2]
- Diabetes: there in an increasing burden of ill health from diabetes, with rates increasing in parallel with the increase in London and England as a whole. It is estimated that about one in four people with diabetes are undiagnosed.

The outlook is improving across south East London for a number of other health issues identified as 'high burden' of ill health, but these remain significant challenges.

- Smoking: there are still nearly one in five adults in south east London who smoke. Smoking still remains the biggest current direct cause of preventable mortality and morbidity. If south east London reduced smoking prevalence to the levels of the best quartile boroughs in England this would further reduce smoking prevalence by a total of 24,000[3]
- Teenage conceptions: rates are still significantly above national and London averages in inner south east London. The borough with the highest rate was Southwark with 42.7 per 1000 conceptions to under 18 year old young women[4].

[1] Alcohol Mortality (2004-2010) - PHE, Local Alcohol Profiles for England [2] Department of Health consultation on the Information Revolution [3] Smoking Prevalence 2009-2012 - Public Health England [4] Under 18 conception rates per 1000 (2011) - ONS

The national and London context is changing the way that health and integrated care services are planned and delivered

The way in which health and integrated care services are planned and delivered is changing.

NHS England London has told us that:

- London has growing and ageing population and a rise in long-term conditions (both single and multiple conditions) will require better primary care and more integrated care
- People in control of their own health and patients in control of their own care is essential
- The way hospitals are organised is unsustainable and does not support the provision of high quality care
- Research, education, new technologies and a better understanding of diseases will help us transform the health service.

As part of a Call to Action[1], NHS England has identified six transformational service models that will define the characteristics of the NHS in five years:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence.

Quality and safety must be at the heart of commissioning and delivery of local services

- Ensuring high quality care requires providers, commissioners and individual professionals to work together and consider the different dimensions of quality to enable the system to:
  - Systematically drive continuous improvements linked to the overarching outcomes or domains set out in the NHS Outcomes Framework
  - Ensure essential standards of quality and safety are maintained (including the London Clinical Standards).

[1] Transforming Primary Care in London: General Practice A Call to Action, NHS England November 2013, http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/12/london-call-to-action.pdf

Significant developments and opportunities within south east London help us to make a strong and innovative response to the national and London context

Our CCGs are playing a key role in providing clinical leadership for their local health systems. In practice this includes:

- Maintaining a constant clinical focus on improving quality and health outcomes and reducing health inequalities
- Engaging and providing leadership to their member practices in the improvement of local services
- Ensuring that public and patient voice is at the heart of commissioning decisions
- Working with local Health and Wellbeing Boards and local partnership arrangements to deliver local Health and Wellbeing Strategies; and now to develop and deliver plans in relation to the Better Care Fund.

We have a longstanding history of joint working across the six boroughs, including:

- Integrated governance, joint working arrangements for working across the six boroughs
- A history of working across the six boroughs on strategic and transformational work – including A Picture of Health for South East London, and more recently the TSA Implementation Programme at South London Healthcare Trust.

The South East London Community Based Care (CBC) Strategy has begun to transform community based care through three delivery programmes:

- Primary and Community Care: Providing easy access to high quality, responsive primary and community care as the first point of call for people in order to provide a universal service for the whole population and to proactively support people in staying healthy
- Integrated Care: Ensuring there is high quality integrated care for high-risk groups (such as those with long term conditions, the frail elderly and people with long term mental health problems) and that providers (health and social care) are working together, with the patient at the centre. This will enable people to remain active, well and supported in their own homes wherever possible
- Planned Care: For episodes where people require it, they should receive simple, timely, convenient and effective planned care with seamless transitions across primary and secondary care, supported by a set of consistent protocols and guidelines for referrals and the use of diagnostics.

South east London has one of the country's six Academic Health Science Centres (AHSCs), King's Health Partners.

South London Health Innovation Network (Academic Health Science Network) is responsible for sharing innovations across the health system, capitalising on teaching and research strengths to drive lasting improvements in health and wellbeing across South London. Programmes being taken forward locally include diabetes, alcohol, musculoskeletal, dementia and cancer.

Our health services have many strengths but quality is variable and we have tolerated unacceptable and unwarranted variation in quality for too long (1 / 2)

No Trust in south east London fully meets the London standards for safety and quality in emergency care and maternity services.

- Compliance with London Adult Emergency Standards varies significantly. Only 30% of the standards were met by all of the hospitals in south east London[1]
- Across south east London there was broad variation amongst hospitals with no individual hospital either meeting or not meeting all of the key national standards for Adult Acute Medicine, Adult Emergency General Surgery, Emergency Departments, Fractured Neck of Femur Pathway, Paediatric Emergency and Inpatient Medicine, Paediatric Emergency General Surgery, and Maternity Services standards
- In February 2014 Queen Elizabeth's Hospital in Woolwich and Princess Royal University Hospital in Orpington were inspected by the Care Quality Commission under their new inspection regime, designed to determine if they are safe, effective, caring, responsive, and well-led. Both hospitals were scored as 'requires improvement' and in one case, a hospital's safety was scored as 'inadequate'

There is significant variation in the performance of acute Trusts, both within and between organisations[2]. Based on analysis prior to the dissolution of South London Healthcare Trust:

- All Trusts in south east London were in the fourth (bottom) quartile for median time in Accident and Emergency from arrival to treatment
- Patients reported bottom quartile experience of care in three of four Trusts – South London Healthcare, Kings College Hospital and Lewisham Healthcare Trust
- Patients diagnosed with cancer were experiencing higher than average over 31 day waits for their first treatment in the majority of trusts with Guys and St Thomas' being in the fourth (bottom) quartile
- Only Kings College Hospital was above average for number of two week referral to first outpatient appointment for breast symptoms with Guys and St Thomas' and University Hospital Lewisham in the fourth (bottom) quartile
- Three out of four Trusts were in the first (top) quartile for the summary indicator on low hospital mortality, although South London Healthcare Trust was in the third quartile for this measure.

In primary care, many patients find it hard to get an appointment with their GP[2]. The services available are inconsistent and quality and outcomes variable, with lower patient satisfaction scores compared to other parts of England.

- Patients report 4th (bottom) quartile experience of care in four of the six CCGs in south east London with the remaining two CCGs, Lambeth and Lewisham, in the 3rd quartile
- All south east London CCGs have lower than average GP access, with Bexley, Lewisham and Southwark in the fourth quartile nationally; and remaining CCGs in the third quartile
- There is significant variation in achievement of GP outcomes, both within and between boroughs. Between the boroughs, performance varies with between 12% and 54% of practices 'achieving' or 'higher achieving' against GP outcomes. Equivalent England average is 62%
- All south east London CCGs have lower than average (1st quartile) primary care spend compared to the rest of England.

[1] London Quality Standards Self-assessment 2013 – March 2014 [2] South east London Strategic Planning Group Data Pack – NHS England November 2013

Our health services have many strengths but quality is variable and we have tolerated unacceptable and unwarranted variation in quality for too long (2 / 2)

Within south east London there are specific challenges to ensure that maternity services provision meets the highest standards of care and quality and health outcomes[1].

- Failure to meet a number of national standards and key performance indicators, for example screening and first antenatal appointment
- Employment and retention of the highly skilled workforce required to deliver a service across all health settings, linking to performance against the London Quality Standards set out elsewhere
- Current capacity issues, which results in maternity services being suspended at hospitals, and women being diverted away from their hospital of choice. Between April 2011 and November 2012, providers of maternity services across SEL suspended services on 37 occasions
- The Care Quality Commission's maternity services survey 2013, highlighted patients views on areas for improvement in each of the SEL maternity service providers including staff attitude in postnatal wards, pain relief and breastfeeding information and advice.

As a system we have need to improve quality and to drive consistency and productivity in community and mental health services[2].

For Mental Health services:

- Services deliver top quartile performance on only one out of eleven observed outcomes, namely Care Programme Approach (CPA) review in the past 12 months
- Three out of six CCGs had high (bottom quartile) incidents of serious harm in mental health care (Lambeth, Lewisham, and Southwark) whilst the remanding 3 are in the 3rd quartile
- Three of six CCGs have low employment for adults with mental health conditions (Bexley, Bromley, Greenwich).

For Community services:

- Immunisation of children is bottom quartile for Greenwich, Lambeth, Lewisham, Southwark and 3rd quartile for the rest
- All CCGs struggle with patient safety in the community with 5 of 6 CCGs in the bottom quartile for pressure ulcer prevention (all boroughs except Lambeth), and 3 in bottom quartile for falls in the community (Lambeth, Southwark and Lewisham)
- All of the SEL CCGs are in 3rd quartile on delayed transfer of care.

[1] ChiMat website - http://atlas.chimat.org.uk/IAS/ [2] South east London Strategic Planning Group Data Pack – NHS England November 2013

Patient satisfaction is low compared to national benchmarks – and there are common themes regarding how patients would like to see services improved

Patient satisfaction is low compared to national benchmarks[1].

- Bexley, Bromley, Greenwich and Southwark are in the bottom quartile nationally for patient experience of primary care. Bexley, Bromley, Greenwich and Lewisham are in the bottom quartile nationally for patient experience of hospital care
- In 2013 three of the four acute trusts in south east London (Kings College Hospital NHS Foundation Trust, Lewisham Healthcare NHS Trust, and South London Healthcare NHS Trust) scored in the bottom quartile nationally for the friends and family test.

There is rich local feedback regarding how patients would like to see services improved.

Themes identified which are common across boroughs include:

- Primary care is valued highly
- There is a need for better and consistent access to services at local level – and at times convenient to the patient
- There is support for community hubs and access to services in community based centres
- Local public and patients would like more and better information about various aspects of services and commissioning
- People in Lewisham have told us how much they value their local hospital
- There is support for services being more joined up.

[1] London Quality Standards Self-assessment 2013 – March 2014 ** South east London Strategic Planning Group Data Pack – NHS England November 2013

Commissioners face a challenging financial position

For CCGs:

- Analysis by NHS England shows that as demand for services is rising, if we continue with the current model of care and expected funding levels, there could be a national funding gap of £30bn between 2013/14 and 2020/21 - this is on top of efficiency savings already being met. This means that we as NHS organisations need to make our money go further
- Financial modelling carried out based on the final national allocation settlement indicates that the scale of financial challenge for south east London CCGs increases from circa £60m in 2013/14 to £75m in 2014/15.
  This represents around 5% of budgets in each CCG.
  Each CCG has plans in place to close this gap
- For 2014/15 the assumption is that there will be a net impact from the transfer of funds to local authorities to create the Better Care Fund. Proposals for these funds have been developed in collaboration with Local Authority colleagues and taken for approval through Health and Wellbeing boards in March 2014.

Scale of financial challenge for CCGs[1]

Net QIPP savings, 000s	2014/15	2015/16	2016/17	2017/18	2018/19	TOT
Bexley	14,694	8,418	5,193	5,762	5,757	**38,824**
Bromley	12,012	12,140	7,900	5,400	5,400	**42,852**
Greenwich	8,600	7,300	4,300	6,000	6,000	**32,200**
Lambeth	15,319	20,233	17,832	14,645	13,081	**81,110**
Lewisham	9,490	13,119	11,546	9,597	9,833	**53,585**
Southwark	15,591	13,219	10,710	9,007	9,327	**57,854**
SEL Total	**75,706**	**74,429**	**57,481**	**50,411**	**49,398**	**307,424**

For Primary Care:

- The new allocation policy agreed in December 2013 results in London area teams being over target by 2.8% and therefore receiving a base level of funding increase in 2014/15 of 1.60% against a national average of 2.14%. This further impacts in 15/16 with a resource increase of 1.29%
- National agreements on inflation uplifts through the Doctors' and Dentists' Remuneration Body are yet to be agreed but together with ONS population growth set a minimum uplift of circa 2.0% in 2014/15. This presents a minimum funding gap of 0.4%. Changes in the business rules regarding non-recurrent reserves put further pressure on available recurrent resources
- Primary Care across London has achieved a £28m financial savings agenda in 13/14 but has a carried forward requirement of £22m in advance of the 14/15 settlement.

For Specialised Commissioning:

- The challenges faced follow the work done in 2013-14 to arrive at a baseline allocation for specialised services across London
- There has been a significant loss of resources to other regions, and it is recognised that further allocation adjustments between NHS England and CCGs will be necessary at the end of quarter one 2014-15. Until then allocations are based on the outcome of the work done by the London technical group, which was agreed in December 2013
- These services face a reduction of approximately 6-7% in 2014-15, and further cutbacks in later years.

[1] Final 2014/15 Operating Plan Submissions to NHS England (CCG Financial Templates)

Our partners face a similar and interrelated set of challenges (1 / 2)

South east London's acute, community and mental health providers face a similar and interrelated set of challenges and drivers to commissioners

Key issues and drivers for providers in south east London include:

- A constrained financial environment
- The implications of regulatory changes and recent key recommendations in relation to safety, quality and patient care (including the Francis Report, the Berwick Report, recommendations as a result of Winterbourne View, the Urgent and Emergency Care review, and the Future Hospitals Commission)
- Uncertainty in the system about the long term provider landscape and future patient flows
- Local service integration including primary care and integrated community care
- The likely designation process for major emergency departments nationally, with associated investment requirements for providers and impacts on patient flows
- Specialist service consolidation / designation in line with the national strategic direction
- New workforce models in response to the need for up-skill staff to work in community and ambulatory settings and staff shortages within the existing workforce
- Information Management and Technology, which will be a key enabler of change for providers, but will also demand time and investment.

London's ambulance service is facing increasing and changing needs for care

Some of the key factors affecting the service include:

- Increasing demand, whereby over the last three years we have seen significant changes in the health needs and expectations of Londoners, with a total increase in incidents of 5% between 2011 and 2013
- Changing profile of demand by illness, including an 11% increase in alcohol related calls between 2011 and 2013; a 19% increase in chest pain related calls between 2011 and 2013; and an 11% increase in dyspnoea calls between 2011 and 2013
- Gap between demand growth and level of funding
- Changing patient needs including those on an ageing population, high and increasing diversity of population, increasing issues as a result of population not registered with a GP, and the need to address the symptoms of mental illness
- Levels of staff utilisation are significantly above the rest of the country, contributing to high staff turnover.

Our partners face a similar and interrelated set of challenges (2 / 2)

The challenge for adult social care

- Many Local Authorities face unprecedented pressures on their resources and in some instances are looking to save over 30% of their current expenditure over the next 3-4 years
- Adult Social Care provision forms a large percentage of any local authority budget and faces the challenge therefore of reducing expenditure and finding more cost effective ways of working whilst maintaining services that are safe and of high quality. Demand in services is growing in some areas with increasing numbers of older residents, residents living much longer with complex care and health needs, increased mental health service demand alongside the continued need to support those with lifelong health and care needs to live as independently and as full a life as possible
- The Better Care Fund has been established in recognition of the challenge to social care and recognition that this challenge can only be effectively met by redesigning adult social care and health provision together. There is a need for joining care and health services more effectively and where and when they are most needed. Earlier identification of need, supporting residents to be able to help themselves where possible and providing care in a planned way are essential to effective social care services. The challenge is to use this fund and other related expenditure to achieve joint care services that improve peoples' health and care provision rather than cost shunting expenditure from one partner organisation to another
- The overall principles of social care are more challenging to deliver in the current climate but remain as important and have to be addressed in any reconfiguration of services. Service users tell us they want:
  - Care that is co-ordinated and joins up around them
  - Personalised care that gives access to information, knowledge and the resources to be able to support their own care and health more effectively
  - To remain at home and live independently for as long and as well as possible.

Success Criteria

Key overarching criteria against which the success of the Programme will be measured

The vision for the Strategy described in previous pages is our response to the Case for Change and our aspirations for south east London. To deliver the vision (as set out on page 18), the following success criteria have been identified against which the programme will be judged.

- Improved health for people in south east London, measured by:
  - sustained improvement against the NHS, public health and social care outcomes frameworks within all south east London boroughs
  - sustained improvement in life expectancy (indicative of length of live) and healthy life expectancy (indicative of quality of life)
- Reduction in health inequalities across south east London, to be measured through an agreed reduction in inequalities across life expectancy and healthy life expectancy within all south east London boroughs
- Achievement of London Clinical Standards across all services where these apply
- All organisations within the health economy report surplus in 2018/19
- No provider under enhanced regulatory scrutiny due to performance concerns.

Introduction to integrated system model

The Integrated System Model has at its foundation in the recognition that we must, and can strengthen the resilience of our local communities. The Kings Fund recently stated that ***Resilient communities are a critical foundation for public health and clinical preparedness. They enable the sustained ability to withstand and recover from adversity: healthy individuals and families with access to health care, both physical and psychological, and with the knowledge and resources to care for themselves and others in both routine and emergency situations.*** (Kings Fund, 2014) This is the core business of each borough's Health and Wellbeing Board and the partners who have developed this strategy have agreed to ensure that they fully support this work.

Primary and community care services are the cornerstone of health and social care and 90% of NHS is provided in the community. SEL will deliver these services through 24 **Locality Care Networks** which will bring together GP practices with wider primary care and community services to work together to support their communities. Those people with long term physical and / or mental health conditions will be able to access services through integrated teams, which bring together social care and wider local authority services, NHS funded services and the voluntary sector.

For people who are most ill and require NHS care provided in hospitals, it is essential that the different parts of the system are well connected as patients experience care across organisational boundaries.

In addition to primary and community care and long term conditions, physical and mental health, the Strategy focuses on a further five priority pathways which support people across hospital and community settings. This strategy does not seek to address each and every pathway that that patients need but focuses on those pathways that require coordinated approaches across our SEL boroughs and different parts of the NHS system.

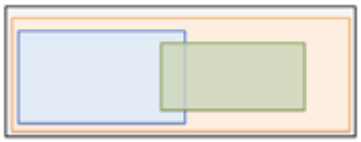
This section is divided into the following subsections:

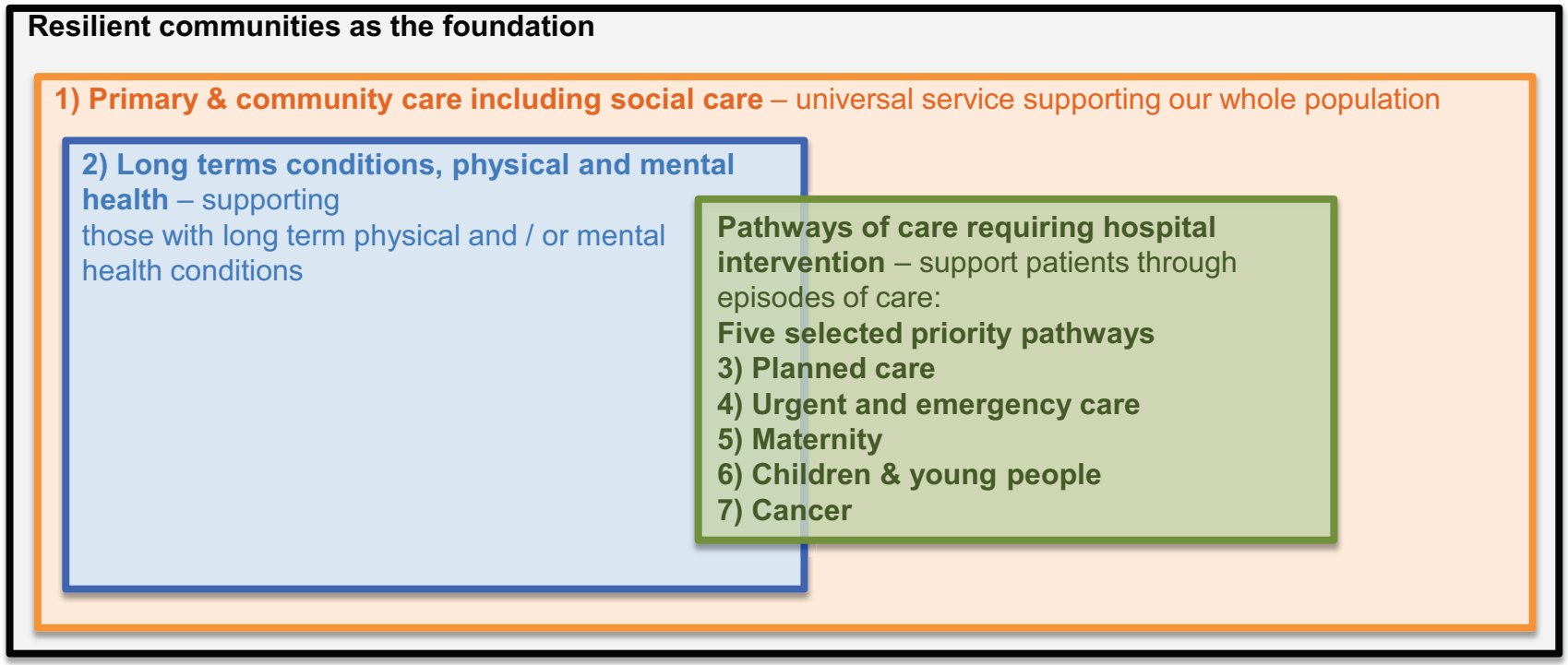
- 4.1 Characteristics of the overarching system
- 4.2 Model
- 4.3 Role of primary care
- 4.4 Approach to long term conditions
- 4.5 Priority pathways
- 4.6 Programme / system level measures

Further development post 20 June submission

The integrated system model will undergo further development and testing, including development through engagement with key stakeholder groups

South east London integrated system model





South east London CCGs and NHS England are working together to develop an integrated care system, delivered through the seven strategic interventions set out above. In this system integrated services will have:

- Involved and informed patients and carers
- Engaged and supportive communities
- Adaptable and capable staff

Underpinned by the characteristics of our integrated system, which are to:

- **Build resilient communities**
- **Promote health and wellbeing**
- **Provide accessible & easy to navigate services**
- **Join up services from different agencies & disciplines**
- **Deliver early diagnosis & intervention**
- **Raise the quality of services to the same high standard**
- **Support people to manage their own health & wellbeing**
- **Achieve improved outcomes for all residents**

System characteristics

The following characteristics underpin how the health and integrated care system will work in south east London:

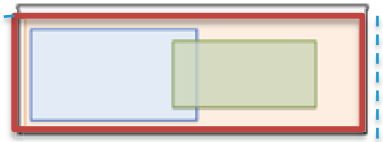
Characteristic of our system	What this means in our system
Build resilient communities	Resilient communities are capable of managing and compensating for adverse situations. They can do this by actively influencing, preparing for and responding to economic, social and environmental change. When times are bad they can call upon the myriad of resources that make them a healthy community. That includes access to good information and communication networks and they can call upon a wide range of resources. Healthy individuals and families have the knowledge and resources to care for themselves and others in both routine and emergency situation with access to health care, both physical and psychological when they need it. We must ensure we reach and support the whole of our population and facilitate a sense of citizenship to support resilience.
Promote health and wellbeing	The promotion of healthy policies and practices to encourage and protect health and wellbeing, e.g. through advocacy, education and training, campaigns. This may be through public health and health promotion, promoting healthy lifestyles, patient empowerment. This includes working with local authorities and health and wellbeing boards to deliver local Health and Wellbeing Strategies and plans. Every part of the system including health and social care need to ensure that “every contact counts” in promoting health and wellbeing. All staff should understand and be able to deliver brief interventions that support the promotion of health and wellbeing.
Provide accessible & easy to navigate services	Helping people to get appropriate health care resources to maintain or improve their health outcomes and supporting them in a consistent, clear way through the health care system. These services should have limited barriers to access and take into account the health needs of the patient. Navigation of services will be facilitated by effective care co-ordination and care planning where appropriate, particularly for people with long term conditions, complexity of care and those patients who are vulnerable or hard to reach.
Join up services from different agencies & disciplines	Working collaboratively across professions, services and organisations (including health, social care and the third sector) to deliver care around the patient. Multidisciplinary teams may include patients, carers, families and communities as well as community nurses, education professionals, social workers, psychiatrists, occupational therapists, various clinicians, and other professions.

System characteristics

The following characteristics underpin how the health and integrated care system will work in south east London:

Characteristic of our system	What this means in our system
Deliver early diagnosis & intervention	Timely and appropriate diagnosis of the early symptoms, signs and stages of a health problem. Effective and early assessment and signposting, appropriate treatment or referral where appropriate. This applies to secondary prevention as well as primary prevention. Primary prevention addresses the root cause of a disease or injury whereas secondary intervention is early diagnosis and prompt treatment to contain a disease and prevent spread to others and/or "disability limitation" to prevent potential future complications and disabilities from the disease.
Raise the quality of services to the same high standard	Ensuring that services and care are delivered to the same high quality standards throughout the system, raising standards across the system to match the best.
Support people to manage their own health & wellbeing	Proactive involvement of patients in their own health, care planning and treatment. This includes the provision of support strategies, information and structures to help people deal with their health problems and to live as normally as possible. For example information about diagnosis, the health care system, access to services and treatment available, involvement in shared decision-making (including use of decision making tools), engagement with health professionals, utilising support from the community and third sector where appropriate. Patients will be involved in the planning of their care, with a written care plan where appropriate. The patient will be involved in the writing of their care plan which will reflect their own responsibility and expectations as well as those of the professionals involved.
Achieve improved outcomes for all residents	The focus of each intervention and the strategy as a whole is to improve the outcome of care for our residents. By outcome, we mean that people will live longer and when people have long term health problems they will experience a better quality of life. For those people who have a terminal illness and can plan their death they will be helped to do this and where they want to be at home, we will enable this to happen wherever possible.

South east London's primary care offer



Clocktower 78,000	**Beckenham Beacon** 55,000	**Eltham** 56,000	**North (Lambeth)** 92,000	**Neighbourhood 1 (Lewisham)** 67,000	**Bermondsey & Rotherhithe** 85,000
Frognall 53,000	**Addington Rd** 55,000	**Excel** 65,000	**South East (Lambeth)** 110,000	**Neighbourhood 2 (Lewisham)** 109,000	**Dulwich** 76,000
North (Bexley) 94,000	**Princes Plain** 64,000	**Network** 69,000	**South West (Lambeth)** 156,000	**Neighbourhood 3 (Lewisham)** 57,000	**Peckham and Camberwell** 59,000
	Chislehurst Rd 62,000				
	St. Pauls Cray 40,000	**Blackheath & Charlton** 80,000		**Neighbourhood 4 (Lewisham)** 66,000	**Borough and Walworth** 72,000
	The Willows 58,000				

TOTAL 1.8m population of SEL

Primary and community care (defined in its broadest sense) will be provided at scale by 24 locality care networks supporting whole populations. This will be a universal service covering the whole population 'cradle to grave'. The changes to primary care will focus on four high impact areas:

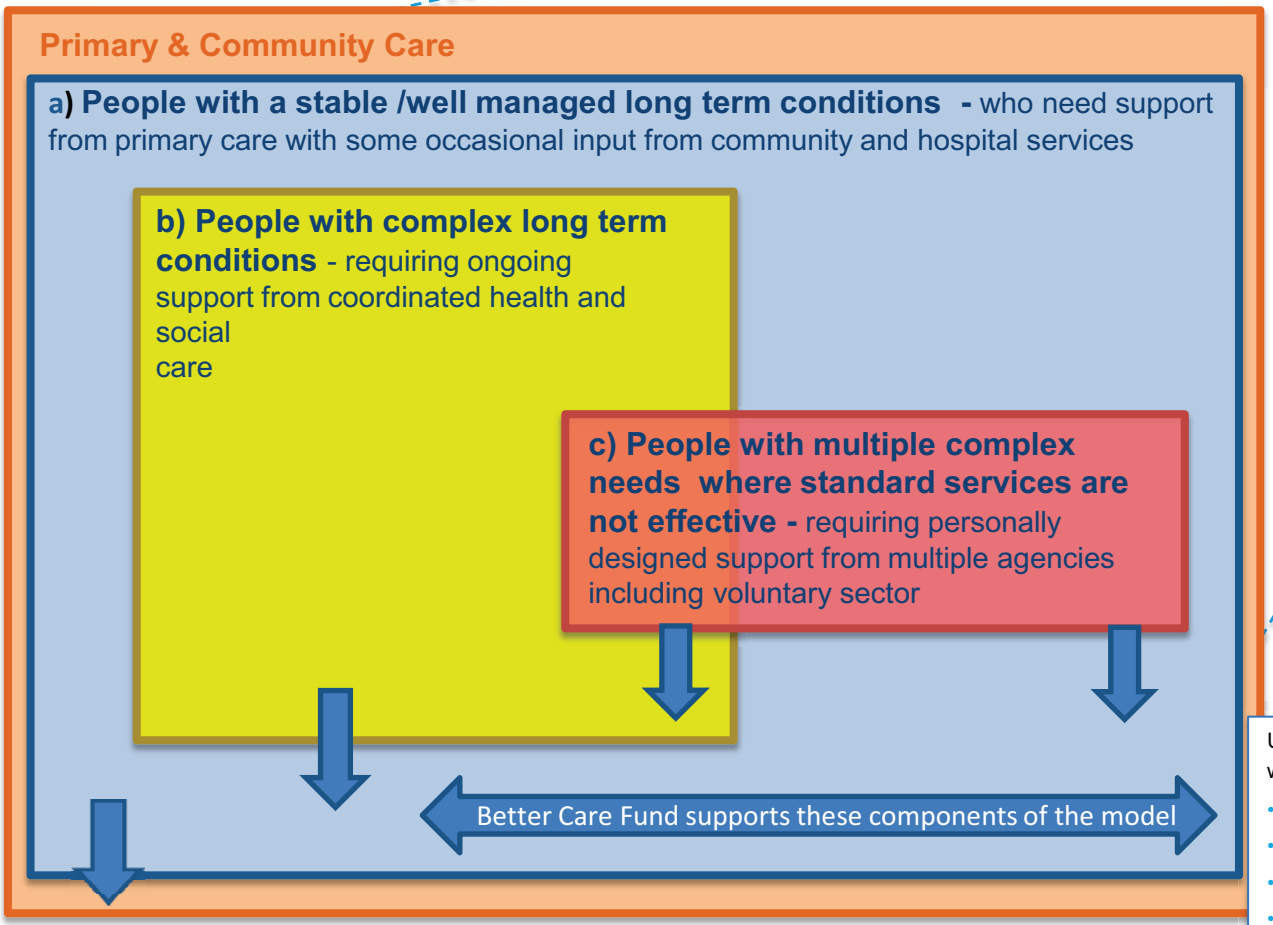
- Proactive care
- Access
- Coordinated care
- Continuity of care

Underpinned by the characteristics of our integrated system, which are to:

- **Build resilient communities**
- **Promote health and wellbeing**
- **Provide accessible & easy to navigate services**
- **Join up services from different agencies & disciplines**
- **Deliver early diagnosis & intervention**
- **Raise the quality of services to the same high standard**
- **Support people to manage their own health & wellbeing**
- **Achieve improved outcomes for all residents**

Long term conditions, physical and mental health

Definition – A Long Term Condition could be diabetes, high blood pressure, multiple sclerosis, being born with a learning disability or acquiring a mental health problem such as schizophrenia. As people age more people have many LTCs including dementia. People with LTC often will suffer from depression and anxiety as well as their physical health problem. Living alone can make managing a LTC harder.

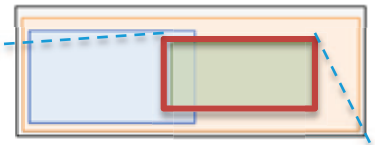


Underpinned by the characteristics of our integrated system, which are to:

- **Build resilient communities**
- **Promote health and wellbeing**
- **Provide accessible & easy to navigate services**
- **Join up services from different agencies & disciplines**
- **Deliver early diagnosis & intervention**
- **Raise the quality of services to the same high standard**
- **Support people to manage their own health & wellbeing**
- **Achieve improved outcomes for all residents**

Key:

Reablement / rehabilitation to enable people to live full and active lives and self manage with support of locality care networks



Priority pathways

EMERGING CONTENT– SUBJECT TO FURTHER REVISION / DEVELOPMENT

3. Planned care including the following key features:	• Pre-treatment and diagnosis: standardised and multidisciplinary approaches; clear care plans; hubs and 'one-stop-shops' where appropriate; diagnostics delivered once in right place at right time; senior opinion early in the pathway; more treatment in the community where appropriate • Treatment: delivered in the most productive and efficient way through standardisation; delivery at appropriate scale; specialty focus on specific areas; movement towards day case procedures - when safe; review current use of outpatient model • Post treatment: As much at home / in the community as possible; 7 day a week transfers to community; early planning throughout pathway • Close collaboration between primary, secondary, social care and social services throughout.
4. Urgent & emergency care including the following key features:	• Rapid access model: home ward + sub acute specialist response (co-located with hospital, emphasis on specialist gerontology/elderly/mental health) • UCC co-located with A&E and out of hours – minor illness, injuries and burns with diagnostics and prescribing • Admit to hospital to 'do and discharge' • Services meeting London Quality Standards
5. Maternity including the following key features:	• Single point of contact – to inform newly pregnant women of their options and choices • Promotion of normalised birth: incl. home birth for multips; birth centres for low risk primips • Continuity of care through a 'midwifery led' model with improved/extended consultant cover • Assessing for women's toxic stress during pregnancy • Services meeting London Quality Standards and other maternity quality standards
6. Children including the following key features:	• Collective focus on the child including, 'every contact counts' • Improved Access – 'no wrong door' • CAMHS/Psychological support • Integrated step-down from hospital designed around child • Services meeting London Quality Standards
7. Cancer including the following key features:	• Saving lives and improving outcomes through prevention and earlier detection, diagnosis and intervention. Reducing variation in care, supporting people and their carers living with cancer as a long term condition and improved end of life care.

Priority pathways support patients through episodes of care, often including hospital care. These pathways have been prioritised based on our Case for Change and strategic context, feedback from our stakeholders and partners. Locality Care Networks will be engaged as patients access these pathway and as will the wider health and social care teams where people have on-going long term conditions.

Underpinned by the characteristics of our integrated system, which are to:

- **Build resilient communities**
- **Promote health and wellbeing**
- **Provide accessible & easy to navigate services**
- **Join up services from different agencies & disciplines**
- **Deliver early diagnosis & intervention**
- **Raise the quality of services to the same high standard**
- **Support people to manage their own health & wellbeing**
- **Achieve improved outcomes for all residents**

Integrated system objectives

All NHS organisations are required to show continued improvement against the seven NHS Outcome ambitions, the NHS, Public Health and Social Care Outcome Frameworks as well as other constitutional measures. A subset of these measures have been identified on which to develop an overall measurement framework for the Strategy. These emerging measures are set out below.

Elements of the "problem we are trying to solve"	Elements of "what are we trying to achieve?"	Outcome measures (Programme level)	Process & proxy measures (Programme level)	System level measures
	Helping people to live independently and know what to do when things go wrong.		➢ (11) Increasing the proportion of older people living independently at home following discharge from hospital	1) Life expectancy 2) Healthy life expectancy 3) Gap in life expectancy 4) COPD mortality 5) Cancer mortality 6) CVD mortality 7) Smoking cessation 8) Healthy weight 9) Alcohol related admissions 10) Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care 11) Increasing the proportion of older people living independently at home following discharge from hospital 12) Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital 13) Emergency admissions 14) Emergency attendances 15) Increasing the number of people having a positive experience of hospital care 16) Delivering the London Quality Standards and other agreed quality standards 17) Health-related quality of life for people with long-term conditions (EQ5D) 18) Sustained financial balance
Too many people live with preventable ill health or die too early.	Making sure primary care services are consistently excellent and with an increased focus on prevention.	➢ (1) Life expectancy ➢ (2) Healthy life expectancy ➢ (3) Gap in life expectancy ➢ (4) COPD, (5) Cancer, (6) CVD mortality ➢ (7) Smoking cessation ➢ (8) Healthy weight ➢ (9) Alcohol related admissions		
	Closing the inequalities gap between worst health outcomes and our best	➢ (3) Gap in life expectancy		
We don't treat people early enough to have the best results.		➢ (4) COPD, (5) Cancer, (6) CVD mortality		
Patients tell us that their care is not joined up between different services.	Developing joined up care so that people receive the support they need when they need it.		➢ (12) Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital ➢ (13) Emergency admissions ➢ (14) Emergency attendances	
People's experience of care is very variable and can be much better.	➢ Delivering services that meet the same high quality standards whenever and wherever care is provided. ➢ Reducing variation in healthcare outcomes by raising the standards in our health services to match the best.		➢ (15) Increasing the number of people having a positive experience of hospital care	
The outcomes from care in our health services vary significantly and high quality care is not available all the time.		➢ (4) COPD, (5) Cancer, (6) CVD mortality ➢ (10) Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	➢ (16) Delivering the London Quality Standards and other agreed quality standards	
	Supporting people to be more in control of their health and have a greater say in their own care.		➢ (17) Health-related quality of life for people with long-term conditions (EQ5D)	
➢ The money to pay for the NHS is limited and need is continually increasing. ➢ It is taxpayers' money and we have a responsibility to spend it well.	Spending our money wisely, to deliver better outcomes and avoid waste.	➢ N/A	➢ (18) Sustained financial balance	

Introduction to Improvement Interventions

The Clinical Leadership Groups have taken forward the development of the seven key improvement interventions. This section sets out the following elements for each key intervention:

- Service vision
- Service model

Each improvement intervention is described over the following pages, Section 5.1 – 5.7. Section 5.8 sets out a consolidated system roadmap detailing the route to implementation for the improvement interventions (to follow for 20 June draft). The emerging impact of each intervention against programme measures is then set out in Section 6.5.

Content on the vision, model and impact for each intervention are still very much a live working content and should be considered in the context of continuing development, testing and iteration.

Further development post 20 June submission

The following will be progressed for each intervention post 20 June:

- Detailed engagement with stakeholders including re-engagement with local authority colleagues post the purdah period
- Further development of the service model and its underlying components
- Quantification of the impact of key changes and elements of the service model (links to Section 6)
- Exploring the implications: what does this mean in practice for communities, institutions and organisations
- Developing a more detailed understanding the implications for supporting strategies (Section 7).

Primary and community care

Service Vision

Summary of emerging Vision themes

- Primary care in the broadest sense delivered to geographically coherent populations and at scale (up to 150,000 population, certainly 40,000 to 80,000)
- A broadly defined “care team” for the population, including community & community mental health services, social care and specialists rather than individual teams, that come together based on patient need
- Services delivered in ways that respond to the varied needs and characteristics of our communities
- Primary and community care which delivers prevention, coordination, access and continuity
- Clear outcome measures that can demonstrate what difference the strategy and its implementation will make
- Primary and community care delivered to consistently high standards across south east London
- Recognition that the future model needs to be sustainable, with a shift in the balance of spend towards prevention
- This will require investment. The percentage of spend will be greater in 5 years time than it is now

Primary and community care

Service Model (1 / 5)

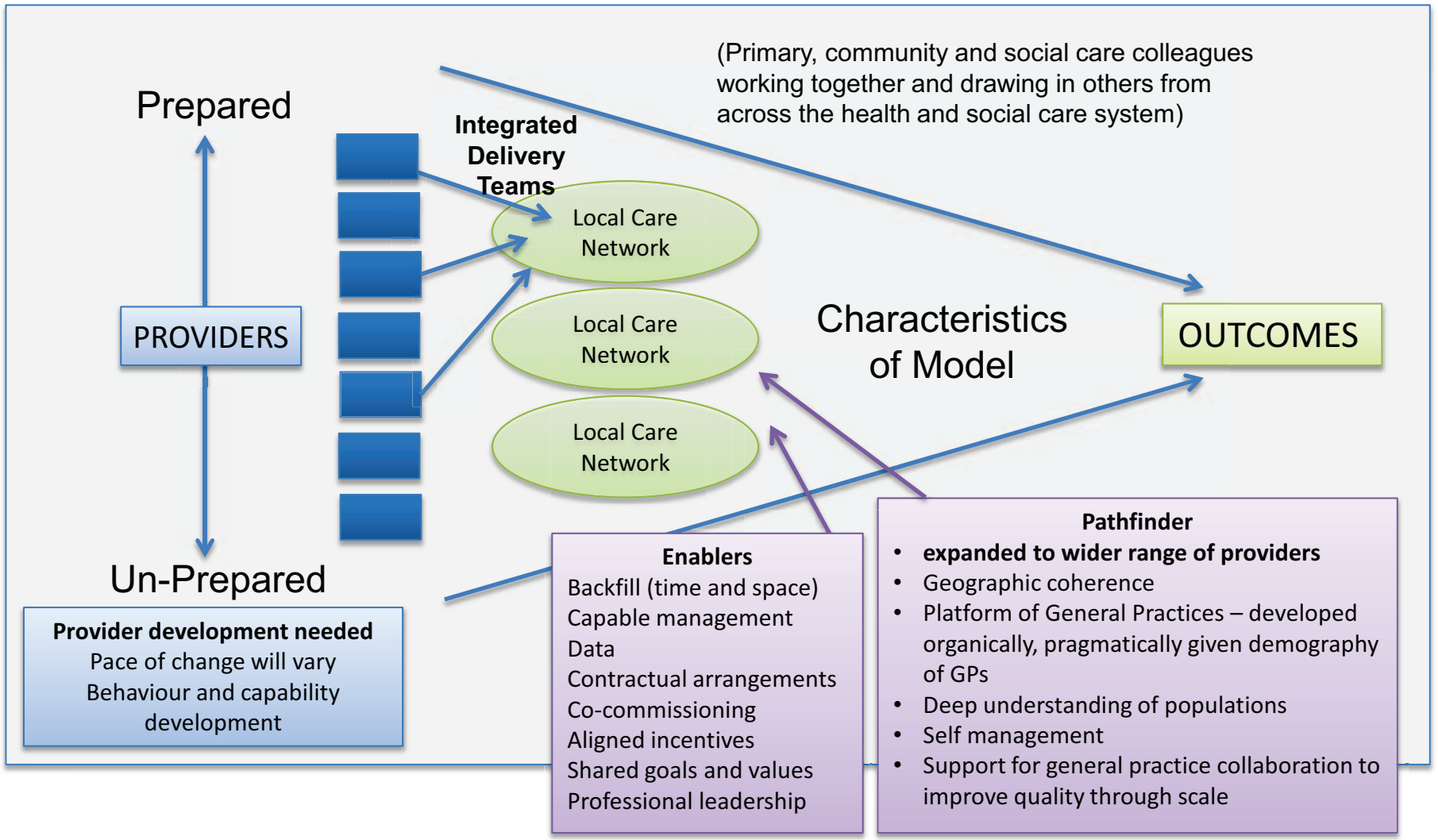
Characteristics of a Primary and Community 'Model'

- Population based and geographically coherent as the basis for primary and community care services
- Broadly defined integrated 'care team' (general practice, community services, social care, mental health, pharmacy, specialist care), with registered list held by general practice at its core
- Enhanced range of services available out of hospital - equitable and consistent quality of care and service offer
- Flexible and responsive to both population and individual patient needs
- Architecture reflective of population characteristics or segments within it
- Relational dependency between or within providers
- Emphasis on early prevention in all areas of care
- Stronger links with mental health, pharmacy and social care
- Sustainable – both the service and system beyond five years
- Exact form may vary… BUT local care networks of community based providers, forming the platform for integrated care systems that utilise the registered list as a unique feature of our primary care system
- Key service characteristics: proactive, accessible & coordinated service, with a flexible, holistic approach, offering continuity

Primary and community care

Service Model (2 / 5) – Key characteristics

A visual 'Model' of the characteristics of the model identified, based on aligning population outcomes and development of integrated delivery teams to deliver them.



Primary and community care

Service Model (3 / 5)

To address the challenges in primary and community care and support the emerging model that will drive its transformation, four high impact interventions have been identified. These are activities and interventions which contribute to improving health and wellbeing by increasing self-reliance, capacity and resilience in both patients, the people who support their care and across local community networks.

Proactive Care – providing a holistic approach that supports population health, wellbeing and prevention building on community networks and encouraging self-reliance.

- Locality Care Networks delivering an 'Every contact counts' approach where each patient contact is an opportunity to address a patient's preventative health needs, to sign post or provide brief intervention and to share a record of that encounter across the network of delivery
- Greater sense of shared responsibility - Primary and community care working with others to support and empower people to take responsibility for their own health, to remain healthy and to stay connected with their community by being able to identify the kind of services that would be most beneficial for them
- Residents have access to and are encouraged to have a personal health plan even if they are generally well, to help them lead a healthier lifestyle
- Residents will be engaged upon and informed about the services available and will be sign posted to appropriate services to help them achieve health and wellbeing
- Local Care Networks that reach out to people who have difficulty accessing services or would benefit from greater access to ensure that they get the appropriate care they need
- Local Care Networks will prioritise ease of system navigation for their population through shared directories of services and single points of access right across health and social care and wider community services (e.g. Housing). A navigator role (with the appropriate skillset) will be key in patient awareness of the services available and personal planning to stay healthy
- Population focused networks of care will strengthen screening and immunisation efforts as a key part of prevention
- Use of technology to more efficiently and more comprehensively support and enable better proactive care

Primary and community care

Service Model (4 / 5)

Accessible Care – supporting all patients, irrespective of their individual circumstances, lifestyle and condition, by providing options to access care that are appropriate to their needs and support their continuity of care.

- Local Care Networks (to be locally defined) will enhance the accessibility of the local community based health and social care system rather than give focus to default and traditional access points. Local Care Networks will provide local access plans which will be determined by and respond to local population characteristics and needs (e.g. language, religion, culture, population mobility)
- Access to care as appropriate – e.g. accessing urgent appointments as needed, which may need to be supported by robust triaging, care navigators (to access complex care), better patient information and incentives to deliver the appropriate care on contact where possible. Access will be based on a minimum offer of care with tiered enhancements as needed
- Strong marketing and branding of the range of primary and community care available to better inform all patients on how to access services
- There are systems within each Local Care Network (LCN) to ensure patients receive appropriate care and in appropriate time in the case of emergencies
- Patients would then have a choice of access options and can decide on the route most appropriate to their needs. Patients with urgent conditions can access the appropriate service on the same day. Local Care Networks will ensure the inclusion of the wider health and care professionals as part of any same day access offer
- Patients can access pre-bookable routine appointments for general practice (Monday to Saturdays) and can access primary care 8am – 8pm every day in their local geographic area for immediate, urgent and unscheduled care
- Use of technology to improve access to support different types of patient interactions that are appropriate to their needs
- Access to services underpinned by an understanding of the key factors that affect patient experience and access to services e.g. patient transport

Primary and community care

Service Model (5 / 5)

Co-ordinated Care – providing an enhanced level of service for patients who require continuity, support, care planning and continuous review in order for them to live a healthier and stable lives in their communities.

- Local Care Networks will systematically identify those people in their area that will benefit from co-ordination of care and a care plan
- Those patients will have a care plan that is:
  - accessible by all care professionals across all providers (in all areas of care) in the network to promote a proactive, integrated, coordinated and holistic approach to patient care, to ensure that every contact counts
  - patient focused which will be regularly reviewed to ensure that it is up to date
  - based on patient goals to support patient agreement and ownership to their care plan and better self-management
  - is patient owned and acts as a patient "passport" to their health services
  - managed by a care coordinator (with the appropriate skillset) when necessary
- Linked to proactive care – Local Care Networks will ensure that all patients have a right to care plan as early as possible to promote better health and well being

Continuity of Care – providing continuity of care for patients who need it, enabled by the effective and timely communication and information sharing between heath care professionals, which ensures that patient care can be coordinated by one clinician or safely transferred between clinicians to provide consistent and coordinated care

- LCNs, working with other related providers or people, identify patients who benefit from coordinated care and proactively review them on a continuous basis and on moving to the LCNs, to ensure good care
- Patients have a named health care professional at the relevant skill level who is accountable for their care
- Having a care coordinator (with the appropriate skillset) who will coordinate the patient shared care plan and effectively navigate through the health system, in coordination with the health care professional accountable for the patient's care and the patient

Long term conditions, physical and mental health

Service Vision

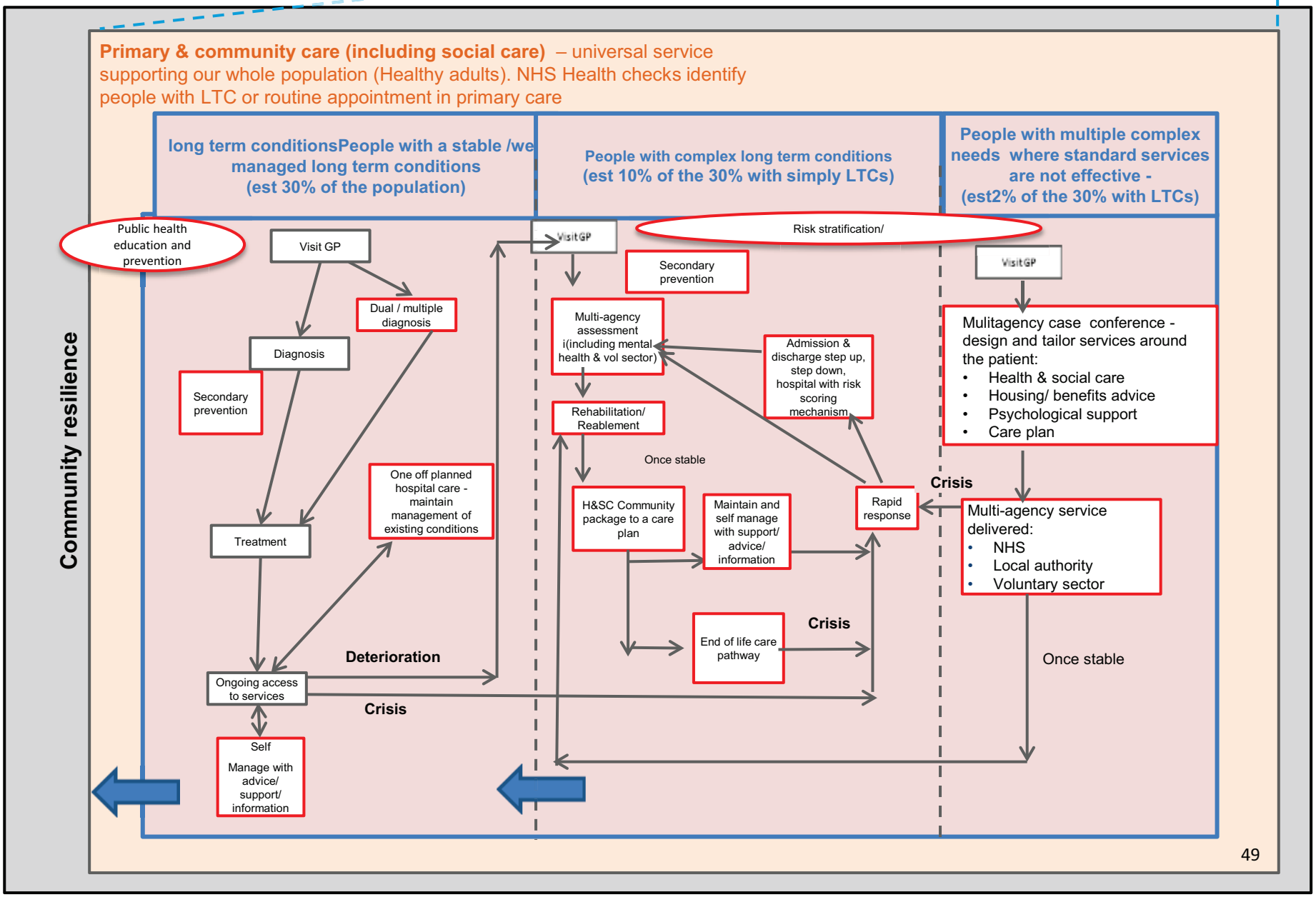
'Ensuring there is high quality integrated services for high risk groups (such as those with long term conditions, the frail elderly and people with long term mental health problems) and that providers (health, social care & 3rd sector) are working together, putting individual citizens at the centre. This will enable people to be active and to feel well-supported in their own homes wherever possible.'

Integrated services will have:

- Involved and informed patients and carers, with care plans developed by and with them, to support them to stay independent and active
- Engaged and supportive communities helping patients to continue to live at home
- Adaptable and capable staff – working together between hospital and community services, mental health, social care and the voluntary sector to provide joined up, flexible assessments and care packages to provide a seamless service from a patient's perspective
- Services designed around the individual patient's needs, with a named care coordinator to ensure these are delivered effectively, and to encourage self-management
- Information flows and record sharing between providers to support coordinated care and proactively identify patients before a crisis
- Connected and intelligent IT that shares health information not just data and the use of systems such as Telehealth to support self-management
- Responsive services so that patients are confident they will receive a prompt assessment if they are at risk of admission to hospital, and proactive discharge planning when necessary
- A relentless focus on the health and well being of people with long term mental health, particularly depression, and physical health problems

Long term conditions, physical and mental health

Service Model (1 / 2) - Emerging more detailed model



Long term conditions, physical and mental health

Service Model (2 / 2) - Long term conditions model in action

The Long Term Condition model is one system that describes different levels of complexity depending on the person's need. People can move between the elements as required. People with physical and mental health problems will be supported by integrated health and social care teams and will access specialised services are required with information flowing between services so that the person experiences a continuity of care. Primary care will be at the heart of the model of care.		
a) People with a stable /well managed long term conditions. Identified by NHS Health Checks or routine appointment with primary care. Where people's condition is not being well managed they would move into complex condition pathway	b) People with complex long term conditions identified by primary care or through systematic risk stratification. The aim is to support people from teams working together. Only where this is not working would they move into the multiple complex need pathway	c) People with multiple complex needs where standard services are not effective identified by any services or risk stratification. The aim will be to take a problem solving approach and to support people from standard services.
Services mainly GP and pharmacy with access to hospital and wider community care as required. Mental health screening for depression and anxiety for people being diagnosed with LTC.	People who have ongoing need for ongoing support to live their lives. Identified by GP or through risk stratification. Locality care networks to coordinate services.	People who access many different services frequently but are not having their needs met. Likely to experience mental health problems and lack support from family networks
Focus on secondary prevention with the aim of improving underlying condition and preventing deterioration/ development of further long term conditions		
Support to the person to manage their own condition through information and signposting; support groups etc.	Multi professional and multiagency assessment including voluntary sector, reablement and rehabilitation with a care package to support once stable or end of life care pathway	Wider multi agency / professional assessment with involvement of wider council (housing, benefits etc), voluntary sector as well as health & social care. Problem solving approach.
Aim to live full and active life with access to primary care as required.	Access to rapid response if care needs change suddenly; care package reviewed with further reablement. Admission to step up/ step down or hospital facilities as required with the aim of enabling people to live their lives fully. Includes support to die at home.	Unique package of care to support the individual to live their life. Transfer package into (b) as required and to support in a crisis. VIP access to services to keep people safe should changes occur.
Focus on reablement and rehabilitation at each step to enable people to live a full and active life and not depend on services except where necessary.		

Planned care

Service Vision

A seamless, high quality planned care service that enables patients to be seen by the right person, in the right place, at the right time.

'*For episodes where people require it, they should receive simple, timely, convenient and effective planned care with seamless transitions across primary and secondary care, supported by a set of consistent protocols and guidelines for referrals and the use of diagnostics*.'

An effective Planned Care service will be based on a number of emerging **design principles**:

- Where possible and appropriate take standardised approaches, including:
  - For providers (GPs, community and acute): processes, equipment, implants and consumables, discharge planning, preoperative care, pre-hospital care and assessment
  - For commissioners: agreeing standards and a common commissioning approach across south east London; agreement of standardised referrals processes and access protocols
- Organise elective and diagnostics services based on pathways with similar patient flow characteristics and separate these flows where appropriate. This is not as simple as a top-down separation of elective and emergency surgery
- Expert involvement (though not necessarily from a hospital consultant) as early as possible in the pathway. Where appropriate involvement of hospital consultants in community referrals
- Having the right information (patient information, tests, diagnostics) in place early in the pathway, and in a way that follows the patient and avoids duplication, inefficiency, re-work
- Involving patients throughout the design of service models and ensuring that they are supported and empowered in their decisions
- Reassign tasks to optimise scarce skilled resources, with staff focusing on the tasks most appropriate to their level and expertise
- Where we have capacity in the system (for example staff, equipment), make best use of this.

TO BE FURTHER DEVELOPED FOR 20 JUNE DRAFT

Planned care

Service Model (1 / 3) – emerging model

TO BE TESTED WITH CLINICAL LEADERSHIP GROUP

Enablers
- **Workforce** - empowered, skilled, trained, supported, cultural change
- **IT** - shared access of appropriate information
- **Patient engagement in design**
- **Commissioning differently -** and in a way that makes sense across south East London
- **Clear Communications -** supporting everything we do

Pre-treatment and diagnosis
- Standardisation
- Patients involved, communication, engagement and expectations
- Clear care plan
- Multi-disciplinary approach
- Hubs and one-stop-shops where appropriate
- Diagnostics - once in right place at right time
- Senior opinion early
- Reduced handoffs
- Reduction in waiting for all diagnostics
- More treatment in the community - where appropriate

Treatment
- Productive and efficient
- Standardisation
- Appropriate scale
- Specialty focus in specific areas:
  - orthopaedics
  - ophthalmology
  - urology
  - others (to be defined)
- Use critical mass
- Movement towards day case procedures - when safe
- Review current use of out patient model

Post treatment
- As much at home / in the community as possible
- 7 day a week transfers to community
- Early planning throughout pathway

Outcomes
- Every contact counts - all pathways and providers
- Incentives aligned to outcomes
- Outcome focused approach to pathway
- Through commissioning:
  - Measure the value - the patient reported outcome as well as clinical outcomes as a measure
  - Measure outcomes not inputs
  - Measure productivity and efficiency

TO BE FURTHER DEVELOPED FOR 20 JUNE DRAFT

Planned care

Service Model (2 / 3) – emerging characteristics

Key characteristics of a potential service model are set out below. These have build on evidence and best practice and have been further refined to reflect the emerging thinking of the Planned Care Clinical Leadership Group at their seminar on 28 May 2014

Scope	• Models should be developed based on pathways with similar patient flow characteristics. Potential pathways to further explore: end to end eye services, orthopaedic surgery (or with specific focus e.g. hip and knee replacements), urology, gynaecology, general surgery, standardised approach to MSK.
Access and referral	• Access policies for elective care and cancer shared with primary and community care. This will help GPs outline to patients prior to referral the patient's responsibilities to attend appointments • A pathway approach with agreed standards to managing referral to treatment and patient information • A referral management or assessment service that accepts referrals and may provide advice on the most appropriate next steps for the place or treatment of the patient? • Central point of receipt of referral that includes prioritisation and triage of referrals and effective booking of appointments.
Diagnostics	Approach diagnostics on a pathway basis rather than in isolation: • Consider having a single two-week diagnostics pathway replicating the approach taken for the cancer two week pathway • GP direct access to diagnostics to reduce the length of a patient's non-admitted pathway and reduce any unnecessary onward referral to a consultant led service • Efficient booking of patients referred for diagnostics • Walk in diagnostics to reduce the timeframe from referral to treatment • 'Sweating' of existing assets and capacity – longer working days / potential remote models • Explore potential for diagnostics capability / hubs situated across the Locality Care Network structure.

TO BE FURTHER DEVELOPED FOR 20 JUNE DRAFT

Planned care

Service Model (3 / 3) – emerging characteristics

Key characteristics of a potential service model are set out below. These have build on evidence and best practice and have been further refined to reflect the emerging thinking of the Planned Care Clinical Leadership Group at their seminar on 28 May 2014

Improving patient outcomes and experience	• Planned patient scheduling to ensure that all patients are reviewed in the clinically appropriate timeframe • The use of shared decision making and other tools • Standardised approaches to pre-hospital care and assessment, preoperative care, discharge planning • Post operative care provided by dedicated team to follow up patients with effective liaison with primary and community care.

Workforce	• Use of multi- disciplinary teams – for example building on the success of the cancer 'MDT' approach
	• Consultants working on rotation avoiding de-skilling units and breaking up pre-existing teams
	• New ways of working for staff and utilisation of greater skill mix where appropriate
	• Reassign tasks to optimise scarce skilled resources, with staff focusing on the tasks most appropriate to their level and expertise:
	  • Trained nurses carrying out less demanding / complex medical processes where clinically appropriate rather than consultants
	  • Consultants working at the 'top of their license'
	  • 'Super-triage' roles.

Information and measurement	• Patient pathway management information based on milestones: first outpatient appointment, key diagnostic test or tests, diagnosis, decision to treat, multi disciplinary team discussion, transfer to another provider, treatment (or decision not to treat) • Agreed KPIs for key parts of the pathway, for example: patient experience & outcomes, theatre productivity, end to end flow, all waiting & defects • Better use of technology to speed up reporting cycles.

Urgent and emergency care

Service Vision

There is a high quality consistent 24/7 emergency and urgent care service in which patients are seen quickly by the right person in the right setting with the following components:

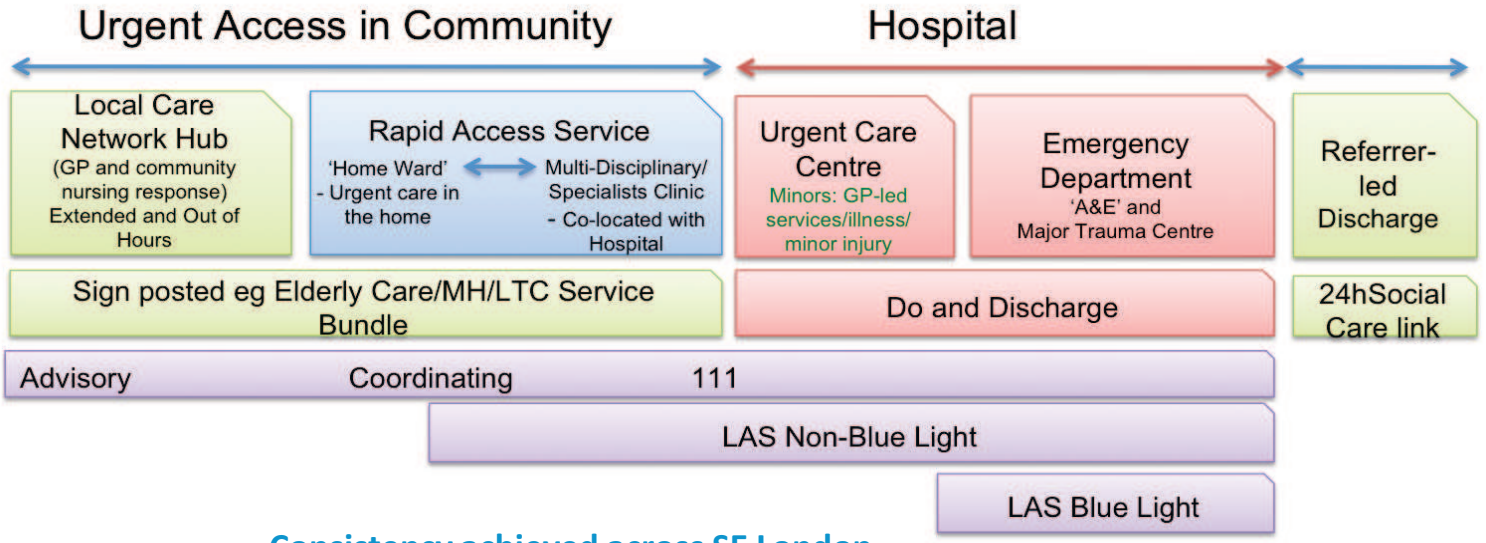
- A proactive, multi-agency approach to managing patients and helping them to remain in the community
- A risk stratification approach that identifies patient at risk and manages them in the community
- When needed, there are services the patient can be referred to for assessment, diagnostic tests and simple treatments in the community (A Rapid Access Service of home ward and specialist clinic co-located in a hospital)
- A&E is truly a specialist service for those in need of emergency care that can only be delivered in hospital
- Care planning for discharge home or normal place of residence commences from the start of an episode of urgent care, with the aim of getting a patient home quickly
- All parts of the health and social care system collectively own and manage system blockages together and throughout the year, seek to improve patient flows and reduce length of stay. This is supported by strong commissioning arrangements to include arrangements for care homes, joined up Information Technology (IT), telemedicine and 'referrer-led' discharge. Emergency and urgent care is supported by Virtual Patient Record and information sharing
- The system is collectively monitored on outcomes with improvements in morbidity, mortality and patient experience, supported by a dashboard, which includes patient experience

Urgent & Emergency Care

Service Model (1 / 4)

Note: further work underway to explore how the service model for urgent & emergency care may be further brought together with thinking on proposed locality care networks

Note:
ED = Emergency Departments (A&E in DGH, Major Trauma Centres)
UCC = Urgent Care Centres



Consistency achieved across SE London

Urgent Access in the community

- 24/7 access across Urgent and Emergency Care
- Local Care Network Hubs deliver more of urgent care – in extended hours
- Rapid Access Service: Home Ward + Specialist 'centre/clinic' co-located with hospital – Multi-disciplinary
- Channelling patients to appropriate services, using risk stratification, full ranges of community and care services wrapped around general practices
- Care homes patients provided with assessment and treatment close to home to support patients with LTCs including mental health – avoiding unnecessary admissions and reduce presentations at Emergency Departments
- Signposted service for elderly care 'bundles of care' away from EDs and UCCs, with a single point of access for all services in the community
- Different relationship and interface between acute/community services and care homes . Give all settings the confidence to 'hold' patients
- 24/7 Cross Boundary Social Care Link implemented including 'Referrer Decides' to facilitate discharge
- Enhanced 111 role as coordinator of responses and sign posting

Urgent Care Centres, Emergency Departments

- Implementation of networks based on London Trauma, Stroke, Cardiology, pathways into community care or hospital
- GP/Primary-led services in UCCs
- Minimum Band 6 Emergency Nurse directing streams into ED
- EDs (local DGH) see fewer patients but with greater acuity
- UCCs manage some/more non-blue light flow and stream patients through faster i.e. compliance with LQS targets
- Experts at the front 'door' getting initial decision right (extends the approach in the Trauma and Stroke pathways)
- 'Do and Discharge' implemented; reducing Length of Stay
- Balanced configuration of Major (Trauma) and Local DGH A&E Centres in SE London in which demand and capacity are aligned
- Integrated net of health and social care out of hospital – clear access routes, mutual understanding of patient need using automated, real-time patient records and tests tracking - connected to signposted services
- Access to paediatric specialist at 'front door'
- Mindset is that whilst ED is a specialist service it sees itself as an extension of community working

Urgent & Emergency Care Service Model (2 / 4)

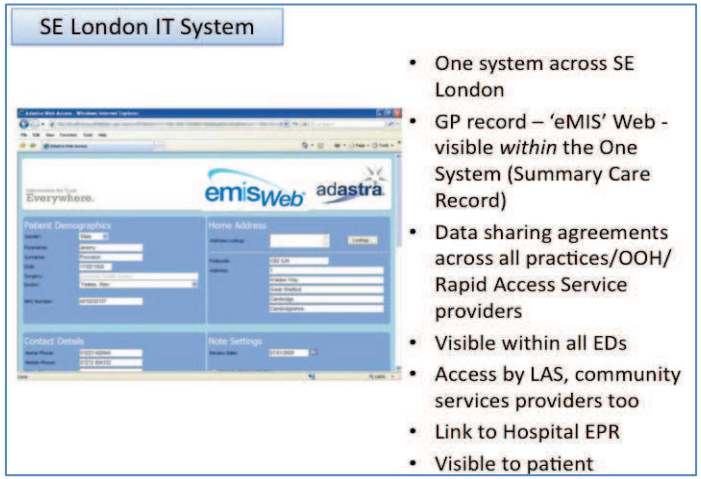
Local Care Network (LCN) Hub (GP and community nursing response)	Extended and Out of Hours GP/Primary cover

- Local Care Network (LCN) Hubs supporting urgent care, includes EDs able to book urgent appointments with GPs (PCC CLG to define)
- Extended LCN Hub hours and Out of Hours giving 24/7 cover (PCC CLG to define)
- Staffed by GPs, primary care nurses
- 24/7 (extended hours and out of hours services when closed)
- Access to GP appointments by ED
- Out of hours covers services when closed
- Vision for improved timely access
- Access to specialists (e.g. through Telemedicine/Hotline and also see ED (Bypass phone number for ED consultants with GPs or/and access to shared email inbox service)
- Out-of Hours co-located with ED

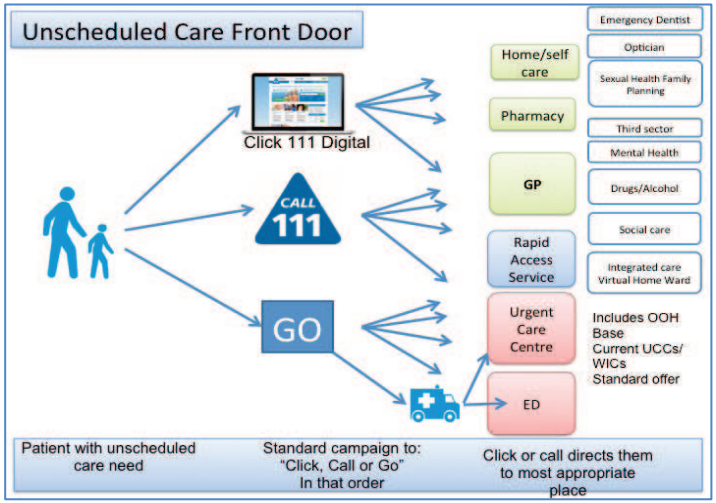
111 Advisory & Coordinating
LAS Conveyancing to right place

- 111 Call handlers educated/trained in the model (advice and coordination)
- 111 Triage role pre-ED attendance – need to know other parts of system
- 111 24/7 Managing 'appointments' to Out-Of-Hours service or ED – explicit role in demand management
- 111 Key access and signposting role – advising and coordinating – see chart below
- 111 enhanced capability: Directory of Services simplified, accurate, up-to-date; excel in navigating patients, operating an 'internal triage' approach to improve directing patients to best access point
- LAS – rapid access to information/ medics (patient specific plans) – dedicated phone line to GPs during opening hours
- LAS implements 'intelligent conveyancing' and Alternative Care Pathways successfully
- LAS Non-blue light goes to ED 'Initial Contact'

IT – virtual record; NHS No. as identifier to enable coordinated care



Improved and timely access to unscheduled care

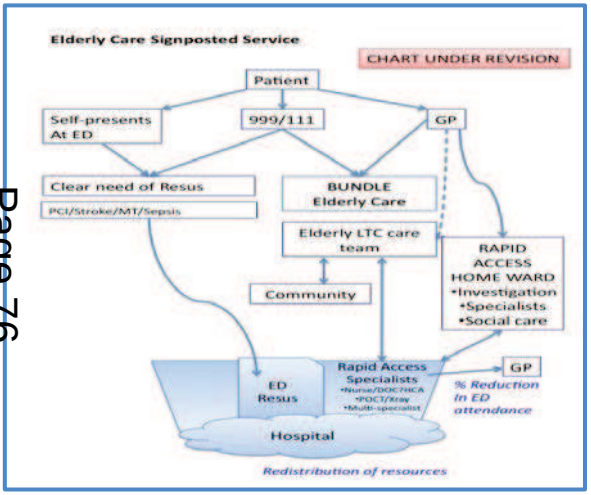


Urgent & Emergency Care Service Model (3 / 4)

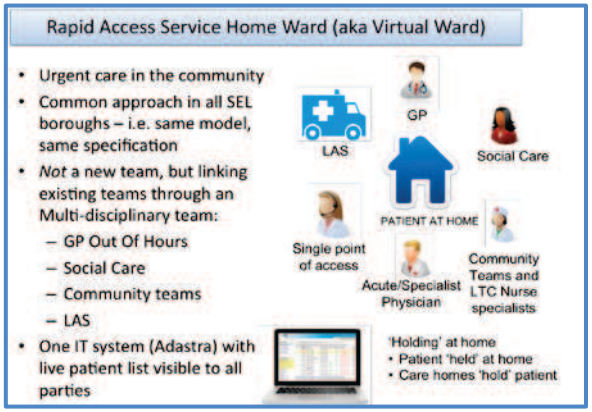
Signposted Elderly Care

'Bundles of care' supporting navigation

- Role of the voluntary sector in-reaching and ongoing support to avoid unnecessary admissions and speed up discharge
- Elderly Care LTC team navigate care



Home Ward



Rapid Access Service:

Home Ward + Specialist Response 'clinic' (Co-located within Hospital)

Rapid Access Service

Home Ward + Specialist Response 'clinic' (Co-located with Hospital)

- Community based team with single point of access
- Consistent approach to service across Elderly/MH/Social care pathway
- Gerontology service for home and hospital-based, assess and treat
- GP/Healthcare referral – possibly carers
- **111 Flag 'known to system'**
- Telemedicine – clinical advice to GPs including acute physician and navigation service for GPs (specialist nurse?)
- Direct access for MH/Alcohol in same model
- Rapid discharge support including cross boundary
- Also preventing re-admissions post hospital discharges
- Networked services away from major centres
- IT integrated – One system/'eMIS' Web and patient-held – see chart on previous page
- Very rapid response directing (Single point of access) to:

Home Ward (Urgent care in the Home) – see chart on left

- Consistent 'Home Ward' capable of assessing and treating people in their own home or nearby, including LTCs
- 'Holding' the patient safely until patient can move to next part of the system
- Care homes are confident of holding patient and bringing assessment in

Specialist response (Co-located with hospital): 'Specialist' Gerontology/MH/SMU community service in a hospital

- Complex needs, holistic, risk stratification
- Blood and urine testing, X-Rays, examination couches (not beds)
- 1st call within 24hrs
- Multi-disciplinary service
- Support discharge home

Urgent & Emergency Care Service Model (4 / 4)

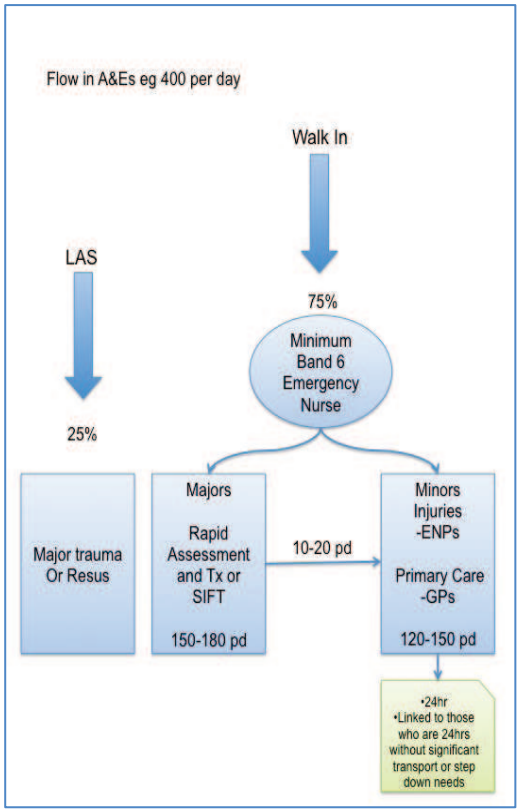
Urgent Care Centre

- 24/7
- All ages, 'No Wrong Door' principle for children
- LAS non-blue light brought to UCC
- Minor illness, injuries and burns
- Diagnostic, X-Ray, Prescribing – antibiotics, analgesics
- Co-location with A&E and Out of Hours – both 24/7
- Non co-located UCC may only be able to operate 12/7 depending on access to diagnostics and access to specialists (e.g. through Telemedicine/Hotline and also see ED (bypass phone number for ED consultants with GPs or/and access to shared email inbox service)
- UCC manages 1st access and triage to A&E if necessary for non-blue lights; Exclusion criteria defined and managed proactively; Flow management protocol (streams)
- Streams managed by GP or experienced nurse – an 'appropriately trained' clinician
- Workforce development across whole system in A&E – GPs with interest and A&E nurses seeing more
- Complete clarity in the information to patients

Emergency Departments

EDs

- Implementation of London Trauma, Stroke, Cardiology, pathways; Experts at the front 'door' getting initial decision right (extends the approach in the Trauma and Stroke pathways)
- Link to Specialist - Rapid Access Service reducing non emergencies; Bypass phone number for ED consultants with GPs or/and access to shared email in box service
- Do and Discharge – see below
- Co-locate with UCC in same area; Common governance model
- Ability to view patient records (passive) with need to record patient consent; includes diagnostic tests and imaging
- Flow management – see chart right
- Clinical Decision Units (CDUs) provide appropriate assessment and treatment completed within 24 or 48 hours and thus preventing formal hospital admission
- CAMHS intensive support to avoid admissions



Do and Discharge (avoiding Admit to do)

Do and Discharge

- **Avoid 'admission to do' by treating and discharging in ED**
- Reducing admissions and ED Length of Stay (LoS) frees up capacity
- Direct access from ED to community services – 'Referrer decides' system
- Ambulatory Pathways consistent, available 24/7 e.g. DVT/PE, Arrhythmias, Cellulitis/other non-septicaemia, Catheters
- Access to immediate and urgent decisive diagnostics ('scheduled') 24/7/POC testing/'sick patient panel' (see Planned care CLG)
- Senior experienced decision-maker
- Post diagnostic review clinics not in ED – 'Hot'/ambulatory care clinics eg Rapid Access Service
- Coordinator /H@H/Home support set up
- Virtual Condition-specific centres enabled by: 'Rich Communication'; IT system joined up patient information
- teleconference/video/skype

Referrer-Led Discharge

24hr Social Care Link

- Single access point across Borough/for a population – and cross boroughs 24/7 365
- Social care/Occupational Therapy and Physiotherapy, Mental Health
- Expedites home care
- IT systems link to manage risk, organize pick up by Community/GP resource
- Link to Rapid Access Service to manage discharges (Community Paediatric Team for children and Young People with LTCs/Complex needs)

Maternity

Service Vision

"To place the needs of women and their families at the centre of maternity care, which supports choice and continuity of care. From preconception through to postnatal support, maternity services will be delivered by a committed and dedicated workforce, who will ensure a safe and positive experience."

Women can expect to receive:

- Timely access to community based antenatal and postnatal maternity services which are closely linked with other community based health, social and voluntary sector services all supporting pregnancy, childbirth and new parenthood;
- Midwifery-led continuity of maternity care as standard;
- Support from clinically expert and highly-skilled multidisciplinary teams delivering high quality, kind, safe and effective services;
- Hospital based medically-led intervention when necessary;
- Support to have a normal birth, in the right location for them, with the least intervention as possible;
- Services and a workforce that promote healthy lifestyles which have a positive effect on the health outcomes for mother and child;
- Involvement and engagement with their wider family supporting healthier lifestyles and better well-being.

Maternity

Service Model (1 / 3)

Introduction

The service model can be summarised as midwifery-led continuity of care ensuring the availability of and access to obstetric-led and specialist care for those who require it. This model emphasises the importance of the maternity workforce, and how their interventions at each stage can contribute to the achievement of high quality and safe maternity care. The model focuses on access to services, the standardisation of care across all providers including protocols and processes as well as more seamless access to specialist services, such as mental health, cardiac or fetal medicine when required.

Continuity of care will put the woman at the centre of her care ensuring timely access to community maternity services. These services will be aligned and work closely with primary care, health visiting and social care services as well as linking into other opportunities for community support, such as children's centres, for women and their families.

The NHS Mandate sets out an aim to improve the women's experience of maternity services through giving the "greatest possible choice of providers" and stating that "every woman has a named midwife who is responsible for ensuring that she has personalised, one to one care throughout pregnancy, childbirth and the postnatal period".

There are a number of definitions of continuity of care and these vary, essentially there is not currently an agreed definition of continuity and whether this relates to the whole maternity pathway or parts of it. However this SE London model puts the woman at the centre of care, with care being provided by a multi-disciplinary team (when necessary) with the named midwife acting as a named trusted other but linking into the multi-disciplinary team for delivery at different points in the care pathway.

There are a number of benefits associated with midwifery-led continuity of care and no adverse effects compared with models of medical-led care and shared care, including for example a reduction in epidurals and instrumental births and increased chances of a spontaneous vaginal birth [DN – reference / evidence being checked].

In terms of the SE London service model, a number of factors needed to be considered, the evidence relating to continuity and midwife-led care in terms of outcomes and benefits to mother and child, combined with the reality of current services and the constraints placed on achieving continuity with catchment boundaries, together with the ambitions for those services over the next five to ten years as discussed and defined within the Maternity Clinical Leadership Group.

Maternity

Service Model (2 / 3) Key Elements

Key Elements

Pre-conceptual Care

Population changes and the increase in complexity and acuity due to a number of factors led to the identification of the need for maternity services to work in conjunction with primary care, public health and others to improve awareness of problems in pregnancy and the impact on outcomes caused by a range of lifestyle choices. This would include the development of strategies around obesity, smoking and childbirth and other wider determinants of health including health education and planning parenthood.

Access to Maternity Services

Improving access to maternity services through a single point of access across SE London as well as direct access to midwifery services to achieve early identification of risk and to develop timely risk and care plans. The model will seek to develop robust standardised care pathways for both low and high risk women to achieve the best possible health outcomes for mother and child. Ensuring that maternity services are designed, located and able to meet the needs of women and their families as well as being more closely aligned to other health, social and voluntary services in the community.

Improving continuity of midwifery-led care across the maternity pathway

To support equality and equity of access developing a core and standardised offering for every woman with a named midwife providing continuity and co-ordination of care ante-natally and post-natally in community and hospital settings including the communication of information across the multi-disciplinary team and institutional and professional boundaries. This includes developing a relationship over the period of the pregnancy with the woman to support improved patient experience and outcomes.

Developing more specialist midwifery teams that offer enhanced midwifery and multi-disciplinary team support for high risk groups including developing care plans whilst still ensuring as high a level of continuity of care as possible across the high risk or specialist pathway.

Maternity catchment areas will be aligned with our borough populations in order to optimise integration with other services in particular health visiting, primary care, social care and children's centres. The purpose being to maximise the opportunity for integrated working and to support continuity of care especially across the antenatal and postnatal pathways.

Maternity

Service Model (3 / 3) Key Elements

Obstetric and Specialist Care

Improved continuity of care and community alignment will help to ensure timely identification, referral and access to specialist services for those women with more high risk or complex needs. This includes standardised protocols and processes across South East London as well as excellent information and communication through an improved IT interface. In addition, developing a South East London approach to meet the required standards for consultant cover, particularly for high risk women that provides the maximum quality and safety for women and babies. This is a challenge to implementation and will be addressed by the setting of a trajectory (as a commissioned minimum) to achieve 24/7 with evaluation / adding to evidence as we progress.

Neonatal Care

Supporting a reduction in neonatal admissions and access to excellent neonatal care when required, including improved access to postnatal services supporting a reduction in neonatal admissions for conditions such as jaundice, weight loss or feeding issues.

Postnatal Care

All maternity units in South East London will aim to achieve the full Unicef Baby Friendly accreditation with midwives being part of the team around the child moving from maternity to community based services. The provision of postnatal care services will include improved access to midwifery and breastfeeding support following birth and discharge. It will include a seamless postnatal overlap and transition to health visiting and primary care linking in to the broader locality/community network to support new parents and babies.

Children and young people

Service Vision

- Services and interventions are focused on providing the best start in life, health and wellbeing, early identification and early intervention, driving better health outcomes and delivering value across pathways for children and young people.
- Pathways for children (eg with complex long term conditions or long term disabilities) receive a consistent approach and highest standards of care across south east London.
- Meet London emergency paediatrics standards and deliver improved health outcomes for specialist paediatrics and community services for children including CAMHS.
- Support a child's physical and mental health needs from birth providing safeguarding and support through promotion of attachment, and psychological support via a network that will provide resilience into adulthood. Working together with other partners and communities to support families in dealing with stress that affects their children's growth and resilience.
- Services that provide a single point of access via "no wrong door", at the right place, at the right level, with the right person, at the right time thus ensuring unscheduled care is delivered to its highest standard. This will be facilitated through comprehensive integration of health and local authority services.
- Will draw on national and local research and evidence to inform practice and the spread of innovation across South East London, and to ensure a highly skilled and effective workforce.

Children and young people

Service Model (1 / 5)

- The integrated system model being developed through the **Clinical Leadership Group for Long-Term Conditions** has been developed to frame the development of the service model for children and young people in the following pages:
- Those with long term physical and / or mental health conditions will be supported with segmentation into three categories. Locality care networks will play a lead role at all stages and there will be a consistent focus on reablement; not just the prevention of deterioration, but returning people to better health
- The service model in the following pages supports the continuum of care:
  - Prevention/universal
  - Early intervention
  - Targeted intervention and urgent care
  - Most complex needs (including mental health), emergency care and conditions requiring highly specialised care
- The following chart summarises the broad framework in which the service elements support children based on needs

Framework for meeting needs of children and young people with LTCs, complex and urgent needs

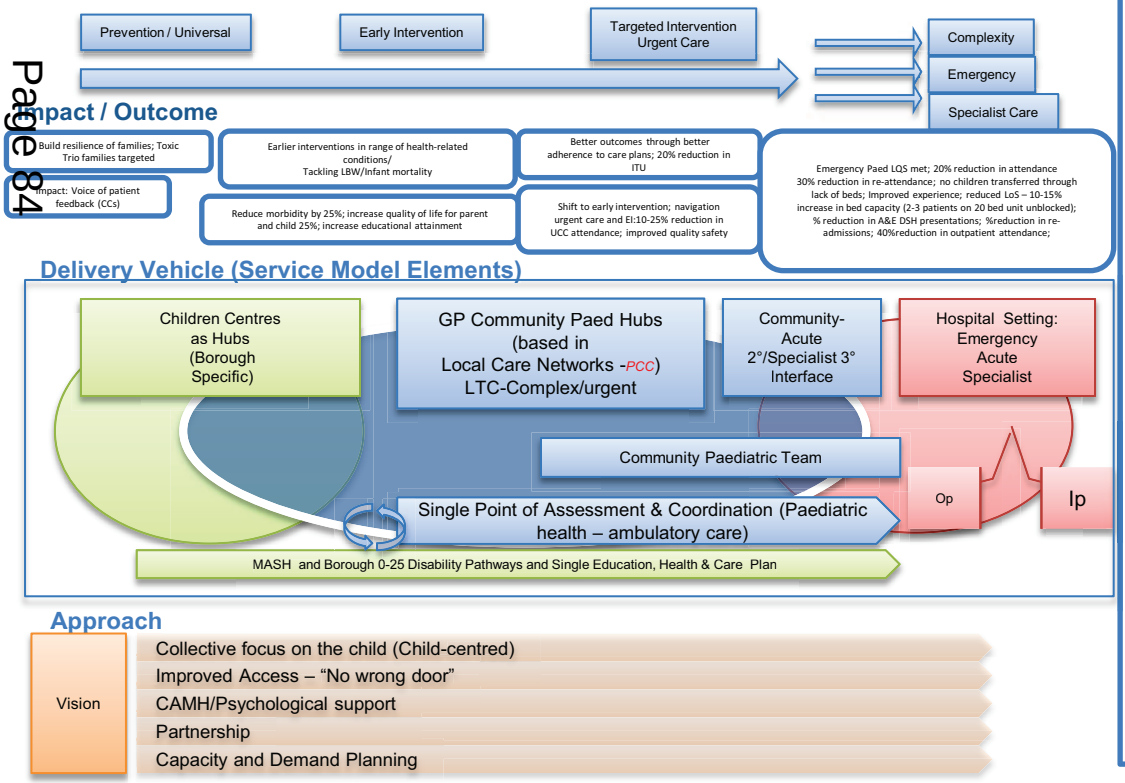
	Children with an LTC	Children with an LTC and other risk factors including psychological / mental health needs	Children with 1+ LTC / complex needs particularly if effective support package not in place

Assessment	• GP centre Community (Local Care Network) Hub in each Locality Care Network
	  • Routine
	  • Urgent access
	• Own GP
	• Link with MASH in some cases
		• GP (Local Care Network) hub diagnosis re unwell
		• Escalate to Community Child Health Team – Specialist Burse, medical, mental health
			• Integrated assessment through Community Child Health Team
			• Linked closely with social care (MASH / Single Plan assessment processes)

Example of child	• Acute illness • Worried but 'well' • Serious injury	• Diabetes, Sickle cell, ASD, range of physical disabilities with health risk components • Social / psychological factors exacerbating condition • Motivation and following care plan important to outcomes	• Children with disabilities and range od identified health records • Children with conduct disorders/ LD/ identified MH conditions/ASD • Safeguarding-related health needs / trauma • Children with a Single Education, Health and Care Plan
Key model elements	• GP Centre (Local Care Network) Hub • Universal services • Children's Centres – linking to health education, parenting, support, signposting, voluntary and peer support • Community Health – Specialist HV, Family Nurse, Practitioner • Linik to safeguarding (MASH where injuries of failure to develop are identified • Hospital Emergency / Acute – ill and injured	• Integrated assessment and coordination particularly for ambulatory care • Community Child Health Team • Community – Acute/Specialist Interface: short stay Paediatric Assessment Unit and Community Child Health Team • Acute Hospital (Planned- e.g. annual sickle cell review – and unplanned)	• Role of GP Hun un universal service working as MDT • Integrated assessment and coordination particularly for ambulatory care including Paediatric Assessment Unit • Community Child Health Team including psychological support • Community – Acute/Specialist Interface:: particularly important in managing for avoidable admissions including short stay Paediatric Assessment Unit • Acute and specialist (tertiary)

Children and young people Service Model (2 / 5)

- There is acknowledgement that strong cohesion link between local authority services and health services is imperative to enable an effective response to the needs of children and young people. Making full use of the Children's Centres and Community services. There is a need to have a strong link between safeguarding hubs such as MASH and the single point of assessment for Paediatric care
- Early identification and intervention as key to improving outcomes and reducing costs
- Underpinning service delivery is a cross-cutting approach based on:
  - Collective focus on the child (Child Centred)
  - Improved access 'No Wrong Door'
  - Psychological and Mental Health support to children and families
  - Working in partnership; capacity and demand planning



Collective focus on the child (Child centred)
- The need to design the service model around the child
- Emphasis on prevention and early intervention – achieving better outcomes
- Every Contact Counts across settings
- Acute – pathway owned by paediatric service front door onwards
- Integrated step-down from hospital designed around child
- Common transparent pathways – asthma, diabetes, autism – followed across SE

Improved Access –'No Wrong Door'
- Access including out of hours with flexibility including community services
- Paediatric Assessment Unit link with tertiary care
- 24/7 care with appropriate range of services
- Hubs and locating expertise where it is needed:
  - Children's Centres; GP Centres; Acute – Community interface - Clarity of each Hub's role and capacity/capability needed
- Community Child Health Team

Psychological and MH support
- Early intervention in universal/community settings; families at risk
- Health and schools working together eg DSH
- Support for families with children under five; intensive support to avoid admissions
- Psychological consultation to primary workers
- Supporting ill children and families

Partnership
- Extending and building on existing networks eg Psychiatric Intensive Care Unit network, Neuro-disabilities
- All organisations need to work in partnership regardless of organisational boundaries eg Lambeth Early Intervention Partnership (LEIP)
- System wide but reflect local borough plans eg HV expansion
- Changing the way services are contracted – health and local authority commissioning

Capacity and demand planning
- Academic Health Unit for Children (Institute of Child Health / Child Health Network)
- Capacity Modeling data
  - Transfers (within and between institutions – before and during treatment)
  - Re-attendance figures – note that this may not be at same institution
  - Complex needs audit
  - Workforce
  - Coordination (note Evelina starting to do this for 3 boroughs)
  - Resource distribution
- Need data to accurately map system for baseline for design and measurement of new system

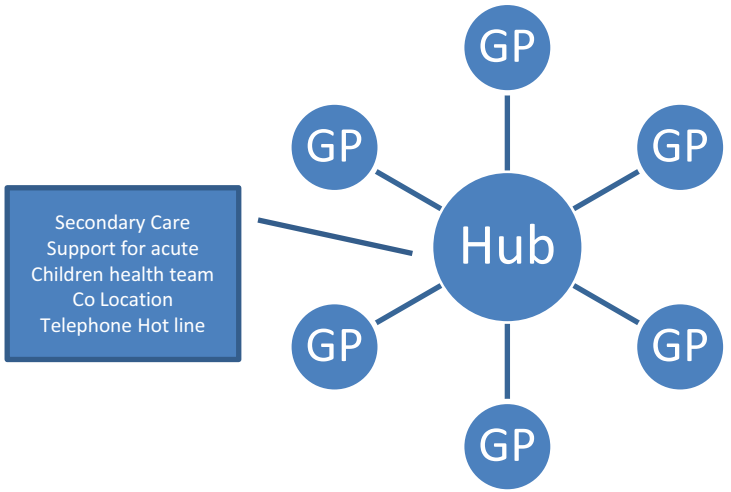
Children and young people Service Model (3 / 5)

GP (Local Care Network) Community Hub

- Centre for management of LTCs and urgent care; upskilled; access to specialist; Centre for Community Child Health Team?
- Increased role of Primary Care centres in management of LTCs and complex needs in children
- Equal access to all - No wrong door
- Based around GP
  First point of entry for a child in community
- Different levels preventative – primary – aspects of secondary – i.e. asthma
- Helping GP deliver good secondary care – asthma, diabetes
- Diagnostic, access to specialists – hotlines
- Practitioners follow patient
- **Ambulatory paediatrics – in reach**
- **Hospital outreach secondary and tertiary**
- Empower parent / careers and YOP; enable self-management
- Flexible pathways:
- How they will work: Acute care plan
- Resource centre
- Tertiary / Specialist - Patient pathways journey
- Secondary +- specialist secondary service; Secondary care expertise in GP / Centre / HUB – a number of models – secondary staff in the locality – referral direct from GP resource
- Assessments – health visitors / health checks
- Outreach skills mix
- Multiagency: Primary – Health, SC, Education, Voluntary
- Secondary universal service - Targeted
- Parenting interventions – post diagnosis, peer support, intensive crisis support
- Access CAMHS some specialist service i.e.consultant

Children's Centres as Hub (Specify through PCC CLG)

- With social care, promote well-being and health
- Midwives, Family Nurse Practitioners (FNP)
- Early years service 0-5; extend as access point for 0-25
- Targeted : speech therapy
- Early identification and intervention of health and developmental issues; upskilling eg MH - low level CAMHS in one stop unit
- Children centres have same geographical boundaries in 5 years –
- Access to physical and MH specialists working in primary centres
- Link with MASH and Single Education, Health and Care Plan processes
- Parenting interventions – peer support and issues based workshops



Consistency across 21 Localities of SE London:
GP (Local Care Network) Hubs are linked

- Virtual Links
- Peer groups
- Could be common standards to link together review outcome together
- Commission pathway of care
- Standards across the localities
- Easily able to access specialist advice
- Consistent outcomes
- Communications on practice
- Reduce boundaries (myth or real)
- Parents / Children view : access – tell story once or understand or action are delivered – support mechanism

Community Child Health Team

- LTC pathway management
- Out of Hours support; Easy access to Paediatric Specialist
- Specialist paediatric nursing for LTCs eg epilepsy, asthma; Joint working with Acute in community settings; nursing across boundaries; neonatal specialists; Paediatric Nurse Consultants; nurse prescribing; Nurse-led Transition
- Coordinating/keyworker for most complex children/LTCs
- Working with school nursing
- Building family resilience and enabling self-management
- Integrated step-down from hospital designed around child to reduce Length of Stay (LoS), improve experience and increase bed capacity through quicker discharge
- Intensive support to avoid admission including MH specialists offering consultation and short intervention
- Doctors remit and safeguarding, social paediatrics, adoption
- New disabilities, complex new developed problems
- Some prevention work – public health overlap
- Some behaviour emotional overlap with CAMHs

Children and young people Service Model (4 / 5)

Integrated assessment and coordination
Two components:

1. Community based, cross-borough multidisciplinary assessment and care coordination
2. Paediatric Assessment Unit (PAU) – short stay health, social care and mental health at front door: hospital-based Short term assessment beds – short stay (consultant led / nursing); link to CAMHS

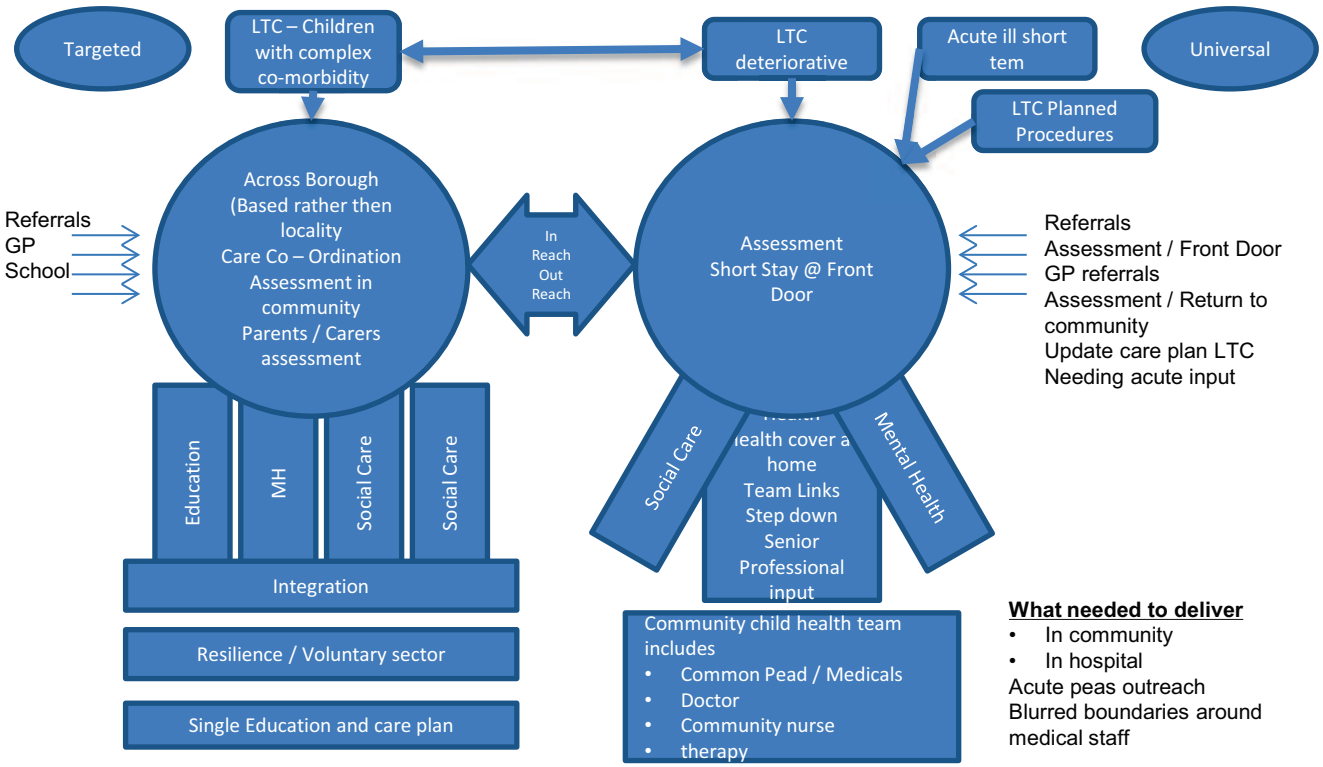
Features of Integrated assessment and coordination

- Access including out of hours with flexibility including community services; Tertiary Centres work as one Single Point of Access for advice, investigations and definitive care linking through PAUs inreach to secondary care
- **Ambulatory paediatrics – in reach**
- **Hospital outreach secondary and tertiary**
- Expect initial assessment at early stage – access – referral
- Screening tool
- Navigation - Access to appropriate level Paediatric specialist knowledge and skill
- Information / Signposting
- Early ID to early intervention
- Not necessarily via children centre hubs more health specific (GP Hub)
- MDT MASH Approach
- Triage across agencies for children with complex needs – social care and health; Continuity of care plans across boundaries eg LTC package in/out hospital
- Information / families
- Support onward referral

Integrated step down from hospital

- Principles – delayed discharges while community cares are triaged; Care planning – shared decision making, relevant /Statement

Integrated assessment and coordination



Children and young people Service Model (5 / 5)

Community-Acute/Specialist interface

- Clarity of each Hub's role and capacity/capability enabling smooth transition
- Type of children – short term illness – discharge / prevention; Deteriorating LTCs – improved assessment wider professional input; Spectrum of children – Acute ill; Deteriorating LTC
- Ambulatory care – in reach / out reach interface
- Short term – short stay Paediatric Assessment Unit (consultant led / nursing) link to CAMHS; Ambulatory – Front door – ambulatory care – includes MH and social care – Assessment beds
- Acute – pathway owned by Paediatric service front door onwards; Senior professional input early
- Condition specific therapy input for LTC children
- Community Multi Agency Planning Pathways (MAPPs e.g. Lewisham) – Care coordination in hospitals for LTCS Deteriorating; Equivalent in community - Link to acute ambulatory care
- Planned-for urgent need
- Trigger point need for ambulatory – escalation
- Referred care plan and support in community – Community Child Health Team (especially nursing specialists)
- Diabetic Nurse specialist outreach / in reach into SNS / initial teaching of staff etc. Management of allergies for example
- Appointments for sharing – critical mass
- Keeping child mobile / maximise independence of child and family; Prevention of admission
- Cross-boundary – tertiary / secondary / community –between, health, education, social care – MASH-type approach support aligned to commissioning; Social care input
- Integrated step-down from hospital designed around child to reduce LoS, improve experience and increase bed capacity through quicker discharge e.g. to Community Paediatric team
- CAMHS 'intensive support' to avoid MH admissions
- Working with GP Out Of Hours to avoid admissions and presentations at A&E e.g. medically led urgent clinics in community settings until 10pm
- Joint working between Acute and Community teams in community settings; nursing across boundaries; Integrated Managers, cross boroughs management

Hospital: Emergency

- 7 days a week, 365 days per year 14 hours per day
- Paediatric competency in A&E; Paediatric specialist available in Emergency Departments
- Consultant-led; Consultant cover till 10pm.
- Quantify the size of unit. Nursing experience / HDU / ITU / Anesthetics
- Safe transfer of critically ill children
- Acute – pathway owned by Paediatric service front door onwards
- Short Stay Paediatric Assessment Units - Unit (consultant led / nursing) link to CAMHS; Ambulatory – Front door – ambulatory care – includes Mental Health and social care – Assessment beds
- Customised environment for children and young people
- Designed around child
- Working with Adult ED
- Adequate inpatient beds
- Multi-disciplinary team training
- Paedriatric A&E, Inpatient, HDU Anaesthetics Integrated
- Appropriate discharge planning
- Integrated care step down (Community Child Health Team)
- Out Of Hours paediatric cover – those units with no paediatric backup – the ability to receive sick children

Integrated step down from hospital

- Principles – delayed discharges while community care is triaged. Care planning – shared decision making
- Step down from tertiary to secondary care
- Paediatric home care team (home support)
- Multicare in-reach – Community Child Health Team
- Ownership of Care Plan
- Nero rehab support – early supported discharge – need whole package and coordination – they could be at home
- Ambulatory care – combined funding with social care – integrated and reflecting on schools and social care
- Ownership of Social Care Pathway defined and owned by appropriate team in complex care
- Step down in complex cases

Hospital: Acute and **Specialist**

- 7 days a week, 365 days per year 14 hours per day
- Acute – pathway owned by Paediatric service front door onwards
- Consultant-delivered care, including "resident shift-working consultant"
- Paediatric A&E, Inpatient, HDU Anaesthetics Integrated
- Integrated step-down from hospital designed around child
- Increasing community support (GP Hub/Community Child Health Team to reduce re-attendance; reduce hospital outpatient attendances
- Psychological support to ill children and families
- In-reach from Community Child Health Team to support discharge
- Outreach from specialists to support GP Hub and prevent (re)admissions and unscheduled care
- Integrated care step down
- Appropriate discharge planning

Cancer

Service Vision

"That SE London make a demonstrable improvement in transforming cancer services – improving outcomes and patient experience. That the population of SE London should have cancer outcomes to match best in world and that all SE Londoners receive excellent care and support".

Key elements

- Encouraging patient/public ownership of health
    - Promoting healthy lifestyle choices for patients and family including during and after treatment
    - Better health promotion and primary prevention
    - Patients supported to self-manage, underpinned by excellent information and rapid re-entry access when needed
    - 24/7 patient helpline
    - Care plans and care co-ordination in place
- Patient experience
    - Improved patient experience and shared decision making
    - Less variability in dying at home
    - Access to diagnostics treatments and services based on clinical need, reducing inequalities including for older patients
    - Equity of access to psychological support
- Pathways
    - Improved screening
    - Stratified pathways
    - Delivering Cancer Waiting Times (CWT) or going further where possible
    - Streamlined access to diagnostics

Cancer

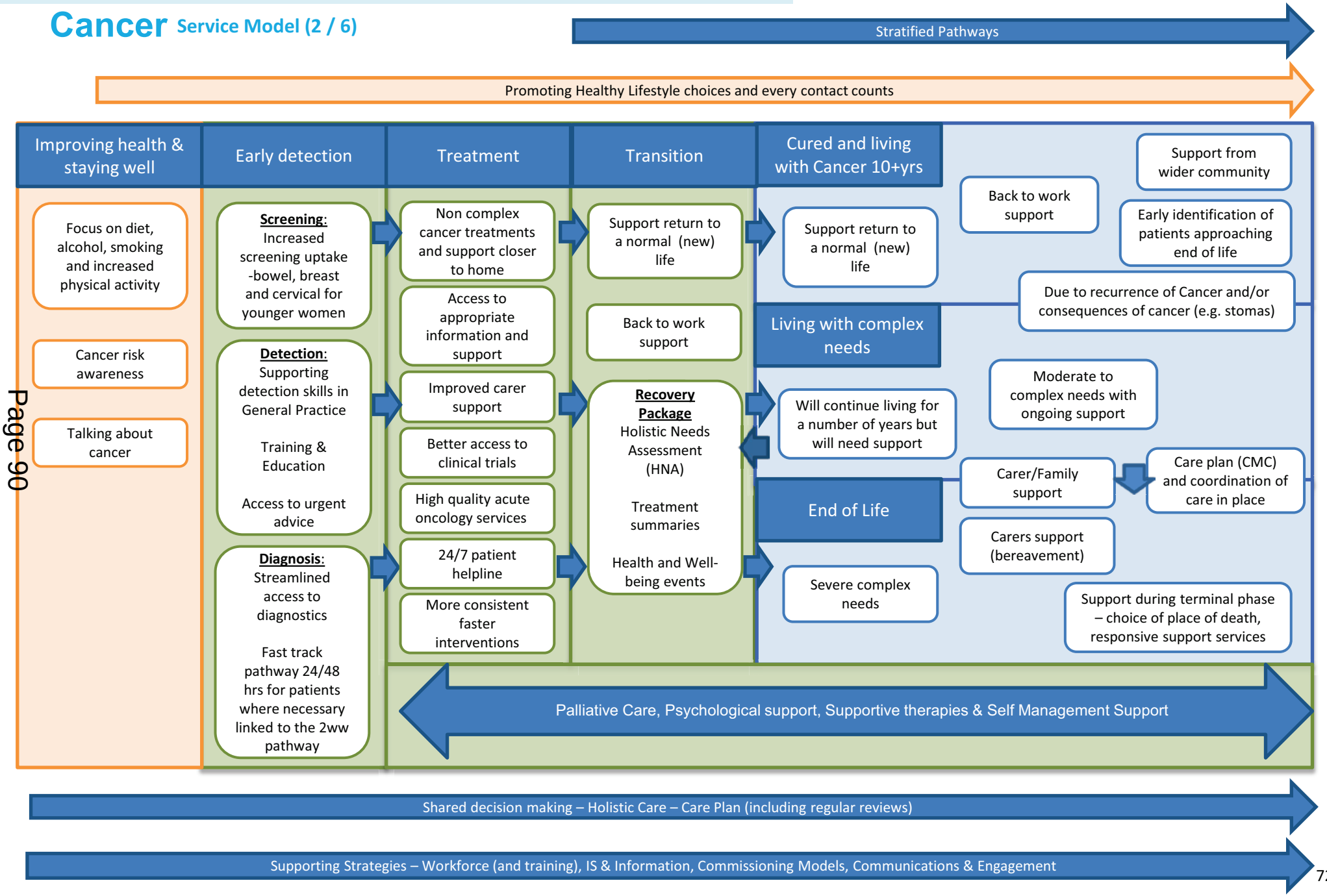
Service Model (1 / 6)

The service model for Cancer focuses on five stages from the cancer pathway with improved carer support key at every point :

- Primary prevention with an interdependency on the Primary and Community CLG
- Early detection for both screening and diagnostic pathways with an emphasis on reducing the number of patients diagnosed in A&E. A key feature being to develop an urgent pathway for patients that cannot wait for 14 days, but are not appropriate for A&E.
- For the treatment phase an emphasis on providing effective Acute Oncology Services with excellent referral processes from A&E to include patients presenting for the first time.
- Enable & support those patients who are cured and living with cancer to return as far as possible to a normal (new) life, with supported self management
- Patients living with complex needs as a result of their cancer and/or their cancer treatment to be managed in the same way as other long term condition patients. There is an overlap between the Long Term Conditions (LTC) CLG and the Cancer CLG
- To provide end of life and palliative care with enhanced carer's support and specialist packages of care. There is cohesion between Cancer and LTC CLGs.

5. Key improvement interventions – 5.7 Cancer

Cancer Service Model (2 / 6)



Cancer

Service Model (3 / 6)

Pathway	Features
Improving health & staying well - primary prevention model	• Consistent healthy lifestyle messages at all points of contact – everyone's job • Physical activity opportunities • Motivational interviewing skills • Targeting of hard to reach groups particularly, and reducing inequalities • Talking about Cancer • Survey patient literature to understand effectiveness • Consistent health checks across all practices • Consistent focus on smoking cessation and aiming to decrease the % of the population that smokes
Early detection and screening	• Increased screening uptake (specifically bowel), better detection • Symptom awareness raising • Talking about Cancer • Systematic messaging about benefits of screening from primary care, pharmacies, secondary care • Follow-up of non-attenders • Urgent pathway for access to specialist within 24-48 hours for patients where necessary. Waiting 2 weeks not always acceptable • Supporting new national screening programs

Cancer Service Model (4 / 6)

Pathway	Features
Early detection - diagnosis	• Reduction in cancer patients diagnosed through A&E • Improved access to appointments and call back service • Support for carers • Improved pathways reducing hand-offs • Increasing patient awareness and understanding reasons for late diagnosis– scope opportunities through pharmacies/other routes, support Be Clear On Cancer (BCOC) • Streamline access to diagnostics including timely results and 1 stop shops • Scope access to specialist advice for GPs • GP/PN training to maximise effectiveness of 2WW referrals – Train The Trainer (TTT), CCGs support Lead, GP role, Significant Event Audit (SEAs) as part of GP appraisal • Support the roll out of Clinical Decision Support (CDS) tool to all practices • Urgent pathway for access to specialist within 24-48 hours for patients where necessary. Waiting 2 weeks not always acceptable
Treatment	• Support for carers • Access to appropriate information and support including psychological therapies, physical activity (and Living With & Beyond Cancer phase) • Provision of non complex cancer services closer to home • Urgent pathway for access to specialist within 24-48 hours where necessary. Waiting 2 weeks not always acceptable • Effective Acute Oncology Services (AOS) with excellent referral processes from A&E to include patients presenting for the first time • High quality acute oncology services • Better access to clinical trials • 24/7 patient helpline • Opening of QMH cancer treatment centre (aim is August 2019) • Implementation of e-prescribing • Increased access to supportive therapies • Palliative care input to start early where needed

Cancer

Service Model (5 / 6)

Pathway	Features
Transition	• Rehabilitation and support to return to normal life • Cancer care review in primary care • Recovery package including holistic needs assessment, treatment summaries, and health and wellbeing events
Cured and living with Cancer for 10+ years	• Stratified pathways • Re-ablement • Support to return to a normal life • Supported self management • All cancer patients flagged on GP systems • GP continuity • Support for carers • Rapid access back into specialist services if needed
Living with complex needs	• Annual invitation with GP or nurse practitioner for simple check and to discuss concerns • All cancer patients flagged on GP systems • GP continuity • Specialist involvement after treatment to take account of consequences of cancer treatment • More than just palliative care as the only after care provision • Support for carers • Implement Holistic Needs Assessment (HNA), stratified follow up • Cancer managed as a Long Term Condition with risk assessment and good supporting information from specialist services (treatment summary) • Patient information and staying healthy advice

Cancer

Service Model (6 / 6)

Pathway	Features
End of life (EOL)	• Support for carers (bereavement) • Primary and community work together to provide coordinated high quality EOL care team around the patient • Regard EOL as beyond cancer and beyond specialist palliative care • Early identification patients approaching EOL to plan and manage better • Use of Multi Disciplinary Team (MDT) for treatment decisions – include palliative and elderly care input as required • Timely and convenient access to equipment • Scope ways to improve support to patient and family/carers 24/7 • Support more patients to achieve their wishes at their end of life • Full implementation of Co-ordinate my Care programme (to ensure sharing of information)

TO BE ADDED FOR 20 JUNE DRAFT

THIS SECTION WILL BE COMPLETED FOR 20 JUNE 2014 SUBMISSION

Introduction to System Impact (1 / 2)

- Commissioners face a substantial challenge over the next five years in terms of improving outcomes, quality, reduced variability and sustainability
- Baselines and trajectories for outcome ambitions have been developed based on a number of triangulated sources including the Case for Change, JSNAs, Commissioning for Value and NHS England (London) data packs (CCG and Strategic Planning Group level), and planning support tools such as the Levels of Ambition Atlas and Operational Planning Atlas
- The first two years of the Strategy will be delivered through the Operating Plans of the six CCGs. Years three to five build on those foundations to deliver system transformation, driven by the seven priority interventions described in Section 5 of this document. The current stage of development of the Strategy is therefore a combination of a shared vision, detailed plans for years one and two, and an emerging view of the impact of years three to five
- Local Health and Wellbeing Boards have been involved in the approval of Operational Plans and Better Care Fund plans containing this data, as well as in many cases the outcome ambition trajectories themselves. These therefore set out the initial level of ambition and minimum requirement for a sustainable system
- In years three to five of the plans this ambition is shown in changes in activity and outcomes to address the scale of challenge for south east London as a system. The combined plans of the CCGs show the required scale of QIPP delivery needed on a recurrent basis to achieve a sustainable economy and reflect the current status of each of the individual CCGs and where they have further ambitions to transform, and collectively build on each others achievements to date. This is underpinned by the work of the CLGs to provide the detail for delivery of these ambitions, including achievement of the London Quality standards.

The impact of delivering our proposed model will be across three main areas:

- Through a much greater emphasis on health and wellbeing, prevention and early intervention we will drive improved health outcomes and reduced health inequalities for our population that enable people to live longer and live healthier lives for longer
- Building on a foundation of community resilience and greater self-care there will be a significant shift of activity and resource from services focusing on late response in secondary care to primary, community and social care, and services enabling self-care. The transformation of our universal primary and community services provided through Locality Care Networks, and the transformation of how we support those with long term physical and mental health conditions will be key to this
- Through delivering consistently high standards of care across all services we will improve patient experience and clinical outcomes and reduce variation for our patients. We will re-shape services to create centres of excellence supporting networks of care. This will require significant one-off investment and will change patterns of spend on local services.

Introduction to System Impact (2 / 2)

FOR 20 JUNE DRAFT: FURTHER ANALYSIS OF CURRENT AND HISTORIC TRENDS AND DEMOGRAPHIC CONTEXT (APPLIES THROUGHOUT THIS SECTION). DEVELOPMENT OF BRIDGE ANALYSIS

This section sets out these impacts in further detail based on the following sections:

- 6.1 Outcomes
- 6.2 Context for financial sustainability
- 6.3 Activity
- 6.4 Finance
- 6.5 Sensitivity
- 6.6 Clinical Leadership Groups impact on programme outcomes

Further development post 20 June submission

- Engagement with stakeholders and wider public on the integrated system model
- Identification of potential implications of the proposed integrated system model on communities, institutions and organisations
- Further development of programme measures to refine selection, confirm baselines and set appropriate milestone targets
- Further work with colleagues in Public Health and more broadly across the Programme to understand impact and trajectories for key population and public health measures
- Development of financial and economic models to test the likely impact of service models being developed by Clinical Leadership Groups
- Capacity modelling on the existing system and proposed integrated system model
- Modelling of investment and transitional costs

Improving outcomes – system objectives

Each CCG has set an initial five year trajectory across the following five outcome ambitions. These are being further refined, particularly for years three to five, through the work of the Clinical Leadership Groups, colleagues in Public Health and broader programme stakeholders in developing the measurement framework for the programme.

Outcome Ambition	Metric	CCG	Baseline	14/15	15/16	16/17	17/18	18/19	INDICATIVE TRAJECTORY
1 Securing additional years of life for the people of England with treatable mental and physical health conditions	PYLL* (Rate per 100,000 population)	BEXLEY	1816.0	1757.7	1701.3	1646.7	1593.8	1542.7	
		BROMLEY	1513.0	1464.6	1417.7	1372.4	1328.4	1285.9	
		GREENWICH	2365.4	2204.9	2124.6	2044.3	1964.1	1883.8	
		LAMBETH	1914.0	1793.5	1736.1	1680.5	1626.7	1574.7	
		LEWISHAM	2114.0	2046.0	1981.0	1917.0	1856.0	1796.0	
		SOUTHWARK	2042.0	1977.0	1913.0	1852.0	1792.0	1736.0	
2 Improving the health related quality of life of people with one or more long-term condition, including mental health conditions	Average EQ-5D** score for people reporting having one or more LTC	BEXLEY	74.6	74.9	75.2	75.5	75.8	76.1	
		BROMLEY	75.7	76.0	76.3	76.6	76.9	77.2	
		GREENWICH	73.3	73.5	73.6	73.8	73.9	74.0	
		LAMBETH	75.4	75.4	75.5	75.5	75.6	75.6	
		LEWISHAM	74.2	74.3	74.3	74.7	75.1	75.4	
		SOUTHWARK	73.4	73.7	74.0	74.4	74.9	75.4	
3 Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	Emergency admissions composite indicator	BEXLEY	1781.0	1704.4	1687.4	1670.5	1653.8	1637.3	
		BROMLEY	1547.9	1470.5	1397.0	1383.0	1369.0	1355.5	
		GREENWICH	2185.9	2124.0	2093.0	2062.0	2031.0	2000.0	
		LAMBETH	2074.0	2032.0	1990.0	1950.0	1910.0	1870.0	
		LEWISHAM	2146.4	2145.0	2144.0	2143.0	2142.0	2141.0	
		SOUTHWARK	2250.0	2137.5	2084.1	2063.2	2042.6	2022.2	
5 Increasing the number of people having a positive experience of hospital care	Proportion or people reporting poor patient experience of inpatient care	BEXLEY	176.5	174.0	172.0	171.5	169.0	167.0	
		BROMLEY	184.9	183.1	177.6	172.2	167.1	162.1	
		GREENWICH	177.5	173.8	171.9	170.1	168.2	166.4	
		LAMBETH	138.0	138.0	137.0	137.0	136.0	136.0	
		LEWISHAM	165.3	164.0	163.0	162.0	161.0	160.0	
		SOUTHWARK	137.0	136.0	135.0	134.0	132.0	130.0	
6 Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	Proportion of people reporting poor experience of general practice and out of hours	BEXLEY	7.0	6.7	6.3	6.0	5.7	5.4	
		BROMLEY	7.4	7.2	6.9	6.7	6.4	6.2	
		GREENWICH	6.7	6.6	6.5	6.4	6.3	6.2	
		LAMBETH	6.1	6.0	5.9	5.8	5.7	5.6	
		LEWISHAM	6.7	6.6	6.5	6.4	6.3	6.3	
		SOUTHWARK	7.5	7.4	7.3	7.2	7.0	6.7	

* Potential years of life lost from causes considered amenable to healthcare
** Standardised generic self-completion measure of health status

TO BE FURTHER REFINED FOR 20 JUNE DRAFT + CHART TO BE ADDED

Context for financial sustainability

- Financial modelling carried out based on the final national allocation settlement indicates that if QIPP within the Operating Plans is not achieved then the spend profile will continue to grow across all areas of care in line with demographic and non demographic assumptions, placing further pressure in the system, as demonstrated in the table, right.

SEL Total £000s	Baseline inc growth excl QIPP years 3 - 5				
	14/15	15/16	16/17	17/18	18/19
Acute	1171695	1157812	1219708	1238145	1250520
Mental Health	299381	293930	307514	311641	316264
Community	216388	204311	218646	230523	242603
Continuing Care	81628	80039	83848	86758	89915
Primary Care	231223	234643	247400	255907	265888
Other Programme	93655	205237	211823	221036	229623
Total Programme Costs	2093970	2175973	2288939	2344011	2394813

- CCG Operating Plan assumptions in relation to activity form a starting basis upon which further modelling is being carried out as part of Clinical Leadership Groups.

DN - to be added for 20 June draft – activity data excluding impact of QIPP

- The scale of financial challenge for south east London CCGs is a minimum cumulative savings of £307m between 2014 and 2019.

Net QIPP savings, 000s	2014/15	2015/16	2016/17	2017/18	2018/19	TOT
Bexley	14,694	8,418	5,193	5,762	5,757	**38,824**
Bromley	12,012	12,140	7,900	5,400	5,400	**42,852**
Greenwich	8,600	7,300	4,300	6,000	6,000	**32,200**
Lambeth	15,319	20,233	17,832	14,645	13,081	**81,110**
Lewisham	9,490	13,119	11,546	9,597	9,833	**53,585**
Southwark	15,591	13,219	10,710	9,007	9,327	**57,854**
SEL Total	**75,706**	**74,429**	**57,481**	**50,411**	**49,398**	**307,424**

TO BE FURTHER REFINED FOR 20 JUNE
DRAFT + CHARTS TO BE ADDED

Sustainability – Activity at point of delivery (1 / 2)

Acute activity by key point of delivery

CCG Operating Plan assumptions in relation to activity form a starting basis upon which further modelling is being carried out as part of the ongoing work of Clinical Leadership Groups. This work is being expanded to more fully consider non-acute points of delivery, working in conjunction with other commissioners, including the NHS England and Local Authorities.

Hence the figures and assumptions used for the 2014/15 Operating Plan submissions should be viewed as a subject to further refinement and potential 'stretch', particularly for years 2016 to 2019.

ACTIVITY by acute point of delivery Total across all CCGs in south east London	2013/14 F'CAST OT	2014/15	2015/16	2016/17	2017/18	2018/19
Elective Admissions - Ordinary Admissions	36423	36729	37086	37096	37156	37222
Total Elective Admissions - Day Cases (FFCEs)	151860	153599	154854	155477	155509	155569
Total Elective FFCEs	188353	190327	191940	192573	192665	192791
GP Written Referrals (G&A)	310692	303619	300089	294600	287479	279580
Other referrals (G&A)	226773	223087	219126	214747	212743	211280
Total Referrals	537465	526706	519215	509347	500222	490860
Non-elective FFCEs	128214	126720	125212	123826	121868	119938
All First Outpatient Attendances	490054	479005	470753	461241	450452	438894
First Outpatient Attendances - following GP Referral	280525	272613	267032	261127	253573	245267
All Subsequent Outpatient Attendances	1146923	1127112	1121830	1119810	1115273	1111180

TO BE FURTHER REFINED FOR 20 JUNE
DRAFT + CHART TO BE ADDED

Sustainability – Activity at point of delivery (2 / 2)

A&E Attendances (excludes Urgent Care Centre activity)

Collective and borough-level interventions for urgent and emergency care include a focus on controlling and reducing A&E attendances across south east London. The high level activity assumptions included in Operational Plans set out the initial level of ambition, subject to further collective challenge as well as quantification of impact through the Urgent and Emergency Care Clinical Leadership Group and other interdependent Clinical Leadership Groups such as Primary and Community Care.

	2013/14 F'cast OT	2014/15 Total	2015/16 Total	2016/17 Total	2017/18 Total	2018/19 Total
Bexley A&E Attendances - All types	82520	82933	81652	80390	79964	79540
% Change		0.5%	-1.5%	-1.5%	-0.5%	-0.5%
Bromley A&E Attendances - All types	115084	107592	109790	111945	114467	117050
% Change		-6.5%	2.0%	2.0%	2.3%	2.3%
Greenwich A&E Attendances - All types	115033	115834	116621	117379	117849	118309
% Change		0.7%	0.7%	0.6%	0.4%	0.4%
Lambeth A&E Attendances - All types	151789	153747	155638	157459	159191	160830
% Change		1.3%	1.2%	1.2%	1.1%	1.0%
Lewisham A&E Attendances - All types	126753	125486	125486	125486	125486	125486
% Change		-1.0%	0.0%	0.0%	0.0%	0.0%
Southwark A&E Attendances - All types	144846	141800	138750	136985	136005	135324
% Change		-2.1%	-2.2%	-1.3%	-0.7%	-0.5%

Notes

The attached profiles reflect a range of local assumptions including anticipated population growth and impact of local schemes in urgent and emergency care such as new urgent care centres. Some key illustrations of this are:

1. *Impact of new Urgent Care centre at Princess Royal University Hospital on Bromley attendances in Year 1*
2. *Impact of new Urgent Care centre at Guys on Southwark attendances in Years 1 to 5*
3. *Impact of significant local development at Vauxhall and New Mills in Lambeth with significant impact on population growth in Years 1 to 5*

Sustainability – Finance (1 / 2)

Over the next five years SEL CCGs revenue allocation is forecast to increase by an average of 10% cumulatively. The table shows the amount per CCG.

Recurrent Revenue, 000s	2014/15	2015/16	2016/17	2017/18	2018/19
Bexley	264,443	273,712	283,129	290,196	297,399
Bromley	383,109	401,481	416,361	431,727	443,402
Greenwich	338,918	350,042	356,380	362,241	368,189
Lambeth	429,218	441,410	449,779	457,965	466,165
Lewisham	381,240	395,138	404,667	414,120	423,581
Southwark	373,656	390,219	400,905	411,294	421,505
SEL Total	**2,169,584**	**2,252,002**	**2,311,221**	**2,367,542**	**2,420,241**

Expenditure is set to increase at approximately the same rate cumulatively, after delivery of QIPP.

Forecast Expenditure, 000s	2014/15	2015/16	2016/17	2017/18	2018/19
Bexley	261,317	271,027	280,375	287,372	294,503
Bromley	379,278	397,465	412,197	427,409	438,967
Greenwich	332,409	350,370	349,369	355,115	360,945
Lambeth	424,924	436,995	445,279	453,381	461,498
Lewisham	368,854	382,697	392,083	401,394	410,716
Southwark	369,684	386,249	396,895	407,169	417,279
SEL Total	**2,138,454**	**2,217,591**	**2,276,200**	**2,331,841**	**2,383,909**

All SEL CCGs are planning to deliver a surplus year on year over the next five years. This ranges from 1% to 2% each year across the individual CCGs within SEL.

Surplus / (Deficit) %	2014/15	2015/16	2016/17	2017/18	2018/19
Bexley	0.05%	1.00%	1.00%	1.00%	1.00%
Bromley	1.00%	1.00%	1.00%	1.00%	1.00%
Greenwich	1.92%	1.97%	1.97%	1.97%	1.97%
Lambeth	1.00%	1.00%	1.00%	1.00%	1.00%
Lewisham	1.00%	1.00%	1.00%	1.00%	1.00%
Southwark	1.06%	1.02%	1.00%	1.00%	1.00%

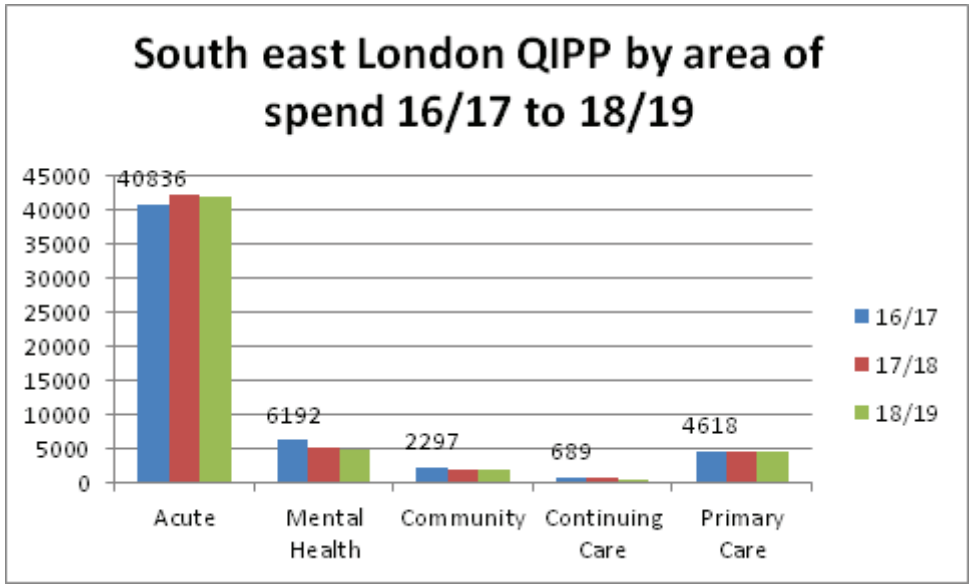
Sustainability – Finance (2 / 2)

In order to meet the rising demand and cost of living increases, CCGs have forecast a requirement to deliver a total of circa £307m net QIPP efficiencies. The first two years are underpinned by plans for delivery. The south east London commissioning strategy is the mechanism for delivering these efficiencies, together with the outcome improvements within the system.

Net QIPP savings, 000s	2014/15	2015/16	2016/17	2017/18	2018/19	TOT
Bexley	14,694	8,418	5,193	5,762	5,757	**38,824**
Bromley	12,012	12,140	7,900	5,400	5,400	**42,852**
Greenwich	8,600	7,300	4,300	6,000	6,000	**32,200**
Lambeth	15,319	20,233	17,832	14,645	13,081	**81,110**
Lewisham	9,490	13,119	11,546	9,597	9,833	**53,585**
Southwark	15,591	13,219	10,710	9,007	9,327	**57,854**
SEL Total	**75,706**	**74,429**	**57,481**	**50,411**	**49,398**	**307,424**

Excluding the CCG running costs the level of QIPP required across the CCG spend on care is £162m across south east London. Operating Plans show this is as being delivered primarily from reductions in spend in Acute (75 – 78%).

SEL Total (£'000s)	16/17	17/18	18/19
Acute	40836	42258	41822
Mental Health	6192	5094	4776
Community	2297	1859	1837
Continuing Care	689	561	498
Primary Care	4618	4568	4399
Total	54632	54340	53332



Better Care Fund

- The June 2013 Spending Round announced the creation of a £3.8 billion Integration Transformation Fund – now referred to as the Better Care Fund – described as 'a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities.
- The six south east London CCGs have all been working with their respective Local Authorities and Health and Wellbeing Boards to develop plans for improving outcomes for south east London residents through improving how health and social care services work together. The Better Care Fund is reflected within the south east London commissioning strategy and our shared plans to commission a transformed model of integrated care and support that is appropriate to their needs, and supports them to live as independent and fulfilling lives as possible.
- It is not new or additional money and commissioners jointly have to make important decisions about how the fund is used.
- The south east London commissioning strategy reflects a sound understanding of the key local challenges and the underlying issues that need to be addressed, with reference to "*Making best use of the Better Care Fund: spending to save?"* which offers an evidence-based guide, using evidence from The King's Fund and others in a number of different areas to aid the discussions between clinical commissioning groups and local authorities through health and wellbeing boards on how the fund would be used to make an impact through primary prevention; self-care; case management, for example.
- Recognising that this is a new initiative, sensitivity analysis has been undertaken which assumes that if the fund does not have the impact assumed, the spend in health will not decrease, requiring the need for increased QIPP to compensate.

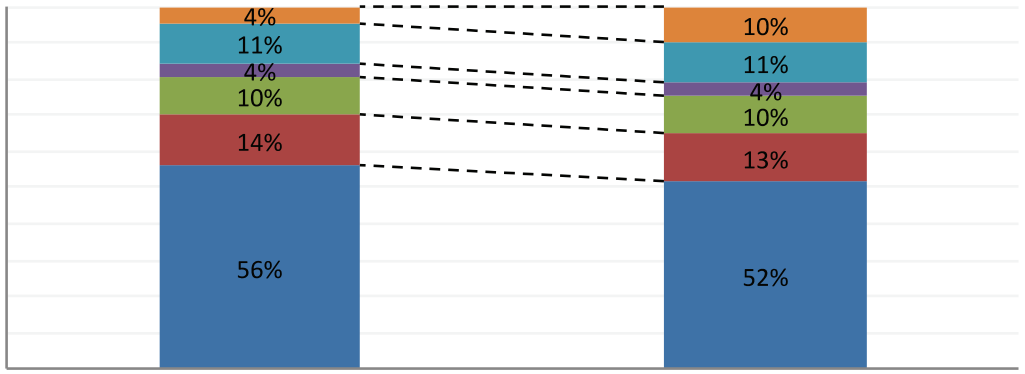
£'000s	Bexley CCG	Bromley CCG	Greenwich CCG	Lambeth CCG	Lewisham CCG	Southwark CCG	SEL Total
2015/16 allocation	13,708	20,837	19,771	22,007	19,740	20,478	116,541
2015/16 spend	13,708	20,837	19,771	22,007	19,740	20,478	116,541

Response to the Challenge – impact on the health system (1 of 2)

- The south east London commissioning strategy as defined by the CLGs is about quality, improved health outcomes, reduced inequalities and sustainable services delivered in the most effective way.
- To achieve this will alter where and how care is delivered and will require investment.
- The Operating Plans reflect the need to reinvest savings generated through QIPP to drive the shift. The investment levels are forecast and will be reviewed through an iterative process to refine. To assess the potential impact of increased investment required, this has been modelled as a sensitivity.
- Indicative impact of the implementation of the strategy have been determined with reference to opportunity for the CCGs within south east London identified in the JSNAs, Commissioning for Value and NHS England (London) data packs (CCG and Strategic Planning Group level), and planning support tools such as the Levels of Ambition Atlas and Operational Planning Atlas.
- The shift, within the combined Operating Plans, shows a reduction in Acute spend from 56% in 2014/15 to 52% in 2018/19 after year on year growth and delivery of QIPP.

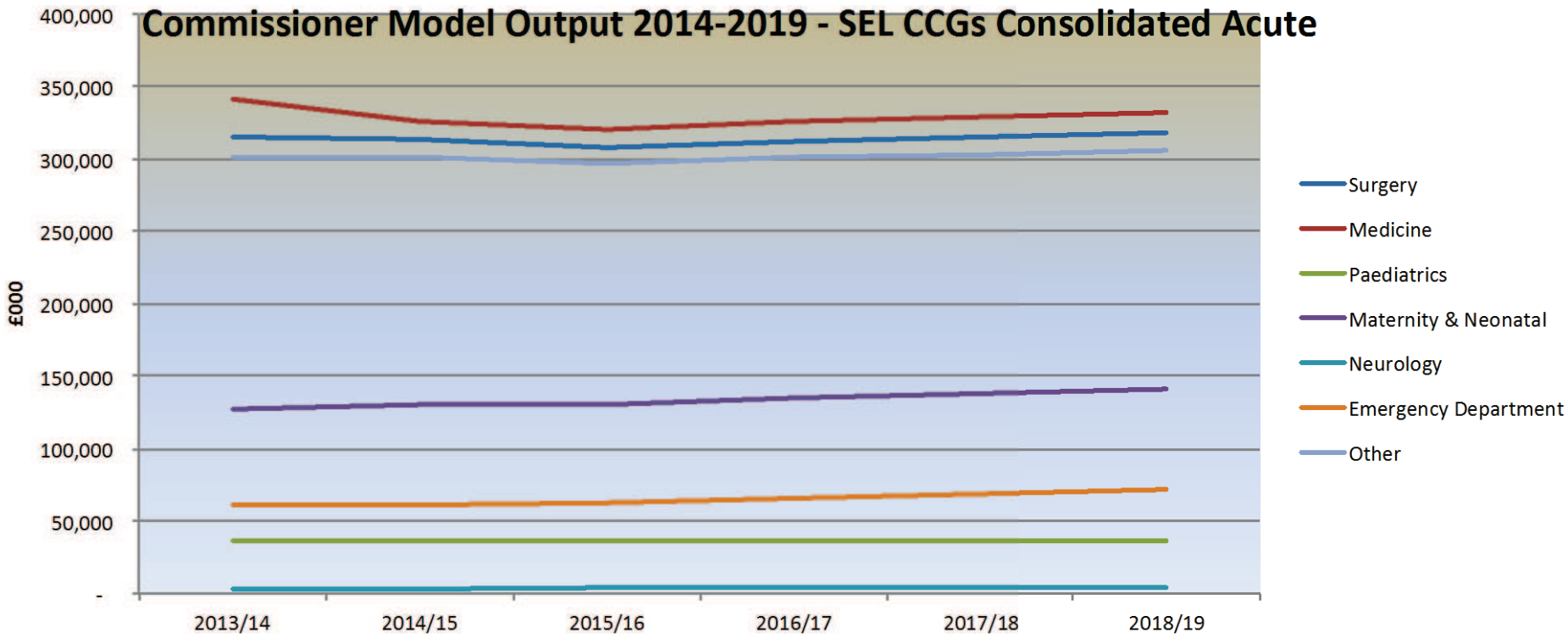
Projected shift in spend over the duration of the Strategy

based on current operational planning assumptions



Response to the Challenge – impact on Acute (2 of 2)

- The south east London commissioning strategy shows a shift in how and where the needs of the local population are met
- In line with growth projections, the demand for services is expected to increase
- Allowing for that growth and through transforming the way in which care is delivered through collaboration and partnership across health and social care, with a resulting impact on services within hospitals
- Over the next five years, the growth in acute specialities is relatively flat, reflecting the shift to provide services differently.



Sensitivity

- The Operating Plan QIPP assumptions are based on the national planning guidance trajectories and linked to the outcome ambitions, based on a number of triangulated sources including the Case for Change, JSNAs, Commissioning for Value and NHS England (London) data packs (CCG and Strategic Planning Group level), and planning support tools such as the Levels of Ambition Atlas and Operational Planning Atlas
- In order to assess the potential scale of risk in relation to delivery of QIPP, the impact of the Better Care Fund and the costs of implementation of the strategy, sensitivity analysis has been undertaken which assumes that if the fund does not have the impact assumed, the spend in health will not decrease, requiring the need for increased QIPP to compensate.
- These have not been applied in a "monte-carlo" style, which would have the impact of applying each sensitivity cumulatively but are shown as their respective impact on the existing scale of the challenge
- The range of impact on the £307m savings required would be an increase of between a further £15m to £45m, based on this assessment.

Sensitivity	Impact (£'000s / %)	Rationale
QIPP under achievement years 3-5 (by 20%)	Adverse £32,461k (10.56%)	Difficulty to implement/ scale of challenge
Better Care Fund impact lower than Operating Plan assumptions, resulting in higher QIPP to maintain sustainability (5 - 15%)	Adverse £8,115k - £24,346k (3% - 8%)	Allocation received but savings in spend do not materialise at scale in plan
Investment including cost of supporting strategies higher than in Operating Plans (+ £5m, £10m and £15m)	Impact on total QIPP required: +£5m: 16/17 59632, 17/18 59340, 18/19 58332 +£10m: 16/17 64632, 17/18 64340, 18/19 63332 +£15m: 16/17 69632, 17/18 69340, 18/19 68332	Require detail and management to contain costs effectively during implementation

Primary and community care

Key Impacts

The matrix below show how this strategic intervention contributes to each programme measure.

Measures for system objectives	Level of Impact (H / M / L)
Life expectancy	H
Healthy life expectancy	H
Gap in life expectancy	H
COPD mortality	M
Cancer mortality	M
CVD mortality	M
Smoking cessation	H
Excess weight (children / adults)	H
Alcohol related admissions	H
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	L
Increasing the proportion of older people living independently at home following discharge from hospital	H
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	H
Emergency admissions	M
Emergency attendances	H
Increasing the number of people having a positive experience of hospital care	L
Delivering the London Quality Standards and other agreed quality standards	M
Health-related quality of life for people with long-term conditions (EQ5D)	H
Sustained financial balance	H

As the core of our integrated system model for south east London, Primary and Community Care has to potential to drive a significant improvement, either directly or in combination with Long Term Conditions and the priority pathways, across the majority of the integrated system objectives, for example:

- Primary prevention activities, together with social care, will have a high impact on:
  - key public health measures including smoking cessation, excess weight and alcohol related admissions
  - Reducing inequalities in health outcomes and life expectancy
- Increased community support and resilience, together with improved coordination of care and access to local services, will support the objectives of increasing proportion of people living independently at home and reducing time people spend avoidably in hospital
- Taken together with the impact of other priority pathways, Primary and Community Care interventions will have a significant impact on reducing mortality, reducing emergency attendances and admissions and improving the quality of life for people with long term conditions
- Through successful implementation of these interventions and corresponding changes driven through other Clinical Leadership Groups, Primary and Community Care will make a significant contribution to the overall sustainability of the health system
- Robust baseline activity data is needed to sufficiently inform the impact on activity especially in emergency admissions and emergency attendances
- The impact on each system objective will vary in the short, medium and long term, depending on the starting point of the individual programme
- Additional measures proposed by the group should include wider primary care activity such as mental health, patient experience of seamless care, pharmacy and end of life
- The impact of primary and community care is closely linked to social care so there is a need to reflect some of the social care objectives in the system objectives e.g. employment, housing, debt

Long term conditions, physical and mental health

Key Impacts

The matrix below shows how this strategic intervention contributes to each programme measure.

Measures for system objectives	Level of Impact (H / M / L)
Life expectancy	M
Healthy life expectancy	M
Gap in life expectancy	H
COPD mortality	H
Cancer mortality	H
CVD mortality	H
Smoking cessation	M
Excess weight (children / adults)	M
Alcohol related admissions	M
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	L
Increasing the proportion of older people living independently at home following discharge from hospital	H
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	H
Emergency admissions	H
Emergency attendances	H
Increasing the number of people having a positive experience of hospital care	L
Delivering the London Quality Standards and other agreed quality standards	L
Health-related quality of life for people with long-term conditions (EQ5D)	H
Sustained financial balance	H

The Long Term Conditions (LTC) CLG in collaboration with the Primary and Community CLG and the Cancer CLG priority pathway will have a high impact on:

- Reducing the gap in healthy life expectancy between boroughs
- Increasing the proportion of people living independently at home following discharge from hospital and being able to self manage their LTC.
- With increased community support and resilience in place the CLG will improve coordination of care, access to local services and support the numbers of people living independently at home
- This will reduce the time people spend avoidably in hospital and have a significant impact on reducing mortality, reducing emergency attendances and admissions and improving the quality of life for people with long term conditions

Further specific measures the CLG are considering:

- Additional years of life for the people of England with treatable mental and physical health conditions
- Reducing Cancer, CVD and COPD mortality
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
- Potential savings associated with avoided hospital care, after costs of care in the community taken into account
- Savings associated with reduced acute bed days
- Reduction in delayed discharges to social care

Planned care

Key Impacts

The matrix below shows how this strategic intervention contributes to each programme measure. The Clinical Leader ship Group is also developing its own measures and objectives specific to elective and diagnostics scope.

Measures for system objectives	Level of Impact (H / M / L)
Life expectancy	M
Healthy life expectancy	M
Gap in life expectancy	M
COPD mortality	H
Cancer mortality	H/M
CVD mortality	M
Smoking cessation	H
Excess weight (children / adults)	M
Alcohol related admissions	L
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	H
Increasing the proportion of older people living independently at home following discharge from hospital	H/M
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	H
Emergency admissions	M
Emergency attendances	M
Increasing the number of people having a positive experience of hospital care	H
Delivering the London Quality Standards and other agreed quality standards	H*
Health-related quality of life for people with long-term conditions (EQ5D)	L/M
Sustained financial balance	H

* = not London Quality Standards per se but emerging model characteristics are likely to drive quality and reduce variation against clinical standards generally e.g. NICE

Focus on faster access and reduced waiting time across the pathway coupled with standardised approaches will contribute to earlier detection and intervention for patients with cancer and other cohorts requiring elective surgery. This has the potential to contribute to improving life expectancy and healthy life expectancy.

Working towards a system where every contact counts with clear clinical signposting can help maximise the impact of smoking cessation and healthy weight with the patient being in the centre of the care pathway. This is also likely to positively impact COPD mortality and CVD mortality.

Standardisation will help to reduce variation and duplication which in turn will drive quality of services up with improved clinical outcomes (for example lower infection rates), potentially reducing the number of avoidable deaths in hospitals. This is also supported by getting a senior opinion early (from an expert not necessarily a consultant).

Increasing capability within the community for diagnostics and some minor elective work will help to reduce waiting time and cancellations will help reduce the amount of time people spend in hospital and improve the flow of the patients that present properly. This will also help to improve the quality of care and in turn improve patient experience through clear linear pathways.

Some reduction in emergency admissions and attendances as a result of improved access reducing the number of patients that need to be admitted as an emergency.

Ensuring that communication and sharing of information that occurs between secondary care, primary care and social care is the best it can be has the potential to drive prevention and discharge management. This will help to empower the patient to understand their condition and the critical things they (or their family) need to know to help manage their condition after an elective episode.

Collaboration between primary care and secondary care, with social care and social services has the potential to reduce the amount of time people spend avoidably in hospital (including reducing lengths of stay) and ensure that elderly patients are able / supported to live independently when moved back in the community. This also has the potential to prevent some admissions through patients being better supported.

Working together to address rising demand for elective care and diagnostics, delivering services more efficiently and effectively whilst maximising value across the pathway will help to deliver sustainable financial balance across the system.

Urgent and emergency care

Key Impacts

The matrix below shows how this strategic intervention contributes to each programme measure.

Measures for system objectives	Level of Impact (H / M / L)
Life expectancy	M
Healthy life expectancy	L
Gap in life expectancy	L
COPD mortality	L
Cancer mortality	L
CVD mortality	H-M
Smoking cessation	L
Excess weight (children / adults)	L
Alcohol related admissions	M
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	M
Increasing the proportion of older people living independently at home following discharge from hospital	H
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	H
Emergency admissions	M
Emergency attendances	M
Increasing the number of people having a positive experience of hospital care	H
Delivering the London Quality Standards and other agreed quality standards	M
Health-related quality of life for people with long-term conditions (EQ5D)	M
Sustained financial balance	M
4 HOUR TARGET	H
CDU reducing use of acute admissions	H

This matrix shows how the strategic intervention contributes to each programme measure.

There is a rapid 24/7 response to urgent care needs. The service model integrates fully with the development of Local Care Network (LCN) Hubs delivering more of urgent care closer to a patient's home, particularly aiming to be the choice to go to for minor injuries and illnesses. Emergency Department (ED) specialists are able to be reached for advice and also can book urgent appointments with GPs for patients who do present at an Urgent Care Centre or ED inappropriately. Clear sign-posting and agreed 'bundles of care' ensure patients receive the right services in the right place. 111 plays an enhanced role in navigating and coordinating an appropriate response to urgent (and not so urgent) needs. LAS has access to patient information and is able to route to the right service for non-blue light calls, including LCNs.

Urgent care in the community is enhanced through the Rapid Access Service (Home Ward and Specialist Response clinics located in hospitals) which particularly aims to support elderly frail patients and those others with LTCs, complex health and mental health needs to avoid the need to present at an Emergency Department. This means fewer vulnerable patients need be spending time in Emergency Departments or admitted to wards whilst awaiting diagnosis, as well as supporting speedier discharge for patients who do need to attend EDs. This may increase life expectancy for those who are frail or with certain LTCs.

Fewer patients from care homes are presenting at A&E and are assessed and treated at home through the 'Home Ward' team (Rapid Access Service).

Within EDs, improved streaming and flow, managed by an experienced Band 6 Nurse and GP provision at the 'front door' ensures patients are seen within the London Quality Standards targets and avoidable admissions are increased. This is enhanced by Clinical Decision Units with beds, able to hold, assess and treat patients without admitting to wards, improving patient experience, avoiding admission and returning home faster. In place are links with 24 hr social care and the voluntary sector able to support the patient on discharge/return home where needed and reduce likelihood of re-attendance with the same urgent need.

Complex needs – including alcohol and mental health related admissions – are more effectively managed to avoid admissions through integrated planning and working between community and specialist services. There is likely to be a reduction in frequent attenders.

Investment in services providing urgent care in the community will impact patient outcomes and shift urgent care activity away from UCCs and EDs.

DRAFT IN PROGRESS

Maternity

Key Impacts

Measures for system objectives	Level of Impact (H / M / L)
Life expectancy	H
Healthy life expectancy	H
Gap in life expectancy	L
COPD mortality	N/A
Cancer mortality	N/A
CVD mortality	N/A
Smoking cessation	M
Excess weight (children / adults)	M
Alcohol related admissions	L
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	H
Increasing the proportion of older people living independently at home following discharge from hospital	N/A
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	M
Emergency admissions	M
Emergency attendances	M
Increasing the number of people having a positive experience of hospital care	H
Delivering the London Quality Standards and other agreed quality standards	H
Health-related quality of life for people with long-term conditions (EQ5D)	L
Sustained financial balance	M

This matrix shows how this strategic intervention contributes to each programme measure.

The strategic vision for maternity services is to place the needs of women and their families at the centre of maternity care. The model of care which is midwifery –led continuity of care includes neonatal care and early years up to 9 months. There are a number of key elements within the maternity service model which support the delivery of these overall programme measures.

Specifically:

- To develop maternity services and a workforce that promote healthy lifestyles which have a positive effect on the health outcomes for mother and child and the wider family.
- To work in conjunction with primary care and others to improve awareness of problems in pregnancy and the impact on outcomes caused by a range of lifestyle choices.
- Promoting early access to maternity services through a focus on hard to reach groups and supporting early identification of risk and consequent care plan development.
- Developing continuity of midwife-led care and reviewing maternity catchment areas in order to optimise integration with other services in particular health visiting, primary care, social care and children's centres.
- The service model enhances specialist maternity services for high risk women or women with complex health needs including perinatal and post-natal mental health.
- Midwives will become part of the team around the child moving from maternity to community based services and will include a postnatal overlap and transition to health visiting and primary care linking into the broader locality / community network to support new parents and babies.
- Improved access to postnatal services will also support a reduction in neonatal admissions.
- improved continuity of care and community alignment will help to ensure timely identification, referral and access to specialist services.
- Developing an approach to meet the required standards for consultant cover , particularly for high risk women that provides the maximum quality and safety for women and babies in hospital during and following delivery.

Normalising birth and supporting women to achieve the best possible outcomes for themselves and their babies is the focus of the maternity strategy. The successful implementation of the strategy will have an overall positive impact in improving the life chances and healthy life expectancy for local people.

Children and young people

Key Impacts

Measures for system objectives	Level of Impact (H / M / L)
Life expectancy	H
Healthy life expectancy	H
Gap in life expectancy	N/A
COPD mortality	N/A
Cancer mortality	N/A
CVD mortality	N/A
Smoking cessation	L-M
Excess weight (children / adults)	M
Alcohol related admissions	M
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	H
Increasing the proportion of older people living independently at home following discharge from hospital	N/A
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	H
Emergency admissions	H
Emergency attendances	H
Increasing the number of people having a positive experience of hospital care	H
Delivering the London Quality Standards and other agreed quality standards	H
Health-related quality of life for people with long-term conditions (EQ5D)	H
Sustained financial balance	M
Mental health and CAHMs admissions	M

At the core of the children and young persons strategy is building community resilience and child-centred services. The service model particularly aims to deliver: early intervention; health care promotion and prevention delivered through Children's Centres and GP (Local Care Network) Hubs; improved access 'no wrong door'; effective assessment and coordination for children with Long term Conditions and Complex needs. These and a more effective interface between community and acute/specialist services will be impacting positively on life expectancy and healthy life expectancy.

Tackling 'Toxic Stress' and promoting emotional as well as physical well-being helps protect the child from adversity and reduces potential mental health conditions. The strategy presents a positive focus on mental health of the child and ensures their support networks help enable this. Up skilling the workforce across a number of system developments with regards to mental health will see an impact on the number of children and young people presenting to CAHMs services. Providing ill children and their parents/carers with psychological support in hospital and at home will improve healthy life expectancy and health-related quality of life.

An integrated paediatric assessment and coordination process, linked to safeguarding processes and the Single Plan for children with disabilities/special learning needs will improve access and outcomes for children and young people with long term conditions and complex needs. Specialist Paediatric Assessment Units (PAU) will improve outcomes and reduce unnecessary admissions in to acute services for children with urgent care needs. GPs will be able to access Paediatric consultancy and advice to deal with urgent needs locally.

Community Child Health Teams manage LTC pathways, providing Out of Hours support, easy access to Paediatric Specialists and paediatric specialist nursing in the community, improving time in hospital and supporting improved quality of life, parental support and therefore mental health and emotional well-being of children. This is supported through a strong link into education and the role Local authorities, public health, and health visitors play in supporting a child's health needs. Services designed around the child and their support network promotes more informed life style choices This directly feeds into smoking cessation, excess weight, and alcohol related admissions within the cohort.

An effectively designed and coordinated community-acute / specialist interface model around PAU and Community Child Health Teams with paediatric team ownership from "front door" will avoid unnecessary admission and improve outcomes across secondary care. This will also speed up discharge ensuring the step down interface between secondary care and community will be efficient and effective. This will be supported by inreach to children with long term conditions in hospital from Community Child Health Teams ensuring services are centred around the child on discharge.

The model will support delivery of the London Quality Standards including specialist paediatric decision-making and cover for Emergency departments.

Ultimately with the reduction in avoidable acute admissions this aims to help to support a sustained financial balance.

Cancer

Key Impacts

The matrix below shows how each of the strategic interventions for the Strategy contribute to each programme measure.

Measures for system objectives	Level of Impact (H / M / L)
Life expectancy	H
Healthy life expectancy	M
Gap in life expectancy	M
COPD mortality	L
Cancer mortality	H
CVD mortality	L
Smoking cessation	M
Excess weight (children / adults)	L
Alcohol related admissions	L
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	L
Increasing the proportion of older people living independently at home following discharge from hospital	M
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	M
Emergency admissions	H
Emergency attendances	H
Increasing the number of people having a positive experience of hospital care	M
Delivering the London Quality Standards and other agreed quality standards	L*
Health-related quality of life for people with long-term conditions (EQ5D)	H
Sustained financial balance	M

The vision of the Cancer Clinical Leadership Group is to make a demonstrable improvement in transforming cancer services – improving outcomes and patient experience. To support this vision, an initial model has been designed that will focus effort in areas where the greatest improvement of outcomes can be made, in particular:

- The approach to early detection and treatment is a fundamental driver of the system objective to reduce avoidable cancer mortality and increase overall life expectancy
- Enhanced and coordinated care and support services within the community will have a significant impact on emergency admissions and emergency attendances, particularly at end of life
- The focus on transition from treatment living with cancer and the effects of cancer will also make a contribution to reducing the amount of time people spend in hospital and the proportion of older people living independently at home following discharge from hospital
- Enhanced support to patients, families and carers will support the ambition of increasing the number of people having a positive experience of hospital care
- Education and training within the workforce (including social care providers and voluntary services) will help support prevention objectives, in particular for smoking cessation.

* Cancer has no specific London Quality Standards, but is following the recommendations in the Five Year Cancer Commissioning Strategy for London

Supporting Strategies

When the strategic opportunities and scope of the Clinical Leadership Groups were agreed, it was acknowledged that there would be some overlap and interplay between the groups and further that there would be a need for cross-cutting supporting strategies to enable the delivery of interventions defined through the groups.

Supporting strategies will be a fundamental part of the development of the strategy after the 20 June NHS England submission and successful implementation of any resulting system changes. Discussions at Clinical Leadership Group workshops and the Partnership Group stakeholder meetings have identified a number of common supporting strategies. Including:

- IT and Information
- Workforce
- Commissioning Models
- Communications and Engagement
- Organisational Design and Change Management
- Estates
- Transport

Further development post 20 June submission

- Establish a governance model for the supporting strategies
- Clearly define and scope the supporting strategies
- Create work and engagement plans for taking forward the development of the strategies

Priority Supporting Strategies

Priority Supporting Strategy	Overview
IT and Information	To drive a consistent and accessible approach to IT and information across all providers including: • Shared definitions and standards • Sharing of patient data and health information across providers • Use of a virtual patient record
Workforce	To develop a new workforce model that meets the needs of an increasingly community based model of prevention and care including: • Use of multi-disciplinary teams, at the right time in the right place • 24/7 care with an appropriate range of skills • Addressing recruitment and retention issues • Supporting cultural and behavioural change to reflect the emphasis on public health and self care
Commissioning Models	To develop innovative approaches to commissioning and contracting that incentivise the right behaviours across the system, including: • Commissioning and providing for outcomes • Development of incentives and contractual levers for change, including quality improvement • Effective co-commissioning to reduce complexity and ensure consistency of approach
Communications and Engagement	To develop the existing Communications and Engagement workstream to support all aspects of the programme over the coming months including: • Coordination of local and south east London-wide engagement on the strategy, including potential impacts on the health system • Communication with stakeholders, patients, local people and staff • Development of proposals for campaign approach to engage patients and local people in the strategy and management of their own health
Estates	To an Estates workstream with particular focus on: • Supporting Locality Care Networks through enabling the bringing together of staff and services • Promoting co-location of services where appropriate • Establishing primary care estate for the 21st Century

Implementation work already underway (1 / 2)

Much of the content in this draft has focused on the future state service models that will be in place by years three to five of the Strategy. However we understand the urgency to change services and significant work is already underway that will deliver foundational elements of the Strategy during years one and two.

Collaboration on the Strategy follows a principle of 'shared standards, local delivery'. In practice this means CCGs working together at the right scale: at borough, cross-borough or south east London level. CCG operating plans set out a series of bold changes that will be delivered in years one and two of the Strategy.

Some examples of significant work already being implement are as follows:

- **Development of wider primary care, provided at scale** South east London CCGs are already working to transform local primary and community care:
  - The six boroughs have developed a model under which services will be provided at scale by 24 locality care networks supporting whole populations
  - This builds on the current pathfinder programme for developing new models of primary care under which there have been 12 applications, each with geographical coherence, with a coverage of more than 750,000 registered patients
  - Southwark CCG have been granted £950k from the Prime Minister's Challenge fund to provide extended access to primary care through neighbourhood working, supporting the implementation of the CCG's Primary and Community Care strategy
  - Lewisham CCG has transformed its Diabetes Pathway utilising various mechanisms to enhance diagnosis across Primary Care, including 'Peer2Peer support' which involves a dedicated clinical lead supporting practices by providing hands on in-practice advice and guidance. This has helped to strengthen and improve the number of patients taken through the 3Rs process (Register, Recall and Review) and the 9 Care Processes (NICE standard).
- **Developing a modern model of integrated care** There has been significant progress to date in the development of integrated care, delivered through south east London's Community Based Care programme. In addition to developing plans with local authorities under the Better Care Fund, CCGs have also achieved a number of other key milestones:
  - Bexley, Bromley and Greenwich CCG are all achieving top 10% performance for avoidable admissions through their local delivery of integrated care services
  - The development and scaling of the Southwark and Lambeth Integrated Care Programme (SLIC)
  - Greenwich achieving national pathfinder for Integrated Care.

Implementation work already underway (2 / 2)

Examples continued:

- **Improving and enhancing local urgent and emergency care** Locally driven work to improve urgent and emergency care including the redesign of Guys and St Thomas Emergency Department and Urgent Care Centre (UCC) in Lambeth and the successful transition of the 111 service to London Ambulance Service and subsequent achievement of all targets.

- **Transforming specialised services** The development of new cancer treatment centres at Guys Hospital and a cancer treatment centre at Queen Mary's Hospital Sidcup

- **Building resilient communities** South east London's CCGs are working with local authorities through Health and Wellbeing Strategies, to build and develop **resilient communities**, for example through the award winning Lambeth Living Well Collaborative

- **Partnership working across south east London** The Programme has 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 providers, to build agreement on priorities, strategic goals and outcomes. South east London's Partnership Group provides a strong and collective transformational leadership of the Strategy, with a shared recognition across all members of the scale of the challenge and also the level of organisational and cultural change needed

- **Clinical Commissioning Groups and membership organisations** The membership nature of CCGs enables change to be clinically led and rapidly delivered across the health system – for example rapid introduction of new referral protocols in relation to cancer waits.

Introduction to programme approach

- Since the start of September 2013, South East London commissioners have been working together to form a new commissioner-led, clinically-driven programme to address the challenges faced across the South East London health system in partnership with providers and the local authorities
- The South East London Commissioning Strategy Programme encompasses the South East London response to NHS England's requirement to produce a five year strategy. The strategy, key interventions and impact assessment have been completed at a high level and will be developed in greater depth and tested both in terms of impact modelling and testing with our stakeholders
- Implementation of the Strategy is underway. We can improve care to patients immediately and the Partnership will drive forward the changes
- The following pages set out the approach used to develop the strategy and next steps through which partners are working together to further develop and implement the Strategy through to 2019.

Programme principles and values

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

Key principles and values for the programme 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.

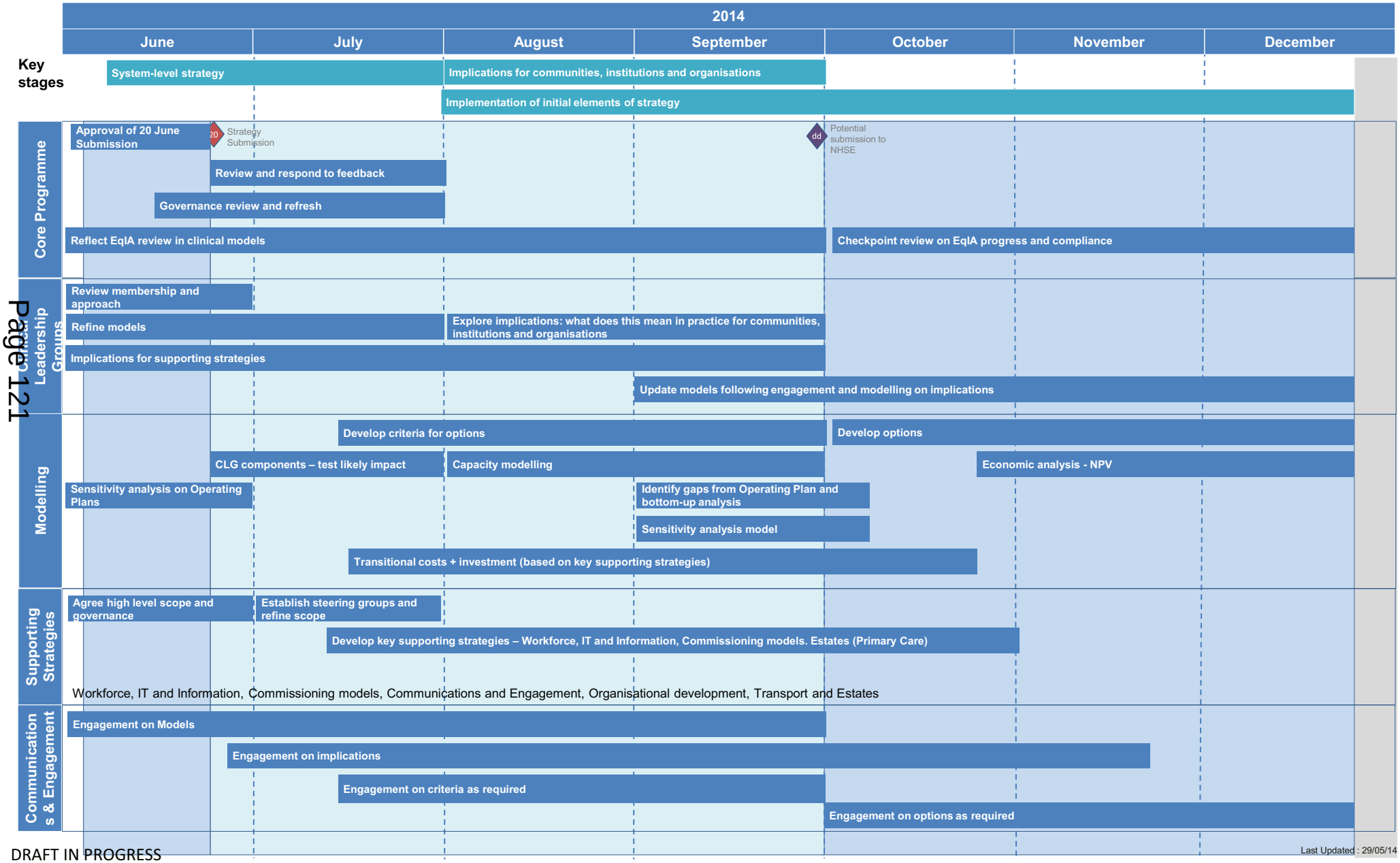
Following these principles and values, the South East London strategy is building on the six individual CCG-level strategies developed locally with partners. CCGs are working collaboratively on the elements of the strategy that cannot be addressed at CCG level alone, or where there is common agreement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

Engagement is being undertaken throughout the process, primarily through existing borough-level engagement, but on a wider basis where this is helpful. Engagement to date has included developing the case for change, scope and vision, the ambition of the programme and is moving on to priorities and models of care as the programme develops.

Specific engagement will take into account equalities aspects and impacts on the nine statutorily protected groups, plus the needs of socially and economically deprived populations and of carers in south east London.

9. Approach – 9.2 Progamme plan to June 2014

Plan for developing the strategy – to December 2014



DRAFT IN PROGRESS

Last Updated : 29/05/14

Approach to strategy development – 2014 – 2019

Submission of the final strategy on 20 June is just the start of the development and implementation of a long term strategic vision and change for south east London:

- 20 June 2014 – Final Strategy submission to NHS England
- July to December 2014 – Work to review and refresh Strategy and set out impact of proposed interventions at an institutional and community level, with engagement on final strategy and implications as they develop
- 2015 – Business Case for any significant service change (if required) and formal consultation (if required)

Approach to engagement

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

Engagement is being undertaken through a number of complementary activities, including the following:

- Using existing borough-level channels and planned activities, supplemented by engagement on a wider basis where this is helpful. Initial engagement included developing the emerging and draft case for change, testing emerging strategic opportunities across south east London and the scope and vision and the ambition of the programme. The focus of engagement is moving onto priorities and proposed models of care as the programme develops.
- Patient and Public Participation:
  - Healthwatch representatives and local patient and public voices have been recruited and are members of each of the seven clinical leadership groups, working with clinicians and social care leads from organisations across south east London on clinical design activities for service improvements and proposed models of care
  - Healthwatch representatives and local patient and public voices are members of the Partnership Group, Clinical Executive Group and the Clinical Commissioning Board, shaping the overall strategy
- An early Equalities Impact Assessment:
  - to ensure that the strategy has considered, from the outset, the potential impact on those protected under the Equality Act 2010 and the additional south east London groups
  - to ensure that plans for further engagement – locally and more widely – are targeted appropriately to reach local people and communities whose voices are seldom heard
- Engagement events:
  - Wider engagement events across south east London or between boroughs with voluntary and stakeholder organisations, patients and local people.
  - Participating in events organised by south east London-based voluntary organisations and other stakeholders where the aim or content is relevant to the development of the strategy.
- Market research:
  - Independent survey with a representative sample of local populations to gain deeper insight into local people's views.

Engagement to date

In line with the engagement approach set out on the previous page, engagement to date includes:

- Understanding feedback from the 'Call to Action' engagement activities across all six CCGs from 2013 and using this to inform the emerging draft case for change
- Understanding feedback on local strategies during 2013 and 2014 and using this to inform the developing draft strategy
- Testing early thinking on the emerging draft case for change with the independently-chaired South East London CCG Stakeholder Reference Group (SRG) in December 2013. Using feedback from this group to inform development of local engagement plans and associated resources for engagement on the full draft case for change and the emerging strategic opportunities across south east London
- Sharing the emerging case for change through the CCGs' existing engagement forums and with NHS providers and local authorities via the programme's Partnership Group. Using feedback to inform development of resources for engagement on the full draft case for change and the emerging strategic opportunities across south east London
- Sharing the full draft the case for change, the emerging strategic opportunities across south east London and the draft vision and ambition through south east London's CCGs', NHS providers' and local authorities' existing engagement forums, SRG membership, Healthwatches, Clinical Executive Group and Partnership Group membership from February 2014
- Publishing plain English and technical summary versions of the draft case for change and emerging strategic opportunities across south east London for on-line engagement with local people and clinicians via all six CCGs' websites from March 2014.
- Regular updates on the strategy development at local public meetings of CCGs' Governing Bodies and Health and Well-Being Boards.
- Updating CCGs' GP memberships with regular briefings on the clinical developments and progress with the strategy.
- Recruiting patient and public voices for direct involvement in the development and shaping of the strategy

Patient and public participation

The following arrangements have been put in place to enable active participation of patients and local people in the clinical design and shaping of the overall strategy:

- **Clinical Leadership Groups** – A Healthwatch representative plus three additional patient/public voices on each of the seven Clinical Leadership Groups to participate in the work for planning service improvements and proposed models of care.
- **Clinical Executive Group, Partnership Group and Clinical Commissioning Board** – A Healthwatch representative plus two patient and public voices to participate in each group on shaping the overall strategy for south east London.
- **Patient and Public Advisory Group (PPAG)** – establishing this group as a collective forum bringing together the strategy's patient and public voices, Healthwatch representatives and other local stakeholders with an interest in the strategy to share messages from different groups and to provide peer support, as well as to advise the strategy on public-facing communications and wider engagement. It is anticipated that PPAG will report to the Clinical Executive Group. Its work is complementary to the independent advisory role to the strategy of the South East London CCG Stakeholder Reference Group.

The programme team is providing further support for representatives and patient and public voices:

- Provision of a high level role description outlining how participants will contribute to groups, clarifying the level of commitment expected by participants and the support available to them in their role
- Ensuring participants are adequately briefed for meetings and workshops – including overview of programme in advance of first meeting, collecting and disseminating their feedback more widely within the programme as appropriate and supporting them, as required, to feedback to their constituent groups and communities.
- Establishing additional support arrangements for participants including mentors.
- Supporting the work of the Patient and Public Advisory Group in communicating the role and work of patient and public voices more widely

These arrangements will be reviewed at the end June 2014 as we move into a further phase of significant engagement and start looking at the impact of proposed interventions on individual organisations and institutions.

Equalities impact assessment

One of the aims of the South East London Commissioning Strategy is to improve health and reduce health inequalities. Ensuring that the health and care needs of seldom heard groups are adequately met is a key element of this strategy.

To support programme engagement activities and to fulfil the need to ensure that we demonstrate that we have considered the potential impact on those protected under the Equality Act 2010, with specific regard given to the general equality duty/public sector equality duty, the South East London Commissioning Strategy Programme has appointed an external partner to undertake an early independent Equality Impact Assessment. During strategy development the Equalities Impact Assessment will:

- Explore how elements of the strategy support or hinder the achievement of the three limbs of the general duty of the Equality Act, namely the elimination of unlawful discrimination, harassment and victimisation; the advancement of equality of opportunity between different groups; and the fostering of good relations between different groups.
- Review the work undertaken to date at a local and collective level to identify:
  - Whether the programme has considered and understood the potential effects of the commissioners' strategy on different equality groups at key stages and assured that we have undertaken work to ensure that there is either no adverse impact or that we have identified a plan to address and to mitigate any adverse impact
  - Whether the programme has considered and identified enhancements to any benefits that could or might accrue to the nine statutorily protected groups (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation, marriage and civil partnership - but only in respect of eliminating unlawful discrimination), plus two locally added groups (carers, deprivation – social and economic) as a result of the commissioners' strategy
  - How communities and protected groups and the additional groups of the six boroughs within South East London are likely to be affected by the strategy
  - What plans for further engagement should be put in place during the further development work on the impact of the strategy including traditionally under-represented groups.

By starting this assessment while the strategy is still in development, the outputs are being fed into the work of the Clinical Leadership Groups and the Communications and Engagement workstream from an early stage. In this way, it is already being used to shape the strategy, ensuring the equalities agenda is a key building block of the integrated system model and related service models for the south east London health system.

Introduction to programme governance

- The South East London Commissioning Strategy Programme governance has been designed to sit within the existing governance and decision making structures of the CCGs and NHSE. It provides formal forums to undertake the four key governance functions of the programme:
  - Senior joint forum for strategic direction and decision making (equivalent to a Programme Board) **– the Clinical Commissioning Board**
  - Collaborative forum for partnership working – **the South East London Partnership Group**
  - Clinical forum to guide design work – **the Clinical Executive Group**
  - Delivery focused forum to manage design and implementation activities – **the Implementation Executive Group.**
- These four functions are supported by a simple programme management structure to monitor and support clinical design and implementation activities
- The approach has been designed to ensure that current and future plans governed under the Strategy Programme are developed in collaboration with key stakeholders including the local community.

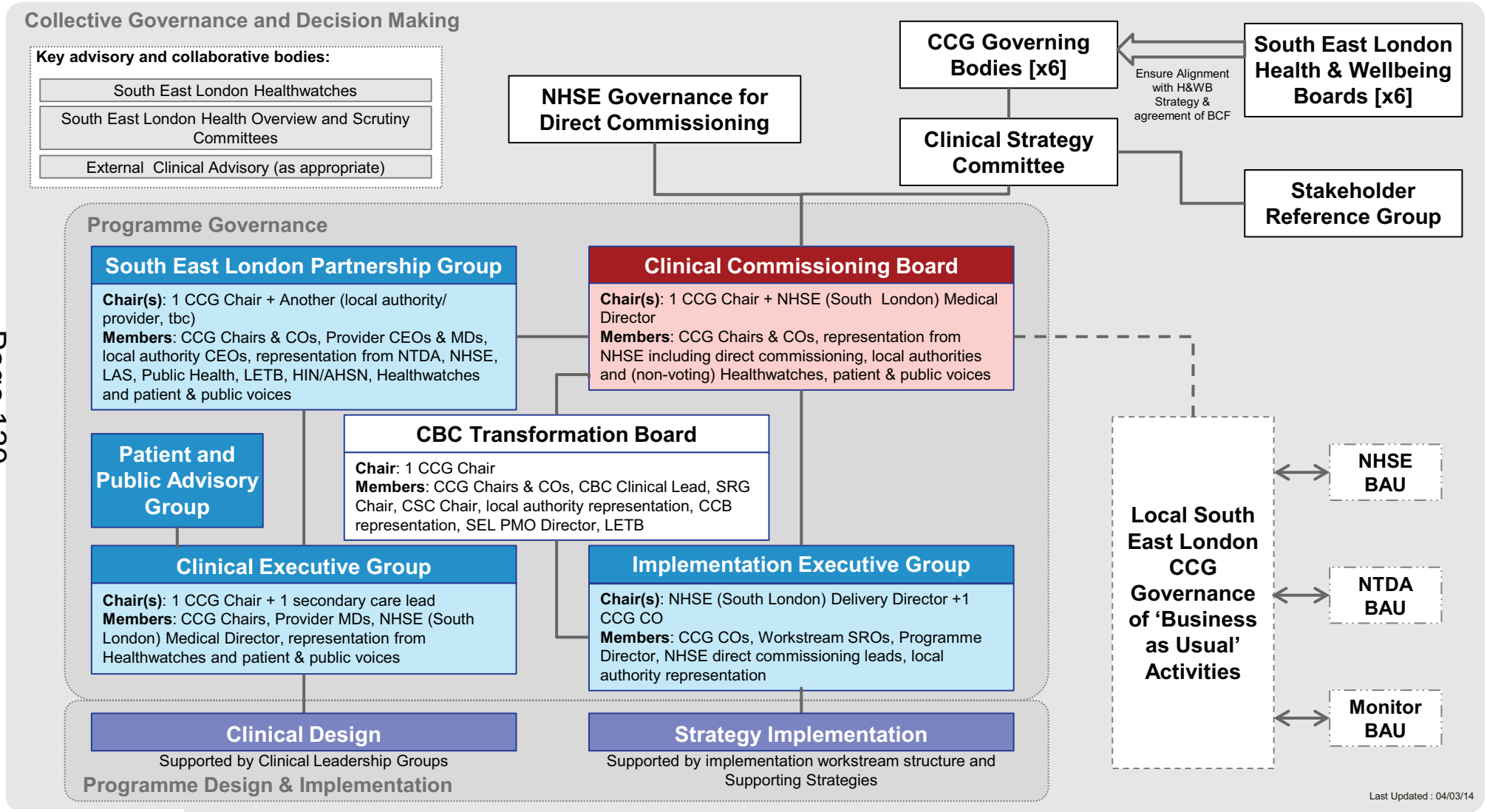
The following pages set out the principles, structure and key roles and functions for governance of the Strategy.

Principles for programme governance

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

- It must ensure the Commissioning Strategy is 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
- It must be open and transparent throughout the process, from identification of need, to implementation of the strategy, with opportunity for challenge by patients and the public
- Patient safety and quality must be at the heart of decision making
- Decisions should take into account patient, carer and community voice
- The roles, responsibilities and accountabilities of the CCGs, NHS England 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 critical path and overall timetable
- Duplication of effort should be minimised across the health system.

Structure and high-level memberships



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
BAU = 'Business as Usual'
CBC = Community Based Care
SRG = Stakeholder Reference Group
CSC = Clinical Strategy Committee

Key

Programme Decision Making	Existing Governance
Programme Governance	Advisory and Collaborative

Key roles and functions

The roles and functions of the South East London Commissioning Strategy Programme specific governance bodies are outlined below. The overall 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 is being delivered primarily through the Clinical Commissioning Board, supported by South East London Partnership Group and the Implementation Executive Group.

- The programme is led by the **Clinical Commissioning Board (CCB)**, which acts as the overall programme board. The CCB is commissioner-led and clinically-driven and steers and makes decisions on the development and delivery of the strategy. Members of the CCB 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 are accountable to the CCB for delivering their agreed share of the benefits of the programme
- The **South East London Partnership Group** is the strategic and partnership forum for the programme. The group is 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 require the support of the Partnership Group
- The **Clinical Executive Group (CEG)** brings together clinical leaders from across South East London to frame and provide oversight of clinical design work by providing guidance and assurance to the individual clinical leadership groups and managing interdependencies across the group. It acts as a conduit for the management and escalation of clinical risks
- The **Implementation Executive Group (IEG)** is the executive group supporting the CCB, providing oversight to planning, implementation, benefits realisation and assurance. The IEG also steers the mobilisation workstream, and has a continuing responsibility to make recommendations to the CCB on the optimal structure and scope of the programme
- The **Public and Patient Advisory Group (PPAG)** is the collective forum for the strategy's patient and public voices: to share learning, provide peer support, facilitate wider engagement and disseminate messages and provide feedback on key programme materials
- The **Community Based Care (CBC) Transformation Board** acts as the programme board specifically for the CBC programme. The group provides leadership and oversight across the three key workstreams of Primary and Community Care, Integrated Care and Planned Care, ensuring alignment with the developing South East London Commissioning Strategy.

Programme design and delivery is undertaken by combination of contributing clinical groups, projects and programmes at varying points in their lifecycle, each requiring the appropriate treatment from a governance and operating perspective.

Collaboration and advice

The programme links to a number of existing advisory and collaborative bodies. Relationships have been established with these groups as appropriate as part of mobilisation and ongoing delivery.

- **Health and Wellbeing Boards (HWBs)** 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. As well as being engaged and involved in the co-development of the Commissioning Strategy, ensuring alignment with local Health and Wellbeing Strategies, Health and Wellbeing Boards have agreed Better Care Fund plans
- **Health Overview and Scrutiny Committees (HOSCs)** will provide local scrutiny and review in line with statutory requirements under the Local Government Act 2000 and Health and Social Care Act 2012
- The programme links to the **South East London CCG 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 links 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 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 which 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.

Introduction to programme risks

- The governance and assurance of the Strategy Programme is supported by a programme risk management framework and risk register
- The risk register captures the key risks to both the **development** and **implementation** of the Strategy, rating these based on impact and likelihood, and setting out mitigation controls and actions
- The following pages set out the highest priority risks to the development and implementation of the Strategy, plus associated mitigations. Full details of impact, likelihood and mitigation for each of the above can be found in the full risk register.

Key risks

Risks to development of the Strategy

The following high level risks have been identified to the development of the five year commissioning strategy. This list will be reviewed regularly through the Clinical Executive Group, Implementation Executive Group and Clinical Commissioning Board.

Title	Risk	Impact	Mitigations
A1. National Specialised Commissioning Timeline	• National timetable for specialised commissioning limits ability to consider whole pathways / maximise impact of local workstreams	• Strategy not able to move forward at required pace or level of quality / completeness. • Data and finance and activity plans for specialist and primary care commissioning may not be available within programme timescales • Impact of proposed Clinical Leadership Group changes on financials and activity cannot be effectively assessed	• Local workstreams continue further work after June to integrate and drive benefits • Close liaison with NHS England. Review and refresh of strategy as data becomes available • Exploration of opportunities for co-commissioning
A2. Provider Engagement	• One or more service providers is insufficiently engaged or subsequently disengages	• Full consequences of change in the local health system are not properly understood • Ability to deliver the proposed strategy could be compromised	• Engagement through CLGs, Clinical Executive and Partnership Group • CEG and CLG Chairs to work with Central team to reinforce importance of contribution
A3. Partner and Stakeholder Engagement	• Insufficient partner and stakeholder engagement	• Strategy not able to move forward at required pace and potential to challenge ability to deliver	• Engagement through CLGs, Clinical Executive and Partnership Group • Local engagement led by CCGs, complemented and supported by work of central team • Clinical leadership includes work with partners and stakeholders
A4. Patient/Public Resistance to Change	• Patients and local people tell us there is no need for change	• Further engagement required Possible challenge to legitimacy of strategy	• Continual engagement through CCGs and south east London –wide work. Clear and consistent messages from system leaders, particularly clinicians
A5. Strategy Development Resourcing	• Work on 5 year strategy and associated communications and engagement, in addition to business as usual activities could overstretch commissioning, finance and teams in both CCGs and NHSE.	• Potential impact on quality / schedule for the south east London strategy - or on delivery of operational imperatives	• Strategy resource levels benchmarked against programmes elsewhere • Resources and delivery reviewed regularly through Implementation Executive Group

Key risks

Risks to implementation of the Strategy

The following high level risks have been identified to the development of the five year commissioning strategy. This list will be reviewed regularly through the Clinical Executive Group, Implementation Executive Group and Clinical Commissioning Board.

Title	Risk	Impact	Mitigations
B1. Insufficient Impact of Change	• When implemented the impact of the strategy is insufficient to meet the need and ambition	• Improvements in outcomes are not met • Quality remains variable • System is unsustainable	• Collective modelling work and triangulation of strategies and plans across south east London
B2. Insufficient investment to deliver the change	• There is insufficient investment available to deliver the scale of change at the pace required	• Improvements in outcomes are not met • Quality remains variable • System is unsustainable	• Detailed planning and modelling to quantify investment needed and when • Use of non-recurrent funds to pump prime change • Including investment requirements in financial modelling
B3. Service Change not Fully Implemented	• Inability to implement sufficient service change	• The need and outcomes outlined in the case for change and strategy are not fulfilled. • Quality remains variable • System is unsustainable	• Supporting strategies to be implemented to enable service change implementation • Ownership by system leaders
B4. Financial Sustainability of Health System	• New service models in primary care and community services do not deliver reduced demand for hospital care or hospital capacity does not reduce in line with demand	• Increased system costs through duplication of services and low productivity leading to poor patient and staff experience • Quality remains variable • System is unsustainable	• Clinical Executive Group and Partnership Group review integrated system model and all draft service models as a whole to ensure that any proposed changes to the health system are effectively balanced. • Impact of areas of early implementation (primary and community care, integrated care) reviewed in models as the develop.
B5. Patient/Public Resistance to Change	• If partners and stakeholders are not sufficiently engaged throughout the development of the five year strategy any proposed service change could be subject to significant local opposition	• Further engagement required Possible legal challenge Delays to implementation of changes • Leading to increased cost and delay	• Engagement activities will be undertaken with a broad range of partners and stakeholders throughout the development and implementation of the strategy • Dedicated communications and engagement enabling workstream to coordinate these activities.
B6. Information Systems	• Lack of integrated or interoperable information systems undermines ability to integrate services across the health system in South East London	• Duplication of system, process or information, resulting in poorer patient experience, poor quality of services across integrated pathways and additional cost	• Information Systems to identify and support improvements required to mitigate.
B7. Workforce	• Workforce requirements of new models of services cannot be met in a timely fashion	• Skills not available in right location to support new models of care • Insufficient capacity in system to support cultural change required to drive new behaviours	• Workforce strategy, with input from LETB to identify workforce impacts of proposed changes and develop plans for resolution

South East London Commissioning Strategy Programme

Commissioning Strategy 2014-19
Appendices A and B

30 May 2014

Version 0.19 – DRAFT (IN DEVELOPMENT)

Contents

Individual Plans on a Page

This Appendix sets out the Plans on a Page developed by south east London CCGs and NHS England Direct Commissioning teams to support the development of the five year Strategy. The Plans on a Page were signed of as at 4 April 2014. These are as follows:

APPENDIX A Bexley CCG – Plan on a Page 2014/19

NHS Bexley Clinical Commissioning Group's Vision is to: Enable Bexley's residents to stay in better health for longer, with the support of good quality integrated care, available as close to home as possible, backed up by accessible, safe and expert hospitals services, when they are needed.

Objectives

1. Prevention: Reducing years of life lost through supporting people to lead healthier lives

2. System Reform & Service Improvements: Improving services & integration and implementing Community Based Care Strategies – particularly for people living with long term conditions

3: Reducing avoidable admissions and time spent in hospital . To increase the proportion of Older People Living independently at home, to avoid admissions in last year of life and enable people to die in their place of choice.

4: Financial Sustainability for the Whole System plus Improving Productivity & Performance

5: Quality & Safety of all Services

1. Delivered by: Collaborating with public health & the HWBB on supporting people to lead healthier & more independent lives (e.g. obesity, diabetes, exercise, smoking.), improving services for cancer, cardiac CVD/CHD, older people, mental health & dementia, MSK, End of Life Care – promoting self management in the below

2. Delivered by: New integrated models of care, with faster access to diagnosis, locally based, which promote health & self management, using prime contractor contracts for MSK, Cardiac, Ophthalmology. Mental Health & Children's Services. Expanded Urgent Care Centres. See also 3 below.

3. Delivered by: Expanding our existing Integrated services for Older People with LB of Bexley community & social care 7 days a week services promoting "home is best". In 2014 new conditions will be treated together with new services for palliative & end of life care. Plus delivering via prime contractor integrated care contracts shown under 2. above.

4. & 5. Delivered by: Ensuring high level of quality, performance and productivity by all providers of services & robust contract management. Development of integrated care prime contractor services with expenditure in line with capita needs and to reduce duplication and wastage. Improved performance within Primary Care. Market testing of relevant services. The CCG managing its expenditure within the levels of income and parameters set.

Governance arrangements: Local Quality & Safety Boards, Governing Body reporting, with leadership and involvement in major projects, Finance Working Groups. Community Based Care program and Implementation Executive Groups for South East London. Robust PMO processes. Local contract management groups. Integrated Care Collaborative with LB of Bexley. Plus Health & Well Being Board. Urgent Care network groups.

Success Criteria:

Measured against NHS Domains 1, 2, 3 & 4.

Specific KPIs established for each service (access, quality, clinical outcomes and patient experience). Introduction within new prime contractor contracts of higher levels of funding associated with clinical outcomes and patient reported outcome measures. Financial balance & sustainability achieved.

High level risks to be mitigated

- Maintaining and improving service quality and safety through significant service change
- Challenge inherent in implementing complex, interdependent, system wide change
- Ability of providers to respond to changes
- Financial sustainability

APPENDIX A Bromley CCG – Plan on a Page 2014/19

NHS Bromley Clinical Commissioning Group's vision is to:
Improve health outcomes and reduce health inequalities across Bromley
Transform the landscape of healthcare, by developing partnerships, leading to an integrated healthcare system with improved access and quality
Create a sustainable health economy reinforced through collaborative working

Improvement Ambition One
Securing additional life for the people of England with treatable mental and physical conditions

Improvement Ambition Two
Improving the health related quality of life of the 15m+ people with one or more long term condition, including mental health conditions

Improvement Ambition Three
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital

Improvement Ambition Four
Increasing the proportion of older people living independently at home following discharge from hospital

Improvement Ambition Five
Improving the number of people having a positive experience of hospital care

Improvement Ambition Six
Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and the community

Improvement Ambition Seven
Make significant progress towards eliminating avoidable deaths in our hospitals , caused by problems in care

Delivered through intervention
Develop integrated care pathway for cardiology
Develop primary care management of patients with long term conditions
Further develop pathways for patients with diabetes
Further develop IAPT services
Review and design CAMHS

Delivered through Better Care Fund (ITF)
Facilitate greater opportunities for patients to self care
Develop step down and discharge services
MDT teams to support people with long term conditions
Further develop integrated pathways for patients with dementia
Develop step up intervention services
Develop planned care pathways
Engage with practices to address variability in performance/perception

Delivered through intervention
Review capacity and disposition of paediatric and maternity services (SEL)
Transforming cancer services (SEL)
Achieving compliance with London Quality Standards (SEL)

Overseen through the following governance arrangements

- Integrated governance process
- Programme delivery structure
- Health and Wellbeing Board oversight
- Strategic programmes lead by clinical commissioners

Measured using the following success criteria

- CCG reports a financial surplus in 18/19
- CCG Balanced Scorecard at Green or Amber Green for all domains by year end 2014-15
- Delivery of the system objectives
- No provider under enhanced regulatory scrutiny due to performance concerns
- With the expected change in resource profile

High level risks to be mitigated

- Lack of capacity for change management across the health economy
- Provider engagement
- Additional financial pressures
- Maintaining and improving service quality through significant service change

APPENDIX A Greenwich CCG – Plan on a Page 2014/19

NHS Greenwich Clinical Commissioning Group's vision is to:

- Secure the best possible health and care services,
- Developed with patients & public, & in collaboration with health & social care professionals & partner organisations
- In primary care and community settings when possible & in hospital when necessary to reduce health inequalities & improve health outcomes.

Objectives

1. Prevention: Reducing years of life lost through supporting people to lead healthier lives
2. System Reform: Implementing Community Based Care Strategy and improving integration
3. Finance: Financial sustainability for commissioners and providers
4. System Performance: Access to services (NHS Constitution)
5. Quality of Services – Safety & avoidable harm
6. Quality of Services – Patient Experience
7. Quality of Services – Clinical Effectiveness

Delivered by: Collaborating with public health on supporting people to lead healthier lives (e.g. obesity, exercise, smoking, alcohol, drugs); improving cancer services, especially screening and early detection best practice commissioning pathways; supporting resilience in families

Delivered by: Implementation of CBC work streams; implementing and further developing local models of integration (Pioneer); improving unscheduled care (Right Care, First Time); self management and supportive technology; closer working between 1° and 2° care; implementation of London Quality Standards

Delivered by: Setting of robust commissioner financial plans (including achievement of control totals, 2% underlying recurrent surplus, and operating within running costs limits); robust contracts with providers; close management of commissioner QIPP initiatives and provider CIPs; managing financial risk across the health economy

Delivered by: Holding providers to account through robust management of contracts & close collaboration with providers and co-commissioners on resolving areas of concern; focus on turnaround on standards not met in 2013/14

Delivered by: Commissioning services in response to identified need (JSNA), embedding quality in service redesign and procurement (e.g. clinically effective evidence based pathways). For commissioned services, quality is delivered by holding providers to account through Clinical Quality Review Groups; incentivisation of quality improvement through CQUIN; close monitoring of trends on safety (incidents, never events, HCAI); listening to patient feedback and improving performance against Friends and Family Test; close collaboration with co-commissioners and regulatory bodies (CQC, TDA, Monitor) to ensure issues are identified and tackled.

Governance: Local CBC Transformation Steering Groups for LTC, Mental Health, Unscheduled Care, Primary Care, Planned Care, Children & Maternity. These are mapped to the South East London wide Community Based Care Strategy work streams; Integrated Care, Primary & Community Care, and Planned Care

Success Criteria: Progress against locally determined ambition levels for outcomes; overall SMART metric will be CCG Balanced Scorecard for all domains at Amber/Green or Green by year end 2014/15. Scorecard maps to **Objectives 1-7** as follows:

- Domain 1: Are local people getting good quality care? – Objectives 5, 6 & 7
- Domain 2: Are patient rights under the NHS Constitution being promoted - Objective 4
- Domain 3: Are health outcomes improving for local people? – Objectives 1 & 2
- Domain 4: Is the CCG delivering services within its financial plans? – Objective 3

High level risks to be mitigated

- Challenge inherent in implementing complex, interdependent, system wide change
- Maintaining and improving service quality through significant service change

APPENDIX A Lambeth CCG – Plan on a Page 2014/19

Lambeth Clinical Commissioning Group mission:

'To improve the health of and reduce inequalities for Lambeth people and to commission high quality health services on their behalf'.

Vision:

People centred – We will work to co-produce services, built around individuals and population needs, enabling people to stay healthy and manage their own care, ***Prevention focussed*** – We will prioritise prevention of ill health and the factors that create it, enabling people to live longer and healthier lives, ***Integrated*** – We will commission services in a way that brings service provision together around the needs of people and reduces boundaries and barriers to care, ***Consistent*** – We will promote high quality, accessible, equitable and safe services and reduce variation and variability in provision, ***Innovative*** – We will use 21st century technologies to provide better services, better information and to promote choices, ***Deliver best value*** – We will ensure we live within our means and use our resources well.

Our Values:

We will always tell the truth; We are fair; We are open; We recognise our responsibilities to service users and the wider public; We act responsibly, *with and for our member practices*, as a public sector organisation

System Objectives

1. Reducing the number of years of life lost by the people of Lambeth and from treatable conditions.	Delivered through Integrated planned care adults (SLIC) for LTC & Older People – @Home & Rapid Response; Integrated care for children & young people; Integrated mental health services – redesign of acute & roll out of Lambeth Living Well Collaborative; Collaborating with public health on supporting people to lead healthier lives (e.g. obesity, exercise, smoking, alcohol, & drugs); improving cancer services - screening and early detection; proactive primary care management of people with LTCs through the Primary Care Incentive Scheme.
2.Improving the health related quality of life of people with one or more long-term conditions - Develop and deliver planned care which reduces premature mortality and improves quality of life, reducing reliance on hospital services and improving the quality of primary care for physical and mental health.	Delivered through SLIC LTC & Older People; Integrated planned care adults (SLIC) for LTC & Older People – @Home & Rapid Response; Pathway redesign including Respiratory, Cardiology, Diabetes, optometry, Gynae, Dermatology, Gastroenterology and Fitness 4 Surgery.
3.Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital covering for physical and mental health.	Delivered through SLIC LTC & Older People; Integrated Children's pathway; primary care development; @Home & Rapid Response; Integrated care for children & young people - Evelina Integration Programme for children's services, redesign of children's community services
4.Increasing the proportion of older people living independently at home following discharge from hospital - Improve the integration and quality of care for older people and reduce the number of avoidable hospital admissions and readmissions.	Delivered through SLIC LTC & Older People; primary care development; integrated mental health care; Integrated planned care adults (SLIC) for LTC & Older People – @Home & Rapid Response; Integrated mental health services – redesign of acute & roll out of Lambeth Living Well Collaborative.
5.Reducing the proportion of people reporting a very poor experience care: •Inpatient •Outpatient •Primary.	**Delivered through Contractual levers** implementation of London Quality Standards; CSU acute contract management / contract meetings; Quality Alerts action plans.
6.Making significant progress towards eliminating avoidable deaths in our hospitals – improving advanced care planning	**Delivered through Contractual levers;** Implementation of London Quality Standards; Contract for 7 day working in local acute and social care services; Roll out of CmC; Cancer pathway reinforced.

Overseen through the following governance arrangements:
i. Programme Boards for Integrated Care for Adults, Integrated Mental Health, Staying Healthy, Integrated Children's & Young People and Primary Care Development
ii. Finance & QIPP Group
iii. Integrated Governance Committee
iv. Governing Body
v. Community Based Care program and Implementation Executive Groups for South East London.
vi. Lambeth PMO.
vii. CSU acute contracting support
viii. SLIC Programme Board with Southwark

Measured using the following success criteria:
i. Measured against NHS Domains 1, 2, 3, 4.
ii. Specific KPIs established for each service (access, quality, clinical outcomes and patient experience).

High level risks to be mitigated:
i. Maintaining and improving service quality and safety through significant service change
ii. Lack of capacity for change management across the health economy
iii. Provider engagement
iv. Challenge inherent in implementing complex, interdependent, system wide change
v. Ability of providers to respond to changes
vi. Financial sustainability

Interventions are delivered through the Lambeth programme structure of Integrated Care for Adults; Integrated Mental Health, Staying Healthy, Integrated Children's & Young People and Primary Care Development

APPENDIX A Lewisham CCG – Plan on a Page 2014/19

- **Better Health - the Five Year Vision:** *To improve the health outcomes for our local population by commissioning a wide range of support to help Lewisham people to keep fit and healthy and reduce preventable ill health*
- **Best Care – the Commissioning Vision:** *To ensure that all services commissioned are of high quality – in terms of being safe, positive patient experience and based on evidence and good practice*
- **Best Value – the Financial Vision:** *- To commission services more efficiently, providing both good quality and value for money, by improving the way services are delivered, streamlining care pathways, integrating services*

Our Ambition: Success Criteria

To reduce the gap in key health outcomes between Lewisham and England by 10% over the five year period and to reduce inequalities within Lewisham. We will measure life expectancy, rates of premature mortality from the three biggest causes of death in Lewisham (cancer, respiratory diseases and cardiovascular disease), infant mortality, patient experience, emergency admissions rates, and end of life care

CCG Commissioning Priorities	Initiatives
Health Promotion - to contribute to the achievement of the Health and Wellbeing Board's strategic priorities to reduce premature mortality and reduce inequalities	Support the Health and Wellbeing Board deliver its strategy to address wider determinants of health, promote health and tackle inequalities; increase the rate of early diagnosis and detection of cancer in Primary Care
Maternity and Children's Care in Hospital - to improve clinical standards and health outcomes and to pilot the 'team around the mother'	develop and implement Integrated team 'mother centred' approach for pre, and post-partum care and providing continuity of services; support the work to improve children's integrated care pathways for chronic disease management
Frail older people – to improve care provided specifically end of life care, falls prevention and in local care homes	Improve systems, processes and care pathways to support people to die in the place of their choice
Long Term Conditions - to implement integrated care pathways including for Diabetes, COPD, CVD, Stroke and dementia	Diabetes; cardiovascular disease; Respiratory/COPD; Dementia; HIV - secure the sustainable improvements in co-ordinated care pathways for adults with long term conditions
Mental Health – to support mental wellbeing and shift more care to be provided in the community	Mental Health including depression/anxiety - commission an integrated system; integrated with primary and community care services where mental health services are on a par with physical services.
Greater integration of health and social care commissioning – to support the delivery of all the above strategic priorities by providing different levels of advice, support and care from a variety of health and social care services to support independence and healthy choices for all.	Establish and sustain effective, integrated teams based in the neighbourhoods; commission a continuum of high quality, effective community based care services..
Primary care development and planned care – to improve the quality and planned accessibility for all	Implement with Members the priorities to improve quality and health outcomes, access and continuity of care and reduce variation between practices
Urgent Care - to ensure that the right care is delivered in the right place, at the right time by commissioning the best network of urgent care providers	support the urgent care network to be easier to navigate in hours and out of hours

Collaborative Commissioning Programmes

- South East London Clinical Leadership Groups
- Lewisham Adult Integrated Care Programme (Better Care Fund)
- Maternity transformation NHSIQ Development Programme

High level risks to be mitigated

- Local engagement and support for service changes
- Provider engagement and responsiveness
- Maintaining service quality and safety
- Financial sustainability
- Complexity and interdependency in system-wide changes
- Attract, train and retain staff across the health system
- Integration of interoperable information systems

APPENDIX A Southwark CCG – Plan on a Page 2014/19

NHS Southwark CCG will work to achieve the ***best possible health outcomes for Southwark people***. The vision for services commissioned on behalf of Southwark's population is that they function to ensure: people live longer, healthier, happier lives no matter what their situation in life; the gap in life expectancy between the richest and the poorest in our population continues to narrow; the care local people receive is high quality, safe and accessible; the services we commission are responsive and comprehensive, integrated and innovative, and delivered in a thriving and financially viable local health economy; we make effective use of the resources available to us and always act to secure the best deal for Southwark

System objective

Integration of Services

Better early detection, case-finding & risk-stratification

Community based integrated service provision structured on a neighbourhood geography for people with LTCs including mental health

Health and social care services operational seven-days-a-week

Commission effective and efficient pathways of care

Commission services that are proactive and provide care which is personalised supports people to maintain their independence

Ensure local people can easily navigate the local health system and can access appropriate care when they need it

Interventions to deliver objectives

Implement a prevention strategy to contract for: *'every contact counts'* health advice interventions; pre-diabetic health checks; hospital providers implementation of NICE smoking cessation guidance.

Commission A&E 'front-end' assessment and triage functions for patients with mental health conditions.

Implement Joint Dementia Strategy to commission new community intervention services for people with dementia including a medicines optimisation programme; and specialist services for people with challenging behaviour.

Programme of IT development to implement a system that will allow primary; community & hospital clinicians to view patients' test and diagnostics result.

Develop a primary care model of early diagnosis and integrated care for children with autism.

Commission enhanced early detection; case-finding; care-coordination & risk management in primary care.

Oversee extension of GSTT '@home' programme including full roll-out of *Homeward* across Southwark.

Commission a model of community-based integrated service provision structured on a locality/neighbourhood geography to improve outcomes for patients with one or more long term conditions (including mental health).

Commission enhanced primary care support to Southwark care homes operating as part of a specialist multi-disciplinary model of care for patients living in residential accommodation in the borough.

Commission for services 7-days-a-week in collaboration with Southwark local authority and NHS England commissioners to support admission avoidance and to improve discharge from hospital.

Remodelling of psychological therapies pathway.

Work with providers to implement contractual requirements to drive secondary care productivity and efficiency savings.

Scope system for referral review against agreed clinical protocols and to enhance use of Choose & Book across the health economy.

Commission pathways for patients referred with common health conditions (e.g. diabetes; respiratory illness; gynaecology) to specialist services provided in community facilities in different locations of the borough. Decommission hospital outpatient pathways to reflect this change of provision.

Review access policies including south east London Treatment Access Policy and consider management protocols and support pathways for people who smoke and require non-urgent elective admission.

Implementation of the CCG primary and community care locality development plan and broader CCG Primary and Community Care Strategy.

Commission enhanced diagnostic capacity in primary and community care settings.

Design and deliver a comprehensive primary care workforce development programme.

Contribute to shaping Southwark Council's approach to commission enhanced community support services (home help and domiciliary services).

Continued implementation of the service model for the Dulwich locality.

Review of urgent care pathway including A&E front-end; UCCs and WICs and commission a model of care to enhance access; quality; % appropriate attendances.

Complete inner south east London procurement for provision of NHS 111 service from April 2015.

Commission London Ambulance Service to safely and effectively increase the proportion of calls treated 'on site' to reduce A&E conveyance rates.

With social care services, commission new services targeted at people 'in-crisis'. This will be initially focussed on people with mental health, alcohol misuse issues and on those who are homeless

Ensuring we deliver our plan

Overseen through the following governance arrangements

1. The South East London Clinical Commissioning Board will be accountable to the Clinical Strategy Committee for the definition and delivery of the South East London 5 Year Strategy. The group will work with the South East London Partnership Group which will provide system leadership and oversight and with supporting groups and worksteams.
2. The CCG Commissioning Strategy Committee will oversee development of the borough strategy and operational plans. The CCG will work in close partnership with Southwark local authority and with the Southwark Health & Wellbeing Board in developing and then implementing plans.
3. The final CCG strategy will be endorsed by Southwark CCG's Governing Body and then approved by member practices at the CCG Council of Members.
4. The delivery of key strategic change programmes will be overseen by the CCG Integrated Governance & Performance Committee, who will receive regular status reports from respective responsible programme groups.

Measured using the following success criteria

1. Delivery of all CCG system objectives.
2. Improve target outcome indicators from NHS Outcomes Framework.
3. CCG achieves financial surplus in all years to 2018/19.
4. No provider under enhanced regulatory scrutiny due to performance concerns.
5. No provider under enhanced regulatory scrutiny due to financial concerns.
6. Provider consistently deliver NHS Constitution standards.

High level risks to be mitigated

Risk 1: CCG does not achieve full delivery of key QIPP programmes, which poses a risk to the financial sustainability of the CCG.

Risk 2: There is insufficient support gained through the planning process from local stakeholders and the population. This could risk increased delay of implementation and increase the cost of necessary changes.

Risk 3: Service quality and safety is maintained and improved throughout the period of service change.

Risk 4: Transformation and service changes do not balance provision at the right stages of patient pathways. A risk that for periods of time there exists either excess or insufficient capacity to meet demand for services.

Risk 5: Technical and financial challenge of ensuring IT systems support effective integration of care pathways.

Risk 6: Implementation of service change may affect ability to recruit, train and retain staff across the health economy.

Interventions to be delivered through Integration Transformation Fund (ITF)

Intervention 1 – Admissions avoidance programmes.

Intervention 2 – Reablement services.

Intervention 3 – Southwark Carers Strategy.

Intervention 4 – 7 day working.

APPENDIX A Primary Care – Plan on a Page 2014/19

Vision

Primary care services that consistently provide excellent health outcomes to meet the individual needs of Londoners

Form

Objective One
Co-ordinated Care

Objective Two
Proactive Care

Objective Three
Accessible Care

Function

Objective Four
Collaborative models of delivery

Quality Standards and Outcomes
- Ensuring consistency of service across London
- Performance management

Premises
- Making best use of the assets available
- Borough based strategic planning to inform investment decisions

Workforce
- Commission and maintain a diverse primary care workforce that supports collaborative 24/7 working

Technology
- Joined up working that meets the needs of patients
- Integrated systems and better data sharing

Commissioning and contracting
- Managing the provider landscape
- Redesigning incentives
- Primary care contract that delivers national consistency which enables programme of change in local context

Stakeholder engagement
- Ensuring ongoing engagement of patients, healthcare providers and other key stakeholders in service design and programme of change

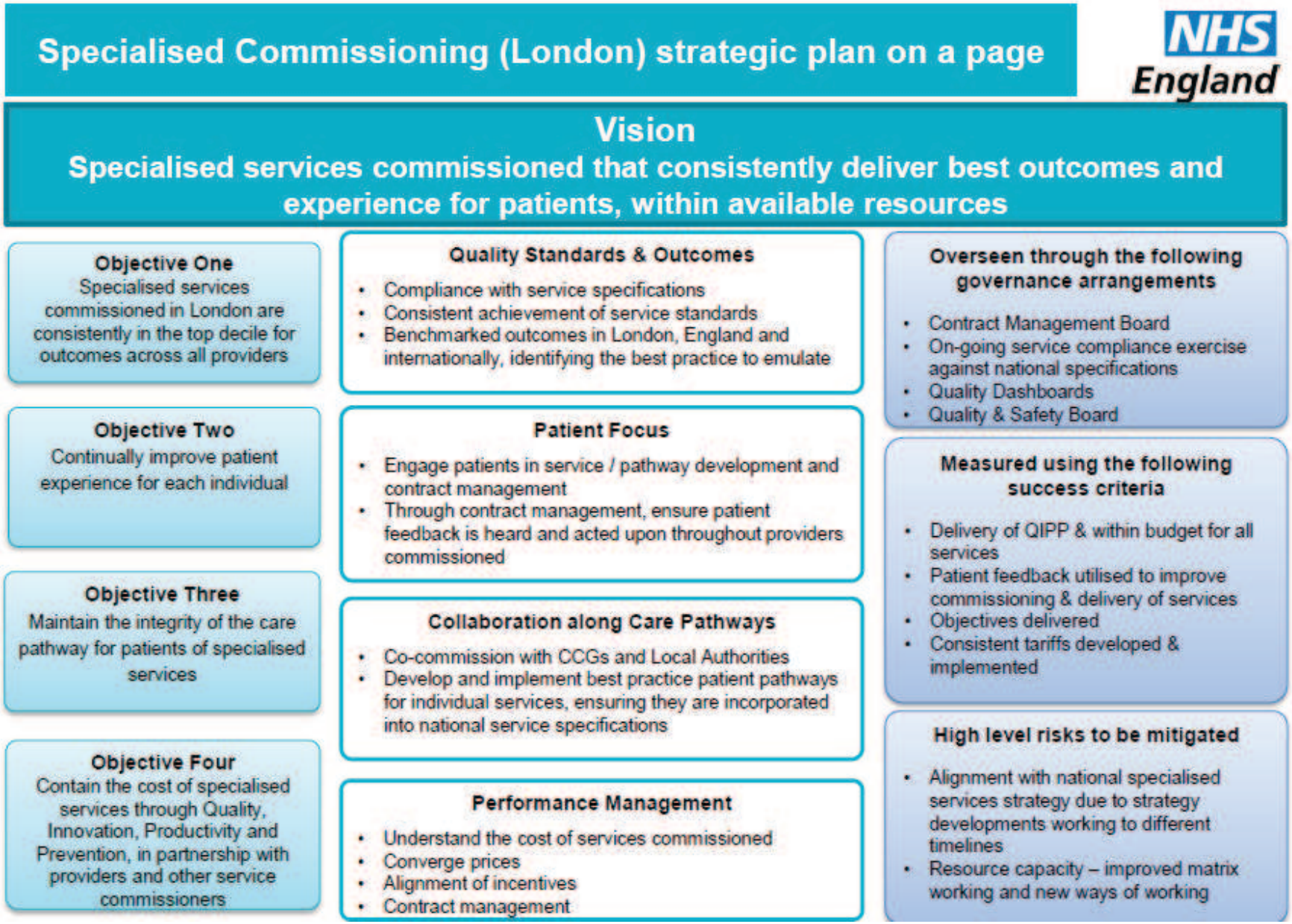
Change management
- Organisation design
- Clinicians and organisations collaborating to deliver integrated care for patients

Governance arrangements
- Overseen by the Primary Care Programme Board
- Involvement in local Strategic Planning Group governance through Clinical Commissioning Board, South East London Partnership Group, and representation in supporting groups and workstreams

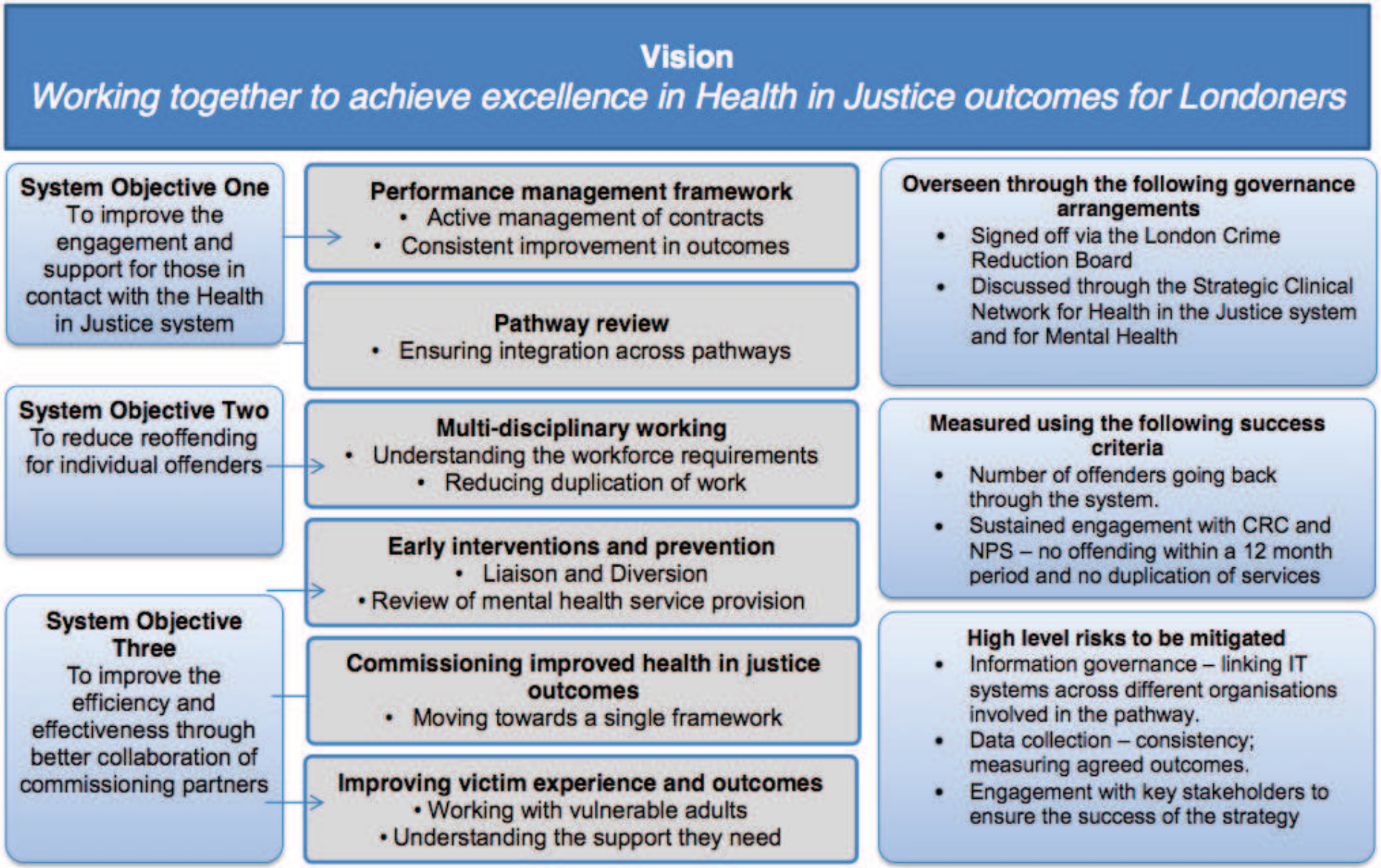
Success criteria
- Enables effective delivery of out of hospital care
- Demonstrable improvement in:
  - Outcome standards across all London CCGs
  - Public confidence in NHS England's ability to address and act upon poor quality (premises, clinicians, systems)
- Ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances.
- Primary care system that prevents ill health and supports healthy lifestyle choices
- Patients and stakeholders are at the heart of commissioning decisions

High level risks to be mitigated
- Information governance – linking IT systems across different organisations involved in the pathway.
- Engagement with key stakeholders will be crucial to ensuring the success of this strategy
- Finance – investment required to support the transformational change over the next 5-7 years

APPENDIX A Specialised Services – Plan on a Page 2014/19



APPENDIX A Public Health – Health in Justice – Plan on a Page 2014/19



Version 1, December 2013

APPENDIX A Public Health – Screening – Plan on a Page 2014/19

Vision

'High quality, accessible screening programmes for all'

Objective One
Coverage and uptake should be increased to at least minimum target (dependent on service)

Objective Two
High quality programmes that deliver the national standard measured by national service specifications and quality assurance processes

Objective Three
Service integration across partners within the pathway measured by pathway referral and treatment times

Objective Four
Patient experience and values are integrated into the design and delivery of services. Measured through the Friends and Family Test and other patient experience metrics

Integration across pathways
- Understand full pathway through to treatment
- Links with providers, IT systems, integration

Reconfiguration of services
- Size and length of each pathway
- Locating services together? Determine how to best provide services across London

Communications and education
- Linkages and profile of the screening services
- Influence education providers to support wider education around screening benefits

Patient focus and clinical excellence
- Move to patient focus from client focused – how to put patient at the centre of delivery
- Performance improvement in providers

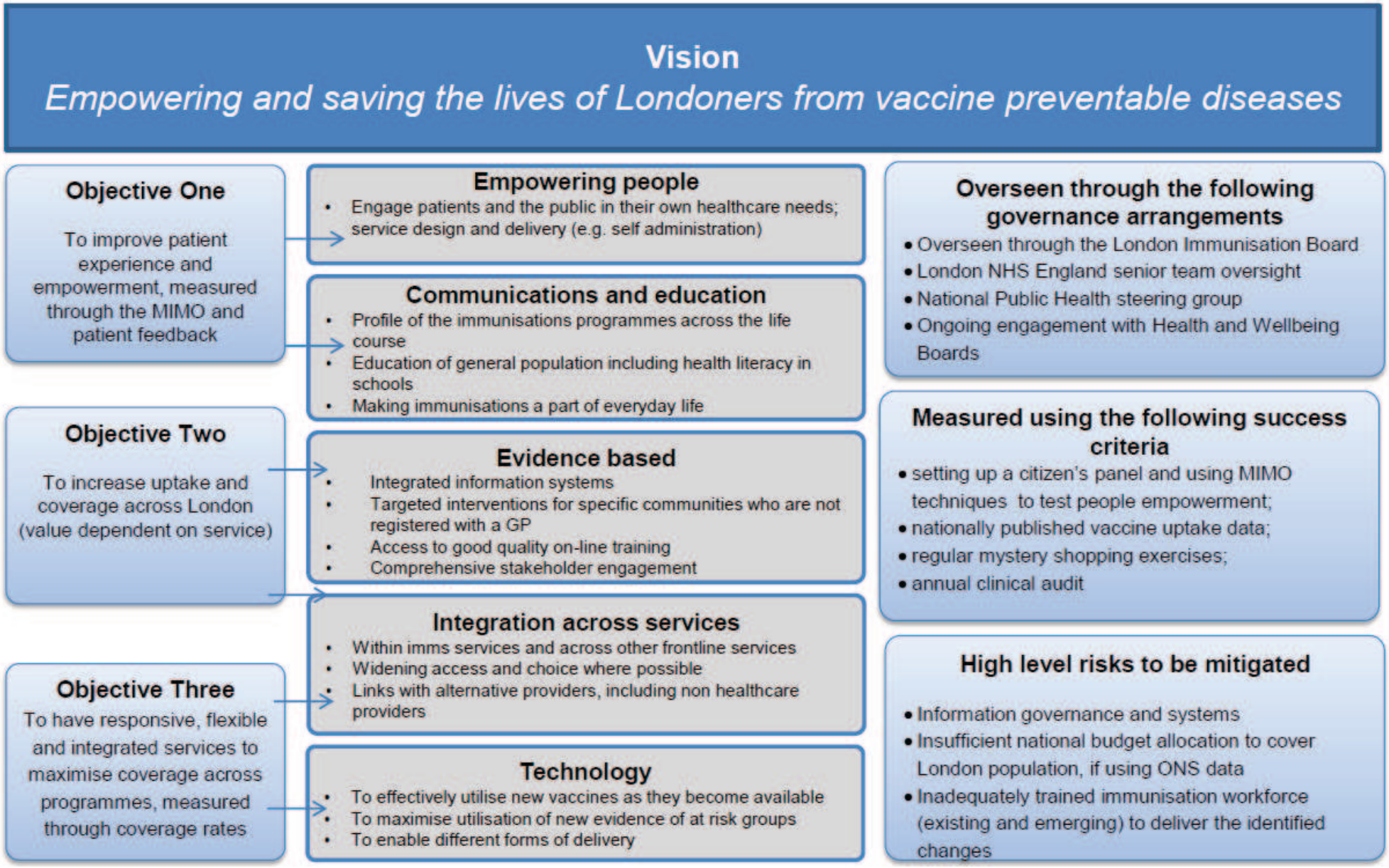
Back office functions
- All working to national / specified standards
- Potential to centralise back office functions
- Sharing data and lessons learnt between screening programmes

Overseen through the following governance arrangements
- Tripartite arrangement with Department of Health and Public Health England to define and deliver policy changes
- Signed off through the London Screening Programmes Board
- Overview and Scrutiny Committees and Health and Wellbeing Boards will support delivery of the plan

Measured using the following success criteria
- Delivery of the objectives
- Has met or exceeded coverage and uptake targets
- Detects and treats patients for preventable diseases
- Delivers value for money across all services

High level risks to be mitigated
- Information governance and IT
- Stakeholder engagement
- Skills, capability and capacity to deliver the identified changes
- The financial requirements may not support the optimum delivery of services

APPENDIX A Public Health – Immunisations – Plan on a Page 2014/19



APPENDIX A Public Health – Military Health – Plan on a Page 2014/19

Military strategic plan on a page

NHS England

Vision

To empower all armed forces veterans to seek equitable access to NHS services, upon discharge

Objective One

Sustain community mental health contract until 2020

Empowering people

- Ensure robust and resilient commissioning of service model

Objective Two

Maintain the Murrison protocol until 2020

Collaborative Commissioning

- All 32 CCGs will be engaged with the evolving protocols

Objective Three

Ensure veterans have access to primary care facilities

Choice

- Each armed forces personnel will be signposted to local primary care providers
- Establish a primary care register template for veterans, subject to a New Patient Registration
- London Armed Forces Network membership will support individual cases with their choices

Objective Four

Ensure transfer of Defence Medical Service (DMS)are completed in a timely manner

Integration across services

- DMS medical summaries are prepared as part of Transition process
- DMS summary is securely transferred to named GP chosen by veteran

Objective Five

To sustain the London Armed Forces Network (LAFN)

Engagement

- Engagement and ownership of all veterans care will be supported and via CCG membership at LAFN

Overseen through the following governance arrangements

- Overseen through the London Armed Forces Network, which meets quarterly
- Military and Community Covenant

Measured using the following success criteria

- NHS England commissioners commit to implement the Military Covenant and afford all veterans the opportunity for access to a GP practice, an NHS Dentist and a Community Pharmacy within 3 months of being discharged, or within four weeks of requesting.

High level risks to be mitigated

- Inability to define and capture all veterans that currently live in London to ensure they receive the support required
- Information governance and systems

Vision for south east London and for CCGs

Our collective vision for the South East London: In south east London we spend £2.3billion in the NHS. Over the next five years we aim to achieve much better outcomes than we do now by:

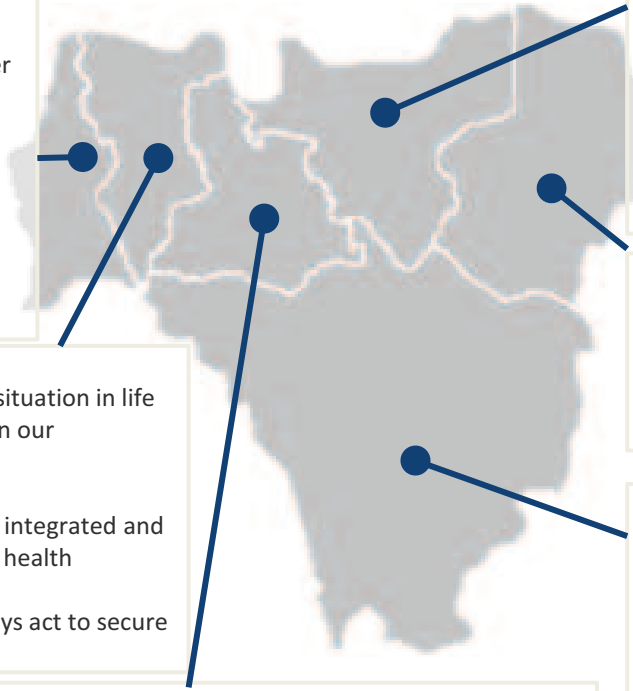
- Supporting people to be more in control of their health and have a greater say in their own care
- Helping people to live independently and know what to do when things go wrong
- Helping communities to support one another
- Closing the inequalities gap between worst health outcomes and our best
- Making sure primary care services are consistently excellent and with an increased focus on prevention
- Reducing variation in healthcare outcomes and addressing inequalities by raising the standards in our health services to match the best
- Developing joined up care so that people receive the support they need when they need it
- Delivering services that meet the same high quality standards whenever and wherever care is provided
- Spending our money wisely, to deliver better outcomes and avoid waste.

Vision for Lambeth CCG:

- People-centred – co-producing services and enabling self-management
- Prevention-focused – enabling people to live longer and healthier lives
- Integrated – reducing boundaries and barriers to care
- Consistent – reducing variation and variability in access and provision
- Innovative – using 21st Century technologies for better services, information and to promote choice
- Value for money – living within our means and using resources well

Vision for Southwark CCG:

- People live longer, healthier, happier lives no matter what their situation in life
- The gap in life expectancy between the richest and the poorest in our population continues to narrow
- The care local people receive is high quality, safe and accessible
- The services we commission are responsive and comprehensive, integrated and innovative, and delivered in a thriving and financially viable local health economy
- We make effective use of the resources available to us and always act to secure the best deal for Southwark



Vision for Greenwich CCG:

- Secure the best possible health and care services,
- Developed with patients & public, & in collaboration with health & social care professionals & partner organisations
- In primary care and community settings when possible & in hospital when necessary to reduce health inequalities & improve health outcomes

Vision for Bexley CCG:

- Enable Bexley's residents to stay in better health for longer, with the support of good quality integrated care, available as close to home as possible, backed up by accessible, safe and expert hospitals services, when they are needed.

Vision for Bromley CCG:

- Improve health outcomes and reduce health inequalities across Bromley
- Transform the landscape of healthcare, by developing partnerships, leading to an integrated healthcare system with improved access and quality
- Create a sustainable health economy reinforced through collaborative working

Vision for Lewisham CCG:

- Better Health - the Five Year Vision: To improve the health outcomes for our local population by commissioning a wide range of support to help Lewisham people to keep fit and healthy and reduce preventable ill health
- Best Care – the Commissioning Vision: To ensure that all services commissioned are of high quality – in terms of being safe, positive patient experience and based on evidence and good practice
- Best Value – the Financial Vision: - To commission services more efficiently, providing both good quality and value for money, by improving the way services are delivered, streamlining care pathways, integrating services

HEALTH AND WELLBEING BOARD			
Report Title	Adult Integrated Care Programme - Update		
Contributors	Executive Director for Community Services and Chief Officer, Lewisham Clinical Commissioning Group	Item No.	4
Class	Part 1	Date:	3 July 2014
Strategic Context	Please see body of report		

1.0 Purpose

1.1 This report provides members of the Health and Wellbeing Board with an update on Lewisham's Adult Integrated Care Programme. The report also seeks agreement to prioritise specific areas of integration work within the Board's work programme and sets out the proposed activity in relation to planning and engagement activity.

2.0 Recommendations

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

- Note the updates provided in sections 4 and 5 which are relevant to the Integration Programme;
- Agree that the Board's work programme should include those priority areas for 2014/15 identified in paragraph 5.1.6;
- Note the activity in relation to planning and setting of Commissioning Intentions;
- Agree the proposals for enhancing communication and engagement activity as set out in section 7.

3.0 Strategic 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 Futures 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 placed a duty on local authorities and their partner clinical commissioning groups to prepare and publish joint health and wellbeing strategies to meet the needs identified in their joint strategic needs assessments. Lewisham's Health and Wellbeing Strategy was published in 2013.

3.4 The Health and Social Care Act 2012 also required Health and Wellbeing Boards to encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area. More recently, the Care Act 2014 brought into law a range of new duties on local authorities and their partners.

3.5 In response to the Government's stated ambition to make joined up and coordinated health and social care the norm by 2018, the Health and Wellbeing Board agreed in 2013 to increase the scale and pace of integrated working across health and social care in Lewisham and established the adult integration care programme.

4.0 National Context Update

4.1 <u>The Care Act 2014</u>

The Care Act received Royal Assent on 14 May 2014. The Care Act reforms the law relating to the care and support of adults and their carers. The Act consolidates previous adult social care legislation and sets out a number of new duties, including :

- A duty on Councils to consider the physical, mental and emotional wellbeing of individuals in need of care;
- A duty to provide preventative services to maintain people's health and to support them to live independently for as long as possible;
- A cap on care costs of £72,000 and monitoring an individual's progress towards the cap;
- New rights for carers, who will be put on the same legal footing as the people they care for, with extended rights to assessment and rights to support if eligible;
- The provision of information and advice about care and support services to people navigate the system and make the best choices;
- The introduction of a minimum eligibility threshold across the country.

4.1.2 The Department of Health is currently consulting on draft regulations and guidance for Part 1 of the Care Act and is seeking views on how the care and support reforms should be delivered. These draft regulations and guidance relate to the care and support reforms and provisions in the Care Act which come into effect in April 2015.

4.1.3 Members are asked to note that a report on Lewisham's progress in relation to the implementation of the Care Act will be presented to the

Health and Wellbeing Board at its next meeting. Meanwhile Members may be interested in the factsheets that have been issued by the Department of Health. These factsheets can be found at: www.gov.uk/government/publications/the-care-bill-factsheets

4.2 The Better Care Fund

4.2.1 Members will recall that the Better Care Fund was announced as part of the 2013 Spending Round and that Lewisham submitted its BCF plan on 4 April 2014 (see Item 5 - Health and Wellbeing Board agenda of 25 March).

4.2.2 NHS England has recently notified all CCGs of the requirement to resubmit their Operational Plans for 2014/15 and 2015/16, including their submission for the Better Care Fund (Publications Gateway Reference: 01685 - 4th June 2014).

4.2.3 NHS England has stated that the BCF plans, submitted on 4 April, have been subject to an assurance process led by Area Teams together with Local Government regional peers. NHS England has said that while the assurance process demonstrated some improvement on the draft plans submitted in February, it also showed that further work is required on many local plans, particularly around the metrics and finance data, and on the extent of provider engagement in the planning process. In light of this, Ministers have confirmed that no BCF plans would be formally signed off in April and that further time should be taken for CCGs and Councils, working with Health and Wellbeing Boards (HWBs), to refine their plans during June.

4.2.4 Additional guidance was meant to have been issued by the end of the first week of June, along with clarification on next steps and timetable, with the data required by 27 June; this additional guidance and information had not been received at the time of writing this report.

5.0 Local Update

5.1 Adult Integrated Care Programme

5.1.2 Activity within the workstreams is progressing steadily and each workstream has been examining and developing those areas which would be further improved through integration.

5.1.3 A number of events and workshops have taken place to understand various pathways, how they interrelate, the services involved at different stages and the purpose of the interaction each service/staff member has with the person at each point; in order to improve service user experiences and outcomes and reduce duplication and inefficiencies. This has included an Adult Integrated Care Mapping workshop which took place on 28 April, a workshop on the Disabled Facility Grants process and another on the falls pathway. The

Information and Advice workstream also plan to carry out a similar exercise in July.

5.1.4 The Programme Board has also agreed to hold two workshops to further define the scope and specifications for the neighbourhood model and to examine in more detail the developments that are needed to support the shift from hospital based to community based settings. The first of these workshops, to review and further develop the neighbourhood model, is to take place on 26 June. As this workshop takes place after the despatch of this report, verbal feedback on the outcome of the workshop will be given to members of the Health and Wellbeing Board.

5.1.5 From those events already held, it is clear that there is an appetite for change and that staff are motivated to transform services. Furthermore, the views and experiences of staff captured at all events will be shared with the *inspiring the workforce* workstream to inform the training needs analysis that is currently being undertaken. It will also be used to extend the programme's understanding of the organisational culture and behaviours that exist across NHS partners and the Council.

5.1.6 Despite the significant activity and progress that has taken place to date, members of the Adult Integrated Care Programme Board are conscious that there is a continued pressure to transform services in some key areas in order to achieve the necessary shift of resources across services and to achieve the required efficiencies. Accordingly, members of the Adult Integrated Care Programme Board agreed that during 2014/15 programme activity should focus on those areas that will:

a) deliver the BCF outcomes – to achieve the shift from hospital based to community based settings;
b) fulfil the requirements of the Care Act – which include those outlined in paragraph 4.1 above;
c) ensure the effective development of Lewisham's neighbourhood model – building on the existing neighbourhood teams, ensuring further integration of relevant services and developing clear pathways.

5.1.7 Members of the Health and Wellbeing Board are asked to note the focus on these areas and to agree that regular progress reports on these areas be included as part of the Health and Wellbeing Board's work programme.

5.2 <u>Workforce Development</u>

5.2.1 As mentioned above, across the workforce there is an appetite for change and to transform services. The overarching aims of the workforce development programme is to establish a common vision and culture for integrated working, break down professional and

organisational boundaries, support new delivery models and develop core practices and behaviours.

5.2.2 The workstream programme is being supported by funding secured from Health Education South London (HESL) of £26k for 2013-14 and £84k 2014-15. Currently underway is a scoping exercise to establish the common culture, values and core behaviours. The next phases will be the design then delivery of a development programme.

6.0 Joint Planning 2014/15 onwards – process and timeline

6.1 The development of joint commissioning intentions are a key aspect of the adult integrated care programme and specifically in defining activity from 2014/15 onwards. The Adult Integrated Care Commissioning Intentions will set out the pace and scale of the changes Lewisham wants to see in the way in which specific services are commissioned to deliver our vision, 'Better Health, Better Care, Stronger Communities' and will translate the vision into joint action.

6.1.2 The Adult Integrated Care Commissioning Intentions will seek to align the desired deliverables in relation to adult services with the resources available through the Better Care Fund, the Council's (Adult Social Care and Public Health) and Lewisham CCG's budgets. The aim is that by using our collective resources to their best effect and by reconfiguring and reshaping the advice, support and care services provided across health and social care, for partners to be more effective in achieving improved health and care and in reducing health inequalities.

6.1.3 This planning is being co-ordinated by the Adult Joint Strategic Commissioning Group (AJSCG). At the last meeting of the AJSCG, on 10 June, an outline work programme was discussed and the Group agreed to produce the draft Adult Integrated Care Commissioning Intentions for the next meeting of the Health and Wellbeing Board on 23 September 2014 and for these to be completed by the end of September 2014.

6.1.4 The Adult Integrated Care Programme Board will continue to be accountable to the Health and Wellbeing Board for the delivery and evaluation of the Adult Integrated Care Programme (AICP), as it has specific responsibility for overseeing the implementation, monitoring and evaluation of the programme and the Better Care Fund plans.

7.0 Commissioning Intentions – engagement and communication

7.1 The Adult Integrated Commissioning Intentions will be a public document for wider engagement with the public, local providers and other stakeholders. An engagement programme and communication plan will be put in place during October – December 2014, to further test that the Adult Integrated Care Programme is focused on the right

priorities and actions to deliver the maximum benefits to Lewisham people over the next two years.

7.2 Before the publication of the Commissioning Intentions, it is planned that a pre-engagement phrase takes place to ensure that there is early and proactive dialogue with the public, local providers and other stakeholders. It is proposed that specific questions should be asked to test the public's support to the key principles that underpin the adult integrated care model, such as prompting and supporting self-management, working with patients and local providers to develop new ways of working, and culture and behaviour changes to proactively manage health and wellbeing.

7.3 Also it is proposed that we share with the public how success would be measured. At present a dashboard of indicators that can be monitored by the Health and Wellbeing Board has been developed by the Director of Public Health which includes the Better Care Fund five national metrics and the local indicator on the quality of care for people with long term conditions. In addition a number of indicators have been selected to show progress against the priority outcomes of the Health and Wellbeing Strategy. (Please see agenda item 6).

8.0 Financial implications

8.1 There are no specific financial implications arising from this update report. As and when reports are presented in future to the Board on service redesign or development these will include details on any required investment or disinvestment, any financial implications for providers and outline any financial risks.

9.0 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 Where there is an integration of services and/or joint funding, then this is dealt with under an agreement under S 75 NHS Act 2006 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.

10.0 Crime and Disorder Implications

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

11.0 Equalities Implications

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

12.0 Environmental Implications

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

13.0 Conclusion

13.1 This report sets out the progress of the integration programme to date and invites members to note and agree any actions proposed within this report.

If you have any difficulty in opening the links above or those within the body of the report, please contact Kalyan DasGupta (kalyan.dasgupta@lewisham.gov.uk; 020 8314 8378), who will assist.

If there are any queries on this report please contact:
Sarah Wainer, Head of Strategy, Improvement and Partnerships, Community Services Directorate, Lewisham Council, on 020 8314 9611 or by email sarah.wainer@lewisham.gov.uk or
Susanna Masters, Corporate Director, NHS Lewisham Clinical Commissioning Group, on 020 3049 3216 or by email on susanna.masters@nhs.net

HEALTH AND WELLBEING BOARD				
Report Title	Housing and Health in Lewisham			
Contributors	Head of Housing, Deputy Director of Public Health.		Item No.	5
Class	Part 1	Date:	3 July 2014	
Strategic Context	Please see the body of the report.			

1. Purpose

1.1. In the autumn of 2013 the Health and Wellbeing Board received an update on the development of new models of housing for older residents.

1.2. This report sets out the wider relationship between housing and health and wellbeing. It summarises Lewisham's housing context and highlights the areas in which housing issues impact on residents' health and wellbeing, under three broad categories of the quality and conditions of homes, the provision of new housing, and the management of homelessness. This section of the report draws on an extensive literature review that has been undertaken jointly by housing and public health staff.

1.3. The report also sets out how services currently work together to effect change and support residents, and subsequently makes recommendations that might enable further joint working between housing, health and social care services in support of the Health and Wellbeing agenda.

2. Recommendation/s

The Health and Wellbeing Board is recommended to:

2.1. Note the three main areas in which housing impacts on resident's health and wellbeing, and the work that is currently being carried out in each;

2.2. Consider and discuss the recommendations made in this report which are intended to further support integrated working across housing, health and social care, which are:

a. To further expand the current focus on prevention, in particular in relation to the provision of aids, adaptations, grants and other support such as the handypersons service, including by considering

how these interventions can be best targeted where they will have the greatest impact;

b. That partner agencies should work more closely together to share intelligence about demand for specialised (or other) housing, including in situations where a lack of appropriate housing is leading to poorer outcomes for residents and/or higher costs for partner agencies. Such closer working would enable housing services to better shape their new provision to the needs of health and care partners;

c. To pilot the provision of a housing advice service in health settings, which might include in working with local integrated services, in order to better sign post residents through the housing system, identify more quickly when a housing intervention or other provision will be required to assist a resident's recovery, and to enable faster resolution of housing issues;'

d. To continue to support the Warm Homes Healthy People Project and where possible help to secure greater engagement and buy in from local healthcare providers.

3. Strategic Context

3.1. Lewisham's Health and Wellbeing Strategy recognises that health and wellbeing is influenced by wider social and economic determinants such as housing. It identifies the need to create physical and social environments that encourage healthy habits, choices and actions

3.2. Addressing issues relating to the quality and quantity of housing stock in the borough relates directly to the Council's Sustainable Communities Strategy (clean, green and liveable) and to the Council's corporate priorities (decent homes for all).

4. Summary

4.1. Both improving the quality and increasing the availability of housing play a key role in promoting health and wellbeing. The health of homeless people is among the poorest in our communities. Hundreds of studies have investigated the health of populations and their housing conditions, resulting in a body of evidence that reveals strong associations between poor health and poor housing.

4.2. The WHO Commission on the Social Determinants of Health has highlighted the need to create healthy housing and healthy neighbourhoods for future health. Within public health more generally, housing policy is regularly cited as a determinant of health and health inequalities as well as having the potential to tackle health inequalities. The well-established associations between poor housing and poor

health suggest that housing improvement may well be justified on health grounds alone.

4.3. Poor quality housing is linked with a wide range of conditions, including respiratory problems, trips and falls and excess winter deaths. Lewisham Council and partners are working to improve the quality of existing housing in the borough and will continue to do so through the Decent Homes Programme, the Grants Team, the Home Improvement Agency and the Private Rented Sector Unit. This report recommends that this focus on prevention should be further expanded and prioritised in order to help residents to continue to live safely in their own homes.

4.4. Increasing the supply of housing is another way in which the Council and partners are contributing to improving quality and availability of housing. New build homes are constructed to modern standards which promote health and wellbeing. The Council, alongside partners, is developing a wide range of housing of all tenures and types, to help meet local demand.

4.5. The Council also plays a role in prioritising the allocation of existing housing in the borough to those most in need. Through the allocations process there are opportunities to reduce overcrowding and the negative outcomes for health and wellbeing associated with overcrowded housing.

4.6. Reducing homelessness reduces the negative impact of homelessness on health and wellbeing. This should not be considered to be limited to work with rough sleepers and single homeless people. Whilst there are specific health issues which are more prevalent in these populations, there are also negative health impacts for homeless families and those households in temporary accommodation.

4.7. There are opportunities for housing, health and social care services to work more closely together within the integrated neighbourhood model that is being progressed through the Adult Integration Programme. The provision of timely information and advice to residents on their housing options, from within a health setting is one way that this could be achieved. For instance, a housing advice officer located either within a new neighbourhood team, or based out of a hospital or other health setting, might enable the provision of better housing advice and support at an earlier stage than is currently possible. This is a project that could be funded on a pilot basis by the housing service in the first instance, and therefore it is recommended that the Board considers and approves a pilot scheme of this nature.

4.8. In the sections that follow this report first explores in more detail the specific housing context in Lewisham and London, and then explores the main areas of interaction between housing and health, namely the quality and conditions of homes, the provision of new housing, and the management of homelessness. The evidence that is contained in these

sections is drawn from a recently completed, and extensive, literature and evidence review which demonstrates why these areas of interaction are particularly relevant, and why the recommendations set out above have been made to the Board.

5. The Housing Context in Lewisham

5.1. The 2011 Census found 116,100 households living in 117,651 dwellings in Lewisham. Projections based on previous Census data suggested that over the next 25 years the number of households in Lewisham will grow faster than the average rates in London and nationally. Lewisham will see particularly strong growth among households aged 35-55.

5.2. Of the 116,100 households in Lewisham nearly 45% are owner occupiers. The remaining 55 per cent rent, either from a social landlord or a private landlord. The number who rent privately doubled between 2001 and 2011, partly as a result of rising house prices.

5.3. Approximately 40 per cent of the social housing stock in the borough is owned by the Council, with Housing Associations owning and managing the other 60 per cent. There are more than 60 Housing Associations in the borough, but the majority of stock is owned by six associations.

5.4. In March 2014 the average price for a property in London was £414,000. In Lewisham it was £319,000. Average property prices have more than trebled in London (and Lewisham) since 1995. The median household income in 2014 is £30,357, and so the average home in Lewisham costs more than 13 times the median household income. Increasing purchase prices mean greater demand for rented accommodation, and a doubling of the private rented sector and as a consequence it is more difficult for the Council to source temporary homes for residents experiencing housing crisis.

5.5. The impact of insufficient supply across all tenures and rising house prices has contributed to a doubling in size of the private rented sector, which in turn is leading to increasing pressure on private sector rents. This is particularly apparent London-wide where rents increased by nearly 10 per cent in the year to March 2013. In Lewisham the annual increase was less steep but still considerably greater than inflation.

5.6. The implication of rising house prices, alongside welfare reforms such as the benefit cap, is increased “acute” demand as shown by increases in the number of households accepted as homeless by the Council and placed in temporary accommodation, and the number of people accepted onto the housing register (waiting list). In 2013/14 684 households were accepted as homeless by the Council, an increase of 20 per cent on the previous year. At the same time the number of properties available for letting decreased by 43 per cent further

increasing the need for the Council to use temporary accommodation. Currently the Council has no choice but to house more than 350 households in this form of accommodation, which is the highest it has ever been. This is a London-wide issue. London has 75 per cent of the country's total homeless households in temporary accommodation and the use of nightly paid accommodation is also rising. As of April 2014, there were 8,301 people on Lewisham's Housing Register.

5.7. While housing and health are closely related in all housing tenures, the Board is asked to note the higher prevalence of poor health and wellbeing in the social sector. In the owner occupier sector, health issues are most prevalent for older occupiers, and the Council and other partners lead interventions in that regard. Younger owner occupiers, though, are less likely to be represented among target groups considered by the board. In the private rented sector, again, residents tend to be younger. However it is in the social sector where health issues may be most prevalent. The Council's allocation policies afford priorities to residents who are accepted as homeless with additional health needs, and consequently it is likely that the greatest prevalence of residents with additional health needs will be in the social sector.

6. Housing Quality

6.1. Aspects of poor quality housing that impact on the greatest number of people include: air quality temperature, accidents (slips, trips, and falls), noise and fires. The health impacts for which there is the strongest evidence base include respiratory conditions, mental health, injury or death from accidents, cold related illness and general physical symptoms.

6.2. It is acknowledged that there are other factors which have a relationship with housing and impact on health, such as Radon and environmental smoke. Fortunately, Radon is not a problem in Lewisham, and the biggest contributor to poor air quality in the home in the UK is smoking, which is currently addressed within other Public Health initiatives.

7. Housing Quality: Cold and Damp

7.1. Cold conditions contribute towards the numbers of "Excess Winter Deaths" (EWD), defined as the additional number of deaths occurring during the winter season compared with the average of the non-winter seasons.

7.2. Evidence indicates that there is a strong association between excess winter deaths and cool household temperatures, with those living in the 25 per cent coldest households being around 20 per cent more likely to suffer an excess winter death than those in the warmest[1]. A review of the evidence shows living in cold conditions is associated with poor

health outcomes and an increased risk of morbidity and mortality for all age groups[2]. Separate from social care costs Age UK estimate an annual cost to the NHS in England of £1.36 billion [3] due to the cold.

7.3. Lewisham had a higher than London average Excess Winter Mortality Index rating for the 2010/11 period, with a total of 90 excess winter deaths in Lewisham during that period.[4]

7.4. Cold homes also increase the risk of developing a wide range of health conditions including, influenza, asthma, pneumonia and accidental injury. As well as non-fatal cardiovascular and respiratory diseases, low indoor temperature also exacerbates existing conditions such as arthritis and rheumatism, increased blood pressure, heart disease and risk of stroke. A lack of adequate heating is also responsible for an increased incidence of hypothermia and heart disease particularly in older people.

7.5. The rates of admission for people with COPD and heart failure are higher in Lewisham than the England average[5] There is clear evidence that living in cold housing is an underlying factor for circulatory and respiratory disease two of the three biggest killers in Lewisham[6].

7.6. Damp is linked with inadequate heating and poor ventilation, leading to high humidity levels and condensation. Damp conditions predispose to bacteria and virus replication, increase proliferation of dust mites as well as mould and fungus formation which can affect respiratory health. The majority of research in this area relates to asthma, and evidence suggests that people with asthma are two to three times more likely to live in damp household conditions[7].

7.7. A previous briefing on the impact of damp and mould on disease in Lewisham was compiled in 2011. It concluded that improvements in housing are likely to improve health for those living in cold damp or mouldy environments. It acknowledged the well established association between living in a damp building and various negative health outcomes and asthma in particular.

7.8. Although the sample size is small, mortality from asthma in Lewisham for people of all ages is not significantly different to the England or London averages from 2006-08. Damp and mouldy conditions however affect children more than they affect adults. This is of note considering standardised admissions for asthma in those 16 years of age or younger in Lewisham are significantly higher than the England admission rate. WHO reports that a considerable proportion of childhood asthma cases is attributable to exposure to indoor dampness and mould[8]. Irritations of the throat and eyes, allergies, rhino-conjunctivitis and eczema have also been observed repeatedly [9] [10] [11] [12]

7.9. Furthermore, specific groups may be both disproportionately exposed to and more vulnerable to the ill-effects of cold homes than others. In

the case of older people or infants for example this may be due, in part, to being more likely to spend longer periods of time in the home and/or being less physically active. The groups which may be disproportionately affected by the ill-effects of cold homes are:

Children and young people

- A study into the effect of poor housing conditions (including cold living conditions) on children, found that children growing up in poor housing conditions were more likely to suffer from mental health problems, such as depression and anxiety, experience slower physical growth and cognitive development, as well as other negative outcomes, such as respiratory problems, long term ill health and disability[13]
- Cold homes have been found to affect the educational performance of children, increasing rates of sickness and absence from school [14]

People with long term conditions

- In 2011, 14 per cent of individuals in Lewisham reported having a long-standing health condition or disability that limited their day to day activities. Existing medical conditions have been found to be exacerbated by cold conditions, including diabetes, certain types of ulcers and musculoskeletal pains[15]. Cold homes can increase the severity of the condition and limits mobility.

Older people

- Research suggests that blood pressure rises in older people with exposure to low temperatures increasing the risk of health and strokes[16]
- Cold houses can affect mobility and increase risks of falls and accidental injuries, negatively affecting strength and dexterity, particularly amongst older people[17]
- A population based study looking at vulnerability to winter mortality in elderly people in Britain found around a 30 per cent increase in mortality in winter amongst people 75 years or older [18]
- Amongst people aged 75 and over the number of households with poor energy efficiency was at 5 per cent in 2011 significantly higher than the 3 per cent across all households.[19]

8. Housing Quality: Reducing incidence of Cold and Damp

8.1. One reason for damp and associated mould is related to the design and construction of buildings. Good design and proper construction can help to prevent problems from occurring. Timely maintenance, including speedy response to flooding are important as well as the need to make occupiers aware of how to use their homes in a healthy manner, for instance, education about how and when moisture is generated and the value of ventilation.

8.2. This paper echoes The World Health Organization's view that housing improvements that ensure the provision of affordable warmth may have the greatest potential to reduce the adverse effects of poor housing and that reducing exposure to damp and mould would be extremely beneficial to public health and prevent or reduce a large proportion of asthma among adolescents and adults

8.3. In February 2013 a report was submitted to the Health and Wellbeing Board which summarised the evidence on the health impacts of fuel poverty and link between cold homes and 'excess winter deaths'. It found that 11.2 per cent of households in Lewisham are classified as being in fuel poverty when defined as needing to spend more than 10 per cent of household income to achieve adequate warmth. The report also describes the benefits of actions to help those at risk of fuel poverty and called for the Health and Wellbeing Board's support for ongoing action in Lewisham on fuel poverty as part of the wider health agenda. This report supports the recommendations to reduce fuel poverty in the borough

8.4. Lewisham's Warm Homes Healthy People (WHHP) project is a Council led initiative part-funded by Public Health. For three years it has provided help for those identified as vulnerable and at risk to the cold, helping them to stay warm and healthy during the colder months. The scheme helps to reduce hospital admissions and seasonal deaths locally. Some of the services provided include:

- A package of support for residents identified as potentially at risk from the cold which includes a winter warm pack, practical advice on keeping warm, advice on switching energy tariff and access to other relevant voluntary sector services.
- Installation of insulation, draught proofing, heating upgrades and repairs; and emergency heating.
- The project also supports community-led fuel poverty events that aim to raise awareness among vulnerable residents about the health risks associated with cold housing and promote locally available sources of support. The project also delivers fuel poverty training to local frontline staff across social services, health, housing teams and voluntary organisations.

8.5. Some key achievements of the 2013/14 WHHP project:

- 437 vulnerable households received a home visit and winter warm pack
- 4300 free measures were provided to vulnerable households to keep warm and reduce fuel bills
- 160 front line professionals received training on fuel poverty and health awareness
- 16 vulnerable households received heating improvements and/or insulation, bringing in £10,500 external funding
- 195 vulnerable households also received smoke alarms and CO detector

- 872 vulnerable households have accessed the service since it began in 2011/12,

8.6. The WHHP project seeks to ensure the support available reaches those most in need. Two key vulnerable groups that the service has had limited success in reaching are low income families and individuals with a health condition, which is a reflection of the low number of referrals received from the health sector.

8.7. Costs to the NHS of treating the illnesses caused and exacerbated by cold homes are in the region of £1.36 billion per year.[20] A cost-benefit analysis by Professor Christine Liddell identified that investing £1 in improving affordable warmth delivered a 42 pence saving in health costs for the NHS.[21]

8.8. The WHHP compliments patient care by preventing illness that can be triggered by a cold/damp home environment. Health professionals have an important role to play in referring patients who may be at risk to the cold to the WHHP project and greater engagement with the local health sector is critical to the success of the WHHP project going forward. It is recommended that the Health and Wellbeing Board continues to support the WHHP initiative and where possible takes steps to secure greater engagement and buy in from local healthcare providers.

8.9. The BRE/CIEH Model HHSRS Cost calculator was used in 2010 to estimate the total cost to the NHS to remedy excess cold and damp to the NHS, compared to the costs to the Council. The annual cost to the NHS of remedying excess cold was estimated to be £4.38million, whereas the cost to LBL was estimated to be £1.28million. The annual cost to the NHS of damp was estimated to be in the region of £78,000, and costs to LBL were estimated to be in the region of £1.7million.

9. Housing Quality: Trips, Falls and Accidents

9.1. There are well known difficulties in establishing exact accident rate statistics arising from the home. Typically data is only gathered at the point of medical intervention and thus many accidents are never acknowledged. Furthermore, the accuracy and consistency of reporting is variable.

9.2. ONS identified home accident deaths as a continually growing problem with approximately 5,000 in 2009 and the WHO (2005, cited in CIEH 2005) produced similar estimates of 4,100 deaths in the home and 270,000 injuries annually. Home and leisure fatal accident rates are twice that of road accidents.

9.3. Under-14s and over-65s have been found to be most at risk of trips and falls, and this paper focuses on evidence available for these two groups.

9.4. Annually, UK ambulance services respond to 700,000 calls from older people who have fallen. About 60 per cent of these cases are taken to hospital[22]. Hip fractures are the most serious fall-related injury in older people, with 15 per cent dying in hospital and a third not surviving beyond one year afterward of those older people that survive approximately half are never functional walkers again.

9.5. In Lewisham approximately 1,000 people aged over 65 present to the Accident and Emergency department with a fall each year. There are also approximately 200 hip fractures each year, which cost just over £1m in total.

9.6. Around 60,000 fractured neck of femurs occur each year in the UK, resulting in up to 14,000 deaths and a cost to the NHS of approximately £1.7 billion. [23] In 2009/10 Lewisham's rate of fractured neck of femurs was not significantly different from any other borough in South East London, nor from England overall but was higher than that of London overall.

9.7. The South West Public Health Observatory injury profile indentifies that hospital admissions and hospital stays more than three days due to unintentional injury were significantly higher in Lewisham than the national average. The two areas greater than the national average by the biggest margin related to hospital admissions related to injury in the over 75's and admissions due to falls in the over 65's. Although the specific breakdown of the nature of falls and whether they occurred in the home is not specified it is reasonable to assume on the basis that the elderly spend up to 90 per cent of their time in the home that this is where a significant amount of these accidents and falls arose.

9.8. Emergency admissions for falls injuries in persons aged 65-79 years was higher than the national average (Lewisham JSNA).

9.9. Kannus et al (2005) estimate that between 30-60 per cent of the over 65 population fall each year. They go on to highlight that 20 per cent of these injuries require medical intervention and are the major cause of functional impairment, disability and death.[24] Falls and resultant fractures in people aged 65 or over account for over 4 million bed days each year in England alone and are the leading cause of accidental mortality in older people[25] .

9.10. 77 per cent of all home injuries among small children (up to five years) are due to falls (Bauer and Steiner, 2009)26, but in childhood, falls are seldom lethal and typically result in only minor injuries. In adolescence and adulthood, falls more commonly lead to hospitalization[27.] Among older people, falls have the most severe health outcomes

9.11. The Health Protection Agency estimate 882,500 accidents led to under 14s attending Accident and Emergency departments as a result of home accidents mostly due to falls or being struck by a static object.[28]

9.12. Falls also result in loss of confidence, continued fear of falling, activity restriction, reduced functional ability, loss of independence, social isolation and thus increased dependency on carers and services.

9.13. The Council and Registered Provider partners provide a range of support to residents which contributes to the prevention of falls. Within the Council these include the provision of aids, adaptations, grants and other support such as the handypersons service. Housing association partners also administer their own aids and adaptations programmes for the same purposes. All of these services provide the opportunity to modify residents' homes in order to make them safer and to reduce the risks of slips, trips and falls, with the cost of intervening in this way very often substantially lower than the cost of supporting residents' to return to health and mobility after a fall.

9.14. The BRE/CIEH Model HHSRS Cost calculator was used in 2010 to estimate the total cost to the NHS of trips and falls on a level and on the stairs. The estimated costs of Falls on the level was estimated to costs the NHS £1.162million, compared to the cost to LBL of £174,000. The estimated costs of falls on stairs was £640,000 to the NHS and £86,000 to LBL. This suggests that there is an opportunity to do more preventative work in this area to reduce costs to the NHS.

10. Housing Quality: Overcrowding

10.1. Under the Housing Act 1985 there are two legal standards that determine if a property is overcrowded. The first is known as the room standard, and the second is known as the space standard. The 'room' standard requires that that no male and female aged 12, or over, should have to sleep in the same room, unless they are partners. The 'space' standard specifies the maximum number of people who can sleep in any room considered suitable for use as a sleeping room dependent on floor area.

10.2. New household formation and children growing up are typical reasons for overcrowding. Another common reason for overcrowding is the presence of individuals who for a variety of reasons, perhaps due to relationship breakdown or recent release form prison, are unable to secure their own housing and are staying with family or friends as a result.

10.3. Findings from the English Housing Survey indicate that the rate of overcrowding in England during 2011/12 was 3 per cent, amounting to 643,000 households living in overcrowded conditions. This is a slight increase from 2 per cent in 2002/03. 2011 Census data for Lewisham shows that 25,722 (22.2 per cent) of households are overcrowded by at

least one room, and 14,387 (12.4 per cent) are overcrowded by at least two bedrooms.

10.4. Although there is data available and recent trends indicate that it has been on the rise, particularly in London and the South much overcrowding is not reported and remains hidden from view. [29] As such the problem may be bigger than estimated.

10.5. Overcrowding is associated with a range of negative outcomes, including poorer child development, communicable diseases, respiratory problems and mental health issues.[30] [31] Numerous epidemiological studies have demonstrated the existence of a significant association between overcrowding and the prevalence of certain infectious diseases. [32] Overcrowding may have a direct effect by facilitating the spread of infectious diseases such as tuberculosis, rheumatic fever and meningococcal disease. [33]

10.6. The Building Research Establishment estimates that the cost of overcrowding on the NHS is £21,815,546 per year[34].

10.7. Overcrowding is also associated with mental health problems. A study conducted in north-west England found an association between overcrowding and the prevalence of psychiatric morbidity in the adult population.[35]

10.8. Several studies have also demonstrated that housing quality constitutes a good predictor of psychological issues and that overcrowding in particular is significantly associated with children's mental health. [36] [37] There is research evidence to show that overcrowding significantly increases levels of stress within families and can lead to interpersonal conflicts and has a negative impact on children's education and development [38] [39].

10.9. As is the case with some of the previously reviewed aspects of poor housing, overcrowding has a greater impact on the health and wellbeing of those who spend the most time at home, typically children, and individuals with chronic health conditions, the mobility impaired and their carers.

10.10. National research into overcrowding has concluded that overcrowding disproportionately affects black and minority ethnic communities. [40] Households headed by ethnic minorities were more likely to experience overcrowding (12 per cent) when compared with households headed by white counterparts.[41] In this respect it is significant that tuberculosis also disproportionately affects black and minority ethnic households.

10.11. The Council operates a number of schemes to support social tenants to move, and to create vacancies in larger properties which can subsequently be let to larger families. In the medium term the development of specialised new housing for older residents is

intended, in part, to act as an incentive to older tenants to downsize to attractive new accommodation, thereby releasing family homes.

10.12. In addition, and in the shorter term, a number of Council schemes have been developed to support moves. A good example is "Trading Places", a project that has been launched over the past year in response to the welfare reform agenda and to support residents to move where they choose to do so. The project, which has drawn funding and staffing support from housing association partners, has successfully supported 40 such moves already, having been in operation for only five months.

11. Housing Quality: Improving the quality of Social Housing in Lewisham

11.1. Increasing the quality of homes is a Council priority. The Council has pursued a mixed approach to securing quality within the Social Housing Sector (measured by the Decent Homes Standard), pursuing stock transfers where residents preferred that, and setting Lewisham Homes to improve the remainder of homes. This programme will have delivered the Decent Homes standard to all homes by the end of March 2016, at which time more than £100m will have been invested in bringing the retained Council housing up to the decent homes standard.

12. Housing Quality: Improving the quality of owner-occupied housing

12.1. Lewisham has a number of services which aim to support people to carry out works in their own homes to improve quality and maintain independence.

12.2. The very popular Lewisham Handyperson Service works across all tenures carrying out small jobs such as fitting grab rails, changing light bulbs and fitting smoke alarms for people who cannot manage themselves. People are charged for materials but not labour. Gardening and decorating are not provided although anecdotally there is a demand for both. The service is advertised through leaflets and posters in venues such as hospitals and GP surgeries. The Handyperson Service carries out approximately 2,000 jobs a year, over half of which are for falls prevention. There is a lack of referrals from health, with the majority of people accessing the service via self-referrals. It is proposed that health and social care colleagues could make better use of this resource and this would maximise the benefit of the service to health and wellbeing.

12.3. The Council's Grants Team provides grants to deal with property that is non-decent and manages the mandatory Disabled Facilities Grants (DFGs), which is available to disabled people across all housing tenures. The Grants Team also informs people where there are other

government improvement grants which may be of benefit to them. The three grants which the grants team administers are:

- DFGs are available to a maximum of £30,000; they are means tested (except where a disabled child is involved) and require the recommendation of an occupational therapist. A discretionary interest-free top-up loan of £15,000 is available in certain circumstances. The majority of the work involves stair-lifts and bathroom alterations.

- Home-repair grants of £3,000 are available to homeowners and tenants with a repairing responsibility with a top-up of a £27,000 interest-free loan to bring properties up to the Decent Homes Standard. These are repayable through a charge on the property.

- There is also a smaller repairs grant of up to £2,000 for homeowners who are in receipt of a qualifying benefit for carrying out emergency works where the home owner is at imminent risk of harm.

12.4. In 2013/14 there were 71 DFGs carried out in Lewisham, at an average cost of £8,090. These adaptations included bathroom adaptations, installation of stair lifts and hoists, all of which contribute to promoting independence.

12.5. Staying Put is Lewisham's home improvement agency. It helps older people and people with a disability to access grant or loan funding for adaptations or repairs. It provides support and advice in planning and arranging the work. The service tends to be used by vulnerable residents who would struggle to organise work themselves or through their family. There is an increasing demand for this service and with limited funds which can increase the time period taken before work can be agreed and completed for qualifying households.

12.6. The Special Duty Team is a small team within the Adult Social Care division which offers a service to vulnerable people living within a variety of tenures to keep their properties clean and free from clutter. The team, in the main, works with tenants with mental health issues who need support to manage their micro environment. An increasing number of referrals are made following a hospital admission, which prevents them returning home without assistance.

13. Housing Quality: Improving the quality of housing in the Private Rented Sector

13.1. The growth of the Private Rented Sector (PRS) has been accompanied by increasing challenges, all of which may impact on health and wellbeing:

- Affordability.
- Poor physical standards
- Rogue landlords

- Insecurity of tenure

13.2. The private rented sector accounts for 25 per cent of the housing market in Lewisham and more than doubled in size between the 2001 and 2011 according to census data. There are more than 30,000 units in the PRS and of those 10,500 are rented to households in receipt of housing benefit. In addition there are estimated to be 700 licensable Houses in Multi Occupation in the borough, of which 166 are licensed.

13.3. The DCLG English Housing Survey 2012/13 shows that:
- The PRS has the highest proportion of non-decent homes (33 per cent) in 2012, 13 per cent of total dwellings had a Category 1 hazard under the HHSRS, but this percentage was more prevalent in the PRS with 19 per cent of PRS dwellings failing the minimum safety standard, compared with 6 per cent of social rented sector dwellings
- PRS dwellings are also more likely than social sector dwellings to fail the decent homes standard due to poor thermal comfort (15 per cent compared with 5 per cent) and disrepair (8 per cent compared with 3 per cent)
- 9 per cent of private rented dwellings had some type of damp problem, compared with 5 per cent of social rented dwellings, partly because PRS dwellings are more likely to be older and have property defects
- 6 per cent of households in the PRS are overcrowded (compared to 1 percent in the owner occupied sector), and overcrowding is a problem likely to increase with welfare reform.

13.4. A survey of homes in the private rented sector in Lewisham which took place in 2011 estimated that more than 35 per cent of homes in the sector failed to meet the Government's Decent Homes Standard.

13.5. An estimated 3,700 landlords operating in the borough, of whom the majority are small landlords with a handful of properties. Many of these landlords do a good job for our citizens and provide good quality accommodation that is well managed and maintained. However, Lewisham, like other London Boroughs, has at the bottom end of the market a small group of rogue or criminal landlords who exploit residents, many of whom are vulnerable.

13.6. In the private rented sector the Council has less direct control over quality. However, Lewisham has developed an approach to drive up quality in the sector by specifically targeting rogue landlords and developing a Private Sector Housing Agency to bring together a number of teams who were working across different services dealing with the private sector.

13.7. Over the past year Lewisham has successfully prosecuted a number of landlords, mostly HMO landlords for failing to licence their properties. The Council's environmental health residential team of 4 staff respond

to a range of enquiries and complaints, around 800 per annum, from private tenants relating to the condition of their properties.

13.8. This team also tackles non-decency in the private rented sector. The primary hazard failures are excess cold, damp and mould and hazards which lead to falls (uneven flooring, poorly constructed stairs etc). Most cases are resolved through support, advice and liaising with landlords. Where this does not result in improvement, enforcement action is taken.

13.9. The Private Sector Housing Agency also works to prevent homelessness and to find good quality accommodation in the private rented sector for homeless families and single people. These tenancies are not just securing supply for our customers but also support the Council's drive to improve standards, leading by example in how to procure, manage and maintain good quality homes for homeless households.

13.10. The PSHA also promotes the benefits to landlords of the Lewisham accreditation scheme to improve the professionalism of local landlords. Our accreditation scheme is part of the London scheme (LLAS). Currently Lewisham has 275 landlords accredited through LLAS but we hope this will substantially increase in tandem with the promotion of the London Rental Standard.

13.11. The London Rental Standard brings together seven landlord accreditation schemes, which will operate under a single framework. The badge will be awarded to all landlords and letting agents who meet a set of significant core commitments set by the Mayor. These outline a minimum level of service that renters should expect including transparent fees, better property conditions, better communication between landlords and tenants, improved response times for repairs and maintenance, and protected deposits.

13.12. As part of our ongoing commitment to tackle poor practice for the PRS, improve standards and protect vulnerable tenants we bid and secured £125K funding from DCLG to support a Rogue Landlord project. In addition the project secured £30k funding from Public Health as the homes of these landlords are very often in the poorest condition with high levels of overcrowding of vulnerable citizens and the resulting health impacts this creates.

13.13. This funding has been used to employ a dedicated enforcement co-ordinator in January 2014 who has worked hard to bring a range of Council services and external partners together (multi-taskforce agency) to co-ordinate all of the enforcements actions across the Council and partners to drive forward prosecutions where appropriate and to ensure all legal avenues are explored and utilised.

13.14. A multi-agency service has been established to bring together all of this activity and to focus enforcement action across the Council and public

sector partners to tackle the worst landlords. This work is also supported by voluntary and community organisations, such as St Mungo's, to ensure that where residents are displaced from poorly managed and maintained properties, they are supported into better homes rather than moving into properties of a similar nature. Given that the residents of properties managed in this way often have additional health or care needs, this activity is directly supporting vulnerable residents, by improving their housing situation.

14. Increasing Housing Supply

New homes of all types

14.1. The Council has long prioritised the delivery of new affordable homes for its residents, and has achieved success in enabling the construction of more new homes than most other authorities. In 2011/12 Lewisham built more new affordable homes than all but two local authorities in the country; in 2012/13 the total completions were the highest in London.

14.2. The Council's New Build Programme, which is being delivered by Lewisham Homes, will provide 500 new homes by 2017. 80% of these will be for rent at social rent levels and 20% will be for private sale. The first six new homes within the Council programme are now in construction at Mercator Road. A firm bid has been made to the GLA for 2015/16 (98 homes) and indicative bids for 2016/17, 2017/18 with a 100 homes each. Each bid should comply with the London Housing Design Guide.

14.3. Registered Providers of Social Housing are also actively developing new housing in the borough. There are approximately 500 new homes which will be completed this financial year, which will be for affordable rent and shared ownership.

14.4. Over the next four years the Council intends to see 2,000 new affordable homes developed in the borough, of which 500 will be Council homes and the remainder will be developed by registered provider partners. These will all be built to London design guide standards, which set minimum space and design parameters and which since their inception have been accepted as a de facto national guide to the specification of new housing. 10 per cent of these new homes will be designed to wheelchair accessible standards.

14.5. The delivery of these new homes will mean that the total stock of affordable housing in the borough will grow by more than 5 per cent, with all of these new homes meeting modern design and access standards. In combination with the decent homes programme, above, and the development of new specialist housing, as set out below, this will lead to a significant improvement in the quality (and quantity) of housing provision in the borough.

Specialist new homes

14.6. A report was brought to the Health and Wellbeing Board in November 2013 which outlined the development plans for new build extra care accommodation for older people.

14.7. To recap, a significant programme of development of new highly specialised housing for older residents is being progressed, and the first new homes as part of this will soon be available. 78 new units of extra care accommodation will be available at Conrad Court in Deptford in August this year. These will be of high quality and in themselves will help to improve provision. They will also offer alternative options to the residents of the Council's Kenton Court and Somerville extra care schemes, both of which are acknowledged to no longer meet modern standards, and which as a result may be redeveloped in the medium term.

14.8. Over the next three years a further 111 new units of modern extra care housing will be constructed, in two schemes which are being developed jointly by the Council and registered provider partners. Again these will add to the number of modern homes available for older residents, and are being designed to lead to a long term reduction in care costs, leading to benefits to health and social care services as well as residents.

14.9. Within the Adult Integrated Care Programme, there is a work stream which focuses specifically on securing wider partnerships, including housing partnerships. This work stream is developing models of supported housing which can support wider Health and Social Care commissioning intentions and deliver cost savings. Pathways into supported housing will also be reviewed to ensure that this resource is being used as efficiently as possible.

14.10. Officers have identified areas which could provide opportunities for housing to support wider commissioning intentions within Health and Social Care. The areas identified are: Learning Disability, Transition Groups, People with Autism, People with Mental Health conditions. For each of these areas, officers are gathering information, researching housing and support models, and working to better understand how these could be implemented locally. Proposals will then be developed for implementation.

14.11. The Health and Wellbeing Board is asked to consider how partner agencies can best support this work, combine intelligence, and come to a collective view on how specialised new housing can be commissioned to better meet residents' needs.

15. Homelessness

15.1. Homelessness is a widespread problem affecting many thousands of people each year. Accurately estimating numbers of homeless people and understanding their health needs is notoriously difficult. Data on those who are homeless often focuses on those in contact with services and so often underestimates the true number.

15.2. Not all long term homeless people sleep rough all the time, they may spend time as "hidden homeless", with friends or in squats, in hostels or other short term accommodation.[42] In Lewisham there are 1,441 households currently in hostels or temporary accommodation.

15.3. In 2013/2014, 9,798 households approached the Housing Options Centre, 1,041 Homeless Applications were made, and 711 Homeless Applications were accepted by Lewisham. Homelessness was prevented in 215 instances. 1,885 people approached the Single Homeless Intervention Project.

15.4. The homeless population is particularly vulnerable to Tuberculosis (TB) and the WHO has claimed that 'TB rates can be up to 20 times higher than in the general population'.[43] This inequality exists due to a range of factors including ease of spread due to living environments, smoking, poor nutrition and alcohol consumption. Furthermore, homeless patients are likely to present much later with advanced disease and less likely to complete treatment once issued treatment. [44]

15.5. Mental ill health should be considered to be both a cause and consequence of homelessness. In the homeless population depression, affective disorders, schizophrenia, psychosis and states of anxiety are common. The World Health Organisation (WHO) Europe found that 20 per cent of homeless people with mental ill-health are dually diagnosed with substance dependence[45]. Less than one-third of homeless people with mental illness actually receive treatment. They are also 9 times more likely to commit suicide than the general population.

15.6. The homeless adolescent population is at increased risk of acquiring STI's and Blood Borne Viruses (BBVs) compared with the general population[46]. There is mounting evidence of unmet sexual health needs in the homeless population in terms of: the supply of information about, and testing for, sexually transmitted infections; condom supply and use; contraceptive advice; and cervical cytology[47] [48]

15.7. According to DCLG[49] and St Mungo's[50]

- Rough sleeping has risen by 31 per cent from 2010-2012
- 24 per cent of rough sleepers reported are in London, which was a total of 3472 in 2012

- The majority of rough sleepers are aged 26 - 49 years old, 73 per cent of rough sleepers in London are in this age group
- 90 per cent of rough sleepers are men
- 35 per cent of rough sleepers have diagnosed mental health problems
- 49 per cent have an alcohol problem
- 41 per cent have drug problems
- 20 per cent start using drugs after becoming homeless
- 23 per cent have dual diagnosis
- The average life expectancy of rough sleepers is 42 compared to a national average of 74 for men and 79 for women

15.8. The average life expectancy of male rough sleepers is just 47 years, compared to 77 years for the general population. Life expectancy of female rough sleepers is even lower at just 43 years. This huge variation demonstrates both the increased health need, and the barriers to accessing health care faced by homeless people.

15.9. Two thirds of street homeless people cite drug or alcohol use as a reason for first becoming homeless and drug users are seven times more likely to become homeless than the general population.[51] Several studies from the UK & Europe demonstrate a high prevalence of illicit drug use and alcohol dependence among the street homeless population.[52] Substance misuse is a common cause of death amongst the homeless population and the physical and mental health consequences of drug and alcohol abuse are wide ranging and often serious. These include serious infectious diseases, respiratory problems, cardiovascular disease and mental health issues to name but a few. [53] [54]

15.10. Despite a considerable burden of health problems faced by the homeless, they are often unwilling or feel unable to seek help. Stigma, discrimination, inaccurate generalisations, genuine or perceived difficulty registering with a GP, an unsettled lifestyle and Homeless people themselves not prioritising their health or being unaware of where to go and what they are entitled to all contribute. [55] [56] [57]

15.11. Despite the improving use of services at a primary level, the homeless population continue to use hospital services at a disproportionate rate to the general populations.[58] DoH in 2010 statistics identify toxicity, substance misuse and mental health problems as the commonest reasons for admission. It found that this group are high users of secondary care, with high rates of emergency admissions that subsequently result in longer times as a hospital inpatient.

16. Tackling homelessness

16.1. There are five priorities within Lewisham's current Homelessness Strategy, these are:

- Preventing homelessness arising where possible and promoting housing options
- Providing long term and sustainable housing
- Protecting and providing support for vulnerable adults and children who are homeless or faced with homelessness
- Promoting opportunities and independence for people in housing need by improving access to childcare, health, education, training and employment
- Reducing Youth Homelessness

16.2. Set out below are some of the key activities which relate to the delivery of this strategy:

- Preventing homelessness by carrying out more home visits, mediation, providing rent deposit incentive scheme for people to access the private rented sector
- Establishing the Single Homeless Intervention & Prevention team as the central assessment and referral agency for single homeless people
- Tackling overcrowding and under-occupation in housing to free up greatly needed family accommodation
- Helping residents find 'in-situ' solutions to maintain independent living – Disabled Facilities Grants to provide aids and adaptations, the Handyperson Service, and other loans to deal with disrepair and alterations
- Providing a flexible and broad range of housing options including the private rented sector, intermediate rent and shared ownership opportunities
- Exploring sub-regional opportunities to provide greater housing choice and availability

16.3. Housing officers at the Housing Options Centre and Single Homeless Intervention and Prevention Team work with people who are homeless or who are at risk of becoming homeless to identify suitable housing for them, according to their needs and an assessment of priority.

16.4. The Private Rented Sector unit works with residents who present as homeless in the Housing Options Centre (HOC) or Single Homeless Intervention and Prevention Service (SHIP) to find them suitable, good quality accommodation in the private rented sector. This can be either as an accepted homeless case in our private sector leased accommodation or the Lewisham Landlord Letting Scheme, a comprehensive tenant finding service, which has both an incentive and bond offered to landlords who are willing to work with our customers.

16.5. Lewisham's Private Rented Sector Unit has two Tenancy Relations Officers (TROs) who support tenants who are being unlawfully evicted or harassed. Over the last year they have actively supported, through case work, negotiations and court appearances, approximately 75 tenants whose landlords were attempting to illegally evict without following due legal process, or harassing them.

17. Conclusion

17.1. Good quality housing plays an important role in promoting health and wellbeing. The Council and its partners are already working closely together to maximise the impact of investment in housing to support health outcomes.

17.2. As set out in this report, the evidence shows that there are three specific areas where further work would have an additional impact in supporting health and wellbeing, and in that regard the following are recommended for the Board to consider and discuss:

- A further expansion of the current focus on prevention through the provision of aids, adaptations, grants and other support such as the handypersons service;

- A greater focus of partnership working to share intelligence about the demand for specialised housing, to better enable housing providers to build or commission new specialised homes;

- To pilot the provision of a housing advice service in health settings, to enable faster resolution of housing issues for residents with additional health needs.

17.3. The Health and Wellbeing Board will be kept fully appraised of developments in this regard, and in relation to all of the current and planned initiatives set out in this report.

If you have any difficulty in opening the links above or those within the body of the report, please contact Kalyan DasGupta (kalyan.dasgupta@lewisham.gov.uk; 020 8314 8378), who will assist.

If you would like any further information on this report please contact Genevieve Macklin, Head of Housing, London Borough of Lewisham, on 020 8314 6057

References

[1] Wilkinson P, Landon M, Armstrong B, Stevenson S, Pattenden S, McKee M, et al. Cold Comfort: The Social and Environmental Determinants of Excess Winter Deaths in England, 1986-96. Bristol: The Policy Press, 2001.

[2] University College London Institute of Health Equity. The health impacts of cold homes and fuel poverty 2011 [updated 12/01/25/]. Available from: www.instituteofhealthequity.org/projects/the-health-impacts-of-cold-homes-and-fuel-poverty

[3] Age UK (2012) *The cost of cold: Why we need to protect the health of older people in winter.* London: Age UK.

[4] Office of National Statistics 2012 http://www.ons.gov.uk/ons/rel/subnational-health2/excess-winter-mortality-in-england-and-wales/2011-12--provisional--and-2010-11--final-/index.html

[5] Reference doc for JSNA

[6] Lewisham Joint Strategic Needs Assessment www.lewishamjsna.org.uk

[7] Williamson IJ, Martin CJ, McGill G, Monie RD, Fennerty AG. Damp housing and asthma: a case-control study. Thorax. 1997;52(3):229-34.

[8] WHO: *Environmental burden of disease associated with inadequate housing*

http://www.euro.who.int/__data/assets/pdf_file/0003/142077/e95004.pdf

[9] Bonnefoy, 2007

[10] Zacharasiewicz et al., 2000

[11] Simoni et al., 2005

[12] McNally, Williams and Phillips, 2001

[13] Harker L, Shelter. Chance of a lifetime : the impact of bad housing on children's lives: London : Shelter; 2006.

[14] Somerville M, Mackenzie I, Owen P, Miles D. Housing and health: does installing heating in their homes improve the health of children with asthma? The Society of Public Health. 2000;114(6):434-9.

[15] El-Ansari W, El-Silimy S. Are fuel poverty reduction schemes associated with decreased excess winter mortality in elders? A case study from London, U.K. ChronicIlln. 2008;4(4):289-94.

[16] Woodhouse PR, Khaw KT, Plummer M. Seasonal variation of blood pressure and its relationship to ambient temperature in an elderly population. Journal of hypertension. 1993;11(11):1267-74.

[17] Department of Health. Health and winter warmth: reducing health inequalities. 2007

[18] Wilkinson P, Pattenden S, Armstrong B, Fletcher A, Kovats RS, Mangtani P, et al. Vulnerability to winter mortality in elderly people in Britain: population based study. British Medical Journal. 2004;329(7467):647-51.

[19] Government DfCaL. English Housing Survey: HOUSEHOLDS. Annual report on England's households, 2011-2012. London: 2013.

[20] Age UK (2012) *The Cost of Cold: Why we Need to Protect the Health of Older People in Winter*. London: Age UK.

[21] 61 Liddell (2008) Op. cit

[22] Lewisham Joint Strategic Needs Assessment

http://www.lewishamjsna.org.uk/a-profile-of-lewisham/demography/population

[23] Lewisham JSNA

[24] Kannus, P., Parkkari, J., Niemi, S., Palvanen, M., (2005). Fall-induced deaths among elderly people. Am J Public Health, 95(3): pp. 422–424.

[25] Falls: The assessment and prevention of falls in older people. Clinical Guideline 21, November 2004

http://www.nice.org.uk/nicemedia/live/10956/29583/29583.pdf

[26] Bauer R, Steiner M (2009). *Injuries in the European Union: statistics summary 2005–2007*. Vienna, Kuratorium für Verkehrssicherheit (Austrian Road Safety Board).

[27] Williams J et al. (2011). Longer term health of young and middle-aged adults following unintentional falls at home resulting in hospitalization.

[28] Health Protection Agency, (2007). Development of a UK Children's Environment and Health Strategy: Regional Priority Goal II: Accidents, Injuries, Obesity and Physical Activity. Didcot, Health Protection Agency: Chemical Hazards and Poisons Division.

[29] Homelessness monitor 2013

[30] Office of the Deputy Prime Minister. London. The Impact of Overcrowding on Health and Education: A review of the Evidence and Literature (2004)

http://dera.ioe.ac.uk/5073/1/138631.pdf

(10 yrs old but good literature review)

[31] Chance of a lifetime: the impact of bad housing on Children's lives, 2006, Harker, L. for Shelter,

http://england.shelter.org.uk/__data/assets/pdf_file/0009/66429/Chance_of_a_Lifetime.pdf

[32] WHO: Environmental health inequalities in Europe: Assessment report 2012

http://www.euro.who.int/__data/assets/pdf_file/0010/157969/e96194.pdf?ua=1

[33] Baker M et al. (2000). Household crowding a major risk factor for epidemic meningococcal disease in Auckland children. *Pediatric Infectious Disease Journal*, 19(10):983–990.

[34] Roys M, Davidson M, Nicol S, Ormandy D and Ambrose P, The Real Cost of Poor Housing (BRE Trust Report FB23, BRE Press, February 2010, page 11

[35] Harrison J, Barrow S, Creed F (1998). Mental health in the north west region of England: associations with deprivation. *Social Psychiatry and Psychiatric Epidemiology*, 33(3):124–128.

[36] Evans GW, English K (2002). The environment of poverty, multiple stressor exposure, psychophysical stress, and socioemotional adjustment. *Child Development*, 73(4):1238–1248.

[37] Evans GW, Saegert S, Harris R (2001). Residential density and psychological health among children in low income families. *Environment and Behavior*, 33(2):165–180.

[38] Friedman D, Social impact of poor housing, ECOTEC, March 2010, page 1

[39] Reynolds L, Robinson N, and Diaz R, Crowded house: Cramped living in England's housing Shelter, p.3

[40] Full house: how overcrowded housing affects families, 2005, Shelter http://england.shelter.org.uk/__data/assets/pdf_file/0004/39532/Full_house_overcrowding_effects.pdf

[41] Department for Communities and Local Government (2013) *English Housing Survey: HOUSEHOLDS. Annual report on England's households, 2011-2012.*London: Department for Communities and Local Government.

[42] Reeve K with Batty E, The Hidden Truth About Homelessness, CRISIS 2011

[43] Burki T. Tackling tuberculosis in London's homeless population. The lancet. Vol 376 December 18/25, 2010.

[44] Homeless Link. TB and homelessness. http://homeless.org.uk/tb

[45] Scott J. Homelessness and mental illness. British Journal of Psychiatry, 1993, 162: 314-324.

[46] Noell J, Rohde P, Ochs L, Yovanoff P, Alter MJ, Schmid S, Bullard J, Black C. Incidence and prevalence of chlamydia, herpes, and viral hepatitis in a homeless adolescent population. Sex Transm Dis. 2001 Jan;28(1):4-10.

[47] Collins E. A service to address the sexual health needs of the homeless population. NursingTimes.Net. Vol: 99, Issue 37, page 53. (2003)

[48] John W, Law K. REVIEW: Addressing the health needs of the homeless. British Journal of Community Nursing, March 2011, vol./is. 16/3(134-9), 1462-4753;1462-4753 (2011 Mar)

[49] DCLG statutory returns 2012

[50] St Mungo's report "Battered, Broken and Bereft - why people still end up rough sleeping" 2011

[51] Kemp P et al (2006) 'Homelessness amongst problem drug users: prevalence, risk factors and trigger events' *Health and Social Care in the Community* 14 (4), 319-328

[52] Fazel S, Khosla V, Doll H, Geddes J. The prevalence of mental disorders among the homeless in western countries: systematic review and meta-regression analysis. PLoS Medicine / Public Library of Science, December 2008, vol./is. 5/12(e225), 1549-1277;1549-1676 (2008 Dec 2)

[53] Dearbhal Murphy (FEANTSA). 2006. The Right to Health is a Human Right: Ensuring Access to Health for Homeless people.

[54] Nat MJ Wright and Charlotte NE Tompkins. How can health services effectively meet the health needs of homeless people? British Journal of General Practice, April 2006; 56: 286-293

[55] "Listening to Homeless People: Involving Homeless people in Evaluating Health Services" Groundswell UK. Healthlink. 2003.

[56] Griffiths S, ODPM (2002) Health of Rough sleepers: Sleeping Rough in Oxford. London: Stationary Office.

[57] WHO regional office for Europe's health Evidence Network (HEN). How can health care systems effectively deal with the major health care needs of homeless people? http://www.euro.who.int/en/what-we-do/data-and-evidence/health-evidence-network-hen/publications/pre2009/how-can-health-care-systems-effectively-deal-with-the-major-health-care-needs-of-homeless-people (January 2005)

[58] Homeless Link UK. Evidence from a National Audit: The health and wellbeing of people who are homeless. www.homeless.org.uk (October 2010)

HEALTH AND WELLBEING BOARD			
Report Title	**Health and Wellbeing Board Performance Dashboard**		
Contributors	Director of Public Health	Item No.	6
Class	Part 1	Date:	3 July 2014
Strategic Context	Please see body of report		

1. Purpose

This report provides members of the Health and Wellbeing Board with a draft Performance Dashboard which has been designed to assist the Board in monitoring the progress against its agreed priorities within the Health & Wellbeing Strategy and the integration of health and care for adults.

2. Recommendations

Members of the Health and Wellbeing Board are recommended to agree the proposed health and care indicators as set out in the attached dashboard at Annex A.

3. Strategic Context

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

3.2 The work of the Board directly contributes to the priority outcome in Shaping our Future 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 placed a duty on local authorities and their partner clinical commissioning groups to prepare and publish joint health and wellbeing strategies to meet needs identified in their joint strategic needs assessments (JSNAs). Lewisham's Health and Wellbeing Strategy was published in 2013.

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

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

4. Background

4.1 In response to the request from members of the Board, the Director of Public Health has worked alongside colleagues within Adult Social Care and the Clinical Commissioning Group (CCG) to produce a dashboard of indicators which would assist members in monitoring health and wellbeing improvements across Lewisham and the effectiveness of the integrated adult care programme.

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

5. Draft Health and Wellbeing Board Performance Dashboard

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

5.2 The indicators will be used to monitor the health outcomes and the integration of health and social care services on an annual or quarterly basis. A brief description of the numerator, denominator and source for all proposed indicators is set out in Annex B, with a glossary of abbreviations at Annex C. It is acknowledged that the Board will wish to monitor progress on delivery of the Health and Wellbeing Strategy priorities and delivery of health and social care integration in a more timely fashion. Therefore further consideration is being given to the development of local indicators which could be tracked monthly and act as 'proxy' indicators.

5.3 Overarching Indicators of Health & Wellbeing

The overarching indicators section is used to understand the nature of health inequalities and on how well we are improving and protecting health. These indicators act as a baseline to measure the achievement of health outcomes and complement other health and social care indicators mentioned under the nine priority areas of the Health and Wellbeing Strategy.

5.4 Integration of Health and Social Care – Better Care Fund

The Better Care Fund requires CCGs and Councils to report against five national metrics alongside a local indicator on the quality of care for people with long term conditions. For ease of reference, these indicators have been shown under a separate section of the dashboard entitled "Integration of Health and Social Care – Better Care Fund".

5.5 Priority Objective 1: Achieving a Healthy Weight

5.5.1 The UK is experiencing an epidemic of obesity affecting both adults and children. It has been widely recognised as a major determinant to premature mortality and avoidable ill health and is a government priority area. Lewisham has significantly higher childhood obesity level compared to England. For adults, the level of obesity is similar to England. The level of excess weight (overweight and obese) is again similar to England but higher than the London level. Local maternal obesity data indicate a higher rate than the England average. Hence it is important to monitor and benchmark both adult and childhood obesity levels.

5.5.2 The National Childhood Measurement Programme monitors childhood obesity levels and the Sport England Active People Survey monitors adult obesity levels at a national and local level. This data is enhanced by local information in the Quality Outcomes Framework (QOF), GP registers and maternal obesity data. Achieving a healthy weight is influenced by a wide variety of activities that impact on diet and physical activity. However routine data for breastfeeding prevalence and physical activity is only collected nationally.

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

5.6.1 Cancer is one of the major causes of mortality in UK, accounting for quarter of deaths in England. Evidence shows that early detection of cancer can improve cancer outcomes and survival rates. Specific public health interventions, such as screening programmes and information/education campaigns aim to improve rates of early diagnosis.

5.6.2 Lewisham has a lower coverage rate for screening compared to England but is steadily improving. However very little current data is available on cancers, especially at lower demographic levels due to governance and data quality issues. Cancer survival rates are nearly 10 years old. Identification of new cancer cases and 2 week wait referrals can give a picture of management of cancer care and act as a proxy measure for cancer survival. Emergency admissions rates for cancer provide a good proxy for survival, but Hospital Episode Statistics (HES) which provide this information are not currently being updated.

5.7 Priority Objective 3: Improving Immunisation Uptake

5.7.1 After provision of clean water, vaccination is the most effective public health intervention for saving lives and promoting good health and uptake of vaccine in a given population is the best indicator of the levels of protection of that population against vaccine preventable disease.

5.7.2 The national immunisation programme in the UK aims to protect the population, or those most at risk in the population against diphtheria, *haemophilus influenzae* type b, human papilloma virus, influenza, measles, meningococcal disease (serogroup C), mumps, polio, pneumococcal disease, rubella, shingles, tetanus, tuberculosis and whooping cough (pertussis).

5.7.3 Uptake of immunisation has been a problem in Lewisham for some time. Recorded uptake of indicator vaccines has been below target, and as a result, significant numbers of children in Lewisham were not protected against potentially serious infections. Due to the low uptake of MMR vaccine, there was an outbreak of measles in Lewisham in 2008 with a total of 275 confirmed or suspected cases. Despite recent improvements in MMR 1 uptake, the greatest challenges in reaching the levels of uptake of vaccine required to protect the whole population are in achieving targets relating to the uptake of the pre-school booster, the second dose of MMR and influenza.

5.7.4 Monitoring the success of the national immunisation programme locally is complex and difficult, but the indicators below are recommended as the best means of assessing the performance of the Partnership on this programme. Notes on why these particular indicators are important are given below.

5.7.5 MMR aims to protect children against measles, mumps and rubella. Two doses are required: MMR 1 at 12 months and MMR 2 at any time after three months have elapsed since MMR1, but before five years of age. Hib/ MenC and PCV boosters are given usually at the same time as MMR1 and aim to protect children against Haemophilus influenzae B, Group C Meningococcus and Pneumococcus.

5.7.6 Uptake of the third dose of diphtheria vaccine (D3) is an indicator of completion of the primary course of immunisation of children under 12 months that aims to protect children against diphtheria, tetanus, whooping cough, polio, Haemophilus influenzae b and Group C Meningococcus.

5.7.7 D4 is the fourth dose of diphtheria vaccine. This is a key component of the preschool booster, which should be given at any time from the age of three years and four months but before the child starts school. The preschool booster completes the protection of children against diphtheria, tetanus, whooping cough and polio.

5.7.8 Human Papilloma Virus is the causal factor in most cases of cancer of the cervix and is transmitted through sexual contact. Human Papilloma Virus (HPV) vaccine is given to girls in Year 8, before they become sexually active to ensure that they are protected against the virus before they come into contact with it.

5.8 Priority Objective 4: Reducing Alcohol Harm

Alcohol is the second biggest avoidable killer behind tobacco in England and consumption is significant and increasing in Lewisham. It has a major impact on health, anti-social behaviour, crime and other important social issues. In Lewisham there are 11,000 drinkers considered to be at high risk of admission and 31,000 drinkers at increasing risk of harm. Alcohol-related conditions[1] include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome, for example hypertensive diseases, various cancers and falls. Deaths from liver disease have been increasing during the past 20 years. Due to small numbers and the time lag in reduced consumption being reflected in improved liver disease mortality rates, the indicator has been classified as potential. There are other potential indicators which can be collected routinely from local data sources. Again, it should be noted that due to governance issues HES have stopped updating their admission data temporarily which has an impact on longitudinal analysis.

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

Smoking is a major cause of premature mortality and a major contributor to CVD, COPD, lung cancer and poor life expectancy outcome. It is the single biggest contributing factor to the gap in healthy life expectancy outcomes between Lewisham and England. Therefore it is important to identify the smokers early and engage them in smoking prevention programmes. Evidence suggests that Illnesses among children caused by exposure to second-hand smoke lead to an estimated 300,000 general practice consultations and about 9,500 hospital admissions in the UK each year. Lewisham still has between 40-50,000 smokers. Over 700, 11-15 year olds take up smoking each year and nearly half of Lewisham children say that someone smokes in their home on most days. Smoking prevalence and 4 week smoking quitters gives you an indication of the quality of our smoking prevention programme. However there are further potential indicators which could be possibly collected routinely to give an account of our smoking strategy.

[1] http://www.lape.org.uk/downloads/Lape_guidance_and_methods.pdf

5.10 Priority Objective 6: Improving mental health and wellbeing

Prevalence of Mental Illness is high in Lewisham.

Lewisham has diverse demographics, which is a major contributory factor to high levels of poor mental health. Improving access to services (IAPT), identifying people at primary care level (SMI, Dementia and CMI), reducing acute admissions and suicide rates are some of the strategic measures taken in Lewisham to improve mental health and well being. However there is very little quality data available to measure mental health outcomes. Potential indicators around early diagnosis and access to services based on local data can be routinely collected.

5.11 Priority Objective 7: Improving sexual health

Sexual health is a local priority due to high rates of teenage pregnancy, abortion, sexually transmitted infections and HIV. Although the teenage conception rate has fallen significantly in Lewisham it remains amongst the highest nationally. The percentage of NHS-funded abortions at less than 10 weeks gestation is a good indication of the quality of contraception services and recommended methods. Maternal 12 week risk assessment is a good indicator for access to maternity services by pregnant women, but unfortunately NHS England had less than 95% coverage so reliable benchmarking in not available. Due to low numbers and recording of HIV testing rates, HIV prevalence is used as a proxy to monitor the outcome for HIV patients. As Chlamydia is one of the major Sexually Transmitted Infections (STI) and its diagnosis rate is collected nationally, it can be used as a proxy for monitoring STI. Lewisham has a high diagnosis rate compared to England, reflecting our high levels of testing.

5.12 Priority Objective 8: Delaying and reducing the need for long term care and support

Research suggests the provision of intensive short term interventions (enablement), at times of crisis, can reduce the demand for institutional and long term care and improve outcomes for service users. In addition, evidence suggests that people's need for ongoing social care support is reduced by 60 per cent compared to those who used conventional home care provision. Furthermore over 60 per cent of people who receive enablement services required no more than six weeks of intervention and support. Most of the indicators chosen to monitor this priority are Better Care Fund metrics.

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

Activity related to this priority is mostly focussed on improving preventative and short term services, as nearly 60% of people in Lewisham do not require ongoing support if they receive a six week package of enablement. The indicators chosen to monitor success include user satisfaction – currently social care related quality of life, but to be replaced and/or supplemented with a new national Better Care Fund satisfaction indicator once it has been developed, rates of new admissions to long term care and the proportion of people discharged from hospital with a short term service who are still living independently three months later.

6. Financial implications

There are no specific financial implications arising from this report.

7. Legal implications

As part of their statutory functions, members of the Board 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 well-being 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.

8. Crime and Disorder Implications

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

9. Equalities Implications

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

11. Environmental Implications

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

12. Conclusion

This report proposes a list of indicators for inclusion in a dashboard, addressing the integration of health and social care and the nine priorities of the Health and Wellbeing Strategy and including an overarching indicators section to monitor health inequalities and how well we are improving and protecting health.

If you have any difficulty in opening the links above or those within the body of the report, please contact Kalyan DasGupta (kalyan.dasgupta@lewisham.gov.uk; 020 8314 8378), who will assist.

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

Annex B: Definitions and Data sources

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

1/2. Life Expectancy at Birth (Male/Female)	
Definition	The average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years a newborn baby would survive if he or she experienced the age-specific mortality rates for that area and time period throughout his or her life. Figures are calculated from deaths from all causes and mid-year population estimates, based on data aggregated over a three year period. Figures reflect mortality among those living in an area in each time period, rather than what will be experienced throughout life among those born in the area. The figures are not therefore the number of years a baby born in the area could actually expect to live, both because the mortality rates of the area are likely to change in the future and because many of those born in the area will live elsewhere for at least some part of their lives.
Numerator	Number of deaths registered in the respective calendar years
Denominator	ONS mid-year population estimates for the respective calendar years
Data source	PHOF 0.1ii http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/6/par/E12000007/are/E09000023

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

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

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

6/7. Slope index of inequality in life expectancy at birth (Males/Females)	
Definition	This indicator measures inequalities in life expectancy. Life expectancy at birth is calculated for each local deprivation decile based on Lower Super Output Areas (LSOAs). The slope index of inequality (SII) is then calculated based on these figures. The SII is a measure of the social gradient in life expectancy, i.e. how much life expectancy varies with deprivation. It takes account of health inequalities across the whole range of deprivation factors within each local authority and summarises this as a single number, which represents the range in years of life expectancy across the social gradient from most to least deprived, based on a statistical analysis of the relationship between life expectancy and deprivation across all deprivation deciles. Life expectancy at birth is a measure of the average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years a newborn baby would survive if he or she experienced the age-specific mortality rates for that area and time period throughout his or her life.
Data source	PHOF 0.2iii http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/6/par/E12000007/are/E09000023

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

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

Integration of Health and Social Care - Better Care Fund

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

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

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

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

14. Rate of avoidable emergency admissions	
Definition	Composite measure of: • unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages); • unplanned hospitalisation for asthma, diabetes and epilepsy in children; • emergency admissions for acute conditions that should not usually require hospital admission (all ages); and • emergency admissions for children with lower respiratory tract infection.
Numerator	Total avoidable emergency admissions for primary diagnoses covering those in all four metrics above, by local authority of residence (NB. This is not the same as adding admissions from the separate metrics as the four separate metrics overlap to some degree and this will therefore lead to 'double counting')
Denominator	Mid-year ONS population estimates
Data source	Data: HSCIC HES/ONS Mid-year population estimates Specification: NHS Quality Premium Estimate http://www.england.nhs.uk/ccg-ois/qual-prem/

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

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

Priority Objective 1: Achieving a Healthy Weight

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

18/19. Excess weight in Children - Reception Year/ Year 6 Children	
Definition	Proportion of children aged 4-5 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.
Numerator	Number of children in Reception (aged 4-5 years) or Year 6 (aged 10-11) and classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex
Denominator	Number of children in Reception (aged 4-5 years) or Year 6 (aged 10-11) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England
Data source	PHOF 2.06 http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: HSCIC National Childhood Measurement Programme (NCMP)

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

21/22. % of physically active and inactive adults	
Definition	The number of respondents aged 16 and over, with valid responses to questions on physical activity, doing at least 150 “equivalent” minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days expressed as a percentage of the total number of respondents aged 16.
Numerator	Number of respondents aged 16 and over, with valid responses to questions on physical activity, doing at least 150 “equivalent” minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the last 28 days
Denominator	Number of respondents aged 16 and over, with valid responses to questions on physical activity.
Data source	PHOF 2.13i http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: Active People Survey, England

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

23. Cancer screening coverage - breast cancer	
Definition	The percentage of women in the resident population eligible for breast screening who were screened adequately within the previous three years on 31 March
Numerator	Number of women aged 53–70 resident in the area (determined by postcode of residence) with a screening test result recorded in the previous three years
Denominator	Number of women aged 53–70 resident in the area (determined by postcode of residence) who are eligible for breast screening at a given point in time.
Data source	PHOF 2.20i http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source: Health and Social Care Information Centre (Open Exeter)

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

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

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

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

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

Priority Objective 3: Improving Immunisation Uptake

29. Uptake of the first dose of Measles Mumps and Rubella vaccine (MMR1) at two years of age	
Definition	All children for whom the CCG is responsible who received one dose of MMR vaccine on or after their 1st birthday and at any time up to their 2nd birthday as a percentage of all children whose 2nd birthday falls within the time period. Estimates for local authorities are based on CCGs, which include all people registered with practices accountable to the CCG.
Numerator	Total number of children who received one dose of MMR vaccine on or after their 1st birthday and at any time up to their 2nd birthday.
Denominator	The responsible population. The CCG is responsible for all children registered with a GP whose practice forms part of the CCG, regardless of residency, plus any children not registered with a GP who are resident within the CCG's statutory geographical boundary.
Data source	PHOF 3.03vii http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by PHE. Available from HSCIC.

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

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

32. Uptake of the fourth dose of Diphtheria vaccine (D4) at five years of age	
Definition	The percentage of children for whom the CCG is responsible who received 3 doses of DTP, polio, Hib as well as the DTP, polio booster at any time up to their 5th birthday. Estimates for local authorities are based on CCGs, which include all people registered with practices accountable to the CCG.
Numerator	The number of children for whom the CCG is responsible who received 3 doses of DTP, polio, Hib as well as the DTP, polio booster at any time up to their 5th birthday.
Denominator	The responsible population. The CCG is responsible for all children registered with a GP whose practice forms part of the CCG, regardless of residency, plus any children not registered with a GP who are resident within the CCG's statutory geographical boundary.
Data source	Local Immunisation Cover Data

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

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

Priority Objective 4: Reducing Alcohol Harm

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

36. Number of practitioners skilled in identifying those at risk from alcohol harm and delivering brief interventions	
Definition	TBC
Numerator	TBC
Denominator	TBC
Data source	TBC

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

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

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

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

40. 4 week smoking quitters	
Definition	This indicator relates to clients receiving support through the NHS Stop Smoking Services. A client is counted as a self-reported 4-week quitter if they have been assessed 4 weeks after the designated quit date and declares that he/she has not smoked even a single puff on a cigarette in the past two weeks. The indicator is a count of treatment episodes rather than people, so an individual who undergoes two treatment episodes and has quit at four weeks in both cases are counted twice.
Numerator	Number of self-reported 4-week smoking quitters.
Denominator	Population aged 16 or over.
Data source	Data – Local NHS Stop Smoking Service database. Specification https://nascis.hscic.gov.uk/download.ashx?src=MetaDataPdf&file=JSNA_Metadata_NI+123.pdf

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

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

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

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

Priority Objective 6: Improving mental health and wellbeing

45. Under 75 mortality rates for those with serious mental illness	
Definition	Rate of mortality in people aged 18 to 74 suffering from serious mental illness standardised and compared to the general population.
Numerator	Deaths from any cause in age range 18-74 at death. MH-NMDS linked over three years and to the Primary Care Mortality Database (PCMD).
Denominator	The mental health population is defined as anyone who has been in contact with the secondary mental care services in the current financial year or in either of the two previous financial years who is alive at the beginning of the current financial year. MH-NMDS linked over three years and to PCMD, in age range 18-74.
Data source	NHSOF 1.5 Data https://www.indicators.ic.nhs.uk/download/Outcomes%20Framework/Data/NHSOF_1.5_I00665_D_V7.xls Specification https://www.indicators.ic.nhs.uk/download/Outcomes%20Framework/Specification/NHSOF_Domain_1_S_V2.pdf

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

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

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

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

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

Priority Objective 7: Improving sexual health

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

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

53. Prevalence of diagnosed HIV infection per 1,000 among persons aged 15 to 59 years	
Definition	People aged 15 to 59 years who were seen at HIV care services.
Numerator	The number of people living with a diagnosed HIV infection resident in a given local health service who were aged 15 to 59 years and who were seen for HIV care at a NHS site in the UK.
Denominator	Estimated total population aged 15 to 59 years resident in a given local health service area (ONS mid-year population estimates)
Data source	Public health England Sexual and Reproductive Health Profiles http://www.phoutcomes.info/profile/sexualhealth/data#gid/8000057/pat/6/ati/102/page/6/par/E12000007/are/E09000023 Original Source - HPA for HIV stats/ ONS for Population http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListDate/Page/1201094588844?p=1201094588844

54. Legal Abortion rate for all ages	
Definition	Legal Abortions: Age Standardised Rate per 1000 resident women aged 15-44
Numerator	Number of all Legal Abortions
Denominator	Number of resident women aged 15-44
Data source	ONS via DH. Detailed data obtained through Local commissioners. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307650/Abortion_statistics__England_and_Wales.pdf

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

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

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

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

57. Adult Social Care Reviews	
Definition	Number of current adult social care service users that have been receiving services for at least twelve months that were reviewed in the last twelve months.
Numerator	Number of reviews undertaken in the last twelve months of long term service users still receiving a service.
Denominator	Number of service users receiving services for at least twelve months currently receiving long term services as at the end of the twelve months.
Data source	HSCIC – subset of old RAP A1 and new SALT Return LTS Table 2b https://nascis.hscic.gov.uk/Portal/Tools.aspx

58. Unplanned hospitalisation for chronic ambulatory care sensitive conditions	
Definition	Directly age and sex standardised rate of unplanned hospitalisation admissions for chronic ambulatory care sensitive conditions for persons of all ages.
Numerator	Hospital Episode Statistics (HES) Continuous Inpatient Spells (CIP).
Denominator	Unconstrained GP registered population counts by single year of age and sex from the NHAIS (Exeter) Systems; extracted annually on 1 April for the forthcoming financial year
Data source	NHSOF 2.3i – NHS Indicator Portal - P01563 Data https://indicators.ic.nhs.uk/download/Clinical%20Commissioning%20Group%20Indicators/Data/CCG_2.6_I00757_D_V6.xls Specification https://indicators.ic.nhs.uk/download/Clinical%20Commissioning%20Group%20Indicators/Specification/CCG_2.6_I00757_S_V4.pdf

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

Annex C: Glossary

APS – Active People Survey

ASCOF -Adult and Social Care Outcomes Framework

BCBV - NHS Better Care Better Value Indicators

BMI – Body Mass Index

CCG - Clinical Commissioning Group

CCGOI - Clinical Commissioning Group Outcome Indicator

CTC – Child Tax Credit

D3 – Third dose of Diphtheria vaccine

D4 – Fourth dose of Diphtheria vaccine

HES – Hospital Episode Statistics

HSCIC - Health and Social Care Information Centre

ICD – International Classification of Diseases

IS – Income Support

JSA – Job-Seekers Allowance

MH-NMDS – Mental Health National Minimum Dataset

MMR- Measles, Mumps, Rubella dose 1

MMR2 - Measles, Mumps, Rubella dose 2

NHSIC - NHS Indicator Portal

NHSOF – National Health Service Outcome Framework

ONS – Office for National Statistics

PCMD - Primary Care Mortality Database

PCT – Primary Care Trust

PHOF - Public Health Outcomes Framework

PHE - Public Health England

QOF - Quality and Outcomes Framework

Health and Wellbeing Performance Dashboard 2014/15

		Frequency	Latest Availability	Prev Yr - Lew	Cur Yr- Lew	Lon	Eng	England Benchmark	Direction from Prev Yr
	Overarching Indicators								
1	Life Expectancy at Birth (Male)(yrs)	Annual	2010-12	77.6	78.2	79.7	79.2	sig high	↑
2	Life Expectancy at Birth (Female)(yrs)	Annual	2010-12	82.3	82.6	83.8	83	sig high	↑
3	Children in poverty (under 16s) (%)	Annual	2011	31.7	30.5	26.5	20.6	sig high	↓
4	Under 75 from CVD mortality (DSR)	Annual	2010-12	96.7	91.0	83.1	81.1	sig high	↓
5	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (DSR)	Annual	2012	2852.9	2496.1	2341.088	2302.7	sig high	↓
6	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Male)	Annual	2010-12	6	6.6				↑
7	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Female)	Annual	2010-12	6.3	6.6				↑
8	Infant Mortality (%)	Annual	2010-12	4.8	4.9	4.2	4.3	similar	↑
9	Low Birth Weight of all babies (%)	Annual	2012	8.3	8.4	7.9	7.3	sig high	↑
	Integration of Health and Social Care - Better Care Fund								
10	Rate of new admissions to long term care (crude rate per 100,000)	Annual/Qtr	2012/13	560.7	612.9	478.2	697.2	-	↑
11	% older people (65+) still at home 91 days after discharge from hospital into rehabilitation/reablement services	Annual/Qtr***	2012/13	89.4	86.5	86.7	81.4		↓
12	Delayed transfers of care from hospital (crude rate per 100,000)	Annual/Qtr**	2012-13	3.0	4.9	6.9	9.5	-	↓
13	Days of Delay (crude rate per 100,000)	Annual/Qtr**	2012-13	108	134	188	285		↓
14	Rate of avoidable emergency admissions (Std rate per 100,000 pop)	Annual/Qtr***	2012/13	172	155	140	179		↓
15	social care related quality of life (%)	Annual	2012/13	17.9	18.3	18.3	18.8	-	↑
16	% people with enough professional support to manage their long term condition	Annual	Jul 12 - Mar 13	58.1	62.3	59.4	65.6		↑
	Priority Objective 1: Achieving a Healthy Weight								
17	Excess weight in Adults (%)	Annual	2012/13	-	61.2	57.3	63.8	similar	N/A
18	Excess weight in Children - Reception Year (%)	Annual	2012/13	24.8	25.0	23.0	22.2	sig high	↑
19	Excess Weight in Children- Year 6 (%)	Annual	2012/13	40.4	38.3	37.4	33.3	sig high	↓
20	Breastfeeding Prevalence 6-8 weeks(%)	Annual/Qtr	2012/13	75.7	73.5	68.5	47.2	sig high	↓
21	% of physically active and inactive adults - Active adults	Annual	2012		54.3	57.2	56.0	similar	
22	% of physically active and inactive adults - Inactive adults	Annual	2012		29.2	27.5	28.5	similar	
	Priority Objective 2: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years								
23	Cancer screening coverage - breast cancer (%)	Annual/Qtr	2013	65.1	66	68.6	76.3	sig low	↑
24	Cancer screening coverage - cervical cancer(%)	Annual/Qtr	2013	71.9	72.4	68.6	73.9	sig low	↑
25	Cancer screening coverage - bowel cancer (%)	Local ad-hoc*	Oct 2011- Sep 2012	-	40.9	-	-	-	
26	Early diagnosis of cancer (%)	Annual	2012	-	39.9	-	41.6		N/A
27	Two week wait referrals (number per 100,000 population)	Annual	2013		2273		2166		
28	Under 75 mortality from all cancers (DSR)	Annual	2010-12	169.4	159.9	139.1	146.5	sig high	↓
	Priority Objective 3: Improving Immunisation Uptake								
29	Uptake of the first dose of Measles Mumps and Rubella vaccine (MMR1) at two years of age	Qtr	2013/14 Q3	88.5	87.3	87.3	92.9	low	↓
30	Uptake of the second dose of Measles Mumps and Rubella Vaccine (MMR2) at five years of age	Qtr	2013/14 Q3	68.1	69.8	80.1	88.4	low	↑
31	Uptake of the third dose of Diptheria vaccine (D3) at one year of age	Qtr	2013/14 Q3	88.4	88.3	89.3	94.4	low	↓
32	Uptake of the fourth dose of Diphtheria vaccine (D4) at five years of age	Qtr	2013/14 Q3	70.5	74.4	78.3	88.8	low	↑
33	Uptake of Human Papilloma Virus (HPV) vaccine in girls in Year 8 in Lewisham Schools	Qtr	2013/14 Q3						
34	Uptake of Influenza vaccine in those over 65 years of age	Annual/Qtr	2012/13	70.1	68.2	71.2	73.4	low	↓
	Priority Objective 4: Reducing Alcohol Harm								
35	Alcohol related admissions (DSR)	Annual*	2012/13	588	614	554	637	similar	↑
36	Number of practitioners skilled in identifying those at risk from alcohol harm and delivering brief interventions (Local source)	Annual*	2012/13		120				

Health and Wellbeing Performance Dashboard 2014/15

		Frequency	Latest Availability	Prev Yr - Lew	Cur Yr- Lew	Lon	Eng	England Benchmark	Direction from Prev Yr
	Priority Objective 5 : Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking								
37	Under 75 Mortality from Respiratory	Annual	2010-12	40.9	38.6	32.6	33.5		↓
38	Under 75 Mortality from Lung Cancer	Annual	2012	23.57	23.04	24.06	24.2		↓
39	Smoking Prevalence (18+) - routine and manual	Annual	2012	25.4	24.3	25.7	29.7		↓
40	4 week smoking quitter (crude rate per 100,000)	Qtr	2013/14 Q2	-	296.9	307.2	316.4		
41	Number of 11-15 year-olds who take up smoking (%)	Biennial	2010		9%				
42	Number of children in smoke free homes (%)	Biennial	2010		57%				
43	Prevalence of Smoking in 15 year olds (proxy: % Never smoked at all - Yr8 and Yr10 children)	Biennial	2010		74%				
44	Smoking at time of delivery	Qtr	2013/14 Q3	2.9%	8.8%				↑
	Priority Objective 6: Improving mental health and wellbeing								
45	Under 75 mortality rates for those with serious mental illness (DSR)	Annual	2011/12	845.7	839.8	-	1,274.8	sig low	↓
46	Prevalence of SMI	Annual	2012/13	1.2	1.2	1.0	0.8	-	→
47	Prevalence of Dementia	Annual	2012/13	0.3	0.3	0.4	0.6	-	→
48	Prevalence of Depression	Annual	2012/13	10.4	5.3	4.4	5.8	-	↓
49	Suicide rates	Annual	2010-12	7.1	7.5	7.5	8.5	similar	↑
50	Self-reported well-being - people with a low happiness score	Annual	2012/13	15.0	10.2	10.3	10.4	similar	↓
	Priority Objective 7: Improving sexual health								
51	Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24 (crude rate)	Annual	2012	4762	4179	-	1979.0	sig high	↓
52	People presenting with HIV at a late stage of infection(%)	Annual	2010-12	51.8	50.9	44.9	48.3	similar	↓
53	Prevalence of diagnosed HIV infection per 1,000 among persons aged 15 to 59 years (crude rate)	Annual	2012	7.78	7.94	5.5	2.1	-	↑
54	Legal Abortion rate for all ages (crude rate per 1000 women)	Annual	2012	32.3	27.4	22.4	16.6	sig high	↓
55	Teenage conceptions	Annual	2012	39.9	42.0	25.9	27.7	sig high	↑
	Priority Objective 8 – Delaying and reducing the need for long term care and support.								
56	Proportion of people using social care who receive self-directed support, and those receiving direct payments (Crude rate per 100,000)	Annual/Qtr**	2012-13	18.6	17.9	19.5	16.8	-	↓
	Priority Objective 9: Reducing the number of emergency admissions for people with long term conditions								
57	Reviews of Adult Social Care Clients	Annual/Qtr	2012/13	64.4	77.9	69.9	65.3		↑
58	Rate of admissions for LTCs to hospital	TBD	Oct 12 - Sep 13	TBD	989.0		787.8	sig high	↓
59	Emergency Readmissions within 30 days of discharge	Annual	2011/12	11.96	12.73		11.78	sig high	↑

Key

sig high -signficantly higher than England; sig low - significantly lower than England
similar - statistically similar to England

Prev Yr - Previous Year; Cur Yr - Current Year (Latest Available Date)

Lew - Lewisham; Lon - London; Eng - England

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

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

Links to Source with their abbreviations

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

Note:

Annual/Qtr* - National Data available both quarterly and annually	Boroughs (Bromley, Bexley, Lambeth, Southwark , Greenwich and Lewisham) from London Bowel Screening Hub
Annual* - Indicators not updated due to lack of HES updates	Annual/Qtr** - Only Local Data available quarterly
Qtr - Financial Quarters	Annual /Qtr*** - 2013/14 Q3 emergency admission rates are available on BCBV metrics for each Ambulator Care Sens
	Local Ad-hoc - Bowel Screening data only available for all 6 South East London

PHOF 0.1i
PHOF 0.1ii
PHOF 1.1ii
PHOF 4.4i
NHSOF 1A (CCG 1.1 DSR)- P01559
PHOF 0.2iii
PHOF0.2iii
ONS
ONS
ASCOF2A (P01514) (Priority 8)
ASCOF2B (Priority 8)
ASCOF2C- NHSIC - P01516
NHS England
BCBV / NHS Comparators (Priority 9)
ASCOF 1A (P01507) (Priority 8)
NHSOF 2.1 (Priority 9)
PHOF 2.12
PHOF 2.06ii
PHOF 2.06ii
PHOF 2.2
PHOF 2.13i
PHOF 2.13ii
PHOF 2.20i
PHOF 2.20ii
London Bowel Screening Hub (six SE Lon Bor) - 44.9% (SEL avg)
PHOF 2.19 – experiment'l stats
Cancer Toolkit GP Profiles
NHSIC - P00381/ PHOF 4.05i
PHOF 3.03viii/ Local Imms Cover Data
Local Immunisation cover data (Q4 TBU)
Local Immunisation cover data (Q4 TBU)
Local Immunisation cover data (Q4 TBU)
Local Immunisation cover data (Q4 TBU)
PHOF 3.03xiv
PHOF 2.18
Lewisham Drugs & Alcohol Team

PHOF 4.07i
NHS Indicator Portal - P00512
PHOf 2.14
Stop Smoking Service (Q3 to be updated)
SHEU Survey (to be completed)
SHEU Survey (to be completed)
SHEU Survey (to be completed)
HSCIC
NHSOF 1.5
QOF
QOF
QOF
PHOF 4.10
PHOF 2.23iii
PHOF 3.02i/3.02ii (NCSP & CTAD)
PHOF 3.04
PHE SH Profile
ONS Abortion Stats
PHE Sexual Health Profile
ASCOF1C- NHSIC -P01509
HSCIC NASCIS RAP A1/SALT
NHS OF 2.03i
PHOF 4.11/NHSOF 3b

itive (ACS) condition.

HEALTH AND WELLBEING BOARD				
Report Title	The Annual Public Health Report 2013			
Contributors	Danny Ruta, Director of Public Health		Item No.	7
Class	Part 1	Date:	3 July 2014	
Strategic Context	Please see the body of the report			

1. Purpose

1.1. This report presents the Health and Wellbeing Board with The Annual Public Health Report 2013 (APHR).

2. Recommendation

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

- note and comment on the content of the report - in particular to note this year's focus on obesity - targeting mothers with young families
- endorse the use of the "Well!" logo to become a trademark for future Public Health reports.

3. Policy Context

3.1. The publication supports achieving the Sustainable Communities priority for Lewisham of healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and well-being.

3.2. Achieving a healthy weight in children and adults is a priority in Lewisham's Health and Wellbeing Strategy and the Children and Young People's plan. The Government's publication Healthy Lives, Healthy People: a call for action on obesity (2011) highlights the health risks of obesity and that individuals should be supported to make healthier choices. The Annual Public Health Report 2013 is dedicated to this topic and produced in the style of one of Britain's best selling women's magazine, with the aim of being accessible to the general public, with a particular focus on families. It provides information in an appropriate format on the scale of obesity and overweight in Lewisham's children and adults, the risks of obesity and what is being done in Lewisham to address this issue.

3.3. Publication of an Annual Public Health Report (APHR) is a new statutory duty on local authorities which was introduced by the Health and Social Care Act (2012).

4. Background

4.1. The prevalence of obesity in adults and children in England has more than doubled in the last twenty-five years. A modelled estimate of adult obesity prevalence in Lewisham is 23.7% which is not significantly different to the England average. Recently published data for Lewisham on the prevalence of excess weight (overweight and obese) in adults is 61.2%, similar to the national average but higher than the London average (57.3%). Maternal obesity data indicate a higher rate than the England average. For children the prevalence of obesity is significantly higher than the England average with 10.7% of reception children and 23.3% of year 6 children obese (2012/13). Obesity levels tend to be higher in deprived areas.

5. The APHR 2013

5.1. The APHR 2013 is made up of three separate sections.

5.2. The first is the publication of the "WELL" magazine with a focus on prospective parents, pregnant and nursing mothers and families and carers of children. It contains information and advice that younger members of the families can pass on to the older adults in their family. It provides information on the risks of overweight and obesity with the focus on how and why making healthy choices on diet and physical activity can enhance the health of families. It provides information on what resources are available in Lewisham to support families to make a healthy choice. Such as breastfeeding support, introducing solids, cooking skills courses, resources in local libraries, free swimming for young people and older people, activities run in schools such as 'Bike it' and weight management services.

5.3. The second section of the APHR 2013 provides an update on the Progress of key Public Health Outcomes. This includes information on performance, benchmarking and key actions proposed for 2014/15 on the following topics: Immunisation; Tackling Tobacco; Promoting Healthy Weight ;Increasing Physical Activity; Improve Sexual Health, Reduce Premature Cardiovascular Mortality; Health Checks, Reduce Premature Mortality from Cancer, Improving Mental Health; Improve maternal and infant health; Reduce Alcohol related harm and Health Protection. This section of the report will be published electronically through the Lewisham JSNA website.

5.4. The third section of the report is the electronic publication of resources to support weight management by health professionals. These include the Weight Management Care Pathway for both children and adults and a range of other resources.

6. Financial implications

6.1 There are no specific financial implications arising from this report. The cost of producing and delivering the report has been covered under existing budgets.

7. Legal implications

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

8. Crime and Disorder Implications

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

9. Equalities Implications

9.1. There are no specific equalities implications arising from this report however addressing health inequalities is a key element of these publications.

10. Environmental Implications

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

If you have any difficulty in opening the links above or those within the body of the report, please contact Kalyan DasGupta (kalyan.dasgupta@lewisham.gov.uk; 020 8314 8378), who will assist.

If there are any queries on this report please contact Danny Ruta (danny.ruta@lewisham.gov.uk) on 020 814 8637

healthwatch Lewisham

Annual Report

2013 – 2014

Health in Lewisham

Population 284,000

Health Issues

17,900 children live in poverty in the borough

Almost a ¼ of year 6 children are obese, higher than the national average

Life expectancy is lower than the national average
for men and women

Rates of sexually transmitted infections and smoking related deaths are worse than the England average

Good News

More people are eating healthier

Fewer young people are being admitted to hospital due to alcohol related harm than the England average

More women are not smoking during pregnancy and more babies are being breastfed

The rate of hip fractures is better than the England average

Priorities in Lewisham include lifestyle and behaviour change, tackling obesity, alcohol and smoking. For further information see www.lewishamjsna.org.uk

Source Public Health England

CONTENTS

FOREWORD

Welcome to the first annual report of Healthwatch Lewisham April 2013 to March 2014.

It is not always easy to get your voice heard and I am delighted to be Interim Chair of an organisation that is creative about how it supports and empowers individuals to speak up about health and social care issues that affect them and the people in their community. Healthwatch Lewisham has worked hard to be fully set up and deliver a comprehensive community engagement programme in its first year. I know this will provide great grounding for all the future work and challenges ahead.

The staff and governance structures are now firmly in place and the staff team, along with a wonderful group of volunteers, have been carrying out vast amounts of community engagement and responding to issues raised by carrying out research, Enter and View visits and through formal escalation processes as appropriate.

With changes in the health and social care sector ongoing, the work of Healthwatch Lewisham will continue to be vitally important in supporting individuals and organisations to influence the planning and commissioning of health and social care services in Lewisham. I would encourage you to be part of the answer by signing up to Upbeat, following us on Twitter @HWlewisham, or attending a bi-monthly reference group meeting as advertised on our website http://www.healthwatchlewisham.co.uk.

I know that Healthwatch Lewisham will carry on engaging with people and organisations across our community, to identify areas of concerns but also to highlight good practice in health and social care to help see improvements and celebrate good news.

I hope you enjoy reading the outcomes and achievements of Healthwatch Lewisham so far.

Chris Freed
Interim Chair

MISSION AND VALUES

Mission

Healthwatch Lewisham is an inclusive network that enables people and organisations in Lewisham to have a say and influence the planning, commissioning and delivery of health and social care services to improve the health and well-being of patients, service users and members of the public.

We Value

- Equality and diversity
- Inclusion
- Public engagement & participation
- Transparency
- Accountability
- Effectively representing the voices of patients, service users and residents of Lewisham

"I can't tell you how much I appreciated our chat last night.
As I said the last place I really wanted to be after a day's training was at the local assembly - but my strong sense of duty dragged me there!
The meeting was tedious, on the whole, but you brought it alive, but most of all after our chat about my mother's situation and applying to the local authority for long-term residential care, you were so supportive and understanding, and for the first time in a few weeks I felt a glimmer of hope, and felt supported in this lonely journey.
I'm so grateful to what you and your team are doing to support and advocate for those without voices. I shall be shouting about you from the rooftops!"

Local resident

INTRODUCTION

Welcome to the first annual report of Healthwatch Lewisham, the local consumer champion for health and social care in the borough.

The Health and Social Care Act 2012 set out that local Healthwatch will be established in April 2013 in every local authority area in England.

Each local Healthwatch is an independent organisation, able to employ its own staff and involve volunteers, so it can become an influential and effective voice of the public. The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. As a member of Health and Wellbeing Board, Healthwatch will provide evidence based reports to influence commissioning.

This year has been a privilege and a challenge as we aim to understand and champion the views and wishes of people living in Lewisham for good quality, safe, appropriate and effective health and social care services. Our main challenge has been the time taken to set up Healthwatch including the governance structure and completing staff recruitment. We are delighted that Chris Freed has stepped in as interim chair while we undertake formal recruitment for a Chair. Our staff team consists of Miriam Long, Manager and Community Engagement team: Marzena Zoladz, currently on maternity leave; Jade Fairfax; Simone Riddle and Gary Davis.

One of our main achievements has been to develop the collaboration with our South East London Healthwatch partners. This has built on the previous work undertaken by LINk and has developed to support collaborative working across the region.

We are pleased through this collaboration to have developed joint Enter and View policies, training and visits.

Community engagement has been the main aspect of our work. We have been busy carrying out over 100 community engagement and outreach activities to over 3,000 individuals at Local Assemblies, public events, health and social care settings and community groups, providing face to face and written information. This work helped develop our priorities which include: access to primary care; mental health; enablement and integrated care. We are pleased with our work with young people especially our Youth Champions.

Marketing and Communication

Marketing and communication is a major factor in making sure that Healthwatch is known across the borough. Healthwatch Lewisham is part of the Healthwatch England network and has a Healthwatch trademark licence to use the Healthwatch logo in all our publications. Over 1500 people subscribe to Update, the Healthwatch Lewisham monthly electronic bulletin and as of 31 March 2014 we had 467 Twitter followers. Healthwatch articles have been written for the Voluntary Action Lewisham bulletin and newsletter, Lewisham Pensioner's Gazette and Lewisham Homes publication. The Healthwatch website is continually updated with health and social care news and resources, Healthwatch leaflets have been distributed throughout the borough at local libraries, GP practices, shops and public venues and a further 10,000 have been reprinted in March due to demand.

Healthwatch Lewisham Reference Group

Healthwatch Lewisham has a reference group which meets every two months to discuss Healthwatch priorities and is open to the public for people to bring issues and concerns and help inform the work.

Current membership includes service users, and professionals from the public, private and the Community and Voluntary Sector.

29 people attended the reference group meeting on 17 March. The meeting focused on Access to Primary Care. Healthwatch Lewisham facilitated discussion around primary care and a health professional delivered a workshop on getting the best out of your GP appointment. The group's agenda planning is led by members and includes feedback from engagement work. The reference group has two sub groups, a data analysis group that meets monthly to analyse Healthwatch comments and feedback and a reading group of volunteers who read and analyse Healthwatch documents.

Healthwatch Lewisham has been fortunate to have the support of 17 volunteers during the year who have worked with us to engage with local people; gather patient and service user experiences; analyse feedback, record data and represent at various meetings. I would like to thank all our fantastic volunteers and staff team who make our work possible.

This annual report is an overview of our work however; more information is available from the Healthwatch office and on our website on www.healthwatchlewisham.co.uk

Miriam Long
Manager

You Told Us

Access to GP's is a real issue for the young people transient communities and non-English speakers

There is a gap in enablement support for people who do not meet the criteria for care services

Carers often feel they are not included in care planning and are left to cope in their caring role

Services need to communicate better with patients, service users, carers and each other in order to provide adequate integrated care

People who use mental health services and their carers told us that medication is not always the right solution. Stress caused by environment and circumstance is a key factor in mental ill health. Services and staff need to work with service users and carers to explore the root cause of people's ill health and behaviours.

COMMUNITY ENGAGEMENT

Lewisham is a richly diverse borough, so we have tailored community engagement to specifically meet the needs of local people including seldom heard groups. We engage with the community and voluntary sector mainly through the Adult Health and Social Care Forum where we facilitate discussion and gather feedback on services relating to our priorities.

Healthwatch Lewisham's overriding aim is to engage with Lewisham's diverse community and the voluntary sector so an initial task was to identify which local groups are aligned to Healthwatch priorities as well as identifying statutory commissioners and providers.

Healthwatch Lewisham has focused on identifying our work priorities, reflecting the key issues local people face. We have engaged with young people; older people; homeless people; people from black and ethnic minority and refugee communities; Carers and people who receive health and care services.

Our priorities were identified by the Healthwatch team during engagement with local communities between July – October 2013. Our main priorities were then approved by attendees of the Healthwatch Lewisham's Wellvember Fayre on 25.11.2013:

Access to primary care

- Healthwatch will engage with commissioners to improve access resulting in better health outcomes for local people including carers, young carers and older people who do not have English as their first language.
- Healthwatch will engage with commissioners and service providers to promote people to be able to manage effectively their own conditions at home.

Mental health services

- Healthwatch will engage with commissioners to promote the development of prevention services.
- Healthwatch will monitor mental health services across the borough taking into account service user and carer feedback.

Enablement

- Healthwatch will research health and care service experiences of elderly people and report findings and recommendations to commissioners
- Healthwatch will engage with commissioners and service providers to help make sure that older people get the care they need following hospital treatment and reduce the number of older people going to A&E because they don't get the care they need at home.

Integrated care

- Healthwatch will engage with commissioners and service providers to present recommendations so that people with complex health and social care needs are supported to live at home and receive joined up care and support from services and teams working closely with their GP.

Priority 1: Access to Primary Care

Access to Primary Care is one of Healthwatch Lewisham's priorities identified by local people in Lewisham.

Healthwatch Lewisham has been focusing community engagement around Access to Primary Care to get a picture of what local people think works well in Lewisham, and what needs improving. We work with the Clinical Commissioning Group (CCG) which responded to Healthwatch and previously the Local Involvement Network's concerns about access.

Residential Homes

Community engagement has been carried out in local residential homes to look at the difficulties that older people in care face when accessing primary care. Feedback was generally positive about accessing primary care however issues were raised to Healthwatch Lewisham around patients that are being referred to hospital and their appointment times being set too early (approx. 07:00) which means waking elderly people up at inappropriate times in the early hours of the morning for hospital transport. This feedback has been raised by Healthwatch Lewisham to the Future Learning and Action Group (FLAG) of the CCG and is being looked into.

Older People's Groups

Engagement has taken place with older peoples groups such as the Positive Ageing Council and Pensioners Forum to gather their experiences of primary care in Lewisham.

Black Minority Ethnic and Refugee Groups

Healthwatch Lewisham works closely with a Vietnamese Group and Turkish group around accessing primary care. Key themes have been identified including the need for language and communication support and escalated to Healthwatch England; relevant feedback will also be reported to the Health and Wellbeing Board (HWBB), Lewisham Clinical Commissioning Group and NHS England, as appropriate.

Healthwatch Lewisham together with the Vietnamese and Turkish Group has translated Healthwatch information and surveys to help gather peoples' experiences.

Local Assemblies
Healthwatch Lewisham have worked with local people at the Rushey Green, Evelyn, Forest Hill and Perry Vale local assemblies through one-to-one sessions and focus groups to discuss what works well and what needs improving in terms of access to primary care.

Home Library Service
Healthwatch Lewisham works with the Home Library Service; the service, run by the library, which is available to residents and their carers who, through age, disability or illness, are not able to visit a library. Healthwatch Lewisham staff and 3 volunteers join the library on their daily rounds, a minimum of three times a week. We ask residents who use this service about their views on health and social care including their thoughts of accessing primary care. All feedback from visits is recorded and a Home Library and Healthwatch Lewisham report will be available in June 2014, which will be reported to the CCG.

Key issues identified	Outcome
❖ Access and appointments ❖ Attitude and Communication	Healthwatch to work together with practices to make sure they act on patient's feedback

Priority 2: Mental Health

Mental Health and Homelessness
Some groups are more vulnerable to homelessness because they have particular support needs. This includes people with a mental illness or addiction.

The Government rough sleeping figures for England indicated 2,414 people slept rough on any one night in England (Autumn 2013). Around 543 people slept rough on any one night in London and 6,437 different people slept rough over a year in London (April 1 2012-March 31 2013). The hidden homeless figure is estimated at 400,000. *Source: Thames Reach.* In Lewisham there were 551 registered homeless households and 921 households in temporary accommodation (April 2010 – March 2011). *Source: Office for National Statistics.*

Healthwatch Lewisham is represented at the Homeless Forum which is always vibrant, well attended and proactive. Meetings highlight that disadvantaged people are "under attack" from many angles. The lack of affordable housing, the reduction in front line support services, the reduction in benefits or the complete cessation of such and the lack of second tier health services impacts on mental health and increases the demand for more costly acute services.

Homeless people by their very nature are transient and therefore do not have a permanent fixed abode. If they are resident in a hostel then they normally have access to a local GP but cannot avail themselves of 2nd tier services such as mental health services until they have been a resident for six months. This can lead to non-diagnosis of severe mental health problems and lack of access to front line support services such as advocacy or psychological therapies.

Within Lewisham there is a very large homeless hostel which takes referrals from 4 boroughs including Lewisham. This is a much needed service but does create problems of cross boundary provision of direct support. For instance someone may reside in Lewisham at the hostel for a long period but is no longer able to go to support services in their original borough of residence and is not always able to access local Lewisham services.

Through our engagement Healthwatch has identified the following areas of concern regarding mental health services:

- Children and Young People mental health services have long waiting times between initial referral and intervention.
- Older adult services need to be equipped to manage dementia. The dementia training provided by MIND is excellent in raising awareness of dementia. Healthwatch recommends that all staff and family Carers have access to this training and follow on support.
- Carers of people who have substance misuse issues are hidden carers with different needs and issues from other carers. Their needs are often missed by service providers.

Healthwatch aims to take this work forward in 2014 to identify solutions and recommendations.

Dementia

Symptoms of dementia will usually get gradually worse. Over time, people with dementia need help to cope at home and they may eventually need residential care in a nursing home. *Source: NHS Choices*

There has been a GP Screening programme which while an excellent initiative, does not solve the problem of referral to appropriate services. Local Authority providers, traditionally, provide mental health treatments aimed at achieving an ultimate recovery or "re-enablement". With regards to Dementia, this is not possible as it is a degenerative disease of the brain and the aim of services should be in managing the condition and maintaining the person's dignity and quality of life.

Priority 3: Enablement & Integrated Care

Healthwatch has engaged with lots of people around the borough about their experiences of enablement and integrated care services including at local assembly meetings; End of Life Care Event; St Andrew's Church Fayre and the North Lewisham Stakeholder Event. The team presented Healthwatch at the Ageing Healthy event at Lewisham Hospital; Community Health and Social Care Forums; Proactive Primary Care Training, and have developed links with Community Connections.

Key issues identified

- Lack of support upon returning home from hospital
- Lack of knowledge about community services available for people returning home from hospital
- Domiciliary care - need for extra support other than support workers
- Coordination of services – letters to outpatients
- District nursing
- Falls – early intervention
- Lots of support out there, it's knowing about it – JOY etc
- Need to map existing provision
- Promoting independent living
- Importance of staying fit and well

Outcomes

Healthwatch is a member on the Community Connections Steering Group, and as a result Healthwatch Lewisham has been asked to recruit and support volunteers to chair local neighbourhood clusters to identify local health and social care needs which can feed back to Healthwatch, Community Connections and the local communities.

Having identified issues within District Nursing System, Healthwatch Lewisham is to undertake interviews with district nursing patients to ensure their views and experiences are being taken into consideration, following an audit to look to remodel the system.

CHILDREN & YOUNG PEOPLE

One in four Lewisham residents is under 19 years old. So it is really important that children and young people have a say in how local services are run. Healthwatch Lewisham has been finding innovative ways to engage with young people.

Know your rights, know your doctor

Healthwatch Lewisham has developed tools to work with young people to obtain their views while raising awareness about what to expect when going to the doctor in relation to quality of care. The tools support Healthwatch England's focus on consumer rights to health or social care service and recent work undertaken by the Lewisham Clinical Commissioning Group, discovering what quality means in health care.

We have used these tools during round table discussions and surveys with Young Carers and the Lewisham Young Mayor's Team to find out experiences young people have at the doctors to support our work around 'access to primary care'.

Issues identified include:

- Young people prefer to make appointments by speaking to someone directly; either over the phone or directly at the reception
- Reception staff attitude was raised as an issue
- The majority did not know where they can go to make a complaint
- Feeling involved in the care of their family was important

Outcomes

Initial findings were presented at the Lewisham Children and Young People's Forum.

There is a young people's area on the website with a link to the survey, and a list of resources around young people and mental health. This section will be developed over the coming months.

Through the workshop's development Healthwatch has been invited to work with two groups of young people at Baseline, XLP youth clubs, and the Horniman Youth Panel.

Healthwatch Young Volunteers

We currently have seven young people who are Healthwatch Youth Champions, six of whom are also trained to undertake Enter and View Visits with our team. After their initial training visit to an older people's residential home they wrote a list of recommendations in order to improve the environment for the home's residents.

Healthwatch Lewisham Supporting HeadStart

Lewisham was approached by the Big Lottery Fund as one of twelve areas in the country to consider how best to improve resilience in young people aged 10 – 14 years.

The key areas of focus for the Big Lottery's HeadStart Programme:

- Building resilience to prevent the onset of mental health conditions
- Four focus areas: family, school, digital and access to services
- Multi-agency leadership
- Early intervention and prevention
- Involvement of the voluntary and community sector
- Young people led services
- Ongoing consultation with parent / carers and young people
- Anecdotal and statistical evidence to demonstrate need
- Innovation

The Stage 2 application form has been submitted for development funding for up to £500,000, and if successful the final Stage 3 deadline is 23rd June 2015 which could potentially bring £10million to the borough from 2016 to 2020.

Healthwatch Lewisham is a key partner in the bid and has been involved in its development since the initial stages of the planning process. Involvement includes attending two stakeholder planning workshops, ongoing meetings, organising a consultation workshop at the Children and Young People (CYP) Forum, and reporting back to our members and the wider community. We joined the HeadStart Steering Group in April.

Children & Young People's Forum

Healthwatch was been elected on to the CYP Forum steering group in January 2014. We delivered a consultation workshop at the forum in March, where professionals and local community groups discussed the role Healthwatch should play to support HeadStart; improve mental health services; support the Community and Voluntary Sector (CVS) sector and the young people they work with.

Engaging with Parents

We currently undertake community engagement activities to engage with parents. This has included 'bounce and rhyme' events at libraries, parent forums and drop-in sessions at Kaleidoscope and parent coffee mornings. Kaleidoscope is a centre that provides services for local children and young people whose health, education or social needs are special. We are developing alliances with partners such as the Parent Partnership Service; Contact a Family, and Lewisham Autism Support.

Engagement at Kaleidoscope

Healthwatch Lewisham was invited in partnership with other organisations to carry out community engagement with service users and parents at Kaleidoscope with different partner organisations starting in January 2014.

This involved serving hot drinks in the kitchen; approaching people in the waiting area to tell them about the drop in service offered at Kaleidoscope; explaining what Healthwatch and the other support organisations do, inviting people to tell us about their experiences of health and social care services either by completing our 'personal story form' or by telling us verbally.

What families told us:

Quality of treatment overall is good and staff are friendly

Coordination of services needs improving

The main issue is waiting times to get a referral and to be seen which are variable and can be very lengthy

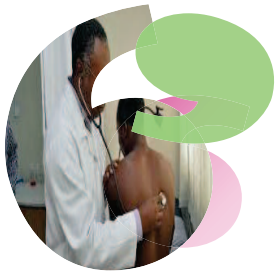
Support for families affected by autism is inadequate.

Outcome

Approximately 60 additional families now know about Healthwatch Lewisham and what services we offer as a result of the engagement undertaken at Kaleidoscope over the past four sessions. A report was written and presented to the Kaleidoscope User Group on the 19th of March. The report was well received, shared between partners, and Healthwatch was invited to continue drop-in sessions twice a month over the next scheduled period and will present a final report at the end of engagement activity, planned to be at the end of June 14.

Partnership building – we work alongside voluntary organisations at the drop-in. Healthwatch has now been invited to participate at future Parent Partnership Service coffee mornings as a result of the Kaleidoscope drop-in.

ENTER & VIEW



As an independent consumer champion of health and social care in Lewisham, Healthwatch Lewisham is able to visit local health and social care services.

Under the Health and Social Care Act 2012, Healthwatch can carry out an Enter and View visit to any publicly funded health and social care provider. These visits can be agreed in advance or can be unannounced spot checks. Healthwatch Lewisham carefully plan Enter and View visits with a clear purpose in mind to help improve health and social care services.

Enter and View visits are carried out by trained Healthwatch staff and volunteers. As well as speaking to people using the service, Healthwatch observe how the service is delivered and the general environment in which it takes place.

Enter & View Training

Healthwatch Lewisham created and delivered a training package specifically for young people to become Enter and View Authorised Representatives. Young Enter and View volunteers will help carry out peer led research in paediatric hospital services and also carry out visits in residential homes to promote intergenerational interaction.

South East London Healthwatch Network

Healthwatch Lewisham has developed a strong collaborative way of working together with Healthwatch Bexley, Healthwatch Bromley, Healthwatch Greenwich, Healthwatch Lambeth and Healthwatch Southwark.

Joint Enter & View Visits

In February 2014, Healthwatch Lewisham created and delivered a training package for 16 South East London Healthwatch volunteers wishing to become Enter and View Authorised Representatives.

Following the dissolution of South London Healthcare NHS Trust (SLHT), local Healthwatch from South East London agreed to work closely together to monitor the transition of services. The South East London Healthwatch Network, developed as a result of LINk legacy, meets on a bi-monthly basis and partners have agreed a programme of Enter and View visits to monitor the merger of services.

On 7 February 2014 the South East London Healthwatch Network carried out Enter and View visits to the Emergency Departments of Lewisham Hospital, Queen Elizabeth and Darenth Valley; a joint comparative report was written and sent to providers in April 2014. In line with the Health and Social Care Act 2014, this report, along with the provider's response was published in May 2014.

A joint Enter and View visit was carried out again by the South East London Healthwatch Network to look at Maternity Services across the boroughs. A joint comparative report has been sent to the providers in May 2014 and will be published, along with the provider's response in June 2014.

The South East London Healthwatch partners will be carrying out visits to Day Surgery and Out Patient Departments across the hospitals in the South East London boroughs over the following months.

Lewisham
Enter & View Visits

After a Care Quality Commission (CQC) report on the Ladywell Unit was published in January 2014 showing standards of 'caring for people safely and protecting them from harm' not being met, Healthwatch Lewisham carried out a visit to all of the wards on the Ladywell Unit.

The aim of the visit was to assess patient experience in the wards, investigate the level of care and to monitor if previous recommendations (identified by LINk) had been actioned. This report will be sent to South London and Maudsley Trust (SLAM) in May 2014; the report along with their response will be published on our website in June 2014.

Over the coming months Healthwatch Lewisham will be carrying out Enter and View visits to GP surgeries following feedback from patients on issues such as access. Enter and view visits are also planned for learning disability care provision following the redesign of provision.

INFORMATION & SIGNPOSTING

- Information and signposting on your health and social care services
- Tell you who to contact when things go wrong

The Healthwatch team responds to signposting requests via the information telephone line and email. A list of useful contacts for most common requests has been produced and is used for quick reference. This is a working document with contacts added to as identified by the team. The list includes details of whom to signpost to e.g. PALS, NHS England, NHS SEL Commissioned Services, LBL Social Care Complaints, LBL Social Care Information Line (SCAIT), Home Visiting Dental Service, Voice Ability, Disability Law Service, etc.

We signpost people to community services that offer support e.g. Community Connections; Home Library Service; Diabetes Support Group; National Child Birth Trust; Debbie Ubbee Trust etc. using our networks and database.

Most common queries continue to be about access to primary care, mainly GP access. On average we receive 6 calls per day requesting information and or signposting. Simple enquires can be addressed in a few minutes however some are serious issues that require some research to find the right organisation to signpost to.

The team signpost to NHS Choices and My Health London and use these sites to search for specific services as requested by people who do not have access to the internet or are unable to search these sites themselves. Callers are signposted to Voice Ability for advocacy support relating to any complaints; signposted direct to NHS England and to local hospital PALS; LBL Complaints department; Adult Social Care Teams and other relevant advice and advocacy services as appropriate.

RECOMMENDATIONS AND FOLLOW UP ACTIONS

We have spent our first year finding out people's views and experiences of our health and care services.

Now is the time to take these forward and to make a real difference to the way services are run.

Following a presentation of people's views at the Practice Manager's Forum, we have been invited to gather patient experience at GP surgeries and to attend the forum regularly and report patient feedback.

Following feedback on district nursing services, the services is being reviewed with the support of Healthwatch.

Healthwatch Lewisham provides monthly reports to the CCG and will report outcomes in our bulletins and website.

Healthwatch Lewisham reported the following health and housing issues and concerns relating to social housing to Lewisham Public Health:

Contamination in lifts and public spaces, contributing to poor health.

Quality of housing is poor, repairs are not carried out leading to damp conditions and mice infestation

Parents said that housing conditions aggravate children's asthma.

We have discussed these issues with health and care commissioners and will be reporting outcomes later in the year.

Care.data consultation extended following recommendation from London Healthwatch organisations.

MEET OUR VOLUNTEERS

Healthwatch Subcommittee

Chris Freed, Interim Chair, Co-opted from VAL Committee

Brian Fisher, Representative from health and social care sector

Val, Fulcher, Representative from health and social care sector

Philippe Granger, Co-opted from VAL Committee

Taiwo Oyekan, Co-opted from VAL Committee

Enter & View Volunteers

Denver Garrison

Desmond Hodgson

Diana Robbins

Elsa Pascal

Jennifer Gillard

Sally Niblett

Margo Sheridan

Community Engagement

Nnenna Nzeh

Denver Garrison

Desmond Hodgson

Margo Sheridan

Elsa Pascal

Youth Champions

Sara Dimtsu

Saffron Worrell

Leia Garwood-Stevenson

Sarah McGinley

Kenya Fantie

Havza Hussein

Data Analysis

Diana Robinson

Jen Gillard

Denver Garrison

Sally Niblett

Desmond Hodgson

INCOME AND EXPENDITURE

Income	
Local Authority	145,604
Brought Forward	9,624
Other Income	1,000
Total Income	**156,228**
Expenditure	
Premises	7,344
Staff Costs	85,518
Volunteer Training and Expenses	641
Office Costs	
Telephone	1,115
Postage, Printing & Stationery	1,297
Photocopying	105
Equipment	5,440
Depreciation	718
Project Costs	
Marketing & Publicity	3,334
Community Engagement/Partnering	1,288
Support and Management Costs	
(Voluntary Action Lewisham)	10,791
Consultancy	7,826
Fees & Charges	
Insurance	572
Bank Charges	109
DBS Arrangement Fees	281
Total Expenditure:	**126,379**
Total	
Income	**156,228**
Expenditure	**126,379**
Balance Carried Forward	**29,849**

WHAT PEOPLE SAY ABOUT US

"I wanted to give you an update on the issue around GP referrals which you sent along to us last month. We had been contacted by the NHS England E-Referrals team, which was hoping to learn more about the experiences of the Local Healthwatch network around automated referrals systems. We were able to pass the issue in your area along to them to help inform their work and understand some of the concerns around the system.

Thank you again so much for escalating this issue to us and helping us to make sure people's concerns are included in NHS England policies on E-Referrals."

Healthwatch England

Thank you, for the nice spotlight from Healthwatch Lewisham on the Lewisham Mental Health Connection - including our launch barbecue on 24th June.

Equinox

*I find **Upbeat** extremely useful and informative for 170's clients*

170 Community Project

I found the Healthwatch volunteers very helpful, they walk around the reception area introducing themselves to parents/carers talking to them about Healthwatch what services they offer and also how other projects/groups at the kaleidoscope Drop-in session can support parents/carers. Make cups of teas/coffees as well as talking to parents/carers whiles they are waiting for help/advice from the drop-in adviser and sometime keeping their children busy...

Contact a Family

Our local Healthwatch has been instrumental when developing our local Big Lottery: Fulfilling Lives HeadStart bid, which aims to build resilience amongst the 10 - 14 target age group, to prevent the onset of mental health issues. Alongside other statutory and voluntary sector partners, Healthwatch has been involved in strategic planning meetings, consultation events and are represented on our HeadStart Lewisham Steering Group. We will continue to work with Healthwatch for the foreseeable future, when improving emotional health and well-being amongst Lewisham families.

Joint Commissioning and Strategy Team,
Children and Young People's Directorate,
London Borough of Lewisham.

I would say Healthwatch have fitted in well within the Resource Space, working within the framework / ethos of the drop in service.
HW have contributed to the running of the space, providing important information and feedback opportunities to parents / carers as well as contributing resources to the space. HW have participated in service review meetings and have provide valuable monitoring reports that have been used to feedback on the space to the wider Kaleidoscope community.

HW have been a great addition to the resource Space.

Kaleidoscope Drop in Service

"We are pleased to report that we continue to enjoy a very productive working relationship with our local Healthwatch. We have welcomed the support that Healthwatch has provided to the Trust during 2013/14, helping us to monitor, measure and improve quality. This has included 2 Enter and View visits, support with our PLACE assessments and mock CQC visits, and membership of our Patient Experience Strategy Committee. We look forward to working with Healthwatch Lewisham during 2014/15"

Lewisham and Greenwich Healthcare Trust

"What I like about Healthwatch Lewisham

I like working with nice people and both my manager and staff at VAL have been really nice and supportive.

I enjoy working in a role that's varied and challenging. I get to do many tasks from marketing, admin, community outreach, and more. I can spend a whole day working in the office, and the next, out and about meeting people, doing presentations and networking.

Healthwatch is a new organisation and I enjoy being part of the development stage being able to contribute to how it's shaped.
There is a real meaning to the work so I feel that when I do something here it will contribute to make things better for others.

A lovely bunch of volunteers support HWL and it's great to work alongside them and be inspired by their passion and time commitment to the values of HW.

The challenging bit is that there are lots of good ideas on how to improve HWL however there is only a small team of staff and volunteers and we need to prioritise so not all the ideas can be implemented. Also HWL remit is so wide that despite best intentions we need to prioritise and focus on a selection of areas.

I also value the fact that I work in my local borough finding out about its issues, organisations and communities. Needless to mention my commute time to work is best I ever had in my life!"

Staff Member

Healthwatch Lewisham has worked with Lewisham Parent Partnership service since meeting at the monthly drop in service that is held at Kaleidoscope Children's Centre. We have continued to work closely together and were invited to our monthly coffee morning sessions. Simone Riddle the community engagement officer met with our parents and carers who were very keen to engage with her on a wide number of issues. Having Healthwatch at our coffee morning sessions is very useful because they are a further service to our parents. Simone listens to each parent and takes on board their views and concerns and advices them accordingly. Parents have commented that they feel that their concerns have been listened to.

Lewisham Parent Partnership Service
Bellingham Children's Centre

CONTACT US

Healthwatch Lewisham
St. Laurence Community Centre
31 – 37 Bromley Road
Catford, London SE6 2TS
Office: 020 3 417 4727
Information Line: 020 7 998 7796
Email:info@healthwatchlewisham.co.uk

Staff Team

Miriam Long, Healthwatch Manager

Jade Fairfax, Community Engagement Officer

Simone Riddle, Community Engagement Officer

Marzena Zoladz, Community Engagement Officer

Gary Davis, Community Engagement Officer

Emma Ward, Community Engagement Officer (July – November 2013)

HEALTH AND WELLBEING BOARD				
Report Title	Healthwatch Lewisham Annual Report			
Contributors	Miriam Long, Manager, Healthwatch Lewisham		Item No.	8
Class	Part 1	Date:	3 July 2014	
Strategic Context	Please see the body of the report			

1. Purpose

1.1 The purpose of the report is to inform the board of the Healthwatch Lewisham annual report which is attached to this report as Appendix A.

1.2 The Healthwatch Lewisham annual report describes the work of Healthwatch Lewisham and its contribution to improving the health and wellbeing of Lewisham's residents which it does by representing local residents and by reviewing the commissioning plans of statutory partners to ensure they meet the needs of local people.

2. Recommendation

2.1 Members of the Health and Wellbeing Board are recommended to note the Healthwatch Lewisham annual report and comment on the priorities, their related issues and outcomes.

3. Strategic Context

3.1 The Health and Social Care Act 2012 set out that local Healthwatch should be established in April 2013 in every local authority area in England.

3.2 Each local Healthwatch is an independent organisation, able to employ its own staff and involve volunteers, so it can become an influential and effective voice of the public. The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality.

3.3 As an independent consumer champion of health and social care in Lewisham, Healthwatch Lewisham is able to visit local health and social care services. Under the Health and Social Care Act 2012, Healthwatch can carry out an Enter and View visit to any publicly funded health and social care provider. These visits can be agreed in advance or can be unannounced spot checks. Healthwatch Lewisham carefully plan Enter and View visits with a clear purpose in mind to help improve health and social care services.

3.4 Healthwatch supports Lewisham's overall Health and Wellbeing Strategy by providing intelligence on community needs, knowledge about issues that affect health and wellbeing, representing the voice of our communities, and providing expertise into service design and delivery.

3.5 The core purpose of local Healthwatch is to be the consumer champion for health and care service users (through section 221 activities set out in the Local Government and Public Involvement in Health Act 2007). It should involve patients, service users and the public in shaping local health and care services; and raise awareness of their views and experiences in relation to those services amongst those in charge of services including commissioners and providers. The functions of local Healthwatch are described in the aims and objectives listed below.

4. Aims and Objectives – Healthwatch functions

4.1 Gather views and understand the experiences of people who use services, carers and the wider community.

4.2 Make people's views known.

4.3 Promote and support the involvement of people in the commissioning and provision of local care services and how they are scrutinised.

4.4 Recommend investigation or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC).

4.5 Provide advice and information about access to services and support for making informed choices.

4.6 Make the views and experiences of people known to Healthwatch England and providing a steer to help it carry out its role as national champion.

4.7 Support any complaints function by signposting people to NHS Complaints Advocacy services.

Background Documents

http://www.legislation.gov.uk/ukpga/2007/28/section/221

http://www.local.gov.uk/c/document_library/get_file?uuid=0a4e69a3-2d07-41d2-896d-0477fde029dc&groupId=10180

https://www.gov.uk/government/publications/local-healthwatch-annual-reports-directions-2013

If you have any difficulty in opening the links above or those within the body of the report, please contact Kalyan DasGupta (kalyan.dasgupta@lewisham.gov.uk; 020 8314 8378), who will assist.

If there are any queries on this report please contact Miriam Long, Manager, Healthwatch Lewisham on 020 3417 4727, or email miriam@healthwatchlewisham.co.uk

healthwatch Lewisham

Annual Report 2013-2014

Healthwatch Lewisham is part of the

Healthwatch England network that gives people a powerful voice locally and nationally

Healthwatch Strategic Aims

Our Work

- Community Engagement
- Children & Young People
- Enter & View
- Information & Signposting
- Representing Local People

Healthwatch Lewisham Priorities

- Access to primary care
- Mental Health services
- Enablement and integrated care

Your Voice Counts

Carers assessments by social services are often missed or ignored

Older People have concerns about long delays in accessing OT assessments so that they can have very simple amendments to their home in order to keep their independence

Quality of treatment overall is good and staff are friendly

Support for families affected by autism is inadequate

Lack of support upon returning home from hospital

Lack of knowledge about community services available for people returning home from hospital

- **Will anyone take notice /pay attention to what I say?**

- **Is it going to make a difference?**

Information and Signposting

- Information and signposting on health and social care services
- Let people know who they can go to when things go wrong

Representing Local People

NHS

Lewisham

Local Authority

Local Community

What People Say About Us

- I found the Healthwatch volunteers really helpful!
- I find **Upbeat** extremely useful and informative for 170's clients
- We will continue to work with Healthwatch for the foreseeable future, when improving emotional health and well-being of amongst Lewisham families
- We are pleased to report that we continue to enjoy a very productive working relationship with our local Healthwatch

healthwatch
Lewisham

Lewisham

Miriam Long
Manager
Healthwatch Lewisham




HEALTH AND WELLBEING BOARD				
Report Title	Immunisation in Lewisham			
Contributors	Director of Public Health		Item No.	8
Class	Part 1	Date:	3 July 2014	
Strategic Context	Lewisham's Health and Wellbeing Strategy has increasing the uptake of immunisation as one of its main priority areas. This report updates members on the current situation and gives an outline of action planned in the coming year.			

1. Purpose

1.1 This paper aims to update members on the current situation in relation to levels of uptake of immunisation in Lewisham. It also outlines the priorities for work to improve uptake in 2014/2015.

1.2 The following diseases are vaccine preventable and their prevention in children and young people will be covered by this report:

- Diphtheria
- *Haemophilus influenza* type b
- Human Papilloma Virus
- Measles
- Meningococcal disease (serogroup C),
- Mumps
- Polio
- Pneumococcal disease
- Rubella
- Tetanus
- Whooping cough (pertussis)

1.3 Influenza and Tuberculosis are also vaccine preventable but are not included in the scope of this report, nor is the prevention of disease by the use of immunisation in groups at high risk of disease or of adults. Reports on these topics can be submitted in future should members require such reports.

2. Recommendations

Members of the Health and Wellbeing Board are recommended to:

- Note the content of this report.
- Endorse the priorities and Immunisation Workplan for 2014/15.

3. Policy Context

3.1 After provision of clean water, vaccination is the most effective public health intervention for saving lives and promoting good health.

3.2 National policy on immunisation is decided by a body known as the Joint Committee on Vaccination and Immunisation, which is a standing committee that advises the Department of Health on immunisation and related issues. The committee is established under the NHS Standing Advisory Order of 1981 and its recommendations are almost always implemented in full.

3.3 Most vaccines are offered during childhood, according to a routine national schedule. South East London's immunisation schedule differs somewhat from the national schedule as it recommends that the second MMR dose is given at any time from three months after the first dose. This variation is in an attempt to maximise uptake of the second dose and is permissible within national policy.

3.4 Since the changes introduced in April 2013, as a result of the Health and Social Care Act of 2012, the responsibility for commissioning national immunisation programmes is no longer a local one. So whereas in the past this was a responsibility of the Primary Care Trust, it is now the responsibility of NHS England, and not of the Clinical Commissioning Group. The role of the Director of Public Health has also changed from being, in effect, the commissioner, to one of scrutiny and challenge of NHS England. However, increasing the uptake of immunisation is one of the priorities of the Be Healthy element of the Lewisham Children and Young People's Plan and has been identified as one of its priorities by the Lewisham Health and Wellbeing Board. Supporting local GP practices in maximising the uptake of immunisation is also one of the aims of Lewisham Clinical Commissioning Group in the context of preventing severe illness requiring admission to hospital, particularly illness due to Influenza, and in supporting local practices to provide high quality services. It is also the case that much effort is required at local level if the national immunisation programme is to be successful, much more support than is currently being provided by NHS England in Lewisham.

3.5 Both Lewisham Public Health and Lewisham Clinical Commissioning Group are, therefore, investing in efforts to improve the uptake of immunisation in Lewisham, and local operational and strategic arrangements to achieve such improvement remain in place in the form of the Lewisham Immunisation Action Group and the Lewisham Immunisation Strategy Group, both of which report to the Lewisham Health and Wellbeing Board via the Lewisham Health Protection Committee.

3.6 However, the roles of the CCG and of the local Public Health team in relation to immunisation, and particularly with NHS England as the lead, are not clear. Clarification of these relative roles will require discussion with NHS England, and this is included in the workplan of the Immunisation Strategy Board for 2014/15.

4. Background

4.1 Uptake of immunisation has been a problem in Lewisham for some time. Recorded uptake of indicator vaccines has been below target, and as a result, significant numbers of children in Lewisham were not protected against potentially serious infections. Due to the low uptake of MMR vaccine, there was an outbreak of measles in Lewisham in 2008 with a total of 275 confirmed or suspected cases. Problems in reaching targets in Lewisham include:

- The highly mobile population locally, which means that children may move before primary courses are complete.
- Children who have left Lewisham not being removed from databases locally, resulting in a probable bias in calculated uptake rates.
- Very complex data collection systems, overly reliant on paper reports on individual children, which have been very difficult to improve. Problems with data has in the past meant that our recorded uptake was substantially below our real uptake – past audits demonstrating up to a 12 % difference.
- Insufficient resources in the past to update and correct data held on children.

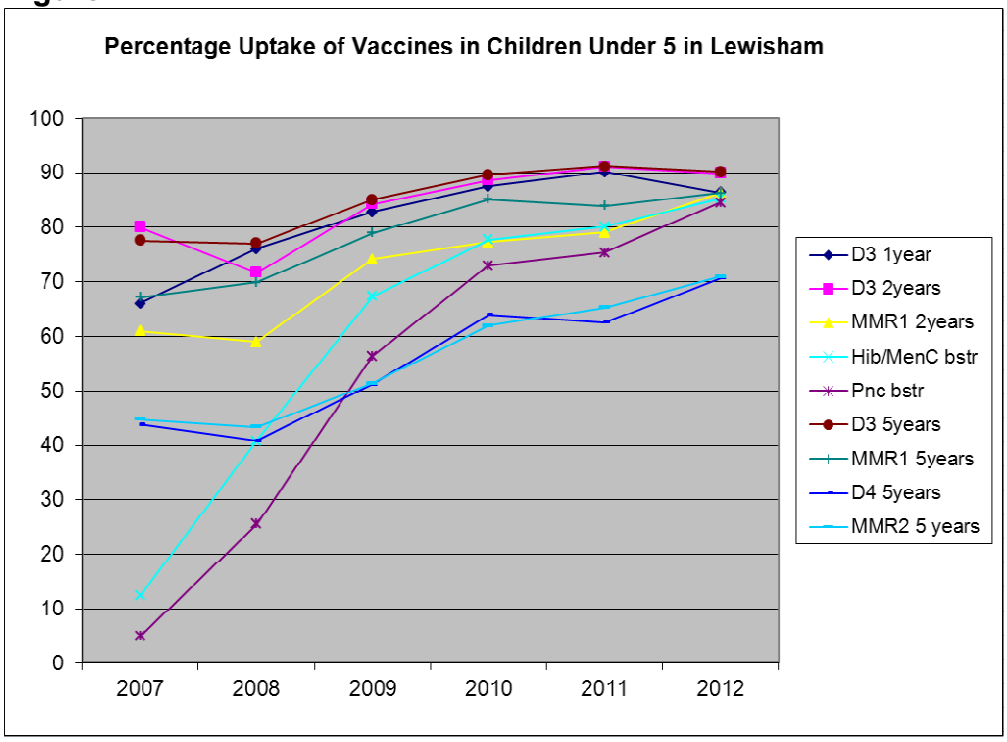
4.2 Parental resistance, especially to MMR, has been a problem, but does not account for most of the gap between our performance and the relevant targets.

4.3 Many of the problems outlined above have been tackled successfully, with dramatic improvements in uptake of all indicator vaccines in the years between 2007 and 2012 (Figure 1). Lewisham's performance in uptake of key routine childhood vaccines during that time demonstrated:

- A broadly sustained upwards trend in the proportion of children immunised at all ages.
- Uptake of the third dose of diphtheria vaccine (D3) at one and two years of age reached target
- Uptake of the first dose of MMR (MMR1) at two years of age improved, but considerable progress was still required to achieve the 95% uptake identified by WHO as necessary to avoid outbreaks of measles.
- Uptake of MMR1 at five years also improved, but was still short of the WHO target.

- Uptake of MMR2 and of the fourth dose of Diphtheria vaccine(D4) was below 70% and remains the greatest challenge.

Figure 1



4.4 Uptake of the third dose of Diphtheria vaccine(D3) is an indicator of completion of the primary course of immunisation of children under 12 months that aims to protect children against diphtheria, tetanus, whooping cough, polio, Haemophilus influenzae b and Group C Meningococcus.

4.5 MMR aims to protect children against measles, mumps and rubella. Two doses are required: MMR 1 at 12 months and MMR 2 at any time after three months have elapsed since MMR1, but before five years of age.

4.6 Hib/ MenC and PCV boosters (bstr) are given at 12 months and aim to protect children against Haemophilus influenzae B, Group C Meningococcus and Pneumococcus. These are relatively new to the programme – hence the apparent rapid increase in uptake of these vaccines.

4.7 D4 is the fourth dose of diphtheria vaccine. This is a key component of the preschool booster, which should be given at any time from the age of three years and four months but before the child starts school. The preschool booster completes the protection of children against diphtheria, tetanus, whooping cough and polio.

5. Recent Performance

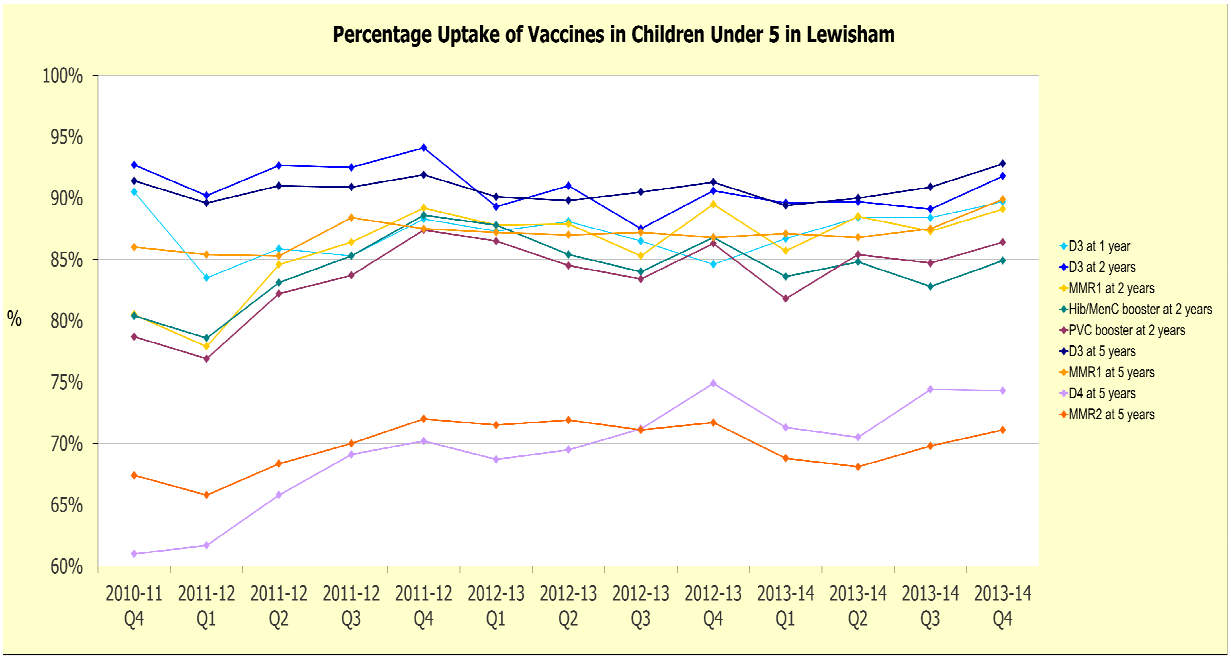
5.1 Despite continuing support at local level and some improvement in uptake of vaccines as a result, significant challenges remain. For example, uptake of the pre-school booster[1] and of the second dose of MMR (MMR2) by the age of five had improved in the latter half of 2012/13 but fell back to previous levels in the first half of 2013/14 (Figure 2). It is not clear why this occurred, but tackling the low uptake of these particular vaccines has proved to be much more difficult than improving the uptake of the first dose of MMR (MMR1). On a more positive note, also in the first half of 2013/14, the uptake of the third dose of diphtheria vaccine[2] at the age of one seemed to be returning to previously high levels as did the uptake of MMR1 at the age of two. All these indicators, however, seem to be subject to much change from quarter to quarter and the most recent information suggests a return to increasing levels of pre-school booster and of MMR 2 at the age of five.

5.2 There is also good news in that improvements in the uptake of Human Papilloma Virus (HPV) have been sustained and indeed further improvement achieved. Levels of uptake of dose 1 of HPV vaccine in girls now in Year 9 are 90.7% and of dose 3 are 87.5%, reflecting a highly successful year in 2012/13 and implementation by the Lewisham School Aged Nursing Service and Lewisham Schools of local strategy to ensure that every opportunity is taken to allow girls to catch up.

[1] D4 is the fourth dose of diphtheria vaccine. This is a key component of the preschool booster, which should be given at any time from the age of three years and four months but before the child starts school. The preschool booster completes the protection of children against diphtheria, tetanus, whooping cough and polio.

[2] Uptake of the third dose of Diphtheria vaccine(D3) is an indicator of completion of the primary course of immunisation of children under 12 months that aims to protect children against diphtheria, tetanus, whooping cough, polio, Haemophilus influenzae b and Group C Meningococcus.

Figure 2

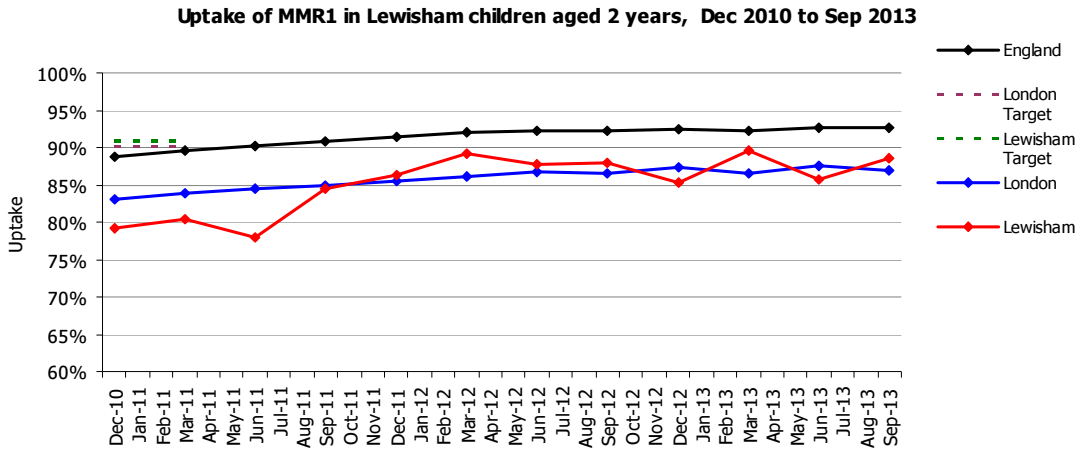


Source: NHS London COVER data

6. Benchmarking

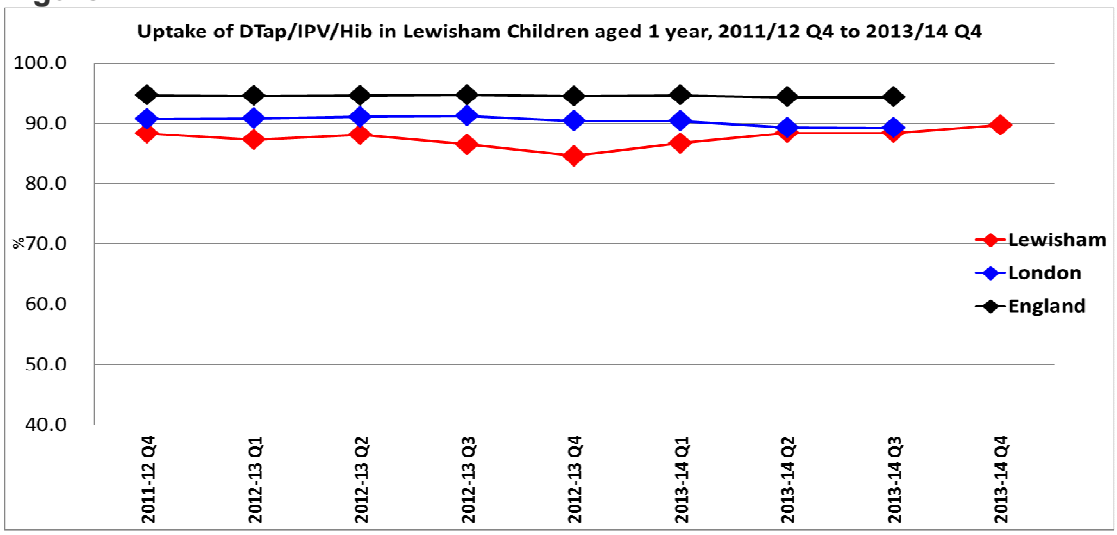
6.1 In terms of uptake of vaccines, in the past Lewisham has not compared well with London, or with England as a whole (Figures 3, 4, 5 and 6). Local action has achieved much, especially in relation to the uptake of the first dose of MMR at the age of two (Figure 3), which was identified as a particular focus locally because of problems with outbreaks of measles in the past. More recently, there has also been an improvement in Lewisham's performance in comparison to London and England as a whole in the shape of a return to previous levels of performance on the uptake of vaccines at the age of one (Figure 4).

Figure 3



Source: NHS London COVER data

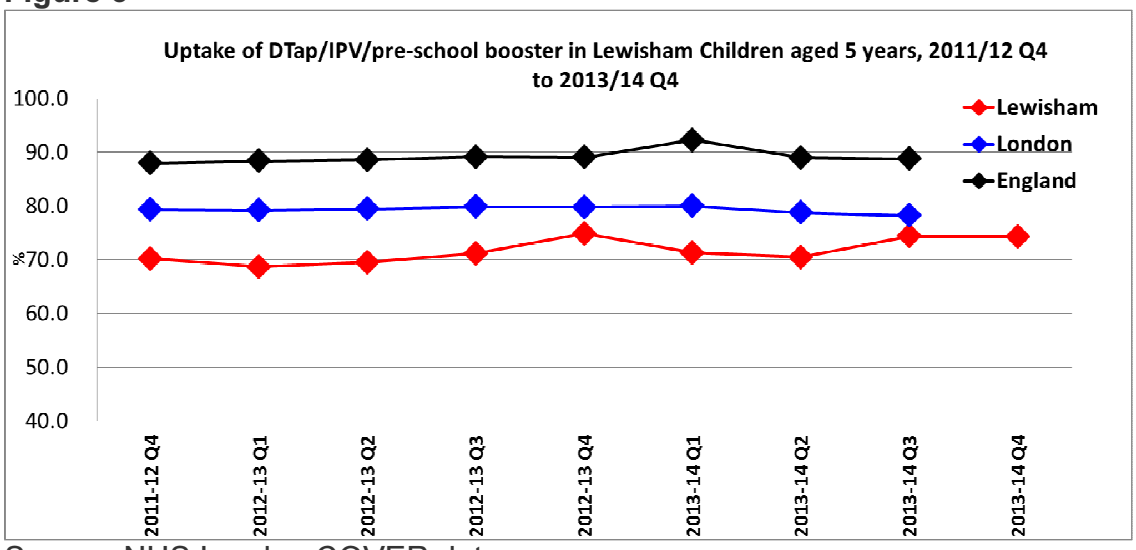
Figure 4



Source: NHS London COVER data

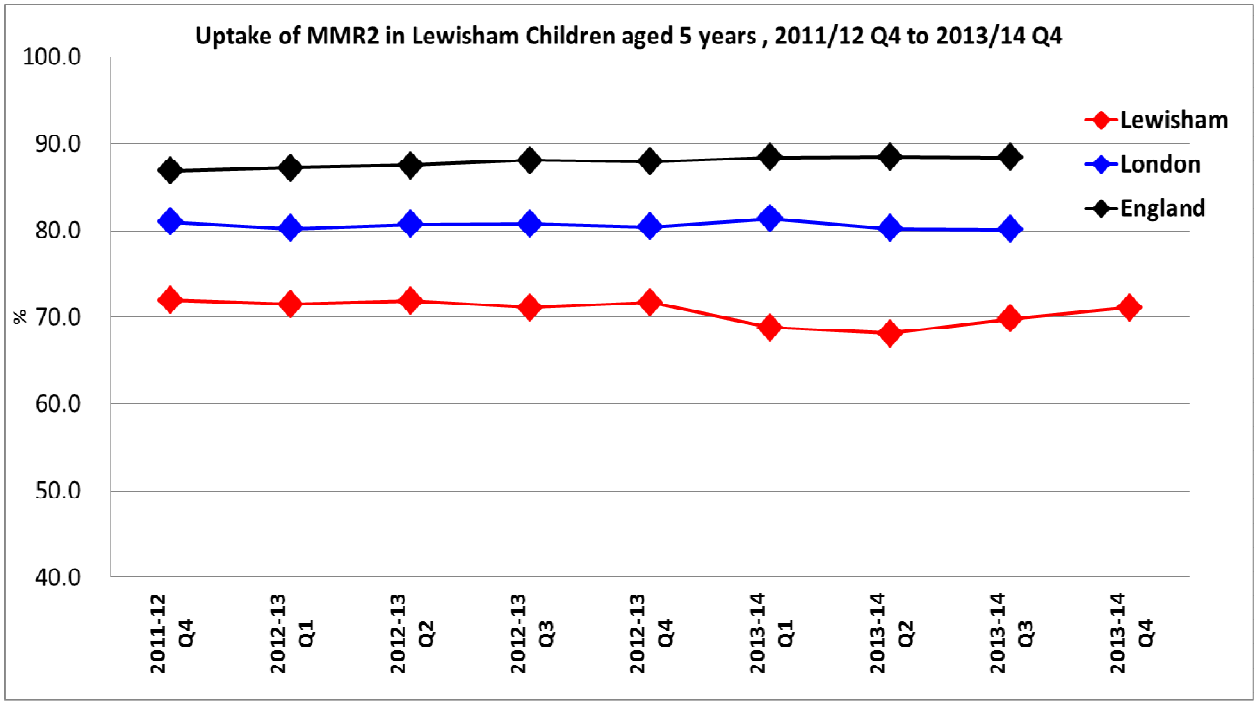
6.2 Uptake of MMR2 and the preschool booster at the age of five has, however, declined relative to England and London as a whole (Figures 5 and 6), though interestingly uptake of these vaccines has also fallen in the Capital and in the Country as a whole.

Figure 5



Source: NHS London COVER data

Figure 6

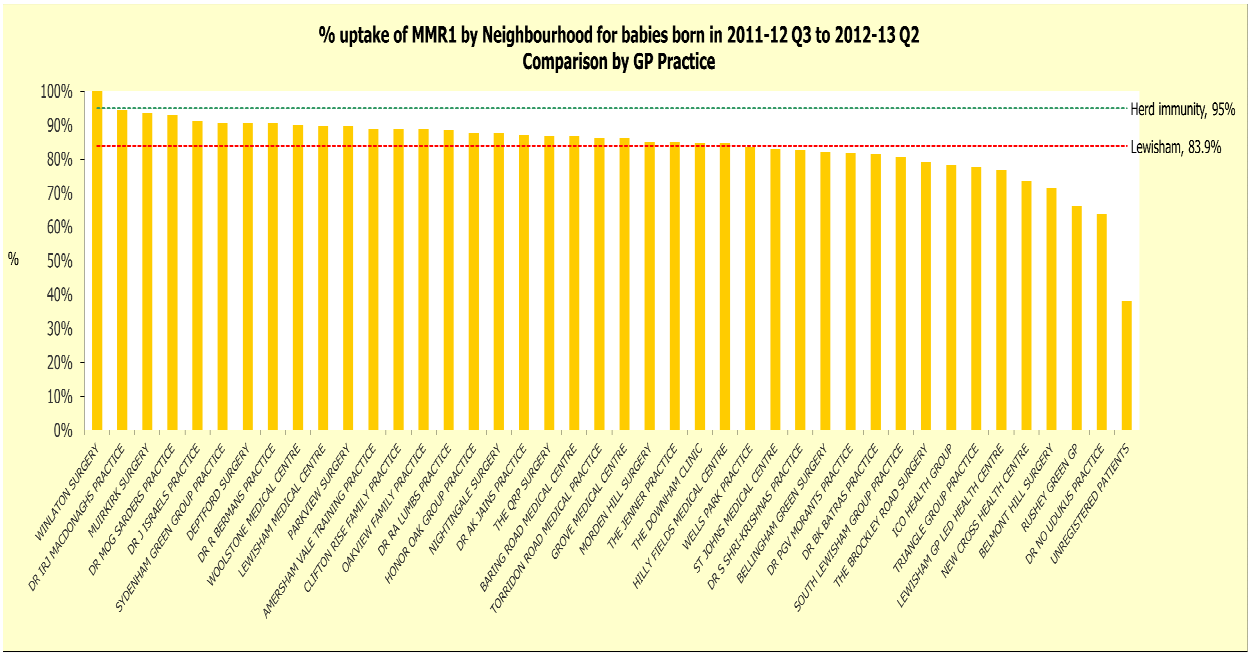


7. Uptake of Immunisation by GP Practice.

7.1 Uptake of vaccine varies considerably between practices (Figure 7). The variation between practices in the uptake of MMR1 at the age of two has reduced considerably since the launch of the MMR pathway, an earlier programme of work with individual practices and the circulation of information to GP practices showing uptake in their practice relative to uptake in their peers' practices. Despite this, variation in uptake by GP practice remains an issue.

7.2 March 2014 saw the launch of a programme of work by the CCG and Public Health-funded team of Clinical Commissioning Facilitators (CCFs) to help individual practices achieve their immunisation targets. This is part of a larger programme of support to practices by this team, which focuses on specific issues for periods of three months or more. Like the earlier programme of support, this should help achieve further reduction in this variation.

Figure 7[3]



Source: Local Child Health Information System (RiO)

7.3 As well as this variation in uptake by practice, it would appear, based on one month's worth of data, that there is also considerable variation by GP practice in the use of the health visiting service by parents to have their children immunised as an alternative to this being done by the GP practice. This is compounded by the fact that demand for immunisation by the health visiting service seems to be rising and the numbers of parents who bring their child to community child health clinics for immunisation is increasing. There has also been a whole range of changes to the national immunisation programme that means more work for the health visiting team. It is recommended that this issue be the subject of a review resulting in a paper that will present options for action, if appropriate.

7.4 A final issue that needs to be considered relates to the provision of immunisation by GPs and the effective postponement of MMR2. The accelerated schedule for MMR 2 was introduced in 2009 following the

[3] This figure provides information on the uptake, by practice, of MMR1 at the age of two in the most recent annual cohort for which this information is available. Excepting where there are reporting issues, it provides the best information available for purposes of comparison.

London-wide measles outbreak in which Lewisham was the focus south of the Thames. The accelerated schedule means that children should be given the second dose of MMR at any time after three months have elapsed since the first dose.

7.5 The aim of the accelerated schedule is primarily to increase uptake of MMR2 and thus help avoid another outbreak of measles in Lewisham. A recent analysis describes uptake of MMR2 increasing steadily up to around 70% just before the age of five where the plateau is maintained until children are past that age. Uptake then rises over the next year to peak at over 90% at 6 years old. Though reassuring that more children are therefore protected in the long–run than uptake at five would suggest, it is also disappointing for a number of reasons – critically because at least some children are not protected at as early an age as possible, but also that our published performance on uptake of MMR2 remains poor, whereas with a little extra effort we could translate our current good performance at six years to better performance on the indicator most widely used to assess local performance on uptake of MMR2. It is also disappointing that the local pathway that encourages GPs to give children the second dose of MMR in good time, well before their fifth birthday does not appear to have been successful.

8. Key actions for 2014/2015

8.1 A Lewisham immunisation workplan has been developed for 2014\15. It is recommended that members support the inclusion of the following actions as priorities in that workplan:

- The development of a new Lewisham Immunisation Strategy, based on an agreement as to the relative roles of NHS England, the Clinical Commissioning Group, Public Health England and the local Children's Commissioning team. The existing Lewisham Immunisation Strategy Group, which has representation at a senior level of all of these stakeholders and which reports to the Lewisham Health and Wellbeing Board, would seem to be the best way of overseeing the development of this new strategy.
- The continuation of a major programme of facilitation of work in primary care aimed at improving uptake of vaccine. The CCG, together with Lewisham Public Health, hopes to support practices in a variety of ways so that they can maximise the uptake of immunisation in their patients.
- A review of use by parents of the health visiting service as an alternative to the GP practice as a means of immunising their children with a report to the JCG and to the Clinical Directors at the CCG on this issue.
- Further development of immunisation care pathways. The pre-school booster pathway will be redesigned and relaunched in July 2014, and will incorporate systematic enquiry about uptake of vaccine in children entering Lewisham primary schools as part of

the school entry process, and involving children's centres in efforts to ensure vaccination of those not already immunised
- Introduction of the new national immunisation programme to ensure that secondary school children and young adults are protected against disease caused by Group C Meningococcus
- Negotiations to introduce the immunisation by midwives of pregnant women against influenza and pertussis.
- Negotiations to introduce opportunistic immunisation of children in settings other than primary care.

9. Financial implications

9.1 There are no financial implications arising from this report.

10. Legal implications

10.1 There are no legal implications arising from this report.

11. Crime and Disorder Implications

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

12. Equalities Implications

12.1 Evidence shows that the following groups of children and young people are at risk of not being fully immunised: children and young people who have missed previous vaccinations ; looked after children; children with physical or learning difficulties; children of teenage or lone parents; children not registered with a general practitioner; younger children from large families; children who are hospitalised; minority ethnic groups; vulnerable children, such as those whose families are travellers, asylum seekers or homeless.

12.2 In the case of MMR, reduced immunisation uptake has also been inversely correlated with socioeconomic wealth. In recent years, concerns about the safety of MMR have led to an overall reduction in MMR coverage in England, most notably in children of more affluent households.

13. Environmental Implications

13.1 There are no financial implications arising from this report.

14. Summary and Conclusion

14.1 Immunisation is a cost effective means of preventing important infectious disease. Uptake of vaccine in Lewisham, though much improved, still requires further improvement if Lewisham children are to be effectively protected. This paper gives the background to this issue in Lewisham and makes recommendations in relation to the key

priorities for 2014/2015. Members of the Health and WellBeing Board are asked to endorse the priorities identified.

If you have any difficulty in opening the links above or those within the body of the report, please contact Kalyan DasGupta (kalyan.dasgupta@lewisham.gov.uk; 020 8314 8378), who will assist.

If there are any queries on this report please contact Donal O'Sullivan at Donal.O'Sullivan@lewisham.gov.uk .

HEALTH AND WELLBEING BOARD				
Report Title	Health and Wellbeing Strategy: Progress Update Healthy Weight / Obesity			
Contributors	Director of Public Health		Item No.	10
Class	Part 1	Date:	3 July 2014	
Strategic Context	Promoting Healthy Weight is one of the priorities within the Lewisham Health and Wellbeing Strategy and the Children and Young People's Plan.			

1. Purpose

1.1 The purpose of this report is to provide an update on the progress towards achieving the improvements and outcomes of the key priority area 1; achieving a healthy weight in children and adults in the Health and Wellbeing Strategy. The focus of the report will be on the objectives and actions identified in the delivery plan of the Health and Wellbeing Strategy.

2. Recommendations

Members of the Health and Wellbeing Board are recommended to:

- Note the content of the report, and
- Comment on the progress on actions to achieve healthy weight in children and adults, as outlined in the report.

3. Policy Context

3.1 Achieving a healthy weight in children and adults is a priority in Lewisham's Health and Wellbeing Strategy and the Children and Young People's plan.

3.2 Reducing Inequality is one of the two principles informing the Sustainable Community Strategy. Achieving a healthy weight also supports the Sustainable Communities priority of healthy, active and enjoyable- where people can actively participate in maintaining and improving their health and well-being.

4. Background

4.1 The prevalence of obesity in adults and children in England has more than doubled in the last twenty-five years. A modelled estimate of adult obesity prevalence in Lewisham is 23.7% which is not significantly different to the England average. Recently published data for Lewisham on the prevalence of excess weight (overweight and obese)

in adults is 61.2%, similar to the national average but higher than the London average (57.3%). Maternal obesity data indicate a higher rate than the England average. For children the prevalence of obesity is significantly higher than the England average with 10.7% of reception children and 23.3% of year 6 children obese (2012/13). Obesity levels tend to be higher in deprived areas.

4.2 This report covers progress towards achieving the improvements and outcomes of the key priority area 1; achieving a healthy weight in children and adults in the Health and Wellbeing Strategy. The focus of the report will be on the objectives and actions identified in the delivery plan of the Health and Wellbeing Strategy. This work is undertaken in partnership by strategy agencies, the voluntary and community sector and by individuals. The objectives in the delivery plan reflect the work of a number of strategies and plans. Detailed plans are available for Breastfeeding, Promoting Healthy Weight in Children and Families Strategy, Physical Activity Plan, Lewisham Food Strategy and Workplace Health.

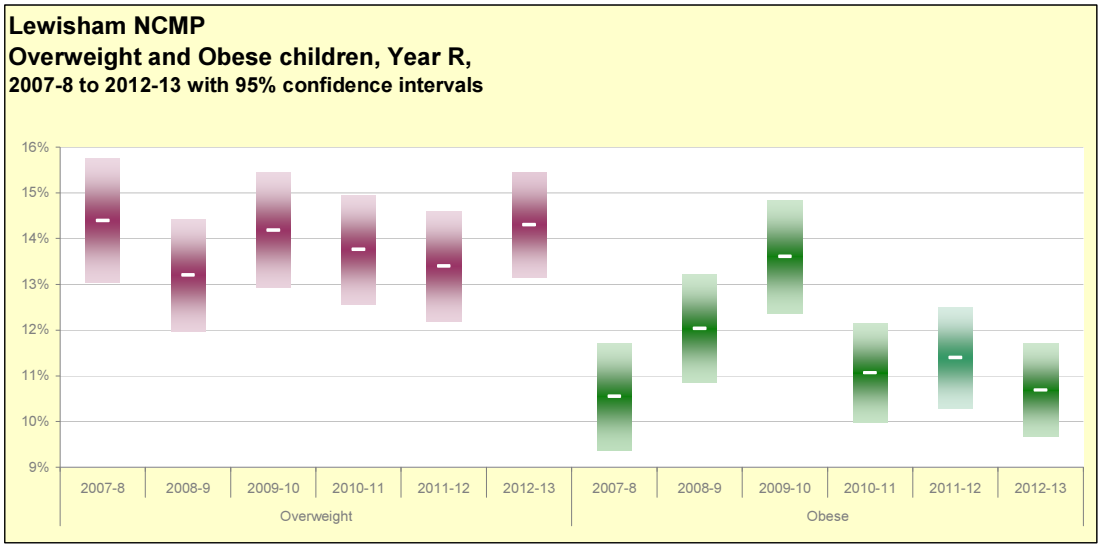
4.3 For this key priority area the Health and Wellbeing Strategy wants to achieve the following:

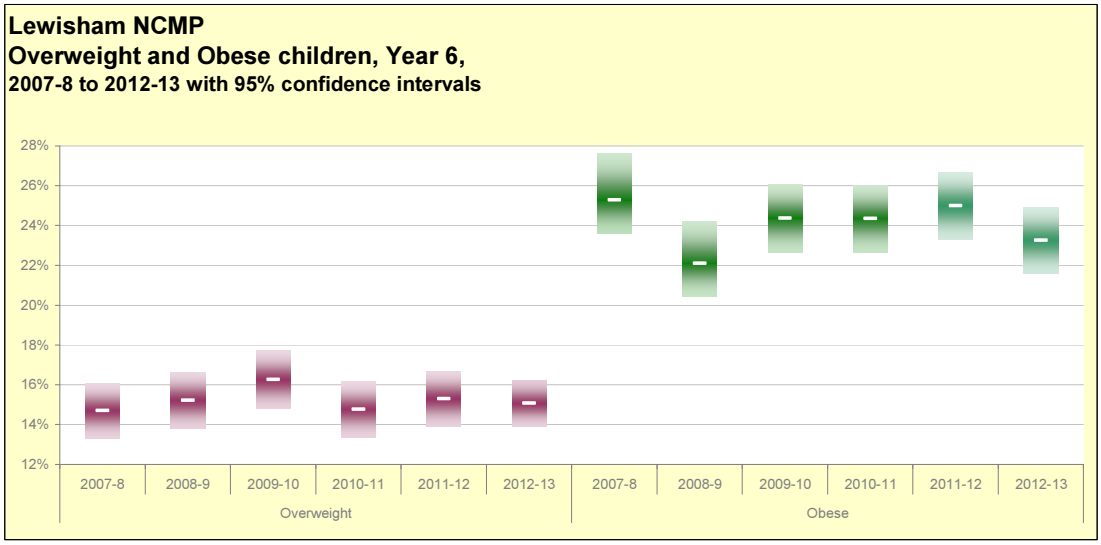
- Lewisham residents to take up opportunities to be physically active and for all children to engage in regular physical activity.
- Help to be available to everyone who could benefit from weight management and to see a significant reduction in the percentage of children and adults who are obese.
- The majority of fast food outlets to offer healthier food options, and no new outlets to open.
- Children in Lewisham to have the same weight distribution as children living in England in 1990.
- A signficant reduction in the prevalence of type 2 diabetes and coronary heart disease.

5. Performance

5.1 Local data for childhood obesity has been available for six years from the National Child Measurement Programme (NCMP). Childhood obesity rates remain significantly higher than the England rate and for 2012/13 Lewisham remains in the top quintile of Local Authority obesity prevalence rates for Year 6. Reception year performance has improved and Lewisham is now in the second quintile. The latest NCMP results (2012/13) show that 10.7% of Reception children are at risk of obesity and this rises to 23.3% in Year 6. The target set for the school year 2012/13 for obesity in Reception (12.2%) and Year 6 (24%) was achieved. As in previous years the proportion of obese children in Year 6 was more than double that of Reception year children, similar to the national results.

5.2 Local analysis of the data reveals that for the six years data has been collected (2007/8 to 2012/13) there is slight variability but no consistent trend over the period in obesity rates in either cohort of children.





5.3 The three year average at ward level shows higher levels of obesity prevalence in the most deprived wards but these are not statistically significant. The national results of the NCMP have shown a strong positive relationship exists between deprivation and obesity prevalence for children with obesity prevalence being significantly higher in deprived areas. The high levels in Lewisham reflect this.

6. Progress update towards achieving the improvements and outcomes on the key priority area: achieving a healthy weight during 2013/14

6.1 There are nine objectives in the delivery plan for this priority area. The following section provides:

- a description of the activities and actions for each objective,
- the indicators used to measure progress for the actions and
- the progress towards achieving the outcomes with a timescale that is annual or to be completed during 2013/2014.

6.2 Capacity building /training – development of knowledge and skills around nutrition, physical activity and healthy weight to deliver effective brief interventions

6.2.1 The indicators used for this objective are the number of staff attending training. There has been significant progress made towards achieving this objective with over 600 staff attending training on nutrition, physical activity and weight management during the year. Examples of the achievements and the numbers attending training during the period include;

6.2.2 Specific training becoming mandatory for some practitioners e.g. raising awareness of maternal obesity is now part of the mandatory training at Lewisham and Greenwich NHS Trust and all midwives attended an annual update (122 staff); all health visitors have to attend training on introducing solids (36 staff attending).

6.2.3 The Let's Get Moving physical activity pathway was delivered in 20 GP surgeries with 120 primary care staff received training. Sessions were also delivered to the wider community. In total over 300 received the Let's Get moving training.

6.2.4 Training on nutrition and weight was also delivered to 145 staff and volunteers with 86% responding they would alter their work practices after attending the training. A successful obesity event for GP's was held in December with over 80 staff attending representing over 24 practices.

6.2.5 The Fitness for Life training for primary schools teachers resulted in 12 schools running the programme with 50 classes. It is expected that schools will fund this programme from the school sports premium from 2016 onwards.

6.3 Breastfeeding support services – providing easier access to breastfeeding and infant feeding support

6.3.1 There has been significant progress made towards this outcome over the year. The indicators for this objective include:

6.3.2 The UNICEF Baby Friendly community stage two award was achieved as scheduled in February 2014. The maternity services will have their final Stage 2 assessment before September 2014. Children's centres too are considering how they can also work towards Baby Friendly accreditation so that they can work more closely with health visitors and maternity services in supporting mothers to breastfeed.

6.3.3 Increasing breastfeeding rates and the proportion exclusively breastfeeding at 6-8 weeks is a key priority for Lewisham. Babies who are not breast fed have an increased chance of being obese. Measures to support breastfeeding women in the community include:

- Seven weekly breastfeeding 'Baby café local' drop-ins in Lewisham, supporting over 600 new mothers and over 2000 attendances during 2013/14.
- A successful breastfeeding peer support programme resulting in 25 active volunteer peer supporters helping to support mothers within the breastfeeding groups and on the post natal ward in Lewisham.

6.3.4 A challenge has been lack of data on breastfeeding initiation and prevalence at 6-8 weeks to monitor performance during the year. This has been due to changes in the reporting procedure for breastfeeding. Nationally data submissions did not have sufficient data coverage to publish data and Lewisham resubmitted data in May. The results for 2013/14 are expected to be available in July.

6.4 Healthier catering – working with early years settings, schools and fast food outlets to increase the range of healthy food options available

6.4.1 Increasing school meals is the only indicator with a timescale for this period but there has been some progress with working with early year's settings and fast food outlets to increase the range of healthy food options.

6.4.2 The proportion of primary school pupils taking school meals has increased from 53% in 2008/09 to 63.1% in 2013/14. It is expected that this will significantly increase next year as in September 2014 all children in key stage 1 (Reception, years 1 and 2) in state-funded schools will be entitled to free school meals. In secondary schools increasing uptake of school meals has proved challenging with pupils less likely to take school meals with the uptake remaining between 32-35% during this period. Examples of work to increase uptake of school meals in this area included; the school catering contract achieved the silver Food for Life award, a review of the secondary school menus was completed and engaging with parents in children's centres and community events to promote school meals to families.

6.4.3 Early years settings have been encouraged to adopt the voluntary food and drink guidelines for early years settings, over 30 settings attended the first round of training with further training planned during 2014. Work is on schedule to meet the target of 50% of settings signed up to the guidelines by March 2015.

6.4.4 Work began on implementing the Healthier Catering Commitments in fast food outlets in Lewisham in 2013. Fifteen businesses have already been successful in meeting the criteria for the scheme and further work is planned with another 40 businesses during 2014.

6.5 Healthier built environment – working with others to create spaces and homes that support health and wellbeing

6.5.1 Work is ongoing on the actions to support this objective with indicators relating to planning, increased active travel and increasing number of community gardens due to be reported in 2015 or beyond.

6.5.2 Success in this area includes approval to include a planning policy in The Development Management Local Plan to prevent the establishment of new hot food takeaway shops in close proximity (400m) to schools.

6.5.3 Cycle parking has been installed along the route of the new super cycle highway in New Cross with TFL funding.

6.6 Physical activity programmes – providing access to a range of activities in schools and in the community

6.6.1 The indicators relating to this objective include increased participation in activities by children and adults. The timescales for reporting are March 2015. Access to a wide range of physical activity or healthy lifestyle programmes has been available to schools and the community and this work is ongoing. Examples of participation rates for each activity in 2013/14 include:

- Thirty two primary schools participated in the Hoops4health programme, an accredited healthy lifestyle programme based on basketball. This service will be de-commissioned from 2016 and it is anticipated that schools will continue to fund this from the school sports premium.
- Change4Life clubs have been established in many schools and the Youth Sport trust have set a target for School Games Organisers to ensure that all Primary Schools in Lewisham have a Change4Life club to engage disengaged pupils to support healthy active lifestyles. This target has proved to be challenging with not all schools engaging with the programme.
- Cycle training resulted in around 1000 pupils taking part in Bike ability level 1 and 2 and around 100 children taking part in the holiday courses.

- Over 51,000 adults and children accessed the free swimming sessions during the year with numbers ranging from 2398 to 6755 per month.
- The discounted cycle loan scheme had around 500 people take part in the last year; this resulted in 50% buying the bike they borrowed.

6.7 Nutrition initiatives – working with communities to improve healthy eating and cooking skills of residents

6.7.1 There has been significant progress on activities to improve healthy eating and cooking skills of residents, unless specified the indicators used for this objective are the number of participants supported by each activity.

6.7.2 The universal free vitamin D (Free D) scheme launched in November has proved to be very successful in engaging with the community and has had a very positive response from families. The vitamins are now easily accessible with around 60 distribution points in the borough including 46 community pharmacies, health centres and children's centres. In the first 4 months over 2500 bottles of women's tablets and 4000 bottles of children's drops were issued. Early indications are that the scheme is reaching 20-30% of those eligible, in line with the target of 25%.

6.7.3 Healthy eating on a budget cookery courses were commissioned and delivery started in December 2013, a total of 6 courses were delivered during the year recruiting 99 participants.

6.7.4 Community projects continue to be supported by nutritionists as part of the Downham Nutrition Partnership and North Lewisham plan. Sixteen groups and a total of nearly 850 residents participated in activities during the period. Also the accredited healthy eating and the cookery workshop training offered as part of Public Health promotion training resulted in 11 residents completing the course. Several of these individuals are now supporting local communities by delivering or volunteering in community cookery programmes in the borough.

6.7.5 The number of food banks in the borough increased over the year, with currently 6 distribution points operational in Lewisham. Processes are being developed to monitor access on a quarterly basis to all distribution points.

6.8 Workplace health initiatives – assisting employers to help their own employees improve their health

6.8.1 There has been some progress on workplace health initiatives with the Council and partner agencies that are represented on the Health and Wellbeing board. Indicators to be reported during this period are feedback from staff that have attended workplace health events.

6.8.2 A joint workplace health group with representation from the Council, Occupational Health providers and Lewisham and Greenwich NHS Trust has been established. Approval is being sought for the Council and partners to sign up top the London Healthy Workplace Charter accreditation. Workplace health events during this period include:

- Health event delivered in November by Health Trainers who provided lifestyle brief interventions on alcohol awareness and healthy eating.
- Health checks sessions for local authority staff in January and February resulted in 52 assessments undertaken with a total of 31 staff signed up for some form of follow up lifestyle support.

6.9 Obesity surveillance – monitoring levels and trends of overweight and obesity in the population.

6.9.1 The indicators for this objective are to increase participation in the NCMP, to determine the prevalence of maternal obesity and adult obesity as part of the NHS Health checks on an annual basis. There has been improvement in monitoring levels and trends of overweight and obesity in the local population through access to a range of data over the last three years. Data that is now available annually include:

6.9.2 Levels of excess weight (overweight and obese) in adults - published annually for the first time as part of the Active People Survey. The result for Lewisham is 61.2%, similar to the national average but higher than the London average (57.3%).

6.9.3 National Child Measurement programme –The NCMP involves the annual height and weight measurement of all children in reception year and Year 6 in schools; in 2012/13 over 6,000 children were measured (3,565 in Reception and 2,442 in Year 6). The participation rate in Lewisham of 92% (exceeding target of 90%) means that robust data are collected, providing valuable information about the trends in underweight, healthy weight, overweight and obesity in children in Lewisham, which will be used to help plan and deliver services.

6.9.4 Prevalence of maternal obesity in Lewisham - data from Lewisham and Greenwich NHS Trust for 2010 - 2012 indicates that maternal obesity rates are higher than the national average (21% compared to 17%). The results for 2012 indicate that 51% of women at their booking appointment were overweight or obese, (30% and 21%).

6.9.5 Levels of excess weight (overweight and obesity) in adults aged 40-74 years – monitored as part of the NHS health checks, indicate levels of 58.2% (October 2102 to October 2013).

6.10 Weight Management programmes – targeting those adults and children already identified as overweight or obese

6.10.1 The indicators for this objective include increased number of referrals and positive outcomes. Two activities reported for this period include the proactive follow up of children as part of the NCMP by school nurses and the commission of a lifestyle referral hub as part of the NHS health Checks. Progress has also been made on developing targeted and specialist weight management programmes which are due to be reported in 2015

6.10.2 The healthy weight school nurse team proactively follow up all children identified as very overweight as part of the NCMP to offer telephone advice or referral to the weight management programmes. In 2013 this resulted in over 600 contacts with families.

6.10.3 A Lifestyle Referral Hub for those identified as high risk after their NHS Health Check became operational in July 2013 with referrals being received from GP surgeries, pharmacies and community teams. This has resulted in increased referrals to weight management and physical activity programmes between April 2013 and March 2014.

6.10.4 A tiered weight management service for adults and children became fully operational in 2013. Referrals to all services have increased during 2013.

6.10.5 The children's weight management services offer a variety of Boost and Mend programmes which are accessible in community venues across the borough. Since the services have become fully operational over 200 families have completed the programmes, with positive outcomes on weight, physical activity and dietary behaviours. All services offer on-going support for families for 12 months to help sustain lifestyle changes.

6.10.6 The adult weight management services include dietetic weight management clinics, Weight Watchers by Referral, community weight management programme (Shape-up) and support by Health Trainers. In 2013 there were over 1800 referrals to the services with the majority of those completing the programmes achieving a weight loss, with 50% achieving a 5% weight loss (range between 2.5% to over 10%).

7. Financial implications

7.1 There are no specific financial implications arising from this report; all activities continue to be delivered within the existing budgets.

8. Legal implications

8.1 There are no specific implications arising from this report.

8.2 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.

9. Crime and Disorder Implications

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

10. Equalities Implications

10.1 Obesity is associated with socio-economic status with higher level of obesity found among more deprived groups. Obesity prevalence also varies between ethnic group and increases with age for both men and women.

10.2 An EAA was carried out on the promoting healthy weight, healthy lives strategy and a health equity audit on breastfeeding. The services and activities to support achieving a healthy weight have been commissioned to meet the needs of communities in terms of accessibility and targeted to promote uptake, these will help to reduce inequalities.

11. Environmental Implications

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

12. Conclusion

12.1 This report provides an update on the progress towards the improvements and outcomes on achieving a healthy weight in children and adults in Lewisham. The focus of the report is on the objectives and actions within the delivery plan of the Health and Wellbeing Strategy, it also covers the ongoing work of the varied strategies and plans that support this priority.

If you have any difficulty in opening the links above or those within the body of the report, please contact Kalyan DasGupta (kalyan.dasgupta@lewisham.gov.uk; 020 8314 8378), who will assist.

If there are any queries on this report please contact Katrina McCormick, Joint Deputy Director of Public Health, London Borough of Lewisham, on 0208 314 9056, or by email at: Katrina.McCormick@lewisham.gov.uk.

HEALTH AND WELLBEING BOARD				
Report Title	Food Poverty In Lewisham			
Contributors	Director of Public Health		Item No.	11
Class	Part 1	Date:	3 July 2014	
Strategic Context	Promoting Healthy Weight is one of the Health and Wellbeing Board's Priorities.			

1. Purpose

1.1 The purpose of the attached briefing paper is to provide information on the causes, scale consequences and current interventions relating to food poverty in Lewisham and to seek endorsement to implement the next steps outlined in the report.

2. Recommendations

Members of the Health and Wellbeing Board are recommended to:

- Note the content of the report and
- Endorse the next steps outlined in the report.

3. Strategic Context

3.1. Achieving a healthy weight in children and adults is a priority in Lewisham's Health and Wellbeing Strategy and the Children and Young People's plan. Additionally Lewisham's Health & Wellbeing Strategy recognises healthy eating as a key determinant of health and wellbeing, whilst he JSNA articulates the complex interaction of social exclusion, unemployment and poverty that can lead to vicious circles of isolation, exclusion and inequality that impact on mental health and wellbeing – also a key priority for the Health and Wellbeing Strategy.

3.2 Reducing inequality – narrowing the gap in outcomes for citizens, is one of the overarching principles of the Sustainable Community Strategy. In addition one of the strategy's priorities is Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and well-being.

4. Background

4.1. Definitions of food poverty focus on issues of access, affordability and healthy food. The London Assembly defines food poverty as, 'the inability to afford or access healthy food'.

4.2. Some people are 'squeezed' into food poverty over a prolonged period of time, others are 'shocked' by an unexpected event or change. Food is a flexible expense and is therefore often compromised.

4.3 A recent report *A Zero Hunger City, Tackling Food Poverty in London (March 2013),* by the London Assembly states:

- There is a correlation between food poverty and income poverty, but it is not entirely caused by a low income; careful budgeting, cooking skills – and chance – can keep a low-income family from food poverty.

- The determinants of food poverty are complex, ranging from global trends in food prices, national levels of poverty driven in part by policies on benefits and the minimum wage, local availability of healthy, reasonably priced food and individual income, skills and knowledge.

- A poor diet has many serious consequences. These include increased risk of illnesses such as: cancer and heart disease, poor infant health, antisocial behaviour in children, loss of independence and increased falls in older people. Counter intuitively, a poor diet can also cause obesity (a phenomenon known as modern malnutrition) which contributes to diabetes and heart disease.

5. Describing Food Poverty in Lewisham

5.1. The precise extent of food poverty in Lewisham is currently not known since borough level data on its extent is not currently collected. A variety of methods to attempt to describe the scale of the issue have been used: a recent report on child hunger in London; a Welfare Reform update from the Council's Benefit Service; London Living Wage data; information on food banks in Lewisham; mapping supermarkets and deprivation in Lewisham; a recent survey of older people and food poverty in London; qualitative data from Lewisham agencies. Although each method has its limitations and assumptions, a consistent picture of great need emerges. It is estimated that:

5.2. The Greater London Authority report, Child Hunger in London reported that 21% of parents surveyed reported skipping meals so that their children could eat and 9% of children in London said they sometime or often go to bed hungry. If these figures were applied to Lewisham it is estimated that 19,000 parents in Lewisham skip meals so their children can eat and 6,000 children in Lewisham sometimes or often go to bed hungry.[3]

5.3. 24,000 people in Lewisham earn less than the London Living Wage, placing them at risk of food poverty. 4,000 earn less than the *minimum wage*, placing them severely at risk.

5.4. Food banks report providing food to approximately 1,000 individual clients between October 2012 and May 2013, with both the number of distributions centres and those accessing them rising in recent months.

5.5. Key charitable organisations have stated that welfare reforms have increased the risk of (food) poverty. 9,301 households have been issued with a summons as a result of lack of payment of new council tax liabilities. Changes to the social fund mean that fewer people are eligible for help. 400 households are affected by the benefit cap, with 120 losing more than £100/week.

5.6. As of 18 September, there were 2,788 tenants in social housing across Lewisham affected by the 'bedroom tax'. The most recent briefing does not indicate the projected cost to each household, although approximately 60% of households provided with accommodation by Lewisham Homes and Phoenix housing are in arrears. The number of people affected by the 'bedroom tax' is falling.

5.7. Six Lewisham wards do not have a supermarket. Three (Evelyn, Whitefoot and Grove Park) are highly deprived or have super output areas of high deprivation. Brockley and Ladywell, while more affluent, have some of the most deprived populations of older people. 500m is an accepted definition of access to a food source; under this definition, parts of these wards have poor access. Further work to better understand access to food in Lewisham is warranted.

5.8. A range of service providers and third sector organisations working in Lewisham report an increase in the incidence of food poverty.

6. Initiatives to Combat Food Poverty in Lewisham

6.1 Work is already being done to combat food poverty in Lewisham. Healthy Start, Free School Meals and Breakfast Clubs are all interventions targeted at children. Free porridge is now available in all schools covered by the catering contract and all 5-7year olds will have free school meals from September 2014. Food banks with varying models of provision are increasing. Housing associations are starting to develop policies for tackling food poverty. The extent of provision by community and faith groups for elderly people is currently unknown.

7. Next Steps

7.1 To use the findings of the report as the foundations for the future development of action plans based on the Greater London Authority report on Child Hunger and London Assembly report on food poverty.

This will become part of the overall strategy for food and nutrition in the borough.

8. Financial implications

8.1 There are no financial implications arising from this report.

9. Legal implications

9.1 There are no legal implications arising from this report.

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

10. Crime and Disorder Implications

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

11. Equalities Implications

11.1 Food poverty and income poverty are related.

11.2 An Equality Analysis Assessment (EAA) will be undertaken on the action plans that are to be developed.

12. Environmental Implications

12.1 There are no environmental implications arising from this report.

13. Conclusion

13.1 The briefing paper highlights that a consistent picture of great need emerges on the scale of food poverty in Lewisham. To seek endorsement from the Health and Wellbeing Board to implement the next steps highlighted in the report; to develop costed and detailed action plans based on the Greater London Authority report on Child Hunger and London Assembly report on food poverty. It is proposed that these action plans will then be presented to the board at a future meeting.

If you have any difficulty in opening the links above or those within the body of the report, please contact Kalyan DasGupta (kalyan.dasgupta@lewisham.gov.uk; 020 8314 8378), who will assist.

If there are any queries on this report please contact Danny Ruta, Director of Public Health, London Borough of Lewisham, on 0208 314 9094, or by email at: danny.ruta@lewisham.gov.uk.

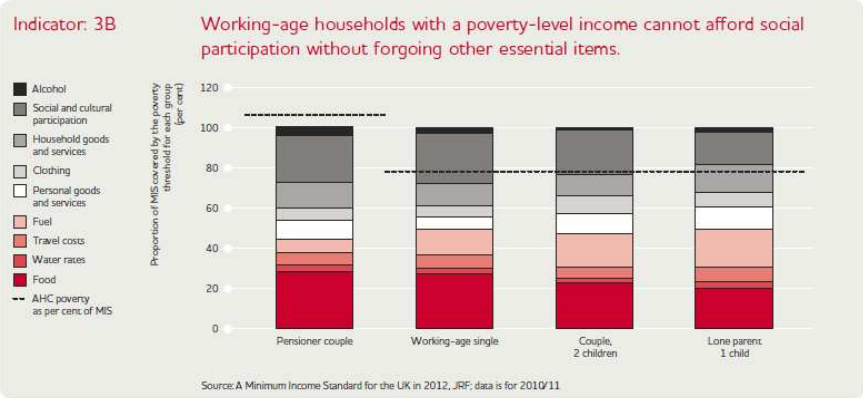
Briefing paper on Food Poverty in Lewisham

Executive Summary

This briefing paper on food poverty in Lewisham has been compiled to provide information on the causes, scale, consequences and current interventions relating to this growing problem.

In its recent paper *A Zero Hunger City,* the London Assembly defines food poverty as 'the inability to afford or access healthy food'.[2] This briefing paper is a local response to the issues highlighted in that report and other work that followed it.

Some people are 'squeezed' into food poverty over a prolonged period of time, others are 'shocked' - interventions should take account of both types of risk. Poverty-level incomes are insufficient to meet basic needs for working age households (see graph). Food is a flexible expense and is therefore often compromised.[1]



Affordability is determined by price and income. Access is determined by geography and income – travel to large supermarkets (which generally provide cheaper food) costs money. Skills in planning, budgeting, shopping and preparing food are also important, especially for those on a low income.

Issues of access and skill differentiate food poverty from "normal poverty"; a family with a low income but good skills and easy access to good value food may not experience food poverty. Conversely, those on low incomes with poor access and low skills are most at risk.

The precise extent of food poverty in Lewisham is currently not known since borough level data on its extent is not currently collected. This paper therefore uses a variety of methods to attempt to describe the scale of the problem, drawing on the following: a recent report on child hunger in London; Welfare Reform update from the Council's Benefit Service on the impact of welfare reforms; London Living Wage data; information on food banks in Lewisham; mapping supermarkets and location in relation to deprivation in Lewisham; a recent survey of older people and food poverty in London; qualitative data from residents and frontline staff (appendix 2). Although each method has its limitations and assumptions, a consistent picture of great need emerges. It is estimated that:

- The Greater London Authority report, Child Hunger in London reported that 21% of parents surveyed reported skipping meals so that their children could eat and 9% of children in London said they sometime or often go to bed hungry. If these figures were applied to Lewisham it is estimated that 19,000 parents in Lewisham skip meals so their children can eat and 6,000 children in Lewisham sometimes or often go to bed hungry[3]
- 24,000 people in Lewisham earn less than the London Living Wage, placing them at risk of food poverty. 4,000 earn less than the *minimum wage*, placing them severely at risk (appendix 1)
- Food banks report providing food to approximately 1,000 individual clients between October 2012 and May 2013, with both the number of distributions centres and those accessing them rising in recent months

- Key charitable organisations such as the Church Action on Poverty and Oxfam have stated that welfare reforms have increased the risk of (food) poverty. In Lewisham 9,301 households have been issued with a summons as a result of lack of payment of new council tax liabilities. Changes to the social fund mean that fewer people are eligible for help. 400 households are affected by the benefit cap, with 120 losing more than £100/week
- As of 18 September, there were 2,788 tenants in social housing across Lewisham affected by the bedroom tax. The most recent briefing does not indicate the projected cost to each household, although approximately 60% of households provided with accommodation by Lewisham Homes and Phoenix housing are in arrears. The numbers of people affected by the bedroom tax is falling.
- Six Lewisham wards do not have a supermarket. Three (Evelyn, Whitefoot and some super output areas of Grove Park) are highly deprived. Brockley and Ladywell, while more affluent, have some of the most deprived populations of older people. 500m is an accepted definition of access to a food source; under this definition, parts of these wards have poor access. Further work to better understand access to food in Lewisham is warranted
- A range of service providers (13) and 3rd sector organisations working in Lewisham report an increase in the incidence of food poverty.

A poor diet has many serious consequences. These include increased risk of illnesses such as: cancer and heart disease, poor infant health, antisocial behaviour in children, loss of independence and increased falls in older people. Counter intuitively, a poor diet can also cause obesity (a phenomenon known as modern malnutrition) which contributes to diabetes and heart disease.

Some work is already being done to combat food poverty in Lewisham. Healthy Start, Free School Meals and Breakfast Clubs are all interventions targeted at children for example free porridge is now available in all schools covered by the catering contract and all 5-7year olds will have free school meals from 2014. Food banks with varying models of provision are increasing. Housing associations are starting to develop policies for tackling food poverty. The extent of provision by community and faith groups for elderly people is currently unknown.

Practical recommendations for tackling food poverty have been made by the London Assembly in their Zero Hunger report (see section 7.1 for details). On 30th October 2013 the London Assembly Economy Committee chaired an informal follow up round table discussion of the issue. Lewisham Public Health team contributed to this discussion which resulted in a draft checklist for boroughs working towards Zero Hunger. Taken together, these recommendations should form the basis of the next steps towards preparing detailed and costed action plans for food poverty as part of the wider food and nutrition context in Lewisham.

1. Methods and Purpose

This document was compiled using searches of current literature, routine data sources, existing work carried out by the Lewisham Public Health team on issues relating to food poverty and discussions with providers of services to Lewisham residents. A full list of references is provided at the end of this document.

The purpose of this paper is to:

- define what is meant by food poverty and how it differs from “normal” poverty
- briefly outline the principle causes and consequences of food poverty
- use various data sources to describe the possible extent of food poverty in Lewisham
- outline what is being done currently in Lewisham to combat food poverty with a view to assessing how this links with the London Food Board’s strategic responsibility for addressing food poverty in London
- lay the foundations for future development of action plans based on the Greater London Authority report on Child Hunger and London Assembly report on food poverty

2. Definitions and Implications

Definitions of food poverty focus on issues of access, affordability and healthy food. The London Assembly defines food poverty as, ‘the inability to afford or access healthy food’ [2].

A GLA report on child hunger and food poverty in London, published in August 2013, emphasises the role of meal planning, budgeting, canny shopping and cooking in protecting families from food poverty.[3] In addition, the recent report *A Zero Hunger City, Tackling Food Poverty in London (March 2013),* by the London Assembly states,

> There is a correlation between food poverty and income poverty, but it is not entirely caused by a low income; careful budgeting, cooking skills – and chance – can keep a low-income family from food poverty.[2]

These definitions have practical implications for describing the scale of food poverty in Lewisham and for possible interventions. Issues of income, access to reasonably priced food and skills are key in attempting to minimise the impact of food poverty on Lewisham residents.

How Food Poverty differs from 'Normal' poverty

There is clearly an overlap between poverty and food poverty. However, as the above definitions make clear, food poverty is a function of poverty compounded by a lack of access to appropriate food and/or a lack of food-related skills and knowledge. Good access and skills are protective of food poverty when on a low income. However, if income is below a certain threshold, even good access and skills will not help.

Squeeze vs Shock

The GLA Child Hunger in London report distinguishes those who are squeezed into food poverty from those who are shocked into food poverty.

> Being shocked into food poverty refers to an unexpected event or change that leaves a family unable to access or afford an adequate amount and the right type of food […] Being squeezed into food poverty refers to how, over a period of time, a series of changes or events can take their toll on families struggling to access or afford an adequate amount of food. [3, p21]

This distinction has implications for how to tackle food poverty in Lewisham. Measures are required to ameliorate both short-term crises and longer term, deeply-rooted causes.

3. Causes of Food Poverty

The determinants of food poverty are complex, ranging from global trends in food prices, national levels of poverty driven in part by policies on benefits and the minimum wage, local availability of healthy, reasonably priced food and individual income, skills and knowledge.

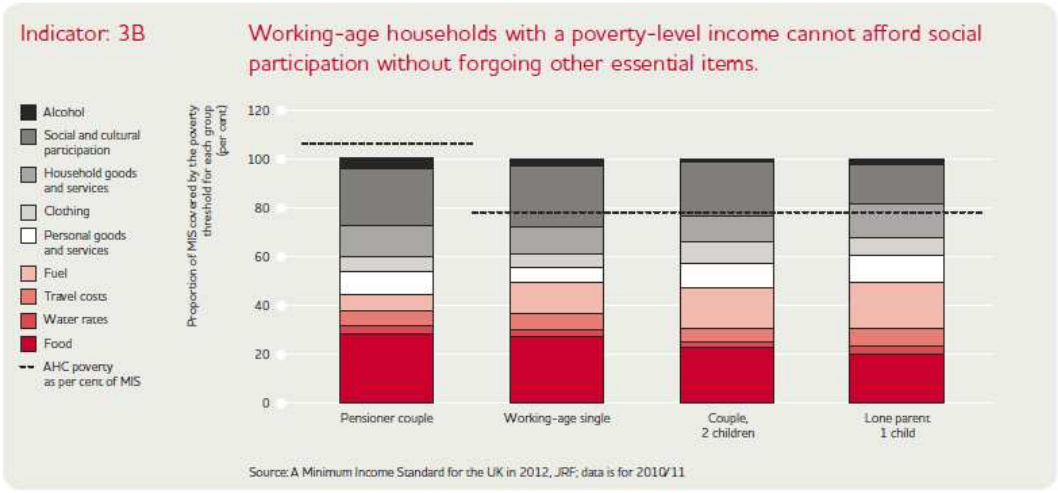
Food Prices

Food prices in the UK have risen faster than the rate of inflation since 2008, caused by a rise in commodity prices, exchange rates and the cost of oil[4]. At a local level, 'convenience' versions of supermarket chains, which have proliferated in recent years, charge almost 30% more for fresh fruit and vegetables than larger branches.[5] Shopping at supermarkets – and therefore gaining access to lower prices - requires transport, which is not always available to those on a low income. Since accessing supermarkets through online shopping requires a minimum spend and internet access, this method of shopping is not practicable for some people on low incomes.

Low Income

As Figure 1 shows, working age people on a poverty threshold wage earn less than the minimum income standard for the UK, meaning they have to make choices between a healthy diet and other essential activities.[6] Poverty-level incomes provide approximately 80% of necessary expenditure. Food expenditure is flexible so this is one area that families can make savings.[7] The current welfare reforms will reduce income for those in receipt of state benefits.[8] The impact of these reforms on Lewisham residents is described in section 4, below.

Figure 1: Poverty level income does not allow for basic needs to be met[6]



Availability/Access

As established above, access to reasonably-priced food is a determinant of food poverty. Access relates partly to income; a higher income makes the transport or delivery costs required to access better value supermarkets affordable and higher, local 'convenience' prices more bearable.

This means that for those on lower incomes, access is closely related to geography. If you lack the means for travel to a supermarket (or to shop online) you are forced to shop locally. If your local shops are expensive then you will be paying a "poverty premium". This is one of the reasons that lower income families spend a greater proportion of their income on food (approximately 30%) than those of average income (12%).[9]

Skills in Meal Planning, Shopping, Budgeting and Preparing Food

As mentioned above, an individual or family's ability to plan meals, knowing where to shop, being able to budget and having the cooking skills to prepare food from scratch has a big impact on whether a family in poverty experiences food poverty.

This is confirmed by a report for the Food Standards Agency that shows that families where the main food provider lacked 'better developed cooking skills' ate less fruit and vegetables and drank more soft drinks.[10] Lower consumption of fruit and vegetables is linked to various poor health outcomes.

There is no data available on cooking, planning and budgeting skills in Lewisham. Work carried out by the Lewisham Public Health Department and various public and 3rd sector providers indicates that there is an appetite for classes teaching this sort of expertise. The Lewisham Public Health team is currently considering how it might evaluate the impact of such programmes more formally which will contribute to the development of the action plans.

4. Describing Food Poverty in Lewisham

Since data on food poverty in Lewisham is not currently collected a number of different approaches to attempt to describe the scale of the problem have been used. These approaches, their principal strengths and weaknesses and a summary of the estimates provided by each method are outlined in the table below,

Although the methods used below are varied and their use requires some assumptions, a reasonably consistent picture emerges with tens of thousands of people having to compromise on food and a smaller but extensive proportion going hungry.

Table summarising methods used to estimate food poverty in Lewisham

	Method	Advantages	Disadvantages	Estimated number affected in Lewisham
1.	Extrapolating data from August 2013 **Child Hunger in London** report	• Primary data • Up-to-date	• Inaccuracies in applying London-wide data to Lewisham • No data on older people, just children and families	• 42% (38,000) of Lewisham parents have reduced the amount of food they buy in the last year • 30% (27,000) of Lewisham parents likely to have bought less fruit and vegetables on a monthly basis due to the expense • 21% (19,000) of Lewisham parents skipping meals so their children could eat • 9% (6,000) of Lewisham children sometimes/often go to bed hungry • 8% (5,000) of Lewisham children likely to have had to skip meals due to lack of food
2.	Using a recent Welfare Reform update from the Council's Benefit Service to outline the number of households with reduced income as a result of the welfare reforms.	• Lewisham-specific data • Up to date • Provides information on families put at risk of poverty as a result of reforms	• Only provides estimate of impact of welfare reforms, not absolute poverty • doesn't give information specifically on food poverty	• 25,000 households in Lewisham will have new or increased council tax liabilities (average impact £2.50/household/week). Of these, 9,301households have been issued with a summons. A total of 3,327 cases have been referred to bailiffs with a further 2,878 cases referred to the Department for Work and Pensions for an attachment to the claimants on-going benefit entitlement. • There have been 1,200 applications for short-term financial support since April (under the scheme replacing the previous national Social Fund scheme) with 435 successful awards. • 400 households have been affected by the benefit cap, with 120 losing over £100/week. • As of 18 September, there were 2,788 tenants in social housing across Lewisham affected by the bedroom tax. The most recent briefing does not indicate the projected cost to each household, although approximately 60% of households provided with accommodation by Lewisham Homes and Phoenix housing are in arrears. The number of people affected by the 'bedroom tax 'is falling.
3.	Using **London Living Wage** data to estimate the number of Lewisham residents in work in receipt of the London Living wage.	• London Living wage is an accepted definition of low income	• assumptions made in applying London data to Lewisham • gives no information on geographical access to food, or skills	• 24,000 people living in Lewisham earn less than the London Living Wage • 4,000 people living in Lewisham earn less than the minimum wage
4.	Numbers of people accessing food banks	• accurate data on those accessing food banks in Lewisham	• likely to underestimate scale of food poverty	• Lewisham Food Bank: 372 clients (12/12-04/13) • New Cross Food Bank: 450-520 families/week (10/12-05/13) • Honor Oak: 119 unique clients (10/12-05/13) • Whitefoot and Downham food +project : 165 clients (10/13 – 05/14)
5.	Mapping deprivation and reasonably priced food sources to identify areas of low income and poor access	• addresses question of food accessibility • identifies areas where practical steps could be taken to improve access	• work in early stages and required further research • variation in levels of income within lower super output areas	• Six wards (Brockley, Evelyn, Grove Park, Ladywell, Telegraph Hill and Whitefoot) have no supermarket • Evelyn, Grove Park and Whitefoot have areas of deprived populations who are at risk of food poverty • Telegraph Hill and Brockley, although more affluent in general, have deprived older populations who are at risk
6.	2012 GLA survey of older people and food poverty	• relatively recent, primary research	• data doesn't allow extrapolation to give prevalence/incidence in Lewisham	• An expected 2,600 people >65 yrs malnourished • majority of older people and those working with them believe that some older people struggle to afford healthy food • Low income is a key factor • Older people are accessing food banks, despite various barriers including access, knowledge and stigma.
7.	Discussions with stakeholders in Lewisham to understand the extent of food poverty	• local, up-to-date information • provides local context for more data-driven approaches	• doesn't give a quantitative estimate	• Food poverty a significant issue in Lewisham

1. GLA Report on Child Hunger in London

There is only one source of primary data on the scale of food poverty in London. In August 2013 the Greater London Authority published a report titled, Child Hunger in London – Understanding Food Poverty in the Capital, August 2013, based on research carried out by Ipsos Mori.[3]

According to the report:

- 42% of parents in London have reduced the amount of food they buy in the last year
- 30% of parents in London reported that they bought less fruit and vegetables on a monthly basis due to the expense
- 21% of parents in London reported skipping meals so their children could eat
- 9% of children in London said they sometime or often go to bed hungry and 8% of parents said their children had to skip meals as there was not enough food to eat

Applying these percentages to 2011 Lewisham census data, and assuming that the patterns observed in London are repeated in Lewisham, it is estimated that:

- 38,000 parents in Lewisham have reduced the amount of food they buy in the last year
- 27,000 parents in Lewisham are buying less fruit and vegetables because of the expense
- 19,000 parents in Lewisham have skipped a meal so their children could eat
- Between 5,000 and 6,000 children in Lewisham sometimes or often go to bed hungry due to a lack of food or have had to skip meals as there is not enough food to eat.

2. Impact on Income of Welfare Reforms in Lewisham

The general trend of welfare reforms is to reduce income derived from benefits[11].

The financial impact of welfare reforms on Lewisham residents is summarised below, based on a Welfare Reform update from the Council's Benefit Service.[12]Since people receiving benefits are by definition already on a low income (and since it is established that food expenditure is an area where families can make savings), it is reasonable to state that these reductions are likely to have an impact on food poverty.

- 25,000 households in Lewisham will have new or increased council tax liabilities (average impact £2.50/household/week). Of these, 9,301 households have been issued with a summons. A total of 3,327 cases have been referred to bailiffs with a further 2,878 cases referred to the Department for Work and Pensions for an attachment to the claimants on-going benefit entitlement.
- There have been 1,200 applications for short-term financial support since April (under the scheme replacing the previous national Social Fund scheme) with 435 successful awards.
- 400 households have been affected by the benefit cap, with 120 losing over £100/week.
- As of 18 September, there were 2,788 tenants in social housing across Lewisham affected by the bedroom tax. The most recent briefing does not indicate the projected cost to each household, although approximately 60% of households provided with accommodation by Lewisham Homes and Phoenix housing are in arrears. The numbers of people affected by the bedroom tax is falling.

Quantifying the impact of these changes on food poverty is difficult because access and skills should also be taken into account alongside reductions in income.

Data from The Lewisham Foodbank confirms that benefit delay (33%), benefit changes (16%) and low income (14%) are key reasons given for people accessing food bank. Accessing a food bank is a reasonable proxy indicator of food poverty, especially given that the social stigma attached to using food banks means they are not always used when needed.[3]

It is likely therefore that many of the households identified above will experience food poverty as a result of these changes. It is reasonable to assume that households losing over £100/week due to the

benefit cap will be severely affected. It is also reasonable to assume that some of those households in arrears as a result of changes to council tax liabilities and the Bedroom Tax will be struggling to meet all the necessary expenses.

Conversations with some public sector frontline staff carried out to inform this paper confirm this, with those in receipt of single benefits thought to be particularly at risk of food poverty. Staff are concerned that Short Term Benefit Advances (administered by the Department of Work and Pensions) are themselves sometimes delayed. In their view, transient food poverty for those affected by welfare reforms was inevitable in some cases, despite the clear plans Lewisham Council has for helping many of those affected.

3. London Living Wage Data

The London Living Wage is an amalgamation of the poverty threshold wage (60% of median incomes) and a "Low Cost But Acceptable" standard of living, plus a premium of 15% to provide a buffer against "unforeseen events". At the time of writing it is £8.80/hour.[13]

Using 2013 London Living Wage data it is estimated there are 24,000 people living in Lewisham that earn less than the London Living Wage and 4,000 earning less than the minimum wage (see appendix 1 for calculation). These estimates are based on the assumption that poverty is equally distributed in the capital. Given Lewisham's deprivation, these numbers are likely to be an underestimate. As demonstrated above, those earning less than the London Living Wage are likely to have to compromise on food expenditure.

4. People Accessing Food Banks in Lewisham

The number of food banks and their use by residents in Lewisham is increasing.

Between October 2012 and May 2013 approximately 1,000 different clients had accessed the three sites* in operation in Lewisham at that time (see table). Since then, a further three distribution sites have been added. Lewisham Food Bank opened a second site in July 2013. Two further distribution centres (not associated with Lewisham Food Bank) in Catford and Downham also opened in October 2013.

Table Showing Number of Clients Accessing Lewisham Food banks 2012/14

Foodbank (Model of Delivery)	Number of clients	Period of time
*Lewisham Food Bank (Trussell Trust)	372 different clients (feeding 903 people)	December 2012 - April 2013
*New Cross Food Bank (FareShare)	450-520 families collect food weekly	October 2012 - May 2013
*Honor Oak Community Centre (Esther Community Enterprise)	119 different clients	October 2012 - May 2013
Whitefoot and Downham Community Food+ project (Matthew Tree Project)	165 different clients (feeding 398 people)	October 2013 – May 2014
Elim Pentecostal Food Bank (Trussell Trust)	unknown	-

Although accurate, up-to-date data on the precise numbers of people accessing food banks in Lewisham is not available, those running distribution centres at the present time indicate that their use is increasing.

Eligibility criteria differ for each organisation. It is possible that some people are accessing food banks inappropriately. However, the cohort interviewed for the Child Hunger in London report made it clear that the stigma attached to food handout meant they did not make full use of this service, even when eligible.[3] With this in mind, using the numbers of people accessing food banks is likely to underestimate food poverty in Lewisham.[i]

[i] This quote from a Lewisham Provider illustrates this stigma well. "We have also offered them {vouchers] to a few clients who had no food or money but turned down the offer of "second hand food"!

Some recently reported reasons for food bank use are listed below:

- benefit changes or delays
- falling / low income
- rent increases / council tax payments / bedroom tax
- People with no recourse to public funds in need of help
- Pensioners with large utility bills
- unemployment
- debt

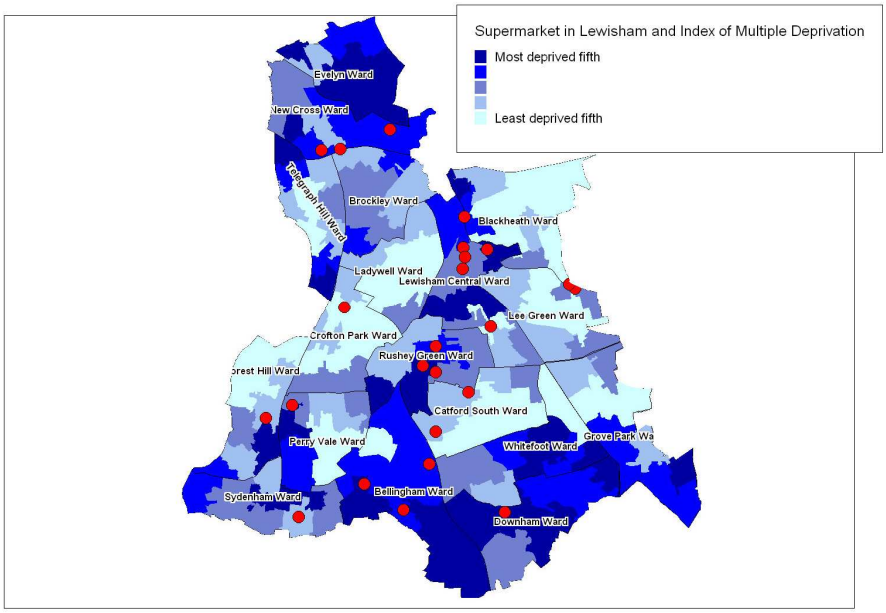
5. Geographical Access to Reasonably Priced Food

The location of reasonably priced food sources is particularly important for those on a low income.

Although a detailed study is beyond the scope of this briefing paper, some preparatory work has been carried out to discover whether there might be areas of Lewisham where access to supermarkets is difficult. 500m is considered a reasonable distance to travel when shopping on foot.[14] As the map below shows, there are six wards in Lewisham without a supermarket (Evelyn, Brockley, Ladywell, Telegraph Hill, Grove Park and Whitefoot). Some residents these areas will be further than 500m from a supermarket and could therefore be said to have poor access.

Evelyn and Whitefoot are recognised as areas of deprivation. However, Telegraph Hill and Brockley, while less deprived in general, both have very deprived populations of older people (ranking 3rd and 4th in the borough). This work highlights that certain populations in Lewisham have poorer access to food because of where they live, an important consideration when designing interventions to improve food poverty. Given that Lewisham is a deprived borough, further detailed work on the location and price of food sources for Lewisham residents might be warranted.

Map of Wards and Location of Supermarkets in Lewisham (Source of supermarket location: Google)



6. GLA Survey of Food Poverty in Older people[2]

In November 2012, the GLA surveyed 32 local Age UK branches and 33 borough-based older people's forums in London. 25 organisations responded to the survey, representing contact with at least 41,000 people.

Data from the survey indicates that a proportion of older people find it harder to afford healthy food. Some groups struggle because of a lack of income (for example those from ethnic minorities who have paid insufficient National Insurance contributions). Other barriers to healthy food include lack of access and information.

The survey found:

- 64% said that older people had found it harder to afford enough healthy food.
- 58% stated that older people regularly struggled to buy affordable healthy food in local shops
- 21% said that more people are accessing food banks than a year ago
- 83% said that older people are accessing food banks because their pension or income is not sufficient
    - 58% said this was because they have to pay other bills
    - 41% said this was because their benefit payments were insufficient
- 79% identified older people not knowing about food banks as a barrier to accessing them
- 64% said older people did not feel comfortable going to food banks
- 43% thought that older people did not know how to be referred to a food bank
- 29% said the food bank was hard to get to

There is a lack of data on food poverty in older people in London and no specific data on Lewisham residents. The table below shows the areas of deprivation for older people in Lewisham (which do not necessarily correspond to the most generally deprived boroughs) highlighting areas that might benefit from intervention for this population.

Table showing deprivation rankings for older people in Lewisham, by ward

Ward name Rank 1 = worst	Evelyn	Bellingham	Downham	New Cross	Whitefoot	Lewisham Central	Grove Park	Sydenham	Telegraph Hill	Brockley	Rushey Green	Perry Vale	Blackheath	Forest Hill	Ladywell	Catford South	Lee Green	Crofton Park
Older people in deprivation (%) Worst 5 ranking	44.4 1	34.3 5	31	41.6 2	28.2	33.4	24.6	28.3	36.2 3	36.1 4	27.5	27.1	24.6	22.4	25.2	19.8	21.9	25.3
Pensioners living alone (%) Worst 5 ranking	42.5 3	44.5 1	44.5 1	40.6	38.1	41.6 5	39.2	41.5	27.3	41.4	35.8	36.3	41.8 4	34.5	30.7	26.3	38.1	34.3

There is some data on malnutrition in older people in Lewisham. The Zero Hunger report state that "malnutrition affects over 10 per cent of older people aged 65 and over".[2] Lewisham has 26,000 people over the age of 65, thus it would be expected that approximately 2,600 to be malnourished.[15]

7. Qualitative Work with Stakeholders

In the course of preparing this briefing paper qualitative information was gathered from key agencies working with people experiencing or at risk of food poverty in Lewisham. Views were sought from health workers, public sector frontline staff and those in the 3rd sector. A selection of quotes is given in Appendix 2.

The exercise confirmed the existence of both transient and long-term food poverty among Lewisham residents and highlighted some key themes:

- issues connected to benefit delay or sanctions
- low income
- people with no recourse to public funds (NRPF)

5. Consequences of Food Poverty

Consequences of Poor Nutrition

One consequence of food poverty is that people reduce spending on healthy foods.[3] A diet low in fruit and vegetable intake is associated with stroke, ischaemic heart disease, colorectal cancer, gastric cancer, lung cancer and oesophageal cancer.[16]

Although counterintuitive, obesity is often linked to a poor diet. The National Heart Forum toolkit for Nutrition and Poverty states that, "the combination of obesity and a diet dominated by sweet, salty and fatty foods with too little fruit and vegetables and fibre is known as modern malnutrition. It is

more common in those from lower socioeconomic groups."[17] Being overweight is responsible for a significant burden of disease, causing diabetes, heart disease and strokes.[16].

Lewisham has high rates of obesity and deprivation. Compared to other London boroughs, Lewisham has the 9th largest proportion of its population in the most deprived quintile[18] and above average obesity.[19] Obesity and the health consequences of a poor diet are likely to be exacerbated by the impact of food poverty as described in this paper.

As mentioned above, malnutrition is a significant issue among older people, a tri-borough taskforce in Lewisham, Southwark and Lambeth has been established to address the issue.

Other consequences of poor nutrition include:

- loss of independence and increased falls and fractures in older people
- low birth weight leading to increased mortality and morbidity throughout childhood, and increased risk of cardiovascular disease in adult life
- increased incidence of stillbirths and neural tube defects (such as spina bifida)
- increased dental caries in children
- link between poor nutrition and anti-social behaviour at school[17]

Social Implications of Food Poverty

The GLA report on Child Hunger in London makes a case for a broad range of consequences of food poverty, over and above poor nutrition. It states:

> [the] stigma associated with free school meals, trouble concentrating at school on an empty stomach and the inability to invite friends home for dinner as key issues affecting the social and health implications of living with hunger. Equally, the ability to build family bonds diminishes if families aren't able to sit down to eat together. Families and children living in food poverty are typically not able to engage in other activities such as school trips and occasional treats, with household income focused on essentials.[3, p8]

6. Initiatives to Combat Food Poverty in Lewisham

The following section outlines the various measures already in place to combat food poverty in Lewisham.

Children and Young People

Healthy Start scheme

Healthy Start is a UK-wide government scheme which aims to improve the health of pregnant women and families on benefits and low incomes. The scheme provides eligible families[ii] with vouchers which can be used to buy milk, fresh or frozen fruit and vegetables and infant formula. The vouchers are worth £3.10 a week and typically the benefit amounts to around £900 to cover the period during pregnancy to when a child reaches their fourth birthday.

Lewisham data indicates that 73.8% of eligible families are registered on the scheme. This is similar to London (74.9%) but lower than England (77.2%) (Dec 2012). On average this equates to 5,500 children and 1,500 women in Lewisham benefiting from the scheme on a quarterly basis.

Beneficiaries are also eligible for free Healthy Start vitamins. In Lewisham a universal vitamin D scheme was launched in November 2013 which means that all pregnant women, post natal women for one year and all children under 4 will be eligible for Healthy Start vitamins.

[ii] Those eligible for Healthy Start are as follows: pregnant and under 18; women more than 10 weeks pregnant or have a child under 4 and she/ family receives one of the following - income support/income-based Jobseeker's Allowance/income-related Employment and Support Allowance/ Child Tax Credit (but not Working Tax Credit unless the family is receiving Working Tax Credit run-on only) AND an annual family income of £16,190 or less (2013/14); Pregnant women or those with a child under four claiming Universal Credits may also be eligible.

Early Years

Pre-schools are offering a wider range of foods at breakfast after having noticed that some children are arriving feeling hungry. Children Centre staff, who have attended the *Eat Better Start Better* training programmes on the National Voluntary Food and Drink guidelines for Early Years in England are better equipped to improve parents' and carers' cooking skills and build their knowledge on age-appropriate nutrition. Two providers are currently offering healthy eating cookery programmes to parents/carers and their children.

Breakfast clubs

The Zero Hunger report states that 71% of London teachers say children are coming to school hungry, with 44% saying the number has increased slightly. The London Assembly advocates for Breakfast Clubs, saying they "are part of the solution. Breakfast clubs in London schools often play a dual role, offering breakfast to children who for a number of reasons have not eaten at home, and early morning childcare, which is particularly helpful for working parents."[2]

The majority of primary schools in Lewisham that are part of the school catering contract provide breakfast clubs. Of these 55 schools, 41 operate breakfast clubs run by schools or the school catering company and 14 do not have breakfast clubs. Pupils at these schools also have access to free porridge for breakfast delivered by the school caterer. A survey has gone to all primary schools which include a question on breakfast clubs to determine the provision in all schools; the results are not yet available.

Free School Meals

For those on a low income a free school meal "provides great relief to the family's food budget".[3]
As the table below shows schools in Lewisham have an average uptake of free school meals of 82% in primary schools, 80% in special schools and 69% in secondary schools. Planned legislation means that free school meals will be provided to all children between the ages of 5 and 7 years from September 2014. Nonetheless, there are clearly children who are eligible for free school meals who are not taking up this valuable resource.

	Daily Total Pupils	**Daily Total FSM Eligible Pupils**		**Daily Total FSM Uptake**			**Daily Total Pupils Eating Paid Meals**		**Daily Total Pupils Eating Packed Lunch**	
		Daily	% of Roll	Daily	% of Roll	% uptake	Daily	% of Roll	Daily	% of Roll
Primary School	17,841	4,818	27%	3,963	22%	82%	6,788	38%	4,790	27%
Special Schools	610	317	52%	253	42%	80%	174	28%	85	14%
Secondary Schools	7,847	2,189	28%	1,503	19%	69%	1,167	15%	0	0%

Older people

Given that there are 26,000 people over the age of 65 in Lewisham, that Lewisham is a deprived borough, and information covered elsewhere in this report indicating that older people struggle to access and afford food, it is likely that there is a great deal of unmet need with regards to food poverty for older people.

Of those that are eligible for adult social care a small proportion choose the option for a meal service There is limited information available on food provision for older people.

Food Banks

At the time of writing there are six known distribution centres operating as food banks in Lewisham. In general they are open once a week for two hours, with the exception of the New Cross Food Banks which is open five days a week for several hours.

1. The Lewisham Food Bank operates two sites in Malham Road (Forest Hill) and Algernon Road (Lewisham). They supply three days' worth of emergency food via a voucher system, signpost clients to other agencies and deliver if needed.
2. The Honor Oak Community Centre food bank has one distribution centre in Turnham Road and is run by a faith group. This food bank does not use vouchers and is open a couple of hours per week.
3. The New Cross Food Bank reports having 10% of local Deptford and New Cross households on its books.
4. A Trussel Trust food bank launched 5th October 2013 from Elim Pentacostal Church, Catford.
5. The Whitefoot and Downham Community Food + project launched on the 24th October 2013 and is based on the Matthew Tree Project, this model is not based on emergency food provision but is a longer tem intervention to support people to move out of food poverty.

Welfare Changes

There are a number of schemes underway to assist those affected by the welfare reforms which may have an impact on food poverty.

Hardship scheme

£100k has been made available to support households affected by the Council Tax Reduction Scheme and suffering exceptional hardship. Qualifying criteria include households where the claimant is disabled or they are responsible for a disabled child, a lone-parent with a child under the age of 5 or someone over 50 years of age and long-term unemployed.

Local Support Scheme (replacing National Social Fund)

In 2013/14 there were 12,000 applicants to the National Social Fund in Lewisham. There were 2,450 applications to the replacement Local Support Scheme in 2013/14 with 745 awards. Applications have been rejected either because candidates did not meet the eligibility criteria or because there was an underlying entitlement to a Short Term Benefit Advance this is administered by the DWP. Lewisham is in the process of reviewing the policy and exploring opportunities to align policy and delivery approaches across Lewisham, Lambeth and Southwark.

'Bedroom Tax'/Under Occupation

Work being led by a group of officers from housing benefit, housing needs, Lewisham Homes and Phoenix) are continuing to work to support residents to find solutions to manage under occupation.

Benefit Cap

Customers that require short-term financial support to manage the changes are being invited to apply for Discretionary Housing Payments (DHP). So far there have been 141 have been awarded DHP. Approximately 124 of those most affected by benefit cap (ie standing to lose more than £100/week) are being offered more intensive support to manage the changes.

Social Housing

A number of housing providers are addressing the issue of food poverty, for example Lewisham Homes (the largest social housing provider in Lewisham) is developing mechanisms to address food poverty faced by residents. They are currently working with Lewisham Foodbank and provide a small number of emergency parcels to residents. They are keen to work with partners across the borough as their front line staff and 'involved residents' are increasingly reporting food poverty / food insecurity is an issue in the properties they manage. Phoenix Housing (the 2nd largest social housing provider) reports referring clients to local food banks and is in the process of collating information on food poverty among their residents.

7. London Assembly recommendations

These recommendations will be used as a basis for developing future detailed action plans to address food poverty as part of the wider nutrition and food context in Lewisham.

7.1 London Assembly Zero Hunger Report recommendations

A series of recommendations for local authorities, schools and emergency food aid organisations has been produced by the GLA's as part of their Zero Hunger City report[2]. These are listed below as a basis for further discussion among key stakeholders.

London boroughs

There should be a food poverty action plan led by borough Health and Wellbeing Boards. A food poverty link worker should be designated in all London boroughs.

Boroughs' food poverty action plans should cover:

- how the particular characteristics of a borough should shape the drivers of, and response to, food poverty, for example if the risk is more widespread or focused on more specific pockets;
- the current response to food poverty and gaps in support
- a systematic approach to provision of information, advice and signposting across all emergency food aid sites, including a clear 'triage' process for priority groups, including repeat users
- brokering support for food aid projects in areas including project management, storage costs and training for volunteers in dealing with different client groups
- assessing how community meals, dining clubs and other community-based projects can assist in addressing food poverty among older people in London
- promoting, expanding and integrating community-based food buying schemes into the wider response to food poverty
- maximising registration and take-up among all children who are entitled to free school meals, as a minimum, and exploring ways to deliver universal school meals.

Schools

Every school governing body should have a plan to identify and address hunger in schools throughout the school day and to support families in food poverty.

This plan should include:

- engagement with the local borough's food poverty link worker;
- addressing hunger among children by ensuring availability of a free breakfast, using Pupil Premium monies if necessary, and maximising registration and take-up among all children who are entitled to free school meals.
- using Pupil Premium monies to provide after-school cooking activities
- advocating for action to address the needs of hungry children during the school holidays.

Emergency food aid organisations

Emergency food aid organisations should regularly analyse their client breakdown and proactively seek out groups that face barriers to accessing emergency food aid, including older people.
Food aid organisations should identify ways to systematically triage service users and liaise with statutory authorities to ensure people can access the support to which they are entitled.

For example, data from food bank clients indicates that older people are not accessing food banks in the numbers that would be expected given the risk of food poverty among this group. There are certainly specific reasons why food banks are by their nature less accessible to older people; therefore models for reaching this group should be explored and successes shared.

Report produced by the Lewisham Public Health Team, June 2014
Robert Marr (Public Health Speciality Registrar)
with contributions from Livia La Camera (Specialist Dietician for Children) & Gwenda Scott (Healthy Weight Strategy Manager

Appendix 1: Calculation of Poverty-Level Wages in Lewisham

Almost 700,000 people in work in London earn less than the London Living Wage (44% of part-time workers and 10% of full-time workers).[20, p1] Of these 700,000, 112,000 are paid less than the minimum wage.

2011 census data gives a London population of 8,173,941 and a Lewisham population of 275,885, or 3.38%. Assuming an equal distribution across London we can estimate:

- 24,000 people living in Lewisham earn less than the London Living Wage
- 4,000 people living in Lewisham earn less than the minimum wage

Both these groups could reasonably be said to be living in poverty, with those earning less than the minimum wage on a particularly low wage. Although this data does not tell us about geographical access to food, or food-related skills, it is reasonable to suggest that many of these people are at risk of food poverty, and that this risk is highest in those earning less than the minimum wage.

Appendix 2: Quotes from People involved with those suffering from Food Poverty in Lewisham

Home visit is now fully embedded ….. Through this practice, we have uncovered a wealth of acute needs but poverty is indeed profound". (Pre-School Manager)

We have noticed that since April a lot of the service users have been requesting food to take home with them at the end of sessions". (Community Project worker for marginalised adults)

Had a patient the other day benefits had been stopped but didn't know as generally went straight into bank left her no money at all no food for her or son for whole weekend. I advised her of foodbank but also no money to get there! (GP)

White English woman in mid 50s with disabled son. Both she and son had issues with ESA and income support. At the point LH staff became involved neither had eaten for the past few days apart from a tin of beans and a packet of biscuits which they had shared. Provided with in-house food parcel while supported to resolve benefits issues. (Lewisham Homes)

We are having to use food banks across our services as benefits are being delayed and women are being sanctioned. This is becoming the norm. We are also having to provide more food resources if the food bank is closed. (Refugee worker)

Mrs C – Early 40s, black and minority ethnic with 9 year old daughter. ESA sanctioned due to hospitalisation. When discharged from hospital after hysterectomy benefits not reinstated due to lack of 'evidence' and physically unable to go to offices to resolve issues. Neither she nor child had food so Salvation Army sent food round to help with food while LH staff supported her to resolve benefit issues". (Lewisham Homes)

Food poverty is a big issue with our clients. We are registered with a foodbank (malham rd) and have given out vouchers. Low income, poor housing equals a poor diet on the whole". (Family Nurse Partnership)

We do see mothers with No recourse to Public Funds who are very limited as to what they can buy. Recently my staff nurse met a mum at 29 catford hill where there are quite a lot of families with NRPF who said she has to walk around and offer to clear up at parties in public halls to get left overs for her 3 children…" (Health visitor lead)

A male user collapsed at Lewisham Library. Staff helped him up and to a chair and asked if he was OK. He said that he hadn't eaten for three days. (Libraries Staff)

Another user attended a council event where there were light refreshments laid on. He was there at the end of the event when staff started clearing away left over food. He politely asked if it was possible to fill a "doggy bag" with some of the leftovers because it was a few days until he would receive his pension and he was hungry". (Libraries Staff)

References

[1] Family and Parenting Institute. Family Matters – Understanding families in an Age of Austerity. 2013: 15

[2] London Assembly; Health and Environment Committee. A Zero Hunger City: Tackling Food Poverty in London. 2013 March: 5

[3] Hall S, Knibbs S, Medien K, Davies G; Greater London Authority. Child Hunger in London. Understanding Food Poverty in the Capital. 2013 Aug: 28-33

[4] Davidson J, Halunga A, Lloyd T, McCorriston S, Morgan C: Transparency of Food Pricing [Internet]. Explaining UK Food Price Inflation. [cited 2013 August 20]. Available from http://www.transfop.eu/media/universityofexeter/businessschool/documents/centres/transfop/UK_Food_Inflation_WP1.pdf

[5] Elgot J; The Huffington Post [internet]. Fruit and Vegetables more expensive in local shops than supermarkets, Channel 4 finds. 2013 January 21 [cited 2013 August 20]. Available from http://www.huffingtonpost.co.uk/2013/01/21/fruit-vegetables-expensive-tesco-sainsburys-local_n_2518888.html

[6] Aldridge H, Kenway P, MacInnes T, Parekh A; Joseph Rowntree Foundation. Monitoring poverty and Social Exclusion 2012. 2012:

[7] Family and Parenting Institute. Family Matters – Understanding families in an Age of Austerity. 2013: 15

[8] Department for Work and Pensions. Benefit Cap (Housing Benefit) Regulations 2012: Impact assessment for the benefit cap. 2012 Jul 16: 2

9 Caraher M; Centre for Food Policy, City University London. Food Prices and Food Poverty: Some Key Facts. 2012 October: 1

[10] Nelson M, Erens B, Bates B, Church S, Boshier B; Food Standards Agency. Low income Diet and Nutrition Survey Volume 3: Nutritional Status, Physical Activity, Economic, Social and other factors. 2007: 188

[11] Department for Work and Pensions. Benefit Cap (Housing Benefit) Regulations 2012: Impact assessment for the benefit cap. 2012 Jul 16: 2

[12] London Borough of Lewisham. Welfare Reform: Welfare Reform update from the Council's Benefit Service . 2013 October

[13] GLA Economics Living Wage Unit. A Fairer London: The 2012 Living Wage in London. 2012 Nov: 7 Available from http://www.london.gov.uk/sites/default/files/living-wage-2012.pdf

[14] Bowyer S, Caraher M, Eilbert K. and Carr-Hill R., *Shopping for Food; Lessons from a London Borough*. British Food Journal, 2009, 111 (5): 452-474

[15] http://portal.lewishamjsna.org.uk/Population.html

[16] World Health Organisation. The World health Report 2002 Reducing Risks, Promoting Healthy Life. 2002:

[17] Press V; National Heart Forum. Nutrition + Food Poverty: A toolkit for those involved in developing or implementing a local nutrition and food poverty strategy. 2004: 63

[18] Greater London Authority. Intelligence Briefing, Social Exclusion team: English Indices of Deprivation 2010: A London Perspective [internet]. 2011 June. [cited 2013 September 11]. Available from: http://www.london.gov.uk/sites/default/files/Briefing-2011-06-Indices-Deprivation-2010-London.pdf

[19] Lewisham Strategic Partnership. Joint Strategic Needs Assessment. [internet]. [undated]. [cited 2013 September 11]. Available from: http://www.lewishamjsna.org.uk/children-and-young-people/childhood-obesity/what-do-we-know/facts-and-figures

[20] London Assembly [internet]. Key Facts and Figures. 2013 March 27 [cited 2013 August 20]. Available from http://www.london.gov.uk/mayor-assembly/london-assembly/publications/a-zero-hunger-city-tackling-food-poverty-in-london

Cooper, Purcell, & Jackson, *Below the Breadline*, Church Action on Poverty, Oxfam GB, Trussell Trust 09 Jun 2014. Available from http://www.church-poverty.org.uk/foodfuelfinance

HEALTH AND WELLBEING BOARD				
Report Title	Voluntary and Community Sector Response to Poverty, with a Focus on Food Poverty			
Contributors	Tony Nickson, Voluntary Action Lewisham Dr Roger Green, Goldsmith's College, University of London.		Item No.	12
Class	Part 1	Date:	3 July 2014	
Strategic Context	Food poverty and insecurity are becoming increasingly visible in Lewisham, affecting the diet, nutrition, mental health and wellbeing of its citizens. These issues are of central concern to Lewisham's Health & Wellbeing strategy and are reflected in its strategic priorities.			

1. Purpose

1.1 The purpose of the report is to inform the Board about independent community responses to poverty in the Borough, with a focus on food poverty; to present findings from Goldsmith's College researchers on the use and operation of Food Banks in the Borough; and to invite the Board to support a 'food summit' to bring together community members, public and voluntary services to address food poverty in Lewisham and identify ways to improve support and co-ordination of voluntary and community action in this area of need.

2. Recommendations

Members of the Health and Wellbeing Board are recommended to:

- Acknowledge the issue of food poverty in the Borough, as indicated by the experiences of local voluntary and community organisations and initial research findings presented;

- Support and endorse a discussion, to be initiated by VAL and partners, with all key stakeholders, including food bank users, to discuss approaches towards solutions to food poverty and insecurity and further investigate why people are increasingly accessing food banks and other food distribution points, with the aim of improving co-ordination and effective support for voluntary action locally in addressing food poverty in the Borough.

3. Strategic Context

3.1 Lewisham's Voluntary and Community Sector has been an active contributor to the development of Lewisham's Health and Wellbeing Strategy.

3.2 The strategy recognises that:

"Voluntary and Community organisations and groups across the Borough provide extensive depth and reach into our communities and through their work provide intelligence on community needs, have knowledge about issues that affect health and wellbeing and represent the voice of our communities".

3.3 Lewisham's Health & Wellbeing Strategy recognises healthy eating as a key determinant of health and wellbeing. The JSNA articulates the complex interaction of social exclusion, unemployment and poverty that can lead to vicious circles of isolation, exclusion and inequality that impact on mental health and wellbeing – also a key priority for the Health and Wellbeing Strategy.

3.4 Lewisham has one of the highest rates of child poverty nationally. 17,900 children in Lewisham live in poverty, according to the 2013 Heath profile for Lewisham, published annually by Public Health England. Lewisham has some of the most deprived areas in the country – and according to the various measures of multiple deprivation, parts of the Borough are becoming more deprived on these indicators. The research that supported Lewisham's Better Start bid shows that in some areas, almost 40% of households are in poverty.

3.5 The Sustainable Community Strategy priorities can be found here:

http://www.lewishamstrategicpartnership.org.uk/docs/SummarySCS.pdf

3.6 The Health and Wellbeing Strategy can be found here:

http://www.lewisham.gov.uk/myservices/socialcare/health/improving-public-health/Pages/Health-and-wellbeing-strategy.aspx

3.7 The JSNA can be found here:

www.lewishamjsna.org.uk

4. Background

4.1 The numbers of people accessing food banks nationally are increasing. Recent estimates indicate that over 4.7 million people are now in food poverty in the UK. The Trussell Trust, which runs over 400 food banks across the UK, has seen a 170% rise in people accessing Trussell Trust food banks in the past 12 months to a figure of nearly 350,000 people. Whereas the Church Action on Poverty/Oxfam report estimated that 500,000 people in the UK were in receipt of food parcels (2013). In Lewisham, the Trussell Trust reports a fourfold increase in Food Bank usage, with numbers growing from 600 for April 2012 to April 2013 to 2600 between April and December last 2013 (Trussell Trust statistics)

4.2 The Centre for Community Engagement Research, Department of Social, Therapeutic and Community Studies (STaCS), Goldsmiths, University of London has undertaken a small scale local study to explore and understand the growing issues of food poverty and food banks in the London Borough of Lewisham.

4.3 There are three food banks and several distribution points currently operating in Lewisham, along with a number of other organisations that are not food banks but distribute food and provide meals in the borough. Mounting anecdotal evidence from the community suggests that the increase in the number of people experiencing hunger, financial hardship and accessing food banks in Lewisham and across the UK is greater than even the Trussell Trust figures would suggest. (Cooper, and Dumpleton, 2013).

4.4 The aim of STaCS' small scale qualitative study is to enable Voluntary Action Lewisham and its partners to gain a better sense of the experience and impact of food poverty in this part of South East London and to support their work with communities across Lewisham who are experiencing financial and related difficulties.

5. Voluntary Sector Response to Poverty: Food Poverty in focus

5.1 In response to increasing food poverty, local communities in Lewisham have organised effectively very rapidly. In less than 2 years, voluntary and community organisations have set up seven 'Food Bank' outlets, run by different groups across the borough. In addition, many more voluntary and community groups are providing other kinds of support with providing food (such as hostels, day centres, community cafes) that does not appear in Food Bank use statistics.

5.2 Faith-based social action has been a significant driver in the development of food banking nationally. In Lewisham, food banking is provided by both faith groups and non-faith independent local activism. Different models are employed, from vouchers obtained via referral agencies, to non-voucher queuing systems and word-of-mouth referral, to low cost purchasing with no referral or voucher system. Volunteers are essential for the operation of all the centres in the Borough.

5.3 All Food Bank providers in Lewisham contacted in the research considered their action in providing free or low cost food to Lewisham citizens to be an emergency response, and most see it as a strictly temporary one. However, the need for emergency food support appears to be growing, and there is concern that what was intended to be a stop gap response will be become a more permanent feature of welfare provision in the Borough.

5.4 Centres are valued by users as points of social contact and advice, as well as for emergency food provisions, and organisations are now responding ad hoc by providing advice services on site; by referring to other services through networks; and by setting up self-help and education schemes, such as allotment development and healthy eating education.

5.5 Other activity undertaken by voluntary and community organisations (other than the direct provision of food via a Food Bank) focuses on education, access to cheap, fresh or home grown food, and on building self-reliance (activity includes food co-ops, a pensioners buying co-op, community gardening/allotment scheme, basic education on 'how to shop').

5.6 The small local study by Goldsmith's University of London *Putting Food on the Table* has identified some of the reasons why local people are resorting to Food Banks in Lewisham. Reasons highlighted are similar to the findings of other research and monitoring reports, such as those from the Trussell Trust. Inadequate income is a major feature - due to low wages, reducing welfare benefits, unemployment, temporary loss of income due to work gaps, cash flow problems (for low income self-employed people), or benefit sanctions. Some have found themselves without income for several weeks. Rising prices of daily items and higher household fuel bills were also reported as factors forcing a cut-back on expenditure on food. Stories of personal despair and helplessness frequently accompany reports of these difficulties.

6. How do we respond?

6.1 VAL, with STaCS at Goldsmith's, proposes to hold a borough-wide discussion (a Food Summit?) of all key stakeholders, including food bank users, to discuss the question of food poverty and insecurity, and why people are increasingly accessing food banks and other food distribution points, and invites the Health and Wellbeing Board to endorse and support this initiative.

7. Financial implications

7.1 There are no financial implications currently identified. There are likely to be costs associated with holding the discussion proposed in 6.1.

8. Legal implications

8.1 There are no legal implications arising from this report.

8.2 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.

9. Crime and Disorder Implications

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

10. Equalities Implications

10.1 The impact of food poverty and insecurity impacts on health inequalities across all equalities groups. The Health and Wellbeing Strategy recognises that health inequalities impact on some groups to a greater extent than others.

10.2 From the limited study undertaken by STaCS at Goldsmiths, initial findings show that the ethnicity of food bank users varied between the 3 main food bank providers, and indicate that not all of Lewisham's communities are being reached through this activity. Further work on the extent of poverty among different communities is needed, and should support discussions in the proposed 'Food summit'

10.3 An Equality Analysis Assessment (EAA) has not been carried out. Ethical permissions for community research were obtained by STaCS report authors under University of London protocols.

10.4 The proposed 'Food Summit' will be an opportunity to address the impact on the 9 protected characteristics and Equality Obligations under the Equality Act 2010.

11. Environmental Implications

11.1 There are no environmental implications arising from this report.

12. Conclusion

12.1 Food poverty is becoming increasingly visible nationally and locally. Voluntary and community organisations in Lewisham have organised rapidly to address this need. Local centres are becoming a focus not only for emergency food provision but also for social contact and access to advice and support services for those with multiple needs. Support for voluntary action to alleviate food poverty in the Borough will benefit from co-ordination of support services, including advice and other professional and statutory services across the Borough. A multi-stakeholder discussion, to be initiated by VAL and partners, is proposed, with the aim of improving co-ordination and effective support for voluntary action locally in addressing food poverty in the Borough. The Health and wellbeing Board is asked to endorse and support this initiative.

Background Documents

http://www.trusselltrust.org/stats (as accessed May 2014)

Eastlondon lines website – stats from Trussell Trust:
http://www.eastlondonlines.co.uk/2014/04/the-rise-of-the-foodbank-6500-eastlondonlines-residents-have-been-forced-to-visit-foodbanks-in-last-year/
(as accessed May 2014)

Cooper, N. and Dumpleton S. (2013) *Walking the breadline. The scandal of food poverty in 21st century Britain*, Church Action on Poverty and Oxfam.
and Oxfam. http://www.church-poverty.org.uk/walkingthebreadline/info/report/walkingthebreadlinefile

Cooper, Purcell, & Jackson, *Below the Breadline*, Church Action on Poverty, Oxfam GB, Trussell Trust 09 Jun 2014
http://policy-practice.oxfam.org.uk/publications/below-the-breadline-the-relentless-rise-of-food-poverty-in-britain-317730

Lewisham Health Profile 2013:
http://www.apho.org.uk/resource/item.aspx?RID=127142

If you have any difficulty in opening the links above or those within the body of the report, please contact Kalyan DasGupta (kalyan.dasgupta@lewisham.gov.uk; 020 8314 8378), who will assist.

If there are any queries on this report please contact Tony Nickson, Director, Voluntary Action Lewisham, tony@valewisham.org.uk

HEALTH AND WELLBEING BOARD				
Report Title	Progress Report on Implementing the National Autism Strategy "Fulfilling and Rewarding Lives" in Lewisham			
Contributors	Corinne Moocarme – Joint Commissioning Laura Harper – Housing, Health and Social Care Integration Project Manager		Item No.	13
Class	Part 1	Date:	3 July 2014	
Strategic Context	Please see body of the report			

1. Purpose

1.1 This report provides a six monthly update for the Board focusing on the main areas of the Self Assessment where Lewisham had rated itself Amber. As requested there is a particular emphasis on the specific identification of adults with Autism in the local housing strategy and more detail on how Lewisham Housing is working to identify a range of housing to support residents with particular needs.

2. Recommendations

2.1 It is recommended that the Health and Wellbeing Board:

- Discuss and note the content of this update
- Support local implementation work
- Agree for another update to be submitted in January 2015.

3. Strategic Context

3.1 The Autism Act 2009 was the first legislation designed to address the needs of Adults on the Autism Spectrum. It placed a duty on the Secretary of State to prepare and publish a strategy for improving the provision of relevant services to meet the needs of this client group. It also required the Secretary of State to issue guidance to local authorities and to NHS bodies and Foundation Trusts about the exercise of their functions concerned with the provision of these services.

3.2 Subsequently, "*Fulfilling and Rewarding Lives – Strategy for Adults with Autism in England"* was published by the Department of Health in March 2010. This was followed by Implementing *"Fulfilling and Rewarding Lives", Statutory Guidance for Local Authorities and NHS Organisations to Support Implementation of the Autism Strategy"* in December of the same year.

3.3 The Strategy set out the key areas for local and national work and focused on laying the foundations for change which involved raising awareness of Autism, particularly across public services; increasing the availability and consistency of diagnosis; taking steps to make services more accessible for adults with Autism, personalisation across all services and looking directly at the challenges faced by adults with Autism in getting into work and keeping a job, as part of the wider goal of achieving full employment.

3.4 "*Think Autism" – Fulfilling and Rewarding Lives, the strategy for adults with Autism in England: an update* was published by the Department of Health, Social Care, Local Government and Care Partnership Directorate in April 2014.

3.5 The *"Think Autism"* strategy identified three reasons for its publication:

- It was a requirement in the Autism Act for the Autism Strategy to be reviewed and to reflect what was heard from people with Autism, their families and from services during this review.
- A huge amount has been done nationally to deliver on the strategy and it was necessary to take stock and move on.
- Many things have changed in services since 2010 with widespread transformation programmes taking place across public services. There is a need to take account of these reforms and how they can be used to improve the lives of people with Autism.

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

3.7 The work of the Board directly contributes to *Shaping our Future's* priority outcome which states that communities in Lewisham should be *Healthy, active and enjoyable – where people can actively participate in maintaining and improving their health and wellbeing.*

4. Background

4.1 Directors of Adult Social Services were requested by the Department of Health in 2013 to take forward the second-self assessment exercise for the implementation of the Adult Autism Strategy.

4.2 Lewisham completed its submission at the end of September 2013. As a requirement of the process it was discussed at the Health and Wellbeing Board on 19 November 2013.

4.3 At the November meeting, the Chair of the Health and Wellbeing Board requested six monthly updates on progress in implementing the National Autism Strategy.

4.4 Lewisham participated in the Self-Assessment Exercise - the purpose of which was to assist the Department of Health in assessing progress against the implementation of the 2010 Adult Autism Strategy. Lewisham completed the submission in September 2013 and this was presented to the Health and Wellbeing Board on the 19 November 2013.

4.5 There were 17 questions in the Self Assessment Framework (SAF) that attracted a RAG rating. Lewisham rated itself Green on 6 questions and Amber on the remaining 11. There were no red ratings. Some of the main areas rated Amber requiring further work to progress were:

- The inclusion of Autism in the local Joint Strategic Needs Assessment.
- Improving the data collected regarding numbers of adults with Autism in the borough.
- The level of information about local support in the area being accessible to people with Autism.
- Promotion of employment of people on the Autism Strategy.
- Specific identification of adults with Autism in the local housing strategy.

5. Progress Report

5.1 In line with the Board's request, this report focuses on the main areas where Lewisham rated itself Amber in the 2013 SAF.

5.2 The inclusion of Autism in the local Joint Strategic Needs Assessment and Improving the data collected regarding numbers of adults with Autism in the Borough.

5.2.1 These two areas are combined as there is a need to have better systems in place for recording number of adults with Autism before we can include Autism in the local JSNA.

5.2.2 In June 2013 Dr Ratna Ganguly, GP Vocational Trainee, Lewisham Public Health produced a report making recommendations for improvements to data collection for adults with Autism. She recommended that there should be a regular audit of people diagnosed with Autism utilising the "READ" codes for Autism that all GPs in Lewisham enter onto the EMIS system. However, to ensure

that this audit is as accurate as possible there needs to be more training for GPs and Practice staff in recognising and identifying Autism, and appropriate referral routes to Autism specific services. The Council is working with Lewisham Clinical Commissioning Group (CCG) to determine how the training can most effectively be delivered.

5.2.3 Both the SLAM Diagnostic Clinic and the Lewisham Information Advice and Support Service are required to collect information on diagnosis as part of their key performance indicators. In addition, from April 2014, local authorities have to now record information about a person's primary reason for support and whether the person has reported certain other health conditions, such as Autism. Over time this will lead to a better understanding of our local population of adults with Autism.

5.3 **The level of information about local support in the area being accessible to people with Autism.**

5.3.1 The Lewisham Autism Information, Advice and Support Service commissioned from Burgess Autistic Trust worked hard during 2013/14 to increase the levels of information available. They have worked with the Local Authority Social Care Advice and Information Team (SCAIT) and many other local organisations (including Job Centre Plus).

5.3.2 Referral pathways have been developed with the National Autism Society Family Service (on transition to adulthood) as well as the Community Mental Health Teams and Learning Disability Services.

5.3.3 The Lewisham Autism Information, Advice and Support Service has received approximately 250 enquiries since its launch in 2012 with the majority of initial enquires being requests for information on available support.

5.4 Promotion of employment of people on the Autism Strategy

5.4.1 There are a number of employment schemes within the Borough for young people aged 16-25 with learning disabilities/learning difficulties not in education or training. There is also a specific scheme for young people with Autism (Care Trade – Autism Project). All schemes will work with adults with Autism. A company called Aurora Options has worked with LeSoCo targeting young people with Learning Disability who are in their last year of college to develop employment pathways and supporting them into employment.

5.4.2 The Lewisham Information and Advice Service have an employment worker who is able to support service users looking for work. Burgess Autistic Trust has delivered Autism awareness training to Jobcentre Plus which included the positive aspects of employing adults with

ASD. They are regularly approaching local Organisations with a view to building links and arranging work placements etc.

5.5 Specific identification of adults with Autism in the local housing strategy

5.5.1 The Housing and Autism Project Group has met twice in 2014 with meetings planned for the remainder of the year at six weekly intervals. The purpose of the group is:

- To better understand and document the level and nature of Autism in the Borough
- To investigate existing housing services and placements for autistic children and adult
- To investigate potential sources of funding – current and future sources – revenue and capital
- To investigate the options for the provision of an Autism housing scheme for local adults either within existing stock or new supply
- To pull out of the needs assessment, various development opportunities into an Autism housing strategy
- To link the Autism housing strategy into the wider learning disabilities strategy and health and wellbeing strategy.

5.5.2 During 2014 the Council has worked with the Campaign for Lewisham Autism Spectrum Housing (CLASH) and Burgess Autistic Trust (BAT) to carry out assessments on seven young people nominated by CLASH to determine their housing need. The Group is currently considering the analysis of these assessments to inform the level of support that young adults with Autism may require to obtain and sustain tenancies.

5.5.3 None of the seven interviewees were currently registered for social housing and work is underway to support those that want help with applications. All wanted to remain living in Lewisham close to family support networks. All felt that they would need support to live independently particularly around shopping, cooking, budgeting and home maintenance.

5.5.4 In addition to the assessments, the Group has been considering various models of supporting adults with Autism in other boroughs with a view to what might work best in Lewisham.

5.5.5 The London Borough of Lewisham Housing Department is working closely with Social Care and Health to identify a range of housing which can support residents with particular needs. Small project groups have been set up to explore housing and support solutions which maximise independence. It is anticipated that initial proposals for improving housing for people with Mental Health issues, Young Adults in Transition and People with Learning Disabilities will be

developed by October 2014. There are also three new build extra care schemes in development for older people. Whilst there may be an element of new provision within future proposals, there will be a focus on maximising the use of existing housing stock to better meet identified needs.

6. Think Autism and the Autism Innovation Fund

6.1 As referenced in Sections 3.4 and 3.5 Think Autism is the Government's update on progress in delivering the National Autism Strategy. The Government carried out a review in 2013/14 and from this fifteen priority challenges for action are listed in Think Autism.

These are:

- **An equal part of my local community**

I want to be accepted as who I am within my local community. I want people and organisations in my community to have opportunities to raise their awareness and acceptance of Autism.
I want my views and aspirations to be taken into account when decisions are made in my local area. I want to know whether my local area is doing as well as others.

I want to know how to connect with other people. I want to be able to find local Autism peer groups, family groups and low level support.

I want the everyday services that I come into contact with to know how to make reasonable adjustments to include me and accept me as I am. I want the staff who work in them to be aware and accepting of Autism.

I want to be safe in my community and free from the risk of discrimination, hate crime and abuse.

I want to be seen as me and for my gender, sexual orientation and race to be taken into account.

- **The right support at the right time during my lifetime**

I want a timely diagnosis from a trained professional. I want relevant information and support throughout the diagnostic process.

I want Autism to be included in local strategic needs assessments so that person centred local health, care and support services, based on good information about local needs, is available for people with Autism.

I want staff in health and social care services to understand that I have Autism and how this affects me.

I want to know that my family can get help and support when they need it.

I want services and commissioners to understand how my Autism affects me differently through my life. I want to be supported through big life changes such as transition from school, getting older or when a person close to me dies.

I want people to recognise my Autism and adapt the support they give me if I have additional needs such as a mental health problem, a learning disability or if I sometimes communicate through behaviours which others may find challenging.

If I break the law, I want the criminal justice system to think about Autism and to know how to work well with other services.

- **Developing my skills and independence and working to the best of my ability**

I want the same opportunities as everyone else to enhance my skills, to be empowered by services and to be as independent as possible.

I want support to get a job and support from my employer to help me keep it.

6.2 The Government is keen to support the delivery of some of the key themes set out in *Think Autism* and as part of this has launched a time limited **Autism Innovation Fund**. The aim of the fund is to help drive creative and cost effective solutions and identify good models of practice that can be replicated in other areas.

6.3 There are four areas (aligned with the priority challenges listed above) where the Government is inviting proposals. These are:

- Advice and Information
- Gaining and growing skills for independence
- Early intervention and crisis prevention
- Employment, particularly involving the use of apprenticeships

Proposals will need to demonstrate the following core characteristics:

- Involvement of people with Autism
- Innovation
- Partnership

Further information about the Autism Innovation Fund is expected by the end of June 2014.

7. Financial Implications

7.1 The Government has announced that there will be available revenue and capital funding of £4.5 million to support the delivery of *Think Autism*. Part of this will be used to launch the Autism Innovation Fund.

7.2 Further details are awaited about the bidding process for this fund and once this is received work will begin with key stakeholders (including adults with Autism and their families) to gather ideas for possible bids and agree those that fit in with local priorities.

7.3 It is expected that all bidding proposals will be able to evaluate and evidence outcomes, including cost-benefit or cost-comparators.

8. Legal Implications

8.1 There are no legal implications arising from this report.

9. Crime and Disorder Implications

9.1 There are no Crime and Disorder Act implications arising from this report.

10. Equalities Implications

10.1 The Equality Act 2010 (the Act) brings together all previous equality legislation in England, Scotland and Wales. The Act includes a new public sector equality duty (the equality duty or the duty), replacing the separate duties relating to race, disability and gender equality. The duty came into force on 6 April 2011. The new duty covers the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

10.2 In summary, the Council must, in the exercise of its functions, have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- advance equality of opportunity between people who share a protected
- characteristic and those who do not.
- foster good relations between people who share a protected characteristic and those who do not.

10.3 All commissioned services for adults with Autism are required to demonstrate diversity in providing a service that matches the culture, race, gender and disability of service users living in Lewisham.

10.4 The equalities implications of any bids submitted to the Autism Innovation Fund and subsequent revisions to the Adults with Autism Commissioning Plan will be considered prior to implementation.

11. Environmental Implications

11.1 There are no environmental implications arising from this report.

12. Conclusions

12.1 Lewisham is looking to establish a community that accepts and understands Autism and which has an infrastructure that provides opportunities for adults with Autism/Asperger's syndrome to live fulfilling and rewarding lives.

12.2 The Self Assessment Framework (2013) provided a good opportunity to recognise our achievements, take stock of our current position and understand where further work was required.

12.3 Presentation and discussion of the SAF in November 2013 provided an opportunity to ensure Autism was on the Health and Wellbeing Board Agenda and the request to provide regular updates is welcomed.

12.4 This update to the Health and Wellbeing Board is timely in that it coincides with the publication of Think Autism and the launch of the Autism Innovation Fund. We look forward to providing further updates as we progress with work in these areas.

Background Documents

Think Autism
https://www.gov.uk/
Think Autism Fulfilling and Rewarding Lives, the strategy for adults with Autism in England: an update. April 2014

Self Assessment Frameworks submitted in 2013
www.improvinghealthandlives.org.uk/projects/Autism2013

Fulfilling and Rewarding Lives
https://www.gov.uk/fulfilling-and-rewarding-lives-the-strategy-for-adults-with-Autism-in-england

Autism in Lewisham
Dr Ratna Ganguly – GP Vocational Training Scheme (GPVTS) in Public Health – June 2013

If you have any difficulty in opening the links above or those within the body of the report, please contact Kalyan DasGupta (kalyan.dasgupta@lewisham.gov.uk; 020 8314 8378), who will assist.

If there are any queries on this report, please contact Corinne Moocarme, Joint Commissioning Team on 020 8314 3342. corinne.moocarme@nhs.net

HEALTH AND WELLBEING BOARD				
Report Title	Health and Wellbeing Board Work Programme			
Contributors	Service Manager – Strategy, Directorate for Community Services		Item No.	14
Class	Part 1	Date:	3 July 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. Strategic Context

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

3.2 The work of the Board directly contributes to *Shaping our Future's* priority outcome that communities in Lewisham should be Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing.

4. Background

4.1 The work programme is a key document for the Health and Wellbeing Board. It allows the Board to schedule activity, reports and presentations across the year. It also provides members of the public and wider stakeholders with a clear picture of the Board's planned activity.

4.2 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.

4.3 Upon agreement of the work programme, the Health and Wellbeing Agenda Planning group will commission the necessary reports and activities.

5. Work programme

5.1 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.

5.2 At the HWB meeting on the 28 January, members agreed to focus on high-level issues, undertaking more detailed reviews as and when necessary. The Agenda Planning Group has requested that reports clearly identify the strategic context and will endeavour to group strategic items on the agenda. Representatives from the CCG requested that consideration of key strategic documents be added to the Health and Wellbeing Board work programme at the Agenda Planning Group.

5.3 A representative from Voluntary Action Lewisham has now joined the Agenda Planning Group to facilitate greater engagement of the voluntary sector.

5.4 The work programme now includes standing items on progress in relation to the Health and Wellbeing Strategy and the Integrated Adult Care Programme.

6. Financial implications

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

7. Legal implications

7.1 The Board's statutory functions are broadly set out in paragraph 4.2.

7.2 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.

7.3 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.

7.4 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.

7.5 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/

7.6 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

7.7 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/

7.8 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.

8. Equalities implications

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

9. Crime and disorder implications

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

10. Environmental implications

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

If you have any difficulty in opening the links above or those within the body of the report, please contact Kalyan DasGupta (kalyan.dasgupta@lewisham.gov.uk; 020 8314 8378), who will assist.

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

Appendix 1

Health and Wellbeing Board – Work Programme

(Updated: 25.06.14)

Meeting date	Agenda Planning		Report Deadline		Agenda Publication
23 Sep 2014	Date TBC		Fri 5 Sept		Mon 12 Sept
Agenda item	**Report Title**	**Deferred**	**Key decision or information**	**Part 1 or Part 2**	**Lead Organisation(s)**
1	Revised Pharmaceutical Needs Assessment for HWB approval			Part 1	PHE
2	Integrated Adult Care Programme			Part 1	LBL
3	HWB Strategy General Progress Update			Part 1	LBL
4	CCG 5-year Strategy			Part 1	CCG
5	Primary Care Development Strategy			Part 1	CCG
6	LSL Sexual Health Strategy			Part 1	LBL
7	Adult Integrated Commissioning Intentions			Part 1	CCG
8	The Care Act Implementation			Part 1	tbc

Meeting date	Agenda Planning		Report Deadline		Agenda Publication
25 Nov 2014	Date TBC		Fri 7 Nov		Fri 14 Nov
Agenda item	**Report Title**	**Deferred**	**Key decision or information**	**Part 1 or Part 2**	**Lead Organisation(s)**
1	Integrated Adult Care Programme			Part 1	LBL
2	HWB Strategy General Progress Update			Part 1	LBL
3	HWB Strategy: Progress Update -Delayed Discharge / Long-Term Conditions			Part 1	LBL
4	HWB Strategy: Progress Update - Air quality / Chronic Obstructive Pulmonary Disease (COPD)			Part 1	CCG/LBL
5	Cancer			Part 1	LBL
6	Emergency Services Review			Part 1	CCG/LBL (tbc)

Meeting date	Agenda Planning		Report Deadline		Agenda Publication
Jan 2015	Date TBC		TBC		TBC
Agenda item	Report Title	Deferred	Key decision or information	Part 1 or Part 2	Lead Organisation(s)
1	Integrated Adult Care Programme			Part 1	LBL
2	Public Health Budget			Part 1	LBL
3	Healthwatch Performance Review			Part 1	LBL
4	HWB Strategy Delivery Group: progress update			Part 1	LBL
5	Developing an Integrated Approach to Public Health in SE London: Establishing an Urban Public Health Collaborative			Part 1	LBL
6	Mental Health			Part 1	LBL
7	CVD			Part 1	LBL

Meeting date	Agenda Planning		Report Deadline		Agenda Publication
March 2015	Date TBC		TBC		TBC
Agenda item	Report Title	Deferred	Key decision or information	Part 1 or Part 2	Lead Organisation(s)
1	Integrated Adult Care Programme			Part 1	LBL
2	HWB Strategy Delivery Group: Annual Report			Part 1	LBL

HEALTH AND WELLBEING BOARD Information Item			
NHS Lewisham CCG Annual Report 2013-14			
Contributor	Head of Strategy & Organisational Development, NHS Lewisham Clinical Commissioning Group		
Date	3rd July 2014	**Item No.**	15

1. Summary

1.1 The CCG's annual report summarises the organisation's financial accounts, governance and achievements for 2013-14.

2. Background

2.1 CCGs are required to publish, as a single document, an Annual Report and Accounts. This will in turn form part of NHS England's consolidated accounts, which will then form part of the DH's consolidated accounts incorporating all NHS bodies.

2.2 The key requirements for CCG annual reports are set out in detail within NHS England draft annual reporting guidance available on the NHSE website.

3. Content

3.1 The Annual Report and Accounts consists of three sections:

1. Annual Report – which must include:

   - Member Practice's Introduction
   - Strategic Report
   - Member's Report
   - Remuneration report

2. Statements by the Accountable Officer

   - Statement of Accountable Officer's Responsibilities
   - Annual Governance Statement

3. Annual Accounts which must consist of:

   - Report by the Auditors to the Members of the Governing Body of the CCG
   - Financial statements

3.2 As well as providing a breakdown of financial expenditure the Annual Report and Accounts includes future strategic financial planning assumptions for commissioning.

If you have any difficulty in opening the links above or those within the body of the report, please contact Kalyan DasGupta (kalyan.dasgupta@lewisham.gov.uk; 020 8314 8378), who will assist.

If there are any queries on this information item please contact Charles Malcolm-Smith, Head of Strategy & Organisational Development, NHS Lewisham Clinical Commissioning Group at: charles.malcolm-smith@nhs.net

NHS
Lewisham
Clinical Commissioning Group

Annual Report & Accounts 2013/14

Annual Report

- Member Practices' Introduction
- Strategic Report
- Members' Report
- Remuneration Report

Statements by the Accountable Officer

- Statement of Accountable Officer's Responsibilities
- Governance Statement

Annual Accounts:

- Report by the Auditors to the Members of the Clinical Commissioning Group
- Financial Statements

Member Practices Introduction

Reflections on the year 2013-14

Our Annual Report and Accounts provides us with the opportunity to look back at the year that has passed and to consider how well we have progressed in delivering our strategic aims, as set out in the CCG's constitution, and to address the key challenges facing the CCG. In this first Annual Report and Accounts, I would like to reflect on some of the key themes of our first year, assess the impact we have had and draw some conclusions for the year ahead.

The first year of any new organisation is a relatively challenging period and for the CCG this has involved establishing new structures and systems and managing resources, in a period of unprecedented change for the NHS as a whole, as well as ensuring continued commissioning support for our membership practices.

Our first priority was to ensure that NHS Lewisham CCG was able to operate effectively following its launch as a legal entity in April 2013. We ensured that the CCG had:

- strong governance arrangements so that the Governing Body's decisions, informed by members' views – and the process by which it makes those decisions – are clear to the wider membership and the public
- internal controls to manage the CCG's resources and risks efficiently
- met its legal and statutory duties
- robust contracting arrangements, including with the new provider, Lewisham and Greenwich NHS Trust, supported by the South London Commissioning Unit, to ensure best value in the way resources were spent
- open and accessible engagement with stakeholders, especially with the public, patients and carers
- strong collaborative relationships with our commissioning partners in the new health and care landscape, particularly with the London Borough of Lewisham and the Health and Wellbeing Board, NHS England, and our neighbouring CCGs across South East London.

Members were able to confirm the strength and sustainability of these new systems through the Governing Body self- assessment, which took place in April 2014 and allowed the Governing Body to review their collective and individual contributions as leaders of the organisation in strategy, accountability, shaping the CCG's culture and identifying those areas which required improvement to be included within our revised Organisational Development Plan for 2014/15.

Our second priority was to ensure clarity about the new CCG's purpose, especially about the specific priorities needed to improve the health of people in Lewisham. Like many organisations in the NHS, the CCG faces many challenges with finite resources, so it was essential that we were clear about where we needed to focus our collective efforts in order to achieve the best for people in Lewisham.

The organisation has a clear vision – to deliver better health, best care and best value for everybody in Lewisham – and has developed three strategic themes:

- Healthy living for all – we will help people to live healthy lifestyles, have healthy families and make healthy choices, while at the same time tackling health inequalities in the borough.

- Frail and vulnerable people – ensuring that they are supported and cared for at all times with dignity, compassion and respect.

- People with long-term conditions, such as diabetes or heart disease – empowering them to have greater control over managing their condition.

Commissioning Intentions have been agreed to deliver this vision for the next two years, and work is under way with the other south east London CCGs to develop a five-year plan for the whole of south east London, to benefit from the advantages of scale and make the best use of opportunities where a wider approach can add value.

In every case, our five year strategic plan, our two year commissioning intentions and our Operating Plan have been developed through dialogue and active engagement with the public, to ensure that the CCG's priorities are aligned with the needs of local people. Members have been well-placed to add value here, as our grouping into four neighbourhoods ensures that we can feed a local perspective and local expertise into Governing Body decisions.

The impact of our commissioning
With our structures in place, and our priorities agreed, we can point to some significant achievements in each of the three areas of our vision for better health, best care and best value. However there remain significant commissioning challenges and risks for Lewisham CCG to address in the forthcoming year. There will be greater demand for health and care services, and we need to find ways of achieving more, with the same or diminishing resources by working differently in partnership with Lewisham people and collaboratively with local providers. This is our key strategic challenge.

Best care
NHS Lewisham CCG recognises the need to respond creatively to the significant risks facing the NHS and to do things differently, so allowing us to improve the quality of care. As a clinician-led organisation, the CCG is well placed to promote innovation in health care and use the opportunities available as part of the new NHS and social care arrangements to respond to these challenges.

Through our public and members engagement during 2013/14, we have heard many concerns about the quality of local service, most recently at the Members Event (March 2014) and the Quality Summit (March 2014). Particular concerns voiced included:

- The experience of users of district nursing services and inpatient hospital care;
- The continued high numbers of pressure ulcers
- The wide variation in the quality of services delivered by different providers, for example primary care and access to primary care;
- The poor communication across health and social care professionals, for example communications to co-ordinate the discharge and follow up care of patients.

In response to this the CCG has been piloting and evaluating a number of new approaches - to improve the quality of care, which are described in greater detail in the report. They include:

- the team around the mother, focusing on the mother's experience, wishes and outcomes from maternity services
- improving access to primary care, where the GP practice proactively contacts a patient to support them to manage their own care better.

- work across south east London to improve the management of patients to prevent pressure ulcers forming and to improve the skills and knowledge of healthcare professionals in all care settings so that they are able to provide more effective care to patients that have acquired pressure ulcers, not all of which are preventable.
- additional support to all care homes, to improve and reduce variation in the quality of care, such as the scheme to prevent falls, which can have such a catastrophic impact on the health and independence of frail elderly people;
- ways to deliver better care and self-management, and fewer emergency admissions for people with long-term conditions, such as the risk profiling project for GPs and collaborative care planning, where the GP and the wider health and social care team work in partnership with the patient and carers on what best meets their individual needs.
- an active review, currently underway, of the district nursing service.

These approaches are evidence-based; pilot schemes are monitored so that what works best for the people of Lewisham can be rolled out across healthcare in the Borough, and as many people as possible can benefit from the new ways of working.

Some examples of how pilot projects have already been mainstreamed across Lewisham include:

- The diabetes champions, who take the message of the benefits of health care and self-management into communities to improve access to services and early diagnosis.
- The 'Three Rs' approach to diabetes, whereby GP practices actively pursue an approach of 'register, recall and review' to improve early diagnosis and therefore better treatment for people with diabetes.
- A complete redesign of services for people with dementia, following consultation with patients, carers and other key stakeholders and then re-commissioning the service;
- A named key worker in every GP practice to promote early diagnosis and self-management for people with COPD.
- Discussions are underway between member practices about the benefits of working together in order to offer alternative ways of working.

We believe that this new clinician-led approach to commissioning is improving the quality and safety of health care in Lewisham. Underpinning everything we do is the drive for quality, so we have implemented a more systematic approach to monitoring and escalating concerns as they arise. We believe we are seeing some improvements already in the three key areas that define quality for patients:

- Safety – we have improved our infection control and child and adult safeguarding arrangements;
- Patient experience – we have improved the experience for patients with long-term conditions and in primary care;
- Effectiveness – our work is based on evidence and, where new or different approaches are taken, on robust evaluation to learn the lessons of what works.

However we know that there is more work to do on improving patient experience particularly in our nursing workforce, maternity and inpatient care – especially around discharge of patients from hospital – and variation in quality and access to primary care services.

Better health

Lewisham faces significant health challenges, as set out in this report. Our population is overall increasing, with high levels of deprivation and significant health inequalities. Overall the trend in life expectancy is improving, however for people living in Lewisham it is shorter than for the London and England. There are higher than average rates of mental health problems in Lewisham. There are increasing numbers of people with long term conditions, in common with other CCGs. Together, these factors will inevitably mean a greater demand for health and care services.

After just one year in operation, it is difficult to assess the impact of the different ways we have commissioned services, especially on the long term health outcomes of Lewisham people. However Lewisham CCG is committed to supporting health promotion interventions which should have a significant impact on improving the long term health of Lewisham people. Also the CCG is committed to working with the Health and Wellbeing Board and public health colleagues to address the wider issues that have an impact on health, such as housing, lack of education and finding ways to promote good health and reduce or prevent ill health in both primary and community care. Examples of where this approach is already having an effect, include:

- improving mumps, measles and rubella immunisation at year 2. This was an early clinical priority identified with members. With huge effort we improved vaccination rates by 10% in a 12 month period, making us one of the most improved CCGs in London on this measure. We are looking to sustain and improve other vaccination levels.
- developing a network of clinical commissioning facilitators who link up with particular practices, to share good practice and to promote health checks, immunisations and to stop smoking;
- encouraging the uptake of vitamin D, by bringing together various parts of the health economy, including the CCG, public health and pharmacies, to launch a campaign to improve access to vitamin D for young children.
- promoting flu vaccinations – working to support GP practices to improve uptake for the over 65s.

Best value

The CCG was able to start 2013/14 by setting a balanced budget, and by the end of the financial year:

- We met all our statutory financial duties, including the need for a 1% surplus.
- We delivered our Quality Innovation, Prevention and Productivity (QIPP) programme savings of £12.1 million, but we were not successful in meeting our plans to reduce significantly the numbers of emergency admissions that should not usually require a hospital admission and the level of new outpatient referrals. The QIPP programme for 2014/15 will focus on reducing unnecessary or inappropriate activity in these areas.

Looking ahead, there are challenges, but our belief is that we can meet these challenges and achieve our goals for the people of Lewisham through working together.

We will do this through delivering our strategic model of care. This is based on shifting the balance of care from emergency responses to care that is proactive and planned. It means developing local neighbourhoods and communities so that services respond to those local needs of these communities, and we are better placed to tackle inequalities in the borough.

Above all it means always putting the individual patient at the centre of care, seeing the whole person and empowering them to act as a partner in improving health.

Dr Marc Rowland
Chair of the Governing Body, NHS Lewisham Clinical Commissioning Group
June 5th 2014

Strategic Report

Lewisham Context

Who we are

NHS Lewisham Clinical Commissioning Group is the organisation responsible for planning, monitoring and buying most of the health services needed in Lewisham, including:

- hospital care
- rehabilitation care
- urgent and emergency care
- most community health services
- mental health and learning disability services.

Some health services in the borough, including GPs themselves, pharmacies, dentists, opticians and some specialist services, are commissioned by NHS England.

We were established in April 2013 as part of the changes to the NHS which put GPs in charge of making decisions about what health services should be available for their patients. Lewisham GPs lead the CCG and every GP practice in Lewisham is a member and able to have a say on the decisions that are made.

We had an allocation of £365 million in 2013-14 to secure the best possible health and care services for Lewisham residents in order to reduce health inequalities and improve health outcomes.

To achieve our vision and tackle the health challenges in Lewisham, we work in partnership with the public, patients and carers, through specially organised public events and through specially-created fora such as our Patient Engagement Group, to ensure that our services will meet the needs of people in Lewisham. Also we work in collaboration with other commissioners, including London Borough of Lewisham, NHS England and neighbouring CCGs to meet our goals and ensure efficient and effective working. .

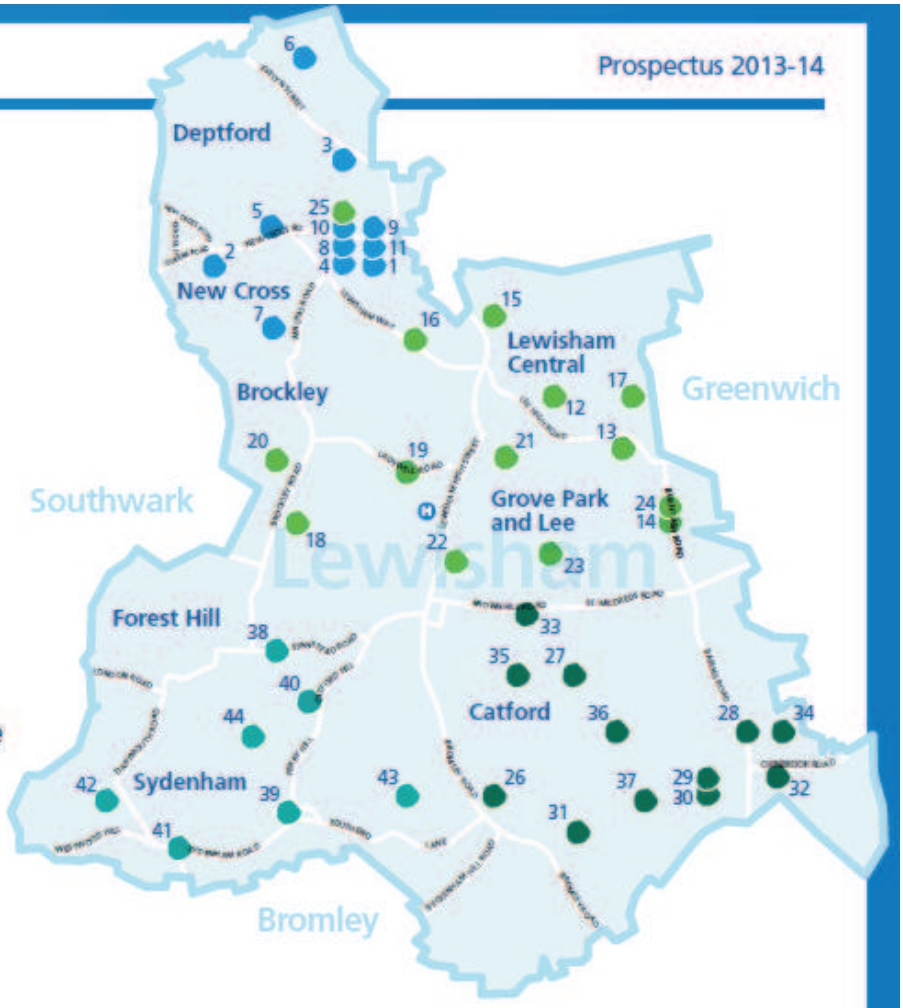
Our Borough

Lewisham CCG is coterminous with the London Borough of Lewisham**.**

Lewisham is a diverse borough with a population estimated at 284,325 people in 2013, 49% male, 51% female. It is a young population, with a quarter (25.4%) under the age of 20. It is also highly mobile, with as many as a fifth of residents moving in and out of the borough every year. This mobility places an additional strain on health services. For example, people who are not registered with a GP are more likely to have to use unplanned, and more expensive, urgent care services. It is also harder to ensure that people take up health screening services, and so miss out on their preventative health benefits.

To assist us in delivering local responsive health and social care services, Lewisham Borough is divided into four neighbourhoods:

GP Practices in Lewisham



Neighbourhood 1 Practices

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

Neighbourhood 2 Practices

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

Neighbourhood 3 Practices

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

Neighbourhood 4 Practices

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

Our population

Lewisham CCG needs to understand the characteristics of Lewisham's population and future trends to be able to effectively plan and buy the most appropriate health services. The information we use to understand the make-up and health and wellbeing of the people of Lewisham is obtained from Lewisham's Joint Strategic Needs Assessment (JSNA). This brings together in one place, to an extent, a wealth of information on the health and social care needs of Lewisham's citizens, complemented by information on the social environmental and population trends that are likely to impact on people's health and wellbeing. The JSNA also includes the community and patient view on local health and social care services. It shows that:

- **Population growth -** Overall the population is expected to grow over the next five years, especially in the 20-64 age group. There has been a sustained rise in the birth rate in Lewisham for several years, reflecting a similar rise in London and the country as a whole. The trend is expected to level off in Lewisham in future years, but because of the previous rise in births the population of children, in particular those aged 5 to 14, will continue to rise.

- **Ethnicity** - Lewisham is a very ethnically diverse borough, particularly in the younger age groups, with 46.5% of the population from black and ethnic minority (BME) groups compared to 40.2% in London as a whole, and 12.5% in England. In 2011, the latest year for which figures are available, the two largest groups were black African (12%) and black Caribbean (11%). Three quarters of school children (77%) are from BME groups and together speak over 170 languages.

- **Deprivation -** deprivation is increasing in Lewisham. The 2010 Index of Multiple Deprivation (IMD) ranked Lewisham as the 31st most deprived borough (out of 354 local authorities in England). This compares to 39th in 2007:

    - There is deprivation across Lewisham, demonstrated by there being no wards in the top 20% of most affluent areas in England.
    - Within the borough there are significant inequalities between wards. Evelyn ward in the north of the borough is the most deprived ward, followed by Bellingham, and Downham in the south. Rushey Green in the centre of Lewisham borough ranks as the 4th most deprived ward;
    - Life expectancy for both men and women in New Cross and Lewisham Central wards is significantly lower than the rest of Lewisham, London and England.
    - A third of Lewisham households are one-person households (34%) compared to 30% in England. Of these, nearly a third are aged 65 and over.
    - Lewisham has a higher proportion of lone parent households (11%) compared to London (9%) and England (7%).
    - Lewisham also has a higher than average problem with housing poverty, for example .

- **Local inequalities -** Unemployment, lack of education and living in poor conditions all have an impact on health.

    There are also significant health inequalities among different ethnic groups. Some of these are genetic related, to an extent, with some ethnic groups more likely to develop coronary heart disease or diabetes. Some are about accessing services: for example, uptake of breast screening is lower in black women, while late diagnosis of HIV infection is more common in black African heterosexual men and women. Black teenage girls are

more likely to get pregnant than white teenage girls. White men and women have higher rates of admission for alcohol-related problems.

Our health challenges

Life expectancy is below that of London and England for both men (78 years) and women (82 years) (2010-12 figures). The Life Expectancy gap between Lewisham and England is reducing. This is improving across the whole borough although there are still variations in different areas.

The main causes of death are cancer, circulatory disease and respiratory disease, similar to many other parts of the country. Compared with London as a whole, both men and women are more likely to die from these conditions before they reach the age of 75.

In Lewisham our particular health challenges include:

- **Health promotion -** Health promotion is the process of enabling people to increase control over, and to improve, their health. Health promotion activities include developing a supportive environment with easy access to information, life skills and opportunities to make healthy choices, such as to stop smoking and to eat more healthily. Specific issues for Lewisham are:

    - A fifth (21%) of the population smoke, more than the national average, with higher rates among those on lower incomes.
    - Around a third of adults in the borough are overweight or obese, compared to just under a quarter (24.2%) in England as a whole.
    - Lewisham also has a high level of childhood obesity, with over four in ten children aged 10-11 and nearly a quarter of 4-5 year olds obese in 2011-2012.
    - Adults in Lewisham are less likely to take part in sport or active recreation compared to both London and the rest of England.
    - Alcohol-related harm is increasing in Lewisham**.**

- **An increase in long-term conditions -** a long-term condition is a health problem that cannot be cured but can be controlled by medicines or other treatments. Examples include diabetes, heart disease, chronic obstructive pulmonary disease (COPD), dementia and depression.

    - Research indicates that nearly 20% of people have more than two long-term conditions and this proportion increases steeply with age. The prevalence of those with two or more long-term conditions is also higher in more deprived populations.
    - Projections suggest that from about 2015 the number of residents over 65 years old will begin to rise. The proportion of over 65s in Lewisham was 9% in 2013, but is expected to rise to 11% by 2028. This is likely to be reflected in an increase in the number of people with long-term conditions.

- **Mental health -** mental health problems are very common. About a quarter of the population experience some kind of mental health problem in any one year. In Lewisham almost 40,000 people a year experience depression, anxiety, panic attacks or phobias.

- **Access and Outcomes –** one of the key health challenges is to commission appropriate services which continue to ensure that they are accessible and appropriate to Lewisham people's diverse needs.

- **Late diagnosis and intervention –** in Lewisham some people seek advice and treatment late which can mean that the treatment is less effective:

    - more than 30,000 residents are estimated to have undiagnosed and therefore untreated high blood pressure
    - uptake of cancer screening is significantly worse than London, with implications for cancer survival, particularly for women, who miss the benefits of early diagnosis
    - one in four HIV infections is diagnosed late when treatment is less effective.

Our partners

We work closely with other commissioning organisations, including London Borough of Lewisham, NHS England, and other CCGs to ensure that we are making the best plans for people in Lewisham and to coordinate health and care services.

The People of Lewisham

We work in partnership with the public. We are committed to engaging with and involving the public to ensure that our plans for health services do meet the needs of local people. Lewisham people are ethically very diverse. So when we carried out a range of public engagement activities during 2013, we tried to reach all our different communities to gather their views on our draft commissioning strategy. In March 2014 we held a Quality Summit to hear the views of Lewisham residents on what quality in healthcare means to them. At these events people requested:

- More support from and services delivered through voluntary and community organisations
- Improved telephone contact and access to GPs
- More Health checks available
- Improved Mental Health Services for adults and young people
- Better communication and publication of support services and self-referral services such as Improving Access to Psychological Therapies (IAPT)
- Better monitoring of Care Homes and publication of monitoring data
- Improved discharge communication with GPs
- Support for individual care plans – held or accessed by patients
- Access to performance data
- Communication – about everything that affects patients; not just on paper
- Respect, Dignity and honesty in all healthcare interactions
- Reduced waiting times – for test results and outpatient appointments
- Greater role for patients in prevention

Elsewhere in this report you can see how some of this work is already in progress; the comments have been incorporated into our commissioning intentions for the next two years.

Lewisham Health & Wellbeing Board - we are a member of the Health & Wellbeing Board, a statutory committee of the London Borough of Lewisham (LBL). It is responsible for jointly planning how best to meet local health and care needs and to promote greater integration and partnership working in Lewisham.

The Health and Wellbeing Board oversees the work of the Children and Young People's Partnership and the Adult Integrated Care Programme. The Public Health and Health Protection team of London Borough of Lewisham support the work of the Health and Wellbeing Board with specific responsibility for the co-ordination of the information on the health and wellbeing of the people of Lewisham, which is summarised in Lewisham's Joint Strategic Needs Assessment (JSNA).

The Health and Wellbeing Board's strategy, agreed in September 2013, sets out the wider health and wellbeing prevention strategy for Lewisham, with nine priority areas:

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

The CCG is fully supporting the delivery of all priorities identified in the Health and Wellbeing strategy, with a specific focus on reducing smoking, alcohol harm, obesity, improving sexual health and increasing cancer awareness, screening and early diagnosis. More details about the Lewisham Health and Wellbeing Strategy for all by 2023 can be found at: http://councilmeetings.lewisham.gov.uk/ieListDocuments.aspx?CId=315&MId=3165&Ver=4

The Joint Strategic Needs Assessment (JSNA is the basis for the CCG plans and the Health and Wellbeing Board's priorities. This means that the Health and Wellbeing Board's priorities are aligned with Lewisham CCG's commissioning priorities, as set out in the Strategic Plan, Commissioning Intentions and Operating Plan.,

South East London Clinical Commissioning Groups - the six CCGs in south east London - Lewisham, Lambeth, Southwark, Greenwich, Bexley and Bromley - have established collaborative arrangements to meet their shared and interdependent commissioning responsibilities. The reason for working collaboratively with the six CCGs is that we believe that we can transform the way services are delivered faster, learn from one another and implement some programmes collectively at scale.

- The commissioners are working together but also in partnership with local people, patients and carers, NHS England, local councils, hospitals, community services, and mental health services on the development of a new strategy. The strategy aims to improve health, reduce health inequalities and to ensure the provision of health services across south east London that meet safety and quality

standards consistently, are sustainable in the longer term and encompass the South East London Community Based Care Strategy

- The strategy is commissioner-led and clinically-driven. It builds on what already works well and is shaped and developed by the views of all the partners and local stakeholders - especially patients and local people. These views are being used from the beginning and throughout the planning process to make sure the strategy is right for south east London. The SEL Strategy has been informed also by the Borough based JSNAs and Health and Wellbeing Strategies.
- Each CCG carried out engagement on the emerging case for change narrative with patients and local people via their existing local engagement mechanisms during January 2014. Feedback has been used to inform development of the full draft case for change. During March 2014, CCGs undertook further engagement with patients, local people and members to finalise the case for change and emerging strategic opportunities.

Our providers

Lewisham people have a wide choice of acute providers across London. The main provider of acute (hospital) services is Lewisham and Greenwich NHS Trust. Lewisham people also use King's College Hospital and Guy's and St Thomas's Hospital.

Lewisham and Greenwich NHS Trust was created in October 2013 as an outcome of the Trust Special Administrator (TSA) programme for South London Healthcare NHS Trust. (There is more detail about this TSA programme later in the report). Lewisham and Greenwich NHS Trust also provides the majority of community health services for Lewisham residents.

Mental health services are mainly provided by the South London and Maudsley NHS Foundation Trust and the voluntary sector.

Our contracts with providers are managed effectively by robust contract management systems, including an integrated performance monitoring report reviewed by our Delivery Committee. We work with providers to ensure that we commission services which are safe and compassionate and listen to patients and relatives when they tell us about their care. Having robust quality performance meetings, receiving reports on quality, undertaking unannounced visits and working closely with the CQC are all examples of how we work with our NHS and non-NHS providers of healthcare.

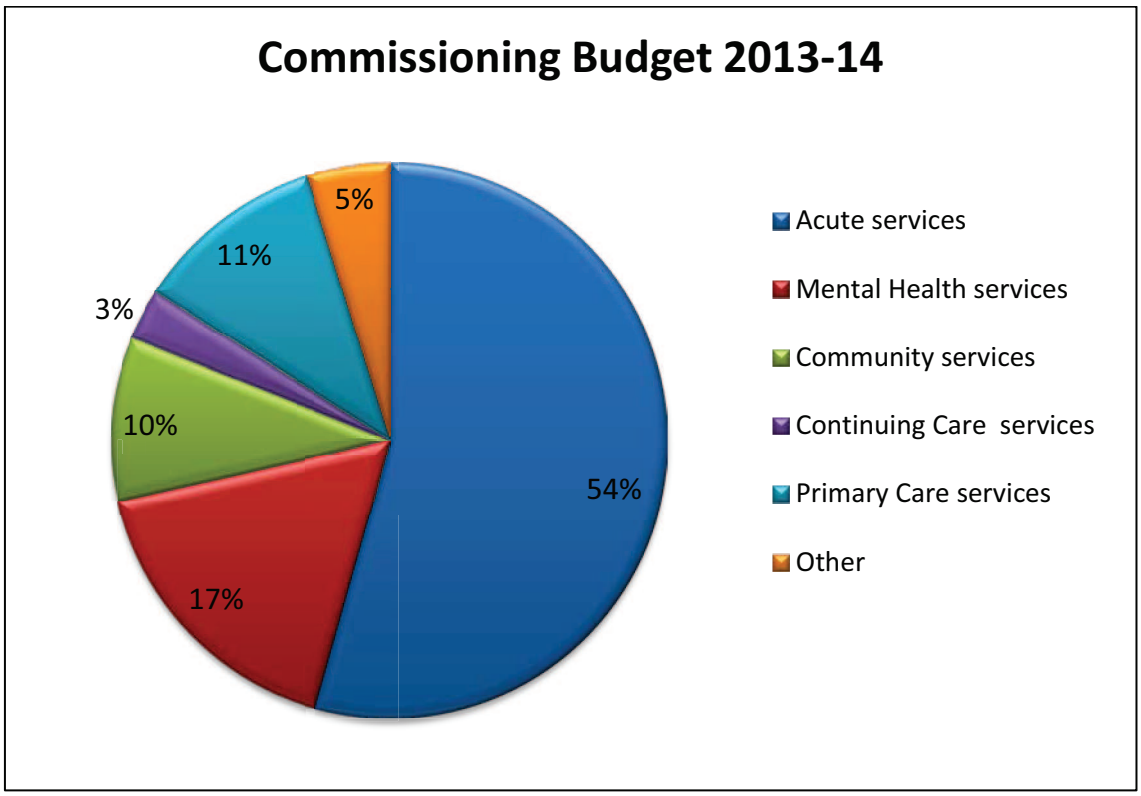
Lewisham CCG is the coordinating commissioner for the Lewisham and Greenwich NHS Trust, working closely with Greenwich and Bexley CCGs. For the 2014/15 contract negotiation the CCGs worked collaboratively with a joint negotiating team consisting of leads from each CCG supported by a range of clinically-led groups and the South London Commissioning Support Unit

A four-Borough arrangement - Croydon, Lambeth, Southwark and Lewisham CCGs – is in place to collaboratively co-ordinate the adult mental health contracts with South London and Maudsley NHS Foundation Trust.

Primary care services, across the country, are having to manage increasing demand for their services because of an ageing population and the rising number of people with long-term conditions, including dementia. This is combined with the higher public expectations of a customer-orientated service, wanting easier access 7 days a week. This has meant that during 2013/14 local GP practices have been considering how they can work together

differently to respond to this increased demand effectively, in a way in which is more sustainable in the longer term.

The following chart shows how we planned to spend our commissioning budget (£365m as April 2013) across different healthcare settings; acute (hospitals), mental health, community and continuing healthcare services.



Trust Special Administrator (TSA)
Following decisions by the Secretary of State for Health in January 2013 on the Trust Special Administrator's report into South London Healthcare NHS Trust, a legal challenge was launched by both Lewisham Council and The Save Lewisham Hospital Campaign into the service change decisions. The outcome of the judicial review was announced in late October 2013.

The CCG welcomed the judgement, although the CCG has always recognised the significant service challenges facing health services and that these need to be addressed through locally determined models which has support of clinicians and local people, hospital providers and other partners including colleagues in South East London CCGs and NHS England to deliver high quality and financially sustainable health services. We have begun work on this through a South East London strategy. Other Secretary of State decisions related to the TSA report have been implemented supported by the CCG leading to the successful dissolution of South London Healthcare NHS Trust on 1st October 2013, including the transfer of the Queen Elizabeth Hospital and merger with Lewisham Hospital to form the Lewisham and Greenwich NHS Trust – further details are provided as an Appendix to this report.

The Francis Report

The importance of public engagement, of listening to patients and carers, was a key finding of the **Francis report into Mid Staffordshire NHS Foundation Trust.** The report raised serious concerns about the care of vulnerable older people and made 290 recommendations to the Secretary of State for Health to improve patient safety. All NHS organisations have been required by NHS England to publish an action plan detailing how the recommendations will be implemented.

In May 2013 Lewisham CCG established a working group to review the Francis Report and prepare a response and action plan. Lewisham CCG supports the Government's response to the Francis Report and is committed to ensuring that the 281 recommendations accepted by the Government are implemented appropriately across the local health system in a timely way. We have identified 56 recommendations which are directly relevant to our work, and prioritised them into four levels of urgency. Of these, 21 are already in place and are being monitored, and 21 have been deemed a priority for 2014/15.

The CCG will work with its service providers to ensure that the remaining 225 recommendations are implemented at the appropriate level across the local health system and with our membership to ensure a fully inclusive response.

In line with the Francis report's recommendations on the need to ensure that patients' and carers' voices are heard, we are committed to engaging with patients and the public.

Our Strategy – responding to the challenges

Our Strategic Vision

Our strategic aim is to improve the health of Lewisham residents by securing the best possible health and care services in order to reduce health inequalities and improve health outcomes, recognising the specific challenges in Lewisham highlighted above.

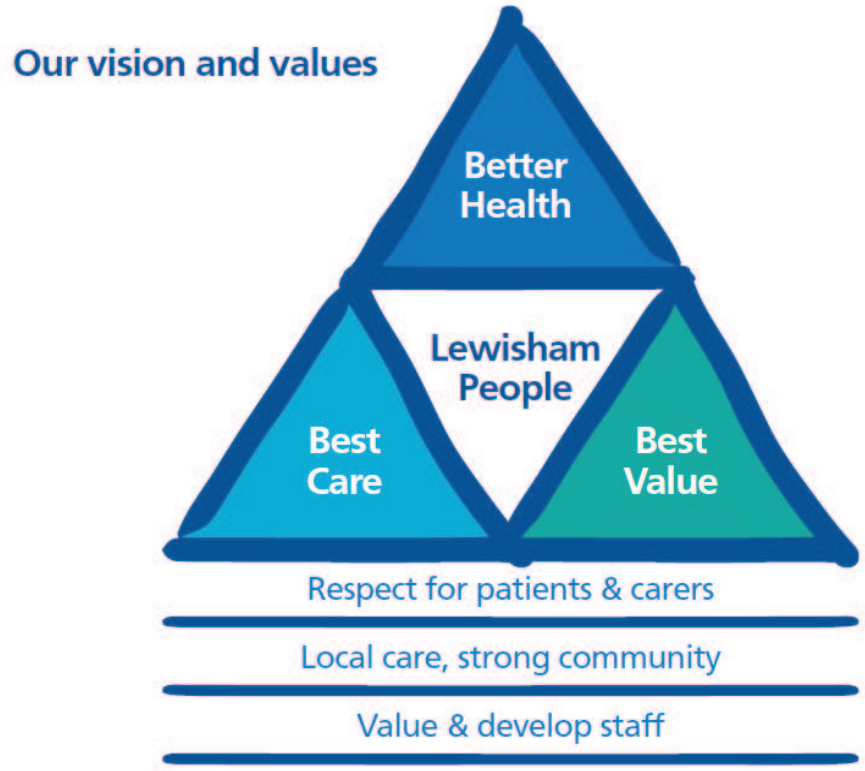
Lewisham CCG's five year Strategic Plan (2013-18) is based on our strategic vision for better health, best care and best value for everybody in Lewisham:

- **Better Health** - to improve the health outcomes for the Lewisham population by commissioning a wide range of advice, support and care to make choosing healthy living easier for people to keep fit and healthy and to reduce preventable ill health and health inequalities

- **Best Care** - to ensure that all commissioned services are of high quality –safe, evidence based and providing a positive patient experience. But also to shift the focus of support and care to prevention, self-care and planned care in the community

- **Best Value -** to commission services which are integrated and sustainable so delivering high quality, effectiveness and value for money.

- **Lewisham People -** working together with Lewisham people is at the centre of everything we do.



In practice, our values mean respecting for patients and carers, providing local care in a strong community and with staff that are valued and developed to make the best use of their skills.

Our model of care

The CCG has developed an overall model of care (our 'business model') to deliver high-quality support and care in partnership with other commissioners and the public, which is affordable. The successful delivery of this model of care will shift advice, support and care to be:

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

Our strategic focus

Looking at the main health needs and trends in Lewisham, listening to feedback from our public and engaging with our partners, we identified three key areas of strategic focus to transform the way in which future services are delivered in Lewisham;

- Healthy living for all – helping people to live healthy lifestyles and make healthy choices, and tackling health inequalities in the borough
- Frail and vulnerable people – ensuring that they are supported and cared for at all times with dignity, compassion and respect
- People with long-term conditions, such as diabetes or heart disease– empowering them to have greater control over managing their condition.

Our strategic outcomes

Our strategic ambition is to reduce the gap in key health outcomes between Lewisham and England by 10% over the five year period and inequalities within the Borough. We will determine our success in improving the health of Lewisham people by measuring life expectancy, rates of premature mortality from the three biggest causes of death in Lewisham (cancer, respiratory diseases and cardiovascular disease), infant mortality, patient experience and end of life care.

A key indicator for Lewisham CCG is reducing premature mortality – potential years of life lost. This indicator is a measure of the ambition to secure additional years of life for people with treatable mental and physical conditions. It compares expected mortality to actual in 5 year cohorts through the population, eg a child death would lose 70 years of expected life, but a 70 year old death may lose 8 years. The rate shown is the total per 100,000 population and the numbers are standardised per registered population.

In previous two year trend in Lewisham has been a nearly 5% reduction per annum. In 2012/13, the potential years of life lost was 2114, which was less than 'like' CCGs of 2226, and slightly higher than England's average of 2061 potential years of life lost per 100,000 registered population.

Below are summarised the high level indicators that we are using to monitor the delivery of the CCG's strategic plan in improving health outcomes. The Strategy and Development Committee monitor these outcome measures. However as these are long-term indicators the

CCG also monitors key performance indicators (KPIs) which are summarised later in this report.

Strategic Outcomes	Measures	Current Level	Target 2018/19
Life Expectancy	Potential years of life lost from causes amenable to healthcare	Females 2110.5 Males 2415.3	Females 2091.1 Males 2409.0
	Life expectancy at birth	Females 81.3 Males 76.7	Females 83.8 Males 79.8
	Disability-free life expectancy at age 65	Females 9.01 Males 8.99	Females 9.20 Males 9.11
Causes of death	Premature mortality Under 75 mortality rate from cancer	125.4 deaths per 100,000	104 deaths per 100,000
	Under 75 mortality rate from cardiovascular disease	84.8 deaths per 100,000	54 deaths per 100,000
	Under 75 mortality rate from respiratory disease (bronchitis, emphysema and other COPD)	36.4 deaths per 100,000	31.5 deaths per 100,000
Infant mortality	Infant mortality Neonatal mortality	3.6 per 1000	*To be confirmed*
	Stillbirths	6.1 per 1000	*To be confirmed*
Patient experience	People feeling supported to manage their condition	61.4%	TBC
End of life care	Proportion who die in hospital; Proportion who die at home	58.3% 20.4%	55.1% 23.1%

The strategic financial assumptions.

CCG allocations are known and published for 2014/15 and 2015/16. This provides a more sound short term footing for Lewisham CCG's future financial plans. The CCG has developed a two year plan in support of the Operating Plan for 2014/15 to 2015/16 and in March 2014 the Governing Body considered a draft budget for these two years. At the same time the CCG has set out a high level five year financial view using NHS England and local planning assumptions. This will be tested and refined during 2014/15 using the South East London Commissioner model in association with other NHS Commissioners in South east London.

Income

In 2013/14 the CCG's revenue allocation was based on the disaggregation of Lewisham Primary Care Trust's budgets. From 2014/15 targeted CCG allocations are set using a new national CCG funding formula. This has been used to inform published allocations for CCGs for the two years 2014/15 and 2015/16. NHS Lewisham CCG is deemed to be under target (i.e. receives less income than a "fair share") and consequently has received higher than minimum growth funding in both years as part of NHS England's "distance from target" approach. The revenue allocation confirmed for 2014/15 is £381.6m and for 2015/16 £395.5m.

Expenditure
Despite higher than minimum growth over the next two years, the predicted cost of healthcare for the current and projected Lewisham population is higher than the CCG's income on a "do nothing" basis. Consequently the CCG must generate financial efficiencies in order to keep pace with the predicted costs of healthcare demand. The efficiency requirement for the two years 2014/15 to 2015/16 is in the order of £25m net (or 3.2% of the CCG's income). The CCG has identified potential savings using the national QIPP framework as part of its commissioning intentions for the two years, with a focus on reducing the number of avoidable hospital admissions through improvements in integrated and urgent care for people with long term conditions.

The CCG has set aside non recurrent investment funds in line with NHS England planning guidance. The CCG will continue its 2013/14 commitment to invest 1% (circa £3.6m per annum) of its budget in the CCG's community-based care transformation strategy in each of the three years 2014/15 to 2016/17. The CCG has identified £1.5m to support the provision of a comprehensive and coordinated package of care for people aged 75 and over, for those with complex needs and to reduce avoidable admissions.

In 2015/16 the CCG will contribute £19.7m of its revenue allocation to the Lewisham Better Care Fund; a joint fund shared between the CCG and the London Borough of Lewisham, for health and social care services, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people.

A copy of the CCG's Strategic Plan can be found here:
http://www.lewishamccg.nhs.uk/newspublications/Publications%20page%20documents/Commissioning%20strategy%202013-18.pdf

2013-14 – putting our vision into practice

The first year of any new organisation is a relatively challenging period, and for the CCG this has been compounded by the fact that we have been designing and implementing new systems and managing our resources in a period of unprecedented change for the NHS as a whole. However, the detailed preparatory work that we carried out as a shadow CCG meant that we started with strong foundations, including financial governance and management arrangements, in place.

We identified the following eight commissioning priorities that we have focused on to transform services during 2013/14.

Strategic Themes	Commissioning Priorities
Healthy Lifestyles and Choice	Health Promotion – smoking cessation, reducing alcohol harm, obesity and preventing cancer
	Maternity and children's care in hospital
Frail and Vulnerable People	Frail older people (including end of life care)
Long Term Conditions	Long Term Conditions – e.g. COPD, diabetes, CVD, dementia
	Mental Health
Deliver Services Differently	Primary care development and planned care
	Urgent Care
	Adult Integrated Care

We can now look back on some significant achievements during our first year of operation, to review the improvements we have made in each priority area, always keeping focussed on our vision of better health, best care and best value for everybody in Lewisham.

Commissioning Priority: Health Promotion

Stopping smoking, health checks and immunisations are three key areas for improving health in the borough, and ones where GPs have a key role to deliver improvements.

Immunisation – an early clinical priority identified with members was improving MMR immunisation at year 2. With huge effort the CCG has improved vaccination rates by 10% in a 12 month period, making us one of the most improved CCGs in London on this measure. We are looking to sustain and improve other vaccination levels.

Lewisham CCG worked in partnership with Lewisham Public Health to develop and deliver a programme to support GP practices in achieving improvements in these health promotion areas. The programme was supported by the CCG's clinical commissioning facilitators, who have been working with member practices. This included developing toolkits and support packs for smoking, health checks and immunisations, in liaison with the Public Health team. These were made available to practices via the CCG bespoke GP Interactive (GPi) website. Also a series of visits were conducted by the facilitators to support practices with systems and processes, sharing best practice and improving outcomes for patients.

Commissioning Priority: Maternity care and Children's Care

Maternity care centred on the mother - Lewisham maternity and early year's services face a number of challenges. As well as a rising population and consequent demand for maternity services, there is a higher risk of adverse outcomes because of underlying health issues, such as increasing obesity rates in women. These present challenges to services and have an impact on health outcomes both for women, new-borns and children under five. Like the rest of London, Lewisham has high caesarean section rates, which have a higher risk of adverse outcomes and potentially impact on women's longer-term health.

A further issue is recruiting and keeping the highly-skilled workforce required to deliver a service across all health settings. In particular, a high number of midwives are eligible for retirement in the next five years. This could also impact on midwifery staffing ratios to achieve the NHS London standard of one midwife to 30 births, across all birth settings.

A project to pilot a new model of delivering maternity services in Lewisham - the team around the mother – has been designed to meet these challenges, which was given the go-ahead by the CCG. This model places the mother and child at the centre of care and integrates community services, especially primary care, health visiting and children's centres, with the midwife supporting the mother at each stage. The intention is that ante-natal and post-natal care, and where possible intra-partum care will be provided within a setting of the mother's choice, be it at home, within acute obstetric-led units or midwifery birthing units. The ultimate purpose is to enable mothers and babies to achieve the best health outcomes.

Extending take-up of vitamin D – before April 2013 Public Health made provision of Healthy Start Vitamin D products through health/children centres. However, less than 5% of the population eligible for free supplementation accessed supplies and access was identified as a barrier for those who had purchased the vitamins. Locally, paediatricians reported a worrying number of infants with bone problems and vitamin D deficiency. Community Pharmacy was approached to see if wider access could be achieved within the local diverse population.

The Local Pharmaceutical Committee (LPC) and Lewisham CCG medicine team were already working with the borough's pharmacies to achieve Healthy Living Pharmacy (HLP) status supporting Health Champion training and accreditation.

The initiative signposted mothers (with their infants) into local community pharmacies to collect their free vitamin D and to seek the advice their pharmacy team can offer. Within three months, HLPs enrolled 5500 mothers/infants into the scheme and had given drops to 2899 infants, tablets to 1336 women with children under 1 year and tablets to 432 pregnant women.

Pharmacies reported the impact as very positive, allowing them to open up conversations about the benefits of Vitamin D and to talk about other vitamins, and what would be best for women and their families. Mothers visiting local community pharmacies to collect free vitamin D for themselves can take advantage of other advice their pharmacy team can offer. Health champions can promote other Healthy Start initiatives, such as provision of vouchers for milk and fruit/vegetable produce.

Commissioning priority: frail older people

Promoting take-up of vaccinations - one of Lewisham CCGs priority areas for 2013-14 was to reduce respiratory-related emergency admissions, especially for older people. The seasonal influenza vaccination programme is a vital tool in this, as there is a direct link between the uptake of the vaccination and associated emergency attendances and admissions.

Lewisham CCG developed and implemented a full immunisation programme in line with the national Directed Enhanced Services scheme, supported by a Local Incentive Scheme to support GP practices to achieve higher uptake of seasonal flu immunisations. We commissioned a dedicated flu coordinator, who worked directly with practices, supporting delivery, managing vaccine availability and developing individual flu action plans for practices.

The programme was widened to encompass primary care and district nurses to enable increased access for housebound patients. This also included enabling GPs who support care homes across Lewisham to identify all 'at risk' residents to ensure they received timely vaccination. The programme saw an increased uptake in all at-risk groups by 3% compared with the previous year, achieving more than 70% uptake in the over 65 at-risk group.

Medicines Optimisation in Practice - older patients and those with long term conditions are gaining more benefit from their medicines from a unique collaboration between Lewisham CCG and Lewisham Council. The Medicines Optimisation Project (MOP) has engaged patients, social workers, domiciliary care staff, pharmacists, doctors and nurses. An overarching joint medication policy, drawn up with input from patients and carers sets out for both NHS and Social Care teams how patients should be supported in managing their medicines.

The policy defines a service that promotes independence and facilitates the care of people in their own homes. It is driving a whole system change in the way patients are assessed and supported in the community for their medicine needs.

Community pharmacies in the borough have been commissioned to provide an enhanced service to support the supply of compliance aids and medication records. GPs have been encouraged to modify prescribing practices. A specialist team, the Lewisham Optimisation Service, have been commissioned to support the project.

Additional support and care - in January 2013, we commissioned a pilot project at a residential and nursing care home, Brymore House, aimed at preventing unnecessary admissions and readmissions to acute services. We provided additional staff and equipment to support patients, so that "double handed support" – two members of staff per patient – was available where patients needed it. At the end of the pilot, the project was evaluated and found:

- a positive patient experience with patients valuing the support of the 'double handers' in aiding their independence
- the majority of patients were discharged home, so readmissions to acute care were prevented
- a cost saving to the health economy.

A second phase of the pilot has been commissioned for 2014/15.

Commissioning priority: people with long-term conditions

Minimising risk – risk profiling is a mechanism for identifying patients at risk of an unplanned hospital admission. Once identified, the patient's health and social care needs are assessed and stabilised in order to reduce the likelihood of an admission, enhance the patient's experience of healthcare services and improve the quality of their lives.

The CCG developed a pilot in 2013, which enabled GP practices to identify which of their patients were at risk of an unplanned admission. Specifically, these were patients who had recently been admitted to hospital, who had not attended a recent outpatient clinic appointment or had other indicators of pressing health and social care support.

In order to ensure that patients were adequately supported once identified by their GP, a multi-disciplinary team approach was adopted, with input from both health and social care

professionals. The pilot began in May 2013 and was completed by 36 out of 41 GP practices in March 2104.

A separate piece of work was conducted to identify frail and elderly people. An event like a fall can be catastrophic for such patients, and the aim was to identify people at risk in order to stabilise their health and social care needs before they experienced such an event. Four practices participated in this pilot. The identified patients were invited to see their GP or nurse in order to establish the support they needed to reduce the likelihood, or speed, of any deterioration which might increase the likelihood of such an event. The pilot ran until April 2014. It will be fully evaluated and risk profiling for patients will continue throughout 2014/15, with support being provided for those patients deemed to be at risk.

Working with patients to improve their health – a collaborative care plan is an agreement between the patient and a health professional to help manage the patient's condition. The aim is to improve the quality of care and outcomes for people with a long-term condition by engaging them more in decisions about their care and helping them to take control of their own health.

This process provides a more collaborative approach with patients, enabling them to proactively manage their conditions. The CCG delivered the first phase of training for 15 GPs, practice nurses and diabetes specialist nurses in March 2014. The programme will be implemented in GP practices in 2014-15 – enabling all patients with a long-term condition to be offered a collaborative care plan.

Diabetes Community Champions - Type 2 diabetes is a growing problem in Lewisham, and latest figures show there are now 15,382 people with diabetes in the borough – with one in five unaware they have the condition. This is expected to soar to nearly 18,400 residents by 2020. You are more at risk of type 2 diabetes if you are from a black and minority ethnic background.

Lewisham CCG commissioned Diabetes UK to deliver a Community Champions programme as a part of our plans to improve diabetes care in Lewisham. Fifteen Lewisham residents from mainly Black, Asian and minority ethnic backgrounds were trained to help their communities to better understand the potentially devastating effects of diabetes. We would wish to consider this model for other long term conditions.

The Lewisham Community Champions have been involved in awareness raising events, which have so far reached over 1,000 Lewisham residents, and last November were presented with awards for their work.

3R's: Register, Recall & Review - Early identification is the cornerstone of enabling people with diabetes to manage their condition better. The CCG developed a programme to enable GP practices to implement best practice, actively managing disease registers, recall and review systems.

Adopting this approach resulted in people with diabetes being recalled at least once a year for review by their GP or practice nurse for an annual check. To complement this approach, the CCG developed its GP Peer2Peer (P2P) programme to support GP practices to improve their 3Rs processes. In addition, practices were offered tools to help them assess what they needed to improve processes.

Improving care for people with respiratory conditions - Lewisham CCG has been providing leadership for the Respiratory Care Pathway programme. The aim is to improve health outcomes for people by reducing A&E attendances, admissions and length of hospital

stay – ensuring an integrated approach to both acute and chronic disease management across the borough.

We knew from our work in 2012-13 that for people with chronic obstructive pulmonary disease (COPD) we needed to concentrate efforts on diagnosis and management for patients in the early stages of the condition. All practices now have a named primary care key worker who is provided with on-going training and access to advice and support from the specialist nurse team.

Access to new equipment and education is provided to all practices with a dedicated resource. The respiratory nurse consultant team provides specialist care outreach. The nurses work alongside community matrons, providing 7 day working.

The CCG also committed to improving the Asthma Pathway. In this context a pathway is described as a journey a patient may take through the health system from prevention to treatment to after care. This involved developing a framework for the education and skills required. New systems to improve efficient prescribing and, crucially, gaining consensus from all providers to improve current pathway delivery.

To support a reviewing of the pathway the CCG held a public event to increase patient awareness, self-management and care of asthma in Lewisham. By involving patients and the public early, we enabled them to influence and shape care pathways at the earliest possible stage – before decisions are made – so that we could be sure that those decisions meet their needs.

Commissioning Priority – Mental Health

Redesign of the dementia pathway - following extensive discussions with users and stakeholders the vision and key outcome measures for local dementia services were clarified to be:

- encourage help-seeking and help-offering (referral for diagnosis) by changing public and professional attitudes, understanding and behaviour
- make early diagnosis and treatment the rule rather than the exception; and achieve this by locating the responsibility for the diagnosis of mild and moderate dementia in a specifically-commissioned part of the system. The aim will be to make each diagnosis well, to break the diagnosis sensitively, and provide individuals with immediate treatment, care and peer and professional support as needed.
- enable people with dementia and their carers to live well with dementia by the provision of good-quality care for all with dementia from diagnosis to the end of life, in the community, in hospitals and in care.

Services were then decommissioned and new services commissioned in 2013/14 to provide:

- new Dementia Assessment, Diagnosis and Treatment service with a single point of Access
- new voluntary sector service to provide support and information on dementia
- new Carer Support Worker specifically for dementia
- new Lewisham dementia services guide for the public
- new training provision for staff within hospitals and care homes
- extended provision of assistive technology
- extended support within day care services

Awareness, Advice and Advocacy – CCG commissions a wide range of diverse voluntary sector groups to provide advice, support and care for people with mental health problems. An example of this is the MindCare service, which provides advice and advocacy to Lewisham residents who have been diagnosed with dementia. They provide a range of activities, including dementia-friendly exercise groups, a walking group and several different advocacy groups. Another important part of the MindCare contract is the provision of Dementia Awareness training, which are free sessions open to members of the public as well as family carers, care workers and other professionals.

Since the commencement of the current contract, the MindCare service has seen a steady increase in the number of referrals and the number of users accessing the service each quarter. In the first three quarters of 2013-2014, the total case load has increased from 190 at the end of 2012/13 to over 750 in the first 9 months of 2013/14.

Commissioning Priority – Primary care development and planned care

Proactive Primary Care - is the process by which a GP practice actively contacts patients with long-term conditions to ask about their wellbeing and support them to access any services they might need, manage their own care better and ultimately improve their health and wellbeing. Its effectiveness in reducing hospital emergency admissions and inpatient stays among chronically ill patients has been repeatedly demonstrated.

The CCG carried out a study to assess the viability of proactive telephone support across Lewisham. The success of the study enabled Lewisham CCG to successfully apply for NHS London Innovation funding to implement a pilot in the borough for Proactive Primary Care. The pilot began in November 2013.

Improving access - a workshop in July 2013 helped GPs to improve access to practices for patients. The Primary Care Foundation was commissioned to support individual practices to review access arrangements by way of a development plan, with 38 out of 41 practices completing the programme. The CCG successfully received funding from Health Education South London to support telephone triage/consultation training for GP practices.

Outpatients' strategy –a Local Incentive Scheme (LIS) pilot to support practice review of referrals was launched in November 2013. It is one of a number of initiatives that has been explored in order to determine how the CCG can best support practices in formalising approaches to clinically appropriate referral review and improving the quality of referrals, as Lewisham CCG has higher levels of outpatient referrals compared to best practice.

Working with primary care to improve services to patients - In July and September 2013 the CCG brought together practices to explore different approaches and models of working together to enable greater sustainability of services to patients. This was further explored with GP practices on an individual basis. The outcome is that the CCG has 2 Pathfinder groups taking this further in 2014/15.

Commissioning Priority – Urgent Care

The Yellow Men were part of an eye-catching NHS poster campaign which was run across south east London to explain that people should only go to A&E when it is absolutely necessary. Lewisham CCG participated in the campaign, aimed at helping people to understand what health services they should use when they are ill and remind them that A&E is only for serious and life-threatening emergencies. The 'yellow men', with their various ailments, appeared across Lewisham in the shopping centre, billboards, in Lewisham Life

and on buses. According to national surveys 39% of A&E attendances could have been treated elsewhere. Across south east London A&Es see around 1500 patients a day and this figure increases over the winter months.

The yellow men highlighted the alternative places people can get the expert advice and treatment they need, including, taking care of themselves at home, GPs, pharmacies and when to come to the urgent care service and A&E.

Effective winter planning of services - in 2013/14 the CCG along with partners from across south east London commissioned an urgent care network manager covering Bexley, Greenwich & Lewisham and a south east London urgent care project manager. Their role was to support effective winter planning across Lewisham. The CCG also allocated £1m to support additional schemes across the health and social care economy, which helped prevent admissions and supported early discharge from Lewisham Hospital.

Commissioning Priority – Integrated Care

By bringing together different professional groups and working across services, we are transforming the way services are delivered to achieve an integrated approach that delivers a better service and aims to meet all a patient's needs. New approaches this year include

Neighbourhood Multi-disciplinary Teams - our GP practices are grouped into four neighbourhood areas, to help ensure local knowledge and a response to local needs. We are establishing multi-disciplinary teams (MDTs) across the borough, covering the same areas, bringing together social workers and occupational therapists employed by Lewisham Council and the community staff employed by Lewisham and Greenwich Healthcare Trusts. The designated practitioners attend regular practice meetings and have built wider links with community mental health practitioners, pharmacists and a range of voluntary sector services to ensure there are a range of support services accessible and available to support individuals.

The teams form part of a wider integration programme that aims to support people at the first point of contact with information and advice, with services that promote wellbeing and early treatment, and with effective management of long term conditions.

Community connections teams, co-ordinated by the voluntary sector, are already established and are actively involved in developing services and supporting people to access a range of support activities which are freely available in the local area. In addition, a single point of access is being established to ensure the pathways are effective to support hospital discharge and to promote opportunities that will avoid a hospital admission.

In 2014/15 there will be further development of the multi-disciplinary teams by using a key worker and joint case management approach, so that the most appropriate practitioner is identified to co-ordinate the individual's support package. Working in partnership across the health economy with collaborative care plans, the MDT will have a range of options available to ensure that support can be tailored to meet the individual's specific needs.

Bringing together adult care - in May 2013, the Government announced its ambition to make joined up and co-ordinated health and social care the norm by 2018. Their goal was for 'care and support built around the needs of the individual, their carers and family that gets the most out of every penny we spend.' The Lewisham Health and Wellbeing Board responded by establishing a group to take forward its Adult Integration Care Programme, underpinned by the Better Care Fund, and building on the work already carried out to develop joint working.

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

Health and social care partners in Lewisham have already taken steps to integrate services in a number of areas. This programme will bring all appropriate adult services to work together to improve health and care and reduce health inequalities by increasing self-help and independence, creating a culture of self-responsibility, prevention and early intervention and providing affordable high-quality advice, care and support close to, or in, people's own homes.

The Virtual Patient Record (VPR) Business Case was approved by Lewisham CCG which will enable primary, community, secondary and social care professionals to share the same patient record. The VPR uses the NHS number as an identifier, with due account of an individual's right to confidentiality, and will enable professionals to view patient records from across the health and care system in the future.

Public Engagement

Public Engagement is intrinsic to all our commissioning activities and during 2013-14 we increased the scope and depth of our engagement activities. Our approach is underpinned by our Engagement Strategy, adopted by our Governing Body in November 2013 and driven by our Public Engagement Group (PEG). PEG is made up of engagement leads from our partner organisations, including the local authority, providers, Healthwatch Lewisham and the voluntary sector. The PEG Chair, who is also our Governing Body Lay Member with responsibility for public and patient involvement, provides a bi-monthly report to our Strategy and Development Committee.

Engaging the public in our commissioning decisions

During October 2013 wide public engagement took place on our Five Year Strategic Plan 2013 to 2018, 'A Local Health Plan for Lewisham'. Over 200 participants gave their views as part of our initiatives, including: focus groups, public meetings and an online questionnaire. We used a range of methods to reach as broad a range of our diverse community as possible, including people with the protected characteristics. Activities included focus groups at supported housing and with homeless people, working with Foodbank, presentations to voluntary sector organisations and we prepared an easy read version of the strategy. Through these activities we identified almost 40 residents who want to remain engaged with us and signed up to our involvement register.

Since January 2014 we have been engaging on our 2-year Commissioning Intentions in partnership with the local authority. The adult integration programme within Lewisham is embedded across the Commissioning Intentions due to our alignment with the borough's Health and Wellbeing strategy. As part of this engagement we established a public reader panel to test the Commissioning Intentions document, including learning-disabled residents and carers, and as a result of their comments we radically changed it and produced a summary.

A significant outcome from this engagement was the suggestion to introduce 'home UTI (urinary tract infection) testing' for people with specific long-term conditions. We will be

working with the local Parkinson's Support Group to develop a pilot project as part of our work to reduce emergency admissions.

Many of our commissioning initiatives involve and build on public and patient views received during our larger engagement exercises. Patients views have informed many of our commissioning initiatives, including:

- 2000 Patient surveys collected during the Review of Urgent Care Appointments
- patient representative on the Improving Diabetes Care Pathway Project Group
- trained 15 local residents as Diabetes Champions
- diabetes patients reviewed and improved a leaflet for the DESMOND programme, a programme of education and self management for people with, or at risk of, type 2 diabetes
- diabetes patients identified need for collaborative care plans
- 40 patients attended a public event to 'Improve the Asthma Care Pathway'
- 35 patients involved in our End of Life Care Event to provide direction and work plan for a newly appointed Macmillan Nurse post.
- 2 lay members will be appointed to the Referral Support Service Project Group.

Engagement with the Healthier Communities Select Committee
We ensure that we meet the requirements of the Health and Social Care Act, 2012 to engage with our Healthier Communities Select Committee on health and social care matters in Lewisham. We attend every meeting as contributors to the general scrutiny of health and care services.

Through our presence at the Committee, we have built further relationships with partners who have presented items to the Committee. We have:

- developed a relationship with and attended local community run libraries
- accepted invitations to attend local ward assemblies.

Public engagement with and through Healthwatch Lewisham

As a key partner, Healthwatch Lewisham takes an active role in the planning, design and delivery of our engagement activities. The Healthwatch Manager and a Healthwatch representative are members of our Public Engagement Group, enabling direct involvement in the strategic planning and monitoring of our engagement initiatives.

We frequently use their local knowledge and understanding as the patient champion body to inform processes and practices of engagement. Recognising their access to the wider community, we have commissioned Healthwatch Lewisham to undertake a number of initiatives in partnership and on behalf of the CCG. We commissioned them to undertake face-to-face interviews as part of our engagement on the five year Strategy and with housebound people for our review of district nursing services. We invite Healthwatch Lewisham to attend all our local events
and provide regular briefings for wider distribution through their newsletter

As they are a locally-funded voluntary sector organisation, we have a corporate objective to provide support to them, for example by providing contacts and network opportunities. We organised a secondment for our engagement officer to work with them one day per week.

The Joint Public Engagement Group and our strategy for the future

Reflecting our strategic role within the Borough's Health and Wellbeing Board and Adult Integration Programme, we are responsible for a new cross partnership group, the Joint Public Engagement Group (JPEG).

The role of JPEG is to function as a sub group of the Health and Well Being Board to ensure that appropriate engagement takes place as part of the Adult Integration Programme, utilising the expertise and existing capacity across the member organisations. It reports through the Health and Wellbeing Board and together with the Chair's report to our Strategy and Development Committee, this ensures a strategic approach aligned with the needs of the whole borough.

We know that we have a long way to go to ensure we do hear the voices of all of the diverse community of Lewisham. In particular we need to be more strategic in reaching those groups whose voices are less often heard. We will build on the activities of our first year by:

- developing our patient reference group
- developing a volunteer participation policy so that participants are repaid out of pocket expenses
- defining our financial needs group
- developing a programme of activity for the South East London Five Year Commissioning Strategy.

Our end of year position for 2013/14

So what has been the impact of our first year's programme?

You can read in this report about some of the programmes we have commissioned to improve health and health care for residents of Lewisham.

Principal Risks

The Governing Body rated four risks with a very high residual risk score at the beginning of the year, these included:

- failure to achieve adequate Information Governance Standards
- claims for NHS Funded Continuing Health Care affecting financial plans
- transfer of Specialist Commissioning will not be cost neutral to the CCG
- failure to safeguard adults.

Further details regarding the systems and processes by which the CCG has managed these risks and uncertainties is provided in the CCG's Governance Statement for 2013/14.

Key Performance Indicators – Non Financial

Lewisham CCG's Governing Body is using a range of performance indicators to assess its progress in delivering its strategic vision and performance. These include a range of outcome, patient experience and quality measures. The CCG is performing well against similar CCG peers on primary care experience measures, including how well people feel supported with their long-term condition, and we have low levels of CDifficile Infections

(Clostridium difficile, a type of bacterial infection that can affect the digestive system)**.** However the CCG has been performing less well in reducing emergency admissions and Improving Access to Psychological Therapy (IAPT) recovery rates. For these areas, where better performance should be achieved, the CCG has put in place Improvement Plans for 2014/15. The CCG also has further to go to identify people with dementia in Lewisham to meet the national aspiration.

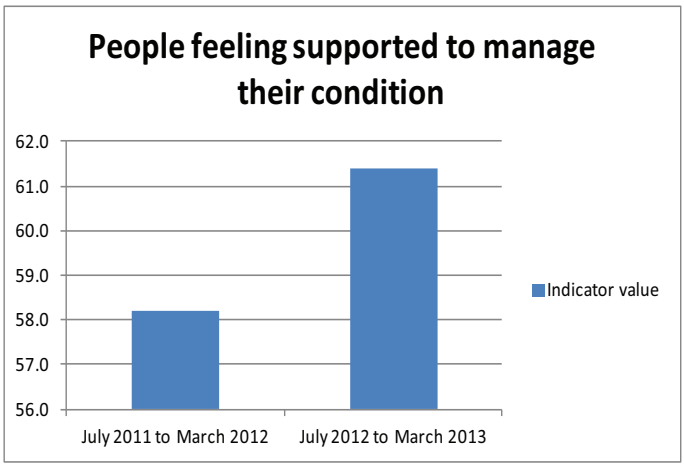
Summarised below are further details about the non-financial indicators.

People feeling supported to manage their condition

This measures the percentage of people with a long term condition who feel supported by services with their long term condition over the last 6 months. Lewisham people respond through the GP Patient Survey, of which this is one of the questions. Improvement would be an increase in this measure.

This encompasses all services, including improvements to care for people with long term conditions that can be achieved through changes to integrated services between health and social care funded through the joint Better Care Fund. As a result this indicator has been chosen as the joint local measure with an aspiration for 14/15 of 64%. This will take Lewisham a long way to the England benchmark of 65.6%.

The improvements in this measure have been consistent and more recent GP Patient Survey results show this measure continuing to improve. This improvement now places the CCG above the London score of 59.4%. Both the London and England scores are lower in 12/13 than in 11/12, which places Lewisham CCG's higher percentage in context



Improving patient experience of primary care and out of hours – this indicator is a measure of the ambition to increase the number of people having a positive experience of care outside hospital, in general practice and in the community. The GP survey of 2012-13 identified on average 6.7% of experiences as negative (or people stating that they had a poor experience). Our performance compares favourably to 'like' CCGs, who score 7.9% of experiences as poor, but less favourably with England's average of 6.1%.

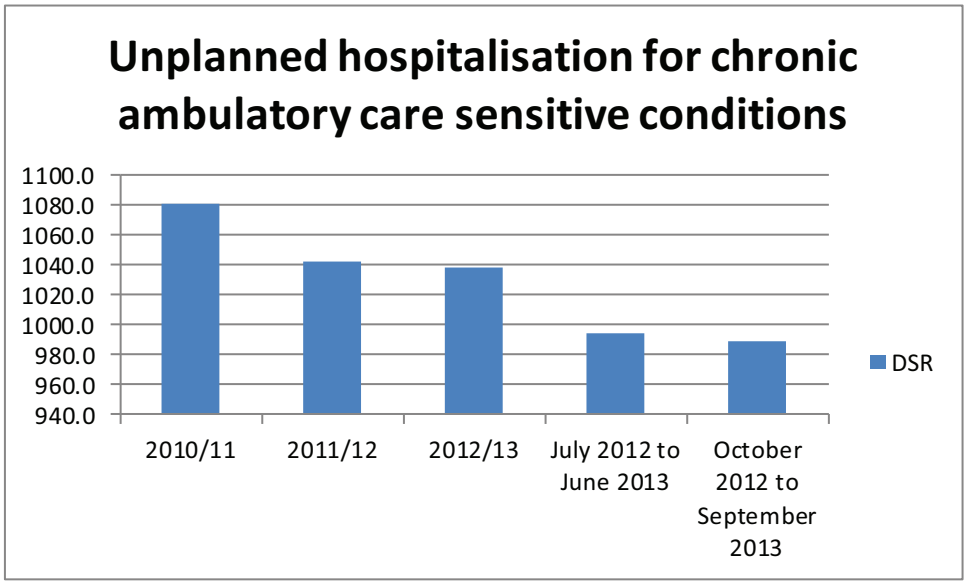
Emergency Admissions Composite Indicator - this indicator measures the amount of time people spend avoidably in hospital, through better and more integrated care outside of

hospital. The following are rates per 100,000 population, directly age-sex standardised (DSR) to the England population, covering:

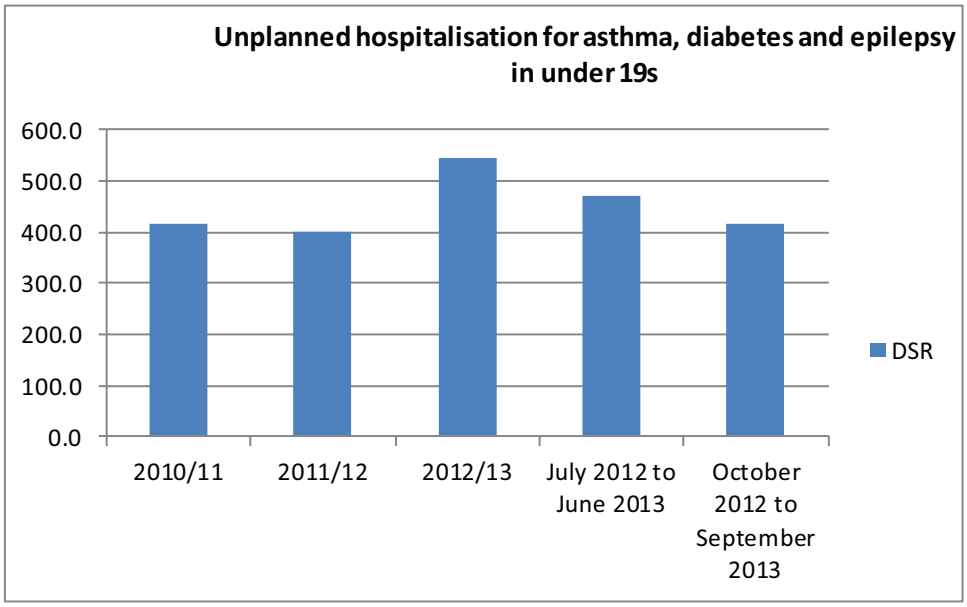
- unplanned hospitalisation for chronic ambulatory care sensitive conditions
- unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
- emergency admissions for acute conditions that should not usually require hospital admission
- emergency admissions for children with lower respiratory tract infections (LRTI)

The detailed trends for the individual indicators is summarised below:

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions and unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s. These measures are derived from hospital episode statistics and relate to emergency admissions for conditions for which alternatives can be put in place e.g. diabetes, heart failure and respiratory conditions, so reductions in these measures are an improvement. They are made into a directly standardised rate by dividing them by the relevant registered population and are measured per 100,000 population. The numbers are rolling annual figures. Both of these measures are reducing in the most recent measures.



DSR= rates per 100,000 population, directly age-sex standardised



DSR = rates per 100,000 population, directly age-sex standardised

- Emergency admissions for acute conditions that should not usually require hospital admission and emergency admissions for children with lower respiratory tract infections. Both of these are derived from Hospital Episode Statistics and represent hospital admissions, which should not normally be admitted. Recent data shows the growth in these measures being stabilised and reversed.

Dementia Diagnosis Rates - this is a measure of the number people identified with dementia on GP registers compared to an expected prevalence (developed by the national Dementia Team but based on Lewisham's population). Current performance for 2012/13 is 53.7%, which is marginally better than London (50.2%) and England (51.8%). The expectation by 2015/16 is that 67% of people with dementia are identified, which is important for early diagnosis and referral to treatment/support. So the CCG's operating plan includes an implementation plan to increase the dementia diagnosis rate.

CDifficile Infections - is measuring the number who acquired Cdifficile infection while staying in hospital or identified in the community and tested at hospital laboratories. Lewisham CCG had 34 infections during 2012/13 and 39 for 2013/14. This is a significantly lower level of infections per registered population compared to England and to our like CCGs.

Improving Access to Psychological Therapy (IAPT) Recovery Rate - measures the number of people entering the service who reach a recovery level at the end of treatment i.e. that people's outcome from treatment is that they have recovered. The current rate for Q2 2013/14 is 33% for Lewisham CCG and the planned actions will aim to achieve 50% tby the end of 2014/15. Lewisham CCG is meeting its plan for the number of people entering treatment.

Urgent and Emergency Care - Long waiting times in accident and emergency departments deliver poor quality in terms of patient experience. Nationally, there is an operational standard of 95% for patients being seen and discharged within 4 hours and we use this

measure to be sure patients are being treated quickly. For Lewisham hospital site performance on the 4 hour standard was 94.6% for 2013/14, just below the national target .

London Ambulance Services (LAS) prioritises all 999 calls into categories with category A being the potentially life-threatening category. The LAS is expected to reach the national standards of 75 per cent of Category A calls within eight minutes and 95 per cent of Category A calls within 19 minutes. For Lewisham CCG performance for both standards has been met for 2013/14.

Waiting times – an individual has the legal right to start their NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate that they should wait longer. Nationally, the Referral to Treatment (RTT) operational standards are that 90 per cent of admitted and 95 per cent of non-admitted patients should start consultant-led treatment within 18 weeks of referral. For Lewisham CCG performance on both standards have been met for 2013/14. However there were ten patients on an incomplete pathway (i.e. still on the waiting list) beyond 52 weeks without being treated at the end of February 2014. Most of these patients were on waiting lists at King's College Hospital and the situation is being addressed.

Cancer waiting time targets – patients can expect to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, should be able to be seen and receive treatment more quickly. The NHS Constitution sets out the following range of standards for cancer against which performance is monitored:

- a maximum 31-day wait from diagnosis to first definitive treatment for all cancers
- a maximum 31-day wait for subsequent treatment where the treatment is surgery
- a maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy
- a maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen
- a maximum 62-day wait from urgent referral for suspected cancer to first treatment for all cancers
- a maximum 62-day wait from referral from an NHS cancer screening service to first definitive treatment for cancer
- a maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers).

For Lewisham people, all cancer standards have been met for 2013/14 with the exception of GP referred patients waiting within 62 days from referral to treatment. For 2013/14 the performance was 83.2 per cent, whereas the national standard is 85 per cent. The Cancer Intensive Support Team are working with local Trusts to improve cancer pathways and agree the recovery actions to improve the performance in this area.

Diagnostic test waiting times - patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral. In Lewisham the performance was 98.5 per cent for 2013/14 against the target of 99 per cent. Unfortunately, in January 2014 Lewisham and Greenwich NHS Trust had some short term problems in their endoscopy booking process and the number of people waiting over 6 weeks has increased, but the Trust aims to recover

the position as quickly as possible and it is expected that this standard will be delivered for 2014/15.

Key performance indicators – Financial

The accounts have been prepared under a direction issued by the NHs Commissioning Board under the National Health Service Act 2006(as amended)

The key financial performance indicators for the CCG are:

- managing within the revenue resource limit notified by NHS England
- managing within the capital resource limit notified by NHS England
- managing within the maximum cash drawdown notified by NHS England
- delivering a 1% surplus against the CCG's recurring revenue budget
- prompt payments as per the Better Payments Practice Code

For 2013/14 the CCG achieved all of the above key financial performance targets. The CCG planned to deliver a 1% surplus of £3.69m against its revenue resource. The actual surplus delivered was £3.73m. The CCG did not receive a capital resource limit for 2013/14 and spent no capital monies. The maximum cash drawdown was not exceeded and the CCG had cash in bank value of £38k at year end (i.e. within the £250k limit as per NHS England guidance). The CCG paid over 95% of invoices (by number and by value) within 30 days of receipt of a valid invoice. The Better Practice Payment Code target is 95%. In addition, the CCG delivered its targeted £12.1m Quality, Innovation, Productivity and Prevention (QIPP) efficiency target in the year. We were not successful in meeting our plans to reduce significantly the numbers of emergency admissions that should not usually require a hospital admission and the level of new outpatient referrals, so we brought forward in year plans to mitigate the overall financial impact The QIPP programme for 2014/15 will focus on reducing unnecessary or inappropriate activity in these areas.

The figures below summarise the key financial performance for the year.

Statement of Comprehensive Net Expenditure

NHS Lewisham CCG

	Administrative Costs	Programme Costs	2013-14 £'000 Total
Other Operating Revenue	(115)	(3,632)	**(3,747)**
Gross Employee Benefits	2,886	1,075	**3,961**
Other Costs	3,624	371,830	**375,454**
Net Operating Costs before Financing	**6,395**	**369,273**	**375,668**
Financing			
Net Operating Costs for the Financial Year	**6,395**	**369,273**	**375,668**
Revenue Resource Limit	**7,160**	**372,250**	**379,410**
(Surplus)/Deficit	**(765)**	**(2,977)**	**(3,742)**

Statement of Financial Position

NHS Lewisham CCG

	31-Mar-14 £'000
Total Non-current Assets	**0**
Current Assets	
Trade & Other Receivables	6,516
Cash & Cash Equivalents	38
Total Current Assets	**6,554**
Total Current Liabilities	**(28,426)**
Total Non-current Liabilities	**(453)**
Total Assets Employed	**(22,325)**
General Fund	(22,325)
Total Taxpayers' Equity	**(22,325)**

Statement of Changes in Taxpayers' Equity

NHS Lewisham CCG

	General Fund	Revaluation Reserve	Total
	£'000	£'000	£'000
CCG Balance at 01 April 2013	0	0	**0**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	**0**
Adjusted CCG Balance at 01 April 2013	**0**	**0**	**0**
Changes in CCG Taxpayers' Equity for 2013-14			
Net operating costs for the financial year	(375,668)	0	**(375,668)**
Total revaluations against revaluation reserve	(375,668)	0	**(375,668)**
Net Recognised CCG Expenditure for the Financial Year	**0**	**0**	**0**
Net funding	353,343	0	**353,343**
CCG Balance at 31 March 2014	**(22,325)**	**0**	**(22,325)**

Statement of Cash Flows

NHS Lewisham CCG	2013-14 £'000
Cash Flows from Operating Activities	
Net operating costs for the financial year	(375,668)
Depreciation and amortisation	0
(Increase)/decrease in trade & other receivables	(6,516)
Increase/(decrease) in trade & other payables	27,264
Provisions utilised	0
Increase/(decrease) in provisions	1,615
Net Cash Inflow (Outflow) from Operating Activities	**(353,305)**
Cash Flows from Investing Activities	
Net Cash Inflow (Outflow) from Investing Activities	**0**
Net Cash Inflow (Outflow) before Financing	**0**
Cash Flows from Financing Activities	
Net funding received	353,343
Net Cash Inflow (Outflow) from Financing Activities	**353,343**
Net Increase (Decrease) in Cash & Cash Equivalents	**38**
Cash & Cash Equivalents at the Beginning of the Financial Year	**0**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	**38**

Better Payment Practice Code 2013/14	**By number**	**By value**
Non-NHS Payables		
Percentage of Non-NHS Trade invoices paid within target	95.09%	97.18%
Percentage of NHS Trade Invoices paid within target	96.00%	99.03%

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

Our plans for the future

Looking back over our first year of operation, we are building on what has worked well, and learning from what needs to improve, to produce our plans for how we will spend our annual budget of around £365 million over the next two years.

Operating Plan for 2014/15 and 2015/16

With so many challenges facing us in the NHS it is vital that we prioritise the areas that we must focus on to achieve our vision of better health for everybody in Lewisham, best care and best value. Based on extensive feedback from member practices, the public, our partners and other key stakeholders for health in Lewisham, our high level priorities for the next couple of years have been agreed to be:

Key Corporate Objectives 2014/15
Cancer - increase the rate of early detection of cancer in primary care.
Health Promotion - support the wider Public Health work on health promotion by Clinical Commissioning Facilitators working with practices
Maternity - develop and implement integrated team 'mother centred' approach for pre, and post-partum care and providing continuity of services.
Children - support the wider work of the Children's Joint Commissioning to develop and implement children's integrated care pathways for Chronic Diseases Management
End of Life Care - improve systems, processes and care pathways to support people to die in the place of their choice.
Long Term Conditions - secure the sustainable improvement in the integration of services to deliver co-ordinated care pathways for adults with long term conditions.
Integrated neighbourhood based teams - establish and sustain effective, integrated multi-organisational and multi-disciplinary teams based in the neighbourhoods, supported by joint approaches and tools.
Community based services - Commission a continuum of high quality, effective community based care services, to reduce unnecessary emergency admissions.
Mental Health - commission a mental health service system where all providers whether statutory, independent or third sector are focused on the key aims of outcomes, safety, choice and access.
Primary Care - implement with Members the priorities for local primary care development and quality improvement strategy with a particular focus on population based commissioning to improve health outcomes.
Urgent Care - commission a simpler, more effective, integrated urgent care network, working with local providers.
Quality - commission high quality care services: Develop and implement a transformation of the local nursing workforce –across primary, community, secondary and social care. Implement effective discharge planning and rehabilitation which delivers the objectives on admissions and maximises the potential for re-enablement.
Public Engagement - ensure that public engagement is intrinsic to all commissioning activities.
Health Outcomes - demonstrate the delivery of better health outcomes for the Lewisham population.
Governance - ensure the CCG have robust governance arrangements for quality, equality, finance, risk management and constitutional requirements.
Partnerships - ensure that the CCG works effectively in partnership with others to realise benefits, including improving population health outcomes.
Leadership - ensure the CCG have strong and robust leadership at all levels to proactively respond to strategic opportunities and challenges effectively.

Refreshing the CCG's Strategic Plan

We will continue to actively engage with members, residents and other key stakeholders as we refresh and update our Strategic Plan by June 2014. Our strategic plan will both inform and be informed by the wider strategic work being undertaken in collaboration with the other CCGs in south east London (Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark) and by NHS England

Sustainability Strategy

The CCG have agreed a Sustainability Policy and the first phase of a Sustainable Development Management Plan. The aim of the plan is to measure our current carbon footprint so that we can develop a realistic strategy to reduce our footprint by 80% by 2050. This is a long term plan and will focus, in 2014/15 in establishing a baseline that we will be able to report next year.

Equality and Diversity Report

Equality Delivery System

Lewisham CCG has adopted the Equality Delivery System (EDS) for the NHS. The EDS gives NHS organisations an opportunity to improve fairness in service commissioning and performance evaluation for the benefit of the whole community – patients, carers and staff. It also enhances collaboration with local stakeholders and interest groups by enabling the analysis of service commissioning, provision and performance which leads to clearer identification of equality objectives and ensures compliance with statutory equality obligations.

The EDS enabled NHS Lewisham to meet the aims of the Equality Act 2010 which is a legal requirement of all public organisations to take the necessary actions to achieve:

- elimination of unlawful discrimination
- advancement of equality of opportunity
- fostering of good relations between individuals and communities.

Lewisham CCG's constitution commits the organisation to work towards meeting the public sector equality duties of the Equality Act 2010 and reduce health inequalities. As commissioners of services, Lewisham CCG recognises that it must account for not only its own organisational equality performance but also that of the providers of services that it commissions.

When making decisions about the services to be commissioned Lewisham CCG ensures that equality and diversity intelligence informs its decisions by routinely using the Joint Strategic Needs Assessment (JSNA) and by carrying out Equality Analysis. Commissioning plans look carefully at population needs, including demographics, inequalities and access to services and set objectives to reduce health inequalities, improve outcomes for patients, ensuring services are accessible and responsive to patient needs.

Our Equality & Diversity Strategy sets out our commitment to fulfilling our equality and diversity responsibilities, as well as to improving health outcomes and reducing health inequalities in Lewisham, and within the strategy we have defined five interim Equality Objectives (to be reviewed during 2014-15). They are:

1. Improvements to primary care access are recognised as being positive for older people and people with long-term conditions
2. Improve the format and methods of materials and systems to support increased understanding of navigating the NHS System for people, including people not familiar with system
3. Ensure that discharge information that patients and GPs receive is sensible, appropriate and communicated well, including drug prescriptions that should be accurate and fully understood
4. Ensure that pathway development plans incorporate training and information for staff in all relevant settings
5. Ensure that papers that come before Lewisham CCG's major committees identify equality-related opportunities, risks and say how these risks are to be managed – this has been delivered already.

We recognise and act upon our responsibilities and duties under the Equality Act 2010 and the Human Rights Act 1988. Our commissioning processes, service access and delivery are grounded in human rights principles known as "the FREDA Principles". This means that commissioning decisions will be subject to:

- Fairness
- Respect
- Equality
- Dignity
- Autonomy

Lewisham CCG published its Public Sector Equality Duty report including Equality Objectives and Action Plan on 31 January 2014. Please click here to view the report http://www.lewishamccg.nhs.uk/news-publications/Publications%20page%20documents/Public%20sector%20equality%20duty%20annual%20report%20(april%202013-Jan2014).pdf

Achievements during 2013/14 include:

- **Public Sector Equality Duty (PSED) compliance : t**he CCG complied with the general and specific duties of the Equality Act 2010 by publishing Equality Objectives in October 2013 and publishing its first annual PSED report by 31 January 2014.

- **CCG Commissioning Strategic Plan to contribute to reducing inequalities**: an equality analysis of the CCG's strategic aims and priorities was undertaken by Lewisham Public Health. It examined the CCG's eight strategic priorities and for each one identified potential positive, negative and neutral outcomes. It concludes that overall the strategy should contribute to reducing inequalities, and highlights potential positive outcomes for disadvantaged groups and for those that share protected characteristics. Further work on equality impact assessment will be undertaken as part of the development of the CCG's commissioning plans.

- **Improving diversity in engagement:** The Public Engagement team of the CCG have been exploring additional opportunities to engage with local people and have developed relationships with local groups and representative organisations to access the voice of patients who do not usually get involved in health dialogues. This will be enhanced as we explore different models of 'social prescribing', referring patients with social, emotional or practical needs to a range of local, non-clinical services,

often provided by voluntary, community and faith sector (VCFS) organisations with in depth knowledge of local communities.

- **Equality analysis** (previously Equality Impact Assessments): An equality analysis form part of Lewisham CCG's commissioning cycle and is considered during the redesign of a service or policy to ensure that the needs of our community groups are being met. Equality Analysis is integrated into the commissioning process enabling commissioners to assess impacts and inform decision making.

  Lewisham CCG will continue to work closely with local partners and Healthwatch Lewisham to ensure that equality and diversity requirements are embedded across its business activities in accordance with the Equality Act 2010.

- **Ethnicity monitoring** - our intention is to improve ethnicity monitoring undertaken by our Quality Monitoring group – FLAG (For Learning and Action Group) - in specific service areas such as IAPT and pressure sores incidents.

Our Employees

We have a stable workforce with low levels of sickness absence (less than 1%), turnover (below 10%) and vacancy rates (5%) (all as at January 2014). These are monitored on a monthly basis.

The members report describes the CCG's approach to staff involvement, including a staff survey, equal opportunities and disability considerations in relation to staffing, statutory and mandatory training requirements and access to learning and development opportunities for our employees.

The Governance Statement summarises the number of persons of each sex who were on the Governing Body and Clinical Directors Committee.

The Remuneration Report summarises the number of other Very Senior Managers (VSM) of each sex.

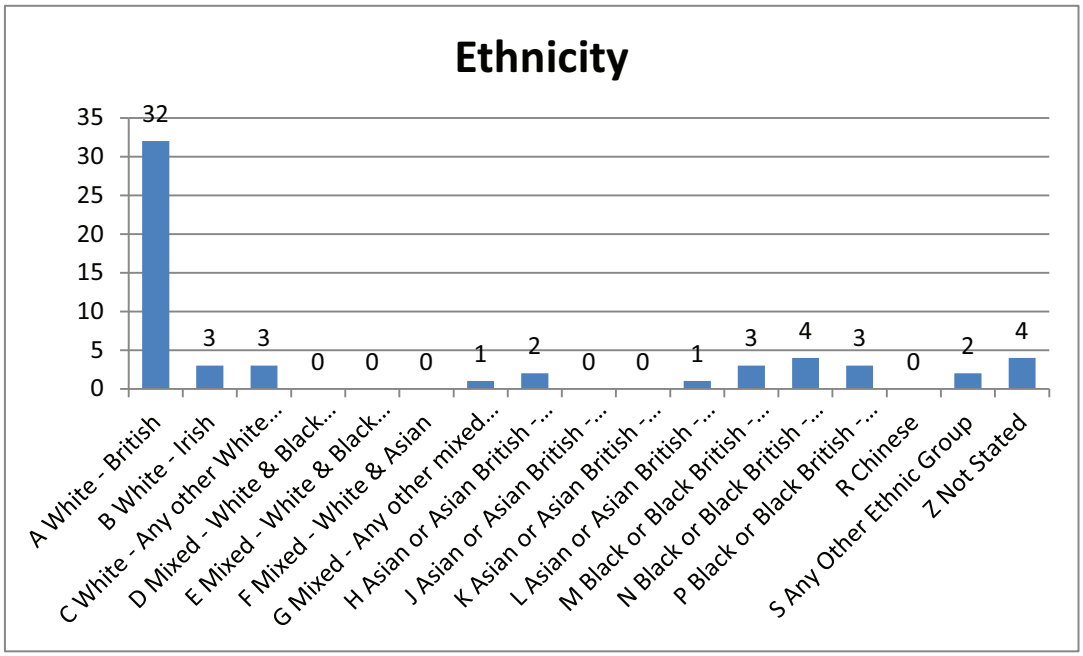
Workforce profile (January 2014)

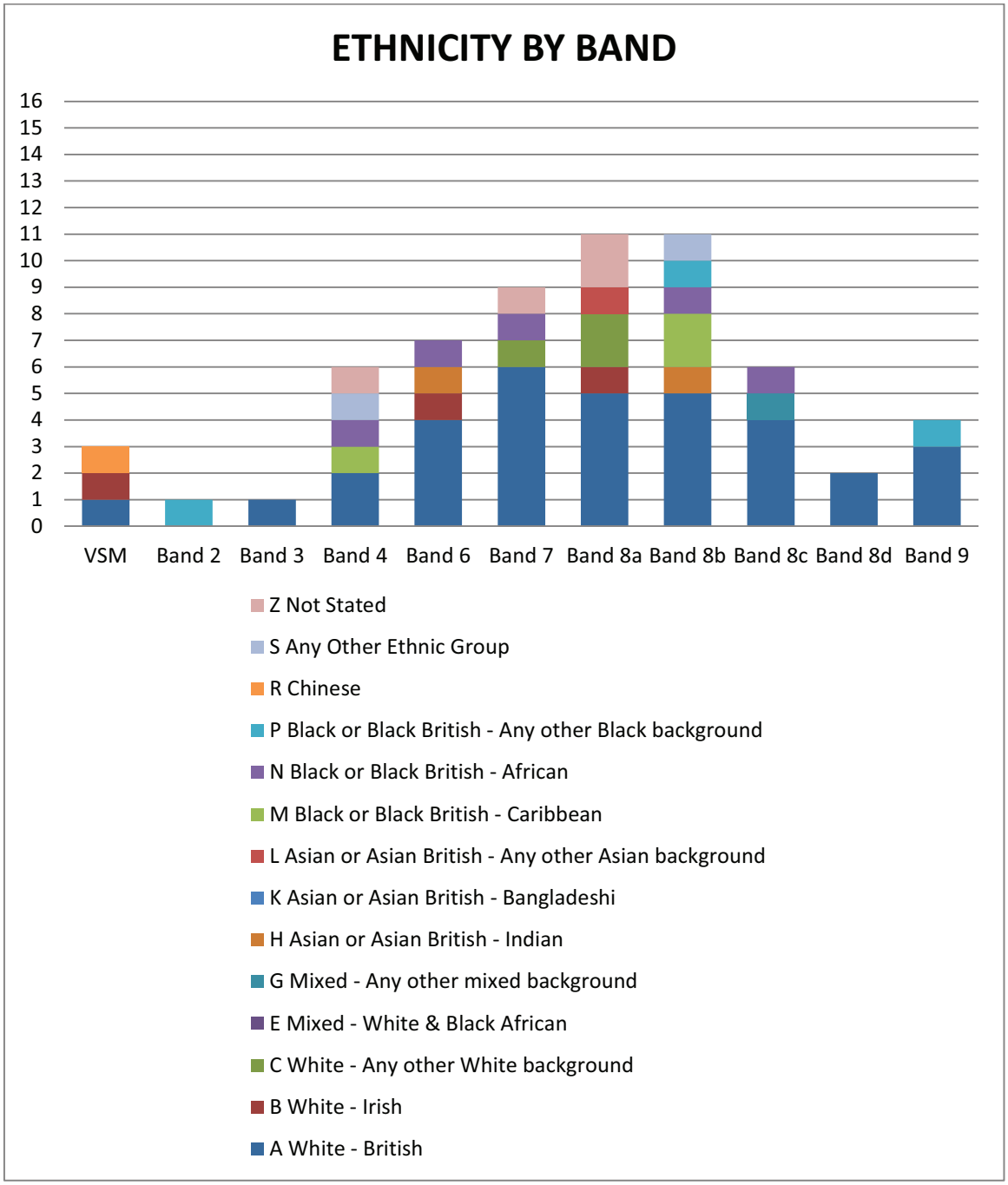
Established posts	Established posts (wte)	In post headcount	In post wte
55	51.6	53	49.08

Equalities profile (January 2014)

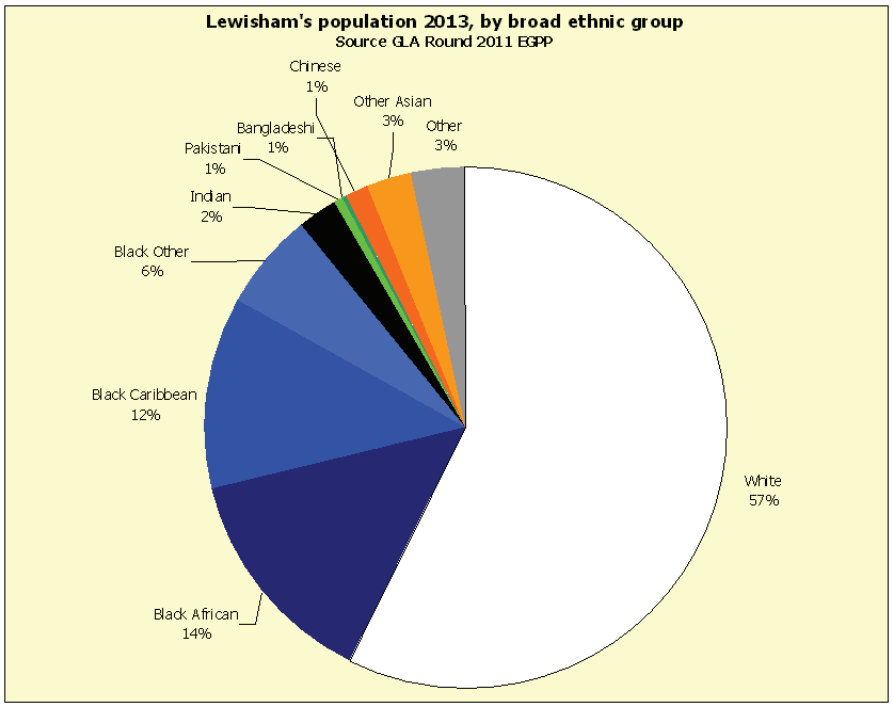
The following charts reflect the profile of the organisation (includes some hosted posts not included in the workforce headcount above), relating to six of the nine protected characteristics. On-going monitoring will help to identify any priority areas to address.

The ethnicity profile of the CCG's staff is shown in these charts:

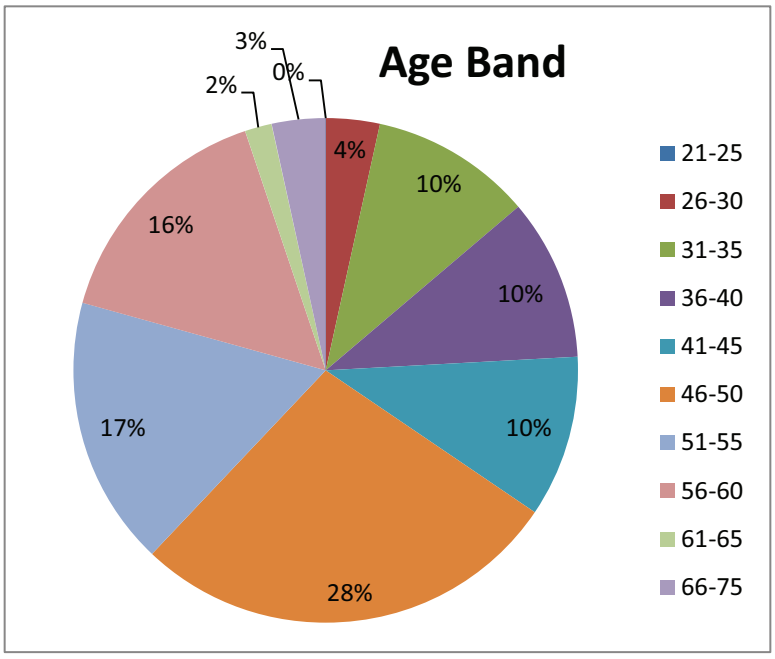


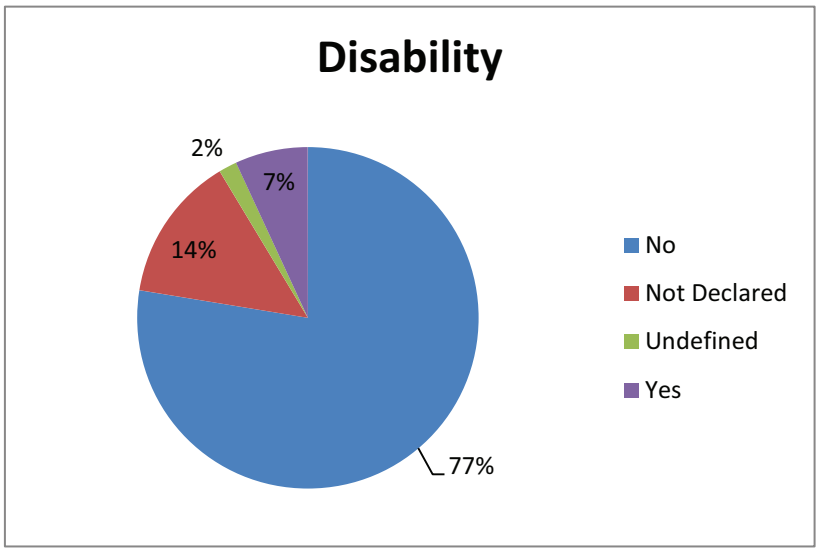

ETHNICITY BY BAND
16
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1
0
VSM
Band 2
Band 3
Band 4
Band 6
Band 7
Band 8a
Band 8b
Band 8c
Band 8d
Band 9
Z Not Stated
S Any Other Ethnic Group
R Chinese
P Black or Black British - Any other Black background
N Black or Black British - African
M Black or Black British - Caribbean
L Asian or Asian British - Any other Asian background
K Asian or Asian British - Bangladeshi
H Asian or Asian British - Indian
G Mixed - Any other mixed background
E Mixed - White & Black African
C White - Any other White background
B White - Irish
A White - British

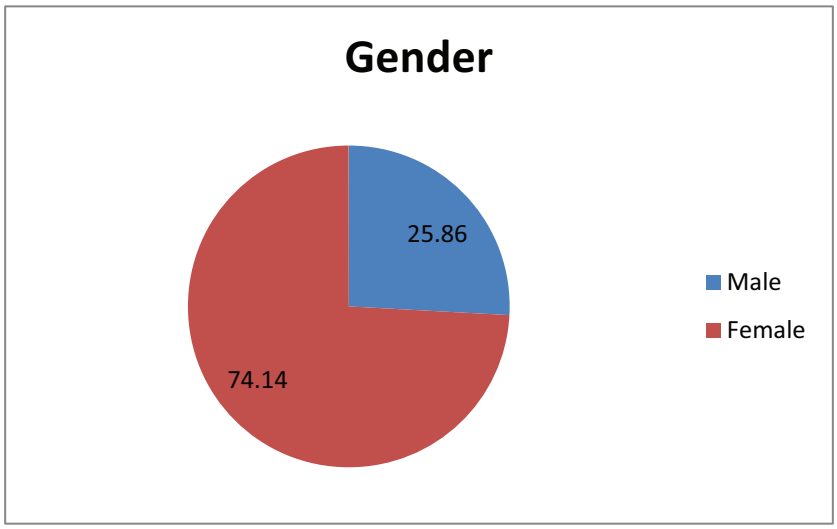
In comparison, the ethnicity profile for the population of Lewisham is as follows:

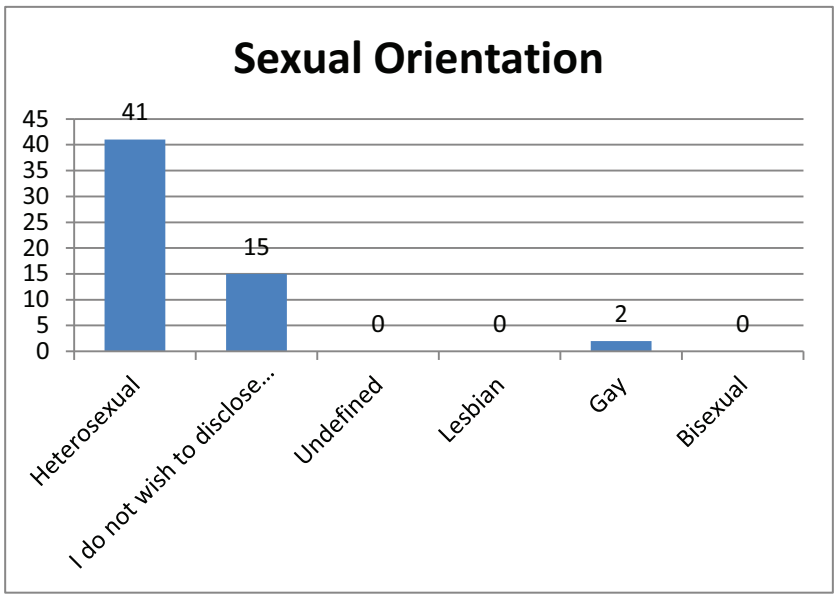


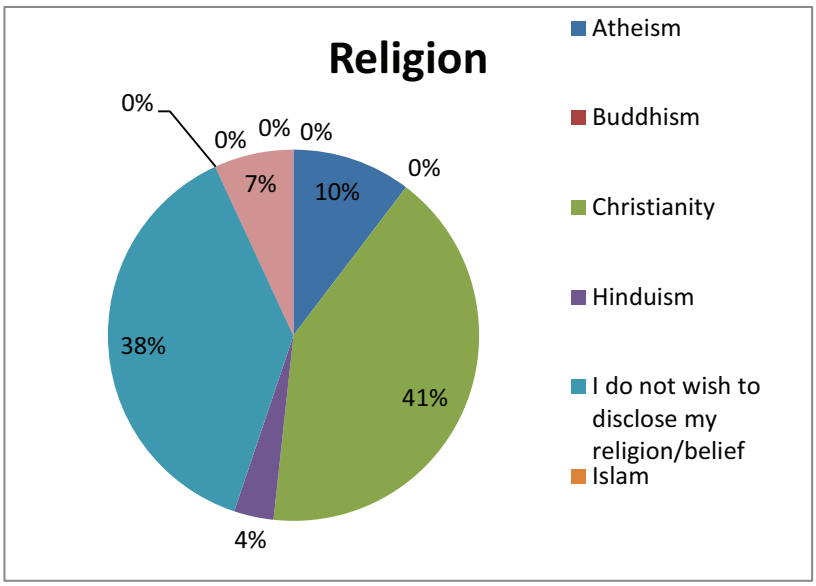
Charts showing the profile of the CCG's staffing by age, gender, disability, sexual orientation and religion are as follows




Disability
2%
7%
14%
77%
No
Not Declared
Undefined
Yes


Gender
25.86
74.14
Male
Female


Sexual Orientation
45
40
35
30
25
20
15
10
5
0
41
15
0
0
2
0
Heterosexual
I do not wish to disclose...
Undefined
Lesbian
Gay
Bisexual



Conclusion

This Strategic Report has reviewed Lewisham CCG's first year in operation and how well the CCG has progressed in delivering the strategic aims, as set out in the CCG's constitution and the NHS Constitutional standards.

At the start of 2013/14 Lewisham CCG faced a number of challenges:

- **Health Challenges** - our population is increasing, with high levels of deprivation and significant health inequalities. Overall life expectancy is improving, however the life expectancy for people living in Lewisham is shorter than for London and England. Mental health problems are greater in Lewisham. In common with other CCGs, we serve a population which is ageing and has increasing numbers of people with long term conditions. This will inevitably mean a greater demand for health and care services.

- **Re-organisational Challenges** – the CCG has different responsibilities from the previous Primary Care Trust (PCT), so had to form new relationships, building on the historical good collaborative working within Lewisham. Particularly important relationships are with other commissioning organisations, including London Borough of Lewisham, NHS England, and other CCGs to ensure that we are making the best co-ordinated plans for people in Lewisham and the best use of resources.

- **Financial Challenges** – it is estimated that the cost of healthcare for the Lewisham population is higher than the CCG's income. So the CCG will have to generate financial efficiencies in order to keep pace with the predicted costs of healthcare demand.

- **Service Challenges** – the public and members engagement activities during 2013 enabled us to hear the many concerns the public and members have about local services, including District Nursing, primary care access, availability of information for patients and the importance of integrating health and social care services. The national debate on the Francis report further highlighted the importance of quality of care, especially for vulnerable older people.

- **Provider Challenges** – in response to the TSA review and the Secretary of State's decisions, the CCG, working with other commissioning colleagues, oversaw the smooth establishment of the new Lewisham and Greenwich NHS Trust. Whilst the judicial review overturned the decision to change A&E and maternity services on the Lewisham Hospital site, NHS Lewisham Clinical Commissioning Group recognises the need to make changes to local health services in order to ensure high quality services are sustainable within available funding. The CCG will not shy away from difficult decisions in our pursuit of our goals to improve patient care and health outcomes for Lewisham people. NHS Lewisham CCG is working with the GP membership and local partners including Lewisham people, NHS providers, NHS England, other local CCGs and the London Borough of Lewisham to ensure that any changes are well planned to the best advantage of Lewisham people

Lewisham CCG has developed a clear vision – to deliver **better health, best care and best value** for everybody in Lewisham. Through dialogue and active engagement with the public we developed our five year Strategic Plan and our two year Commissioning Intentions, which is informing the refreshed SEL Strategic Plan. We believe these plans will enable us to respond effectively to the above local challenges, ensure that we use our finite resources to best effect and improve the health of Lewisham people.

We recognise that we have to do things differently in partnership with the public and our local providers. We need to shift the balance of care from emergency responses to care that is proactive and planned. It means developing local neighbourhoods and communities so that services respond to those local needs and we are better placed to tackle inequalities in the borough. Above all it means always putting the individual patient at the centre of care, seeing the whole person and empowering them to act as a partner in improving health.

This Strategic Report attempts to provide a fair review of the CCG's performance. It summarises key aspects of the commissioning work undertaken during 2013/14 and the early indication of its impact on outcomes, national standards and key performance indicators.

After just one year in operation, we believe we have demonstrated some improvements in the quality and safety of local health care, but there remains much more to do to improve patient experience, particularly in community services, maternity and inpatient care – especially around discharge of patients from hospital – and variation in quality and access to primary care services.

We believe that the new clinician-led approach to commissioning is improving the quality and safety of health care in Lewisham. Underpinning everything we do is our dialogue and engagement with Lewisham people as our belief is that by working together we can meet these challenges and achieve our goals for the people of Lewisham.

5th June 2014
Martin Wilkinson
Chief Officer

APPENDIX A

Trust Special Administrator (TSA) programme for South London Healthcare NHS Trust

The TSA programme was completed at the end of September 2013. It had achieved the dissolution of South London Healthcare NHS Trust and the safe and effective transfer of the Trust's services, staff and sites to other local NHS organisations, in accordance with the decisions of the Secretary of State for Health:

- The transfer of the Queen Mary's Sidcup site to Oxleas NHS Foundation Trust, with a range of acute hospital services to be delivered on that site by Dartford and Gravesham NHS Trust, Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust.
- The acquisition of the Princess Royal University Hospital by King's College Hospital NHS Foundation Trust
- The transfer of the Queen Elizabeth Hospital to Lewisham NHS Trust, as a merger by acquisition.
- The Secretary of State's remaining decisions were implemented as follows:
- Implementation of the efficiency savings decision for the transferred hospitals is continuing as part of the efficiency programmes of the NHS organisations to which the hospitals were transferred.
- Oxleas NHS Foundation Trust working with NHS Bexley Clinical Commissioning Group, the local authority, other NHS organisations and other partners to implement the decision to develop the Queen's Mary's Hospital site in Bexley as a vibrant hub for local services.
- The decision that vacant or poorly utilised premises should be vacated and sold where possible was partially actioned by South London Healthcare NHS Trust prior to dissolution and the NHS organisations to whom premises were transferred are continuing the programme.
- The decision that the Department of Health should pay the additional annual funds to cover the excess costs of the PFI buildings at Princess Royal and Queen Elizabeth hospitals was implemented.

The decisions made to aid implementation that:

- the Department of Health should write off South London Healthcare Trust's accumulated debt was implemented.
- the Department of Health should provide additional funds to cover the implementation of the recommendations was implemented. Additional funds were provided by the Department of Health and commissioners. The detail is set out in the NHS Trust Development Authority's board report 'Securing sustainable healthcare for the people of South East London'
- a programme board be appointed under an independent Chair, reporting to Sir David Nicholson as Chief Executive of the NHS Commissioning Board and David Flory as Chief Executive of the NHS Trust Development Authority, to ensure the changes are effectively delivered - A programme board was appointed to oversee the implementation of the changes delivered by the TSA programme. The TSA continued to act as chair of the programme board until the dissolution of South London Healthcare NHS Trust, in line with the TSA report
- the decision relating to operational service changes across south east London, subject to the amendments proposed by Sir Bruce Keogh, could not be implemented due to the outcome of Judicial Reviews.

Members' report

NHS Lewisham CCG was made up of the following member practices during 2013/14:

Practice Name	Neighbourhood	Address
Mornington Surgery	1	433 New Cross Road, SE14 6TJ
Queens Road Practice	1	387 Queens Road, New Cross, London, SE14 5HD
Kingfisher	1	Kingfisher Medical Centre, Staunton Street, Deptford, SE8 5DA
Clifton Rise	1	Clifton Rise Family Practice, Waldron Health Centre, Stanley Street, London, SE8 4BG
New Cross Health Centre	1	New Cross Health Centre, 40 Goodwood Road, New Cross, SE14 6BL
Grove Medical Centre	1	Windlass Place, London, SE8 3QH
Vesta Road Surgery	1	58 Vesta Road, London, SE4 2NH
Amersham Vale Training Practice	1	Waldron Health Centre, Stanley Street, London, SE8 6TJ
Deptford Surgery	1	502-504 New Cross Road, London, Se14 6TJ
Waldron Family Group Practice	1	Waldron Health Centre, Stanley Street, London, SE8 4BG
Deptford Medical Centre	1	2 Pearsons Avenue, SE14 6TG
Belmont Hill	2	The Surgery, 36 Belmont Hill, Lewisham, SE13 5AY
Lee High Road	2	Lewisham Medical Centre, 308 Lee High Road, Lee, SE13 5PJ
Lee Health Centre	2	Lee Health Centre, 2 Handen Road, Se12 8NP
Morden Hill	2	The Surgery, 21 Morden Hill, London, SE13 7NN
St Johns Medical Centre	2	56-60 Loampit Hill, Lewisham, SE13 7SX
The Surgery, 20 Lee Road	2	The Surgery, 20 Lee Road, Blackheath, SE3 9RT
Brockley Road	2	465-467 Brockley Road, Brockley, SE4 2PJ
Hilly Fields Medical Centre	2	172 Adelaide Avenue, Brockley, SE4 1JN
Honor Oak Group Practice	2	Honor Oak Health Centre, 20 Turnham Road, SE4 2LA
Triangle Group	2	The Triangle Group Practice, 2 Morley

Practice Name	Neighbourhood	Address
		Road, London, SE13 6DQ
Rushey Green	2	The Primary Care Centre, Hawstead Road, London, SE6 4JH
Woodlands Health Centre	2	4 Edwin Hall Place, Hither Green Lane, London, SE13 6RN
Nightingale	2	2 Handen Road, SE12 8NP
Hurley Group	2	Waldron Health Centre, Amersham Vale, London, SE14 6LD
South Lewisham	3	50 Conisborough Crescent, Catford, London, SE6 2SP
The Surgery, Torridon Road	3	The Surgery, 80 Torridon Road, Catford, SE6 1RB
Downham Family Practice	3	Downham Health and Leisure Centre, 7-9 Mooreside Road, Downham, BR1 5EP
The Surgery, Downham Way	3	The Surgery, 481-483 Downham Way, Downham, Kent, BR1 5HU
The Surgery, Winlaton	3	139 Winlaton Road, Bromley, Kent, BR1 5QA
The Surgery, Chinbrook	3	32 Chinbrook Road, Grove Park, London, SE12 9TH
Parkview Surgery	3	186 Brownhill Road, Catford, London, SE6 1AT
Marvels Lane Health Centre	3	37 Marvels Lane, Grove Park, SE12 9PN
The Surgery, Muirkirk Road	3	50 Muirkirk Road, Catford, London, SE6 1BQ
The Surgery Boundfield Road	3	The Surgery, 103 Bounfield Road, Catford, SE6 1PG
Oakview Family Practice	3	190 Shroffold Road, Downham, Kent, BR1 5NJ
Baring Road Medical Centre	3	Baring Road Medical Centre, 282 Baring Road, London, SE12 0DS
Jenner Practice	4	201 Stanstead Road, Forest Hill, London, SE23 1HU
Sydenham Green Group Practice	4	26 Holmshaw Close, Sydenham, London, SE26 4TH
Woolstone Medical Centre	4	Woolstone Road, London, SE23 2TR
Sydenham Surgery	4	2 Sydenham Road, Sydenham, SE26 5QW
Wells Park Practice	4	The Wells Park Practice, 1 Wells Park Road, Sydenham, London, SE26 6JQ

Practice Name	Neighbourhood	Address
Bellingham Green Surgery	4	Bellingham Green Surgery, 24 Bellingham Green, Catford, London, SE6 3JB
Perry Vale Medical Centre	4	The Vale Medical Practice, 195-197 Perry Vale, Forest Hill, London, SE23 2JF

The Chair of the CCG was Dr Helen Tattersfield until 31st August 2013 and from 1st September the Chair of the CCG has been Dr Marc Rowland. Mr Martin Wilkinson has been the Accountable Officer for the entire year.

The Membership Body, which at NHS Lewisham CCG has been known locally as the Clinical Directors Committee (supported by wider membership structures as set out in our constitution), has comprised the seven elected GP members of the CCG's Governing Body plus the Accountable Officer (or his deputy).

During 2013/14 this included:

- Dr Helen Tattersfield (Chair) – until 31st August 2013.
- Dr Marc Rowland (Chair from 1st September 2013 – previously a Clinical Director)
- Dr David Abraham (Senior Clinical Director)
- Dr Judy Chen (Clinical Director)
- Dr Hilary Entwistle (Clinical Director)
- Dr Arun Gupta (Clinical Director)
- Dr Faruk Majid (Senior Clinical Director)
- Dr Jacky McLeod (Clinical Director – from 1st October)
- Mr Martin Wilkinson (Accountable Officer)

The Governing Body during 2013/14 has included the members of the Clinical Directors Committee shown above, Mr Tony Read, the Chief Financial Officer and four independent members:

- Dr Suparna Das (Designated secondary care doctor) – to 1st June 2013
- Prof Ami David (Designated nurse member)
- Mrs Diana Robbins (Lay member)
- Mr Ray Warburton (Lay member)

The CCG's Audit Committee comprised the following members during the year ending 31st March 2014:

- Mr Ray Warburton (Chair)
- Mrs Diana Robbins
- Dr Faruk Majid
- Dr Suparna Das (until 1st June 2013)
- Prof Ami David

Details of the members of other committees can be found in Annual Governance Statement and further details of the Governing Body and Clinical Director's Committee can be found in the Remuneration Report.

Pension liabilities
The accounting policy for pension liabilities is detailed in note 1.7.2 to the Financial Statements. Note 4.5 to the Financial Statements provides detail on the treatment of pension liabilities. The Remuneration report provides details of pension disclosures for Governing Body members and CCG Directors.

Sickness absence data
A table is included in the financial statements at note 4.3.

The CCG's Sickness Absence Policy confirms the importance of promoting and supporting the health and welfare of its employees whilst at the same time being committed to achieving excellence in terms of attendance at work. An employee assistance scheme is provided to support staff. Our policies also confirm that the CCG will ensure that it abides by its duty of care to all staff, and other such legislation in order to provide a supportive environment within which sickness absence levels can be reduced.

This can be achieved by the implementation of positive procedures and guidelines. A consistent and pro-active approach to improving attendance is being applied in the following areas:

- monitoring the attendance of staff on a regular basis
- positively reinforcing the good attendance of staff
- showing an understanding towards those who need to be absent from work on a long term basis through sickness; and dealing fairly and consistently with staff whose attendance is of concern
- ensuring that managers are supported, trained and encouraged to manage sickness absence competently, fairly and consistently in line with good practice.

Sickness absence rates are affected, among other things, by leadership and the working culture. At the CCG, there is an inclusive and supportive leadership style and culture. Our sickness absence rate is currently running at 0.96% (year to date) which is significantly lower than the NHS national average of 3.8%. Sickness absence is recorded, verified, monitored and reported (monthly in arrears) as part of the monthly HR Workforce Report to the CCG management team. Sickness absence data reported includes sickness absence reason, days lost, full time equivalent days lost, and number of episodes. It also categorises the absence by short and long term. The HR Business Partner works closely with managers to ensure that sickness absence cases are managed in a timely way and in accordance with the CCG's Sickness Absence Policy.

External audit
The external auditor for the CCG, appointed by the Audit Committee for 2013/14 was Grant Thornton UK LLP. The 2013/14 fee is £111k; including a premium for first year audit costs of £8k refunded to the CCG by the Audit Commission.

Audit Services:	£103k
Other Services	£0

Disclosure of Serious Untoward Incidents
Information relating to the disclosure of incidents involving data loss and confidentiality breaches can be found in the Annual Governance Statement.

Cost allocation and setting charges for information
We certify that the clinical commissioning group has complied with HM Treasury's guidance on cost allocation and the setting of charges for information.

Principles for remedy

The Health Service Ombudsman is responsible for handling complaints from the public that relate to maladministration and has set out the six principles which underpin this work, which are to:

- get it right
- be customer focused
- be open and accountable
- act fairly and proportionately
- put things right
- seek continuous improvement.

The CCG continues to work hard to meet the standards set within these principles, working closely with partner agencies such as Healthwatch Lewisham, providers of NHS services and NHS England to ensure a robust service which reflects the principles of being open and enabling continuous improvement to meet the needs of residents within the borough.

NHS Lewisham CCG encourages feedback, positive and negative, so that we can make improvements based directly on the concerns of patients and the public. During 2013/14, there were 16 formal complaints, of which eight were complaints regarding access and eligibility for services, for example individual funding requests considered by the CCG and access to IVF, four were sent to the complaints office for information only, 3 related to treatment and 1 to continuing care services.

The investigations into complaints about the CCG have resulted in changes and learning, for example:

1. A complaint was received about a member of staff who had conducted a care assessment, focusing on attitude and outcome of the assessment. The CCG has, as a result, reviewed communication processes in the joint commissioning team and is addressing the individual issues through the line management process. The CCG is committed to listening to the concerns raised by members of the public about its staff and acting on them to improve the delivery of services.
2. A complaint was received relating to a delay in oxygen therapy for a child. The CCG has facilitated a meeting between the family and the safeguarding children team to resolve issues that have arisen and ensure that effective communication and planning take place in the future.

Employee consultation

Organisational change is managed in accordance with the principles and procedures contained within the CCG's Organisational Change Management Policy. This policy has been recently updated and is awaiting ratification. The CCG also informally communicates with employees via a monthly staff bulletin and monthly staff briefing. The CCG is also participating in the NHS Staff Survey. This will provide the CCG with the opportunity to build up a picture of staff experience, and to compare and monitor change over time and to identify variations between staff groups. All permanent members of staff were eligible to participate between 27th January and 9th March 2014. The CCG response rate was a 68%, compared to a national response rate of 49%. The results are being communicated to staff and an action plan developed to address any issues and concerns.

Disabled employees

Disabled employees are protected under the "protected characteristics" of the Equality Act 2010. The CCG's Equality & Diversity Policy confirms that the CCG will make reasonable adjustments to working conditions or to the physical working environment where that would help overcome the practical effects of a disability. The policy also confirms that the CCG will provide support to enable disabled members of staff to participate fully in meetings and training courses. Reasonable adjustments will be taken into account and full use will be made of the advice and assistance available via current government employment initiatives when consideration is being made of a disabled applicant's suitability for a vacant post. The CCG's Sickness Absence Policy confirms that every effort will be made to facilitate an employee's return to work including making reasonable adjustments under the Disability Discrimination Act 1995 which may include applications for grants where appropriate and taking advice from Disability Advisers in the Employment Service. This policy has recently been updated and is awaiting ratification.

Emergency preparedness, resilience and response

NHS Lewisham CCG is a Category 2 responder under the terms of the Civil Contingency Act (2004). Under the terms of the Act the CCG is required to support Category 1 responders. In the NHS in London, NHS England takes the lead role for emergency preparedness, resilience and response and has developed London wide incident response plans. The CCG has played an active part in supporting the development and testing of these plans.

In addition the CCG has developed and tested its own Business Continuity Plan, which is consistent with the requirements of NHS England.

Statement as to Disclosure to Auditors

Each individual who is a member of the Membership Body at the time the Members' Report is approved confirms:

- So far as the member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is unaware; and,

- That the member has taken all the steps that they ought to have taken as a member in order to make them self aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information.

5th June 2014
Martin Wilkinson
Chief Officer

Remuneration Report

As the Accountable Officer for NHS Lewisham Clinical Commissioning Group I am required to produce and sign a remuneration report as part of the CCG's Annual Report and Accounts. I am not a member of the CCG's Remuneration Committee, which is established within the CCG's constitution and is accountable to the CCG's Governing Body. The role of the Remuneration Committee is to make recommendations to the Governing Body on determinations about the remuneration, fees and other allowances, including pensions, for members of the Governing Body and the CCG's very senior managers.

My role in the area, as delegated to me by the CCG Membership in the CCG's constitution, is to approve arrangements for discharging the CCG's statutory duties as an employer and to approve human resources polices for employees and for other person's working for the CCG.

The Remuneration Committee comprised of four members and met on two occasions during the past year. Chair of the committee is Mr Ray Warburton, Lay Member of the CCG's Governing Body. A full list of members, their roles and the number of meetings each attended is below.

Members	Role	30-May	27-Jun
Prof Ami David	Designated Nurse	Y	Y
Mrs Diana Robbins	Lay Member	Y	Y
Mr Ray Warburton	Lay Member	Y	Y
Dr Suparna Das*	Designated Secondary Care Doctor	Y	X

* Dr Suparna Das resigned her position at the CCG on the 1st June. A new Designated Secondary Care Doctor took up his post in April 2014
In addition to the members listed above, the following CCG employees provided the committee with services and/or advice which was material to the committee's deliberations.

Name	Role	Service
Mr Martin Wilkinson	Chief Officer	Advice
Mrs Lesley Aitken	Corporate Services Manager	Administration

The following persons who are not employees of the CCG also provided services and/or advice to the committee. Both are employees of NHS England at South London Commissioning Support Unit and provide specialist Human Resources support to the CCG as part of commissioning support service level agreement agreed with CCGs in south London. The CCG paid South London Commissioning Support Unit £82k for Human resources support in 2013/14.

Name	Role	Service
Ms Gail Tarburn	Head of Human Resources	Advice
Ms Caroline Linden	Human Resources Business Partner	Advice

Remuneration Policy

The Committee's deliberations are carried out within the context of national pay and remuneration guidelines, local comparability and taking account of independent advice regarding pay structures.

The CCGs remuneration policy is consistent with nationally agreed pay awards for very senior managers and Agenda for Change Terms and Conditions of Employment. The Remuneration Committee assesses the performance of staff employed on Very Senior Manager (VSM) Pay in line with the VSM Framework, comparable benchmarking and local pay arrangements and agree proposed performance assessment ratings.

Senior managers' performance related pay
The CCG does not have a policy of performance related pay for senior managers.

Senior managers' service contracts
The CCG's policy concerning senior managers' contracts is that they are on-going (reviewed on an annual basis), with a notice period of 6 months. Termination payments are calculated on the basis of one month's pay for every completed year of service.

CCG may terminate the appointment at any time and with immediate effect by making a payment in lieu of notice, as a lump sum payment equal to that of the basic salary (as at the date of termination) which would have been payable during the notice period, less income tax and national insurance contributions. Payments in lieu of notice are at the sole and absolute discretion of the CCG and with the approval of the CCG's Remuneration Committee.

Payment in lieu of notice do not include: a) any additional payments that might otherwise have been due during the period for which payment in lieu is made; b) any payment in respect of benefits one would have been entitled to receive during the period; c) any payment in respect of any holiday entitlement that would have accrued during the period for which the payment in lieu is made.

Payments to past senior managers

No significant awards were made to past senior managers during the financial year 2013/14.

Senior managers' salaries and allowances (audited)

2013-14

Name and title	Salary & Fees (bands of £5,000) £000	Taxable Benefits (rounded to the nearest £00) £000	Annual Performance Related Bonuses (bands of £5,000) £000	Long-term Performance Related bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	TOTAL (bands of £5.000) £000
Martin Wilkinson	110 – 115	1.6			105 – 107.5	215 – 220
Diana Braithwaite	85 - 90	0			27.5 – 30	115 – 120
Antony Read	100 - 105	0			40 – 42.5	140 – 145
Susanna Masters	60 - 65	0			25 – 27.5	90 – 95
Alison Browne	90 - 95	0.2			42.5 - 45	135 - 140
Dr Helen Tattersfield	20 - 25					20 - 25
Dr Marc Rowland	50 - 55	0				50 - 55
Dr David Abraham	55 - 60	0				55 - 60
Dr Faruk Majid	55 - 60	0				55 - 60
Dr Judy Chen	30 - 35	0				30 - 35
Dr Hilary Entwistle	25 - 30	0				25 - 30
Dr Arun Gupta	25 - 30	0				25 - 30
Dr Jacqueline McLeod	10 - 15	0				10 - 15
Ray Warburton	10 -15	0				10 -15
Diana Robbins	5 - 10	0				5 - 10
Dr Suparna Das	0 - 5					0 - 5
Professor Ami David	10 - 15	0				10 - 15

Senior Managers' Pension Benefits (audited)

NHS Lewisham Clinical Commissioning Group is required to disclose the pension benefits for those persons disclosed in the Senior Managers' Salaries and Allowances table, where the Clinical Commissioning Group has made a direct contribution to a pension scheme.

GP members of the Governing Body are office holders and are not deemed as employees of the CCG. The posts are therefore not pensionable.

From 1 April 2013, NHS England became the employing agency for all types of GPs and pension contributions have been made by NHS England rather than the CCG. Where fees for service have been paid directly to GP practices, the practice is the employing agency and not the CCG.

During 2013-14 the CCG incorrectly collected pension contributions from two GP officer holders and paid pension contributions to the NHS Pensions Agency. The CCG has made arrangements for the contributions to be refunded and the pension records to be corrected.

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £000
Martin Wilkinson	5.0 - 7.5	15.0 - 17.5	27.5 - 30.0	80 - 85	325	419	88	15
Diana Braithwaite	0.0 - 2.5	5.0 - 7.5	10.0 - 12.5	35 - 40	154	188	30	12
Antony Read	0.0 - 2.5	5.0 - 7.5	35.0 - 37.5	105 - 110	532	599	55	13
Susanna Masters	0.0 - 2.5	2.5 - 5.0	35.0 - 37.5	105 - 110	672	737	51	8
Alison Browne	0.0 - 2.5	5.0 - 7.5	20.0 - 22.5	65 - 70	418	492	66	12

Pay multiples (audited)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the financial year 2013/14 was £150k - £155k (pro rata). This was 3.23 times the median remuneration of the workforce, which was £46,398.

In 2013/14 no employees received remuneration in excess of the highest paid member of the Membership Body/Governing Body. Remuneration ranged from £13k to £150k.

For the purposes of calculating pay multiples remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Off-payroll Engagements

	Number
Number of new engagements or those that reached six months in duration between 1 April 2013 and 31 March 2014.	1
Number of the above which include contractual clauses giving the CCG the right to request assurance in relation to Income Tax and National Insurance obligations.	1
Number for who assurance has been requested.	1
Of which, the number:	
For whom assurance has been received.	1
For whom assurance has not been received.	0
That has been terminated as a result of assurance not being received.	0

	Number
Number of off-payroll engagements of Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year	2
Number of individuals that have been deemed " Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility", during the financial year (this figure includes both off-payroll and on-payroll engagements)	14

One of these engagements lasted for 5 months and one for 12 twelve months. These members of the Governing Body were paid by their general practices which, in turn, were reimbursed by the CCG in compliance with HMRC guidance.

Membership Body and Governing Body profiles
The Membership Body for the NHS Lewisham CCG is known as the Clinical Director's Committee. The table below shows the list of members of the Governing Body and the Clinical Directors Committee.

Members	Role	Governing Body Member	Clinical Directors Committee Member
Prof Ami David	Designated Nurse	Y	N
Dr Arun Gupta	Clinical Director	Y	Y
Dr David Abraham	Senior Clinical Director	Y	Y
Mrs Diana Robbins	Lay Member	Y	N
Dr Faruk Majid	Senior Clinical Director	Y	Y
Dr Helen Tattersfield*	Chair	Y	Y
Dr Hilary Entwistle	Clinical Director	Y	Y
Dr Jacky McLeod	Clinical Director	Y	Y
Dr Judy Chen	Clinical Director	Y	Y
Dr Marc Rowland**	Clinical Director / Chair	Y	Y
Mr Martin Wilkinson	Chief Officer	Y	Y
Mr Ray Warburton	Lay Member	Y	N
Mr Tony Read	Chief Finance Officer	Y	N
Dr Suparna Das ***	Designated Secondary Care Doctor	Y	N

* Dr Helen Tattersfield resigned her post as Chair and member of the Governing Body effective from 1st September.

** Dr Marc Rowland became Chair of the Governing Body from 1st September, previously he had been a Clinical Director.

*** The role of Designated Secondary Care Doctor was vacant from 1st June 2013 until 1st April 2014.

Profiles of Governing Body Members and Clinical Director Committee Members

Professor Ami David MBE
Designated Nurse Member of the Governing Body.
Visiting professor of primary care nursing at London South Bank University, Non-Executive Director Medway Community Health Care; formerly Non-Executive Director NHS Bromley and senior management roles in PCTs, Strategic Health Authority, and Health Authorities.

Member of:
Governing Body
Audit Committee
Remuneration Committee

Dr Arun Gupta
Clinical Director

Partner of South Lewisham Group Practice. Previously National Clinical Lead for Choose and Book. A Lewisham GP for 14 years.
Member of:
Governing Body
Clinical Directors Committee
Strategy and Development Committee

Dr David Abraham
Senior Clinical Director
Partner of Morden Hill and a GP in Lewisham for 25 years. Former member of Lewisham PCT Professional Executive Committee.
Member of:
Governing Body
Clinical Directors Committee
Strategy and Development Committee (Chair)

Mrs Diana Robbins
Lay Member
Consultant working in health and social care, local and central government. Formerly a Non-Executive Director, South London and Maudsley NHS Mental Health Trust and for Lewisham and Guy's NHS Mental Health Trust.
Member of:
Governing Body
Audit Committee
Remuneration Committee
Strategy and Development Committee

Dr Faruk Majid
Senior Clinical Director
Partner of Hilly Fields Medical Centre and a former member of Lewisham PCT Professional Executive Committee. A Lewisham GP for 23 years.
Member of:
Governing Body
Clinical Directors Committee
Audit Committee
Delivery Committee

Dr Helen Tattersfield
Chair
Formerly chair of Lewisham Federation for practice based commissioning and neighbourhood medical lead for Lewisham PCT. GP principal of Oakview Family Practice for 21 years.
Member of:
Governing Body (Chair) – until 1st September 2013
Clinical Directors Committee (Chair) – until 1st September 2013
Strategy and Development Committee – until 1st September 2013
Delivery Committee (Chair) – until 1st September 2013

Dr Hilary Entwistle
Clinical Director
Partner of Woolstone Medical Centre for 24 years. Formerly PCT neighbourhood medical lead and co-chair of neighbourhood practice based commissioning group.
Member of:
Governing Body
Clinical Directors Committee

Delivery Committee

Dr Jacky McLeod
Clinical Director
Dr Jacky McLeod has been a Lewisham GP for 20 years. She is currently a salaried GP at the Vale Medical Centre where she has worked since 1996, and is also an experienced GP Appraiser and Tutor.
Member of:
Governing Body – from 1st October 2013
Clinical Directors Committee – from 1st October 2013
Delivery Committee – from 1st October 2013

Dr Judy Chen
Clinical Director
Partner of Rushey Green Group Practice for 17 years. Named GP for Children's Safeguarding in Lewisham.
Member of:
Governing Body
Clinical Directors Committee
Delivery Committee

Dr Marc Rowland
Chair
Partner of the Jenner Practice and formerly co-chair of neighbourhood practice-based commissioning group and vice chair of the Lewisham Federation. Has been with the practice for 34 years.
Member of:
Governing Body (Chair – from 1st September 2013)
Clinical Directors Committee (Chair – from 1st September 2013)
Strategy and Development Committee
Delivery Committee (Chair – from 1st September 2013)

Mr Martin Wilkinson
Chief Officer
Previous roles include Director of Strategy & System Management and Director of Commissioning (NHS Lewisham), Director of Service Development (Bexley Care Trust)
Governing Body
Clinical Directors Committee
Strategy and Development Committee
Delivery Committee

Mr Ray Warburton OBE
Lay Member
Consultant supporting health and social care organisations. Previously, roles in Older People & Vulnerable Adults Branch / NHS Equality Team, Department of Health, higher education and local government.
Member of:
Governing Body
Audit Committee (Chair)
Remuneration Committee (Chair)
Delivery Committee

Mr Tony Read
Chief Financial Officer
Previous roles in the NHS include senior positions in finance and strategy across south east London including Director of Strategy for NHS South East London. Tony is a Fellow of the Chartered Association of Certified Accountants.
Member of:
Governing Body
Strategy and Development Committee
Delivery Committee

Dr Suparna Das
Designated Secondary Care Doctor
Consultant anaesthetist, with previous roles as Assistant Director of South London Cardiac and Stroke Network, as well as in business and management consultancy positions. Governing Body Secondary Care Doctor role held jointly with Lambeth and Southwark CCGs.
Member of:
Governing Body (until 1st June 2013)
Remuneration Committee (until 1st June 2013)

Other senior managers
Mrs Susanna Masters
Corporate Director
Member of:
Strategy and Development Committee

Ms Diana Braithwaite
Commissioning Director
Delivery Committee

Ms Alison Browne
Nurse Director

Register of interests

Name and role in organisation	Company/ Organisation	Position/ Shareholding/ remuneration	Directorships and or other significant interests	Any connection with a voluntary or other organisation contracting for the NHS	Research funding / grants that may be received by the individual or any organisation they have a role in	Other specific interests / Any other specific relationship which the public could perceive would impair or otherwise influence the individuals judgement or actions in their role within the CCG	Personal interest or that of a family member or close friend
Dr Marc Rowland Chair	Partner in Jenner GP Practice	South East London Doctors Cooperative (SELDOC)	None	None	Small sum for GP research received by the Practice Approx £5000 to Practice	Professional Advisor to the Institute of Medical Education at the London Southbank University	
Dr Arun Gupta Clinical Director	Partner Half time – South Lewisham Group Practice	Partner South East London Doctors Cooperative (SELDOC)	None	Attend BHF Board for IKIC	None	Clinical Advisor to Public Health	
Dr Hilary Entwistle Clinical Director	Senior Partner Woolstone Medical Centre Member of SELDOC	Senior Partner South East London Doctors Cooperative (SELDOC)	None	None	None	None	
Dr David Abraham	Morden Hill	GP South East				Member of IFR panel and is	

Senior Clinical Director	Medical Practice	London Doctors Cooperative (SELDOC				remunerated for one session a month.	
Dr Faruk Majid Senior Clinical Director		GP South East London Doctors Cooperative (SELDOC)	None	None	None	None	
Martin Wilkinson Chief Officer	Lewisham CCG	Chief Officer Lewisham CCG	None	None	None	None	
Tony Read Chief Finance Officer	Lewisham CCG	Chief Financial Officer Lewisham CCG	None	None	None	None	
Aileen Buckton Director of Adult Social Care	Non-voting member Lewisham CCG	None	None	Director of Adult Social Care Lead Commissioner for Joint commissioned services (Adult)	None	None	
Ray Warburton Lay Vice Chair	Lewisham CCG	None	Director of Ray Warburton's Perspectives Limited		None	Member of the NHS Equality and Diversity Council	
Diana Robbins Lay Member	Lewisham CCG	None	None				
Dr Judy Chen	Partner Rushey Green Group	None	None	My practice supports Rushey Green Time		One of my salaried GPs is the Drug and	I am a carer in Lewisham for a

Clinical Director	Practice – practice provides cover to UCC for one day a week			Bank I am named GP for safeguarding		Alcohol lead for Lewisham and the practice provides an in-house service for community detox for alcohol. Grant Thornton UK LLP is Rushey Green Group Practice accountant.	young adult with learning difficulties. My daughter and I as her carer use the services provided by the Children's Transition Team and Adults with Learning Disabilities Team
Prof. Ami David MBE Board Member Nurse	Lewisham CCG			Director AD Community Nursing Consultant a subsidiary of Prasand International Limited specialising in risk management and offering consultancy/project management to health care organisations (private and NHS) and Royal Colleges. Visiting Professor of Nursing Leadership and Expert Practice London South Bank University. Fellow Queens Nursing Institute Nurse Member Lambeth and Southwark CCGs			

				Governing Body Nurse Member			
Dr Jacqueline McLeod Clinical Director	Practice	GP Appraiser, NHS SE London; GP Tutor, NW London Shared Services. Occasional OOH GP sessions for Lewisham Hospital UCC SELDOC					
Dr Helen Tattersfield Chair	Oakview Family Practice	GP (Proprietor) Oakview Family Practice South East London Doctors Cooperative (SELDOC)	None	Chair Downham Nutrition Partnership	None	None	Husband (Marco Lenzi) Is Business Manager
Dr Suparna Das Secondary Care Doctor	Lewisham CCG		Director e3 Intelligence Ltd Healthcare Consultancy	Lambeth and Southwark CCGs and Governing Body Secondary Care Doctor	None		

5th June 2014
Martin Wilkinson
Chief Officer

Statement of Accountable Officer's Responsibilities Requirements

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Mr Martin Wilkinson to be the Accountable Officer of the Clinical Commissioning Group.

The responsibilities of an Accountable Officer, including responsibilities for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Clinical Commissioning Group Accountable Officer Appointment Letter.

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the *Manual for Accounts* issued by the Department of Health and in particular to:

• Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

• Make judgements and estimates on a reasonable basis;

• State whether applicable accounting standards as set out in the *Manual for Accounts* issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,

• Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Martin Wilkinson
Accountable Officer
5th June 2014

Governance Statement by the Chief Officer as the Accountable Officer of NHS Lewisham Clinical Commissioning Group

Introduction

The clinical commissioning group was licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the NHS Act 2006.

The clinical commissioning group operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to the clinical commissioning group taking on its full powers.

As at 1 April 2013, the clinical commissioning group was licensed in full without any conditions.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Clinical Commissioning Group's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money*. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the Clinical Commissioning Group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

Compliance with the Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice.

The Clinical Commissioning Group Governance Framework

Governing Body

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states:
"The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it."

The CCG is governed by its constitution, signed by all the CCG's members. The constitution sets out the CCG's governance structures and processes including the role of the Governing Body and its individual members. In summary, each member of the Governing Body shares responsibility as part of a team to ensure that the group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of its constitution. Each Governing Body member brings their unique perspective, informed by their skills, knowledge and experience.

During the year, the Governing Body:

- has been responsible for approving the functions of the group
- led the development of our vision as set out in our 5-year strategic plan
- signed off the two-year commissioning plan and monitored in year performance
- Received an integrated performance report, with additional exception reports, through which the Governing Body has been advised of the quality and safety of commissioned services and other performance and financial issues. Where necessary the Governing Body has taken appropriate action.

- received and taken assurance that strategic risks were effectively mitigated
- ensured that all conflicts of interest or potential conflicts of interest were effectively managed
- strengthened the strategic working relationship with the Lewisham Health and Well-Being Board and has contributed to the development and implementation of the Health and Well-Being Strategy in partnership with our colleagues at the London Borough of Lewisham and other members of the Health and Well-Being Board
- worked jointly more recently with the Local Authority, local providers and the public to take forward the integration of adult and children's services. This work has been supported by our planning for the Better Care Fund.

There were eight meetings of the Governing Body held in public during the year. All of the meetings were well attended and were quorate. The table below shows the Governing Body members and attendance record. The Governing Body and all other committees discussed below were supported by the CCG management team, with appropriate attendance, as required.

Members	Role	April	May	July	Sept	Oct	Dec	Feb	March
Prof Ami David	Designated Nurse	Y	Y	Y	X	Y	Y	Y	Y
Dr Arun Gupta	Clinical Director	Y	Y	Y	Y	Y	Y	X	Y
Dr David Abraham	Senior Clinical Director	Y	Y	Y	Y	X	Y	Y	Y
Mrs Diana Robbins	Lay Member	Y	Y	Y	Y	X	Y	Y	Y
Dr Faruk Majid	Senior Clinical Director	Y	Y	X	Y	Y	Y	Y	Y
Dr Helen Tattersfield*	Chair	Y	Y	Y	Resigned 1st September				
Dr Hilary Entwistle	Clinical Director	Y	Y	Y	Y	Y	X	X	Y
Dr Jacky McLeod	Clinical Director	Joined 1st October					Y	Y	Y
Dr Judy Chen	Clinical Director	X	Y	Y	X	X	Y	Y	X
Dr Marc Rowland**	Clinical Director / Chair	Y	X	Y	Y	Y	Y	Y	Y
Mr Martin Wilkinson***	Chief Officer	X	Y	Y	Y	Y	Y	Y	Y
Mr Ray Warburton	Lay Member	Y	Y	Y	Y	Y	Y	Y	Y
Mr Tony Read	Chief Financial Officer	Y	Y	Y	Y	Y	Y	Y	Y
Dr Suparna Das ******	Designated Secondary Care Doctor	Y	Y	Resigned 1st June					

* Dr Helen Tattersfield resigned her post as Chair and member of the Governing Body effective from 1st September.
** Dr Marc Rowland became Chair of the Governing Body from 1st September, previously he had been a Clinical Director.
*** Mr Tony Read deputised for Mr Martin Wilkinson on 4th April.
**** The role of Designated Secondary Care Doctor was vacant from 1st June 2013 until 1st April 2014.
Absences are normally agreed with the Chair as members are frequently required to attend other meetings.

The Governing Body's self-assessment of its effectiveness during 2013-14 was undertaken as a workshop on 3rd April 2014. The Governing Body used the NHS Leadership Academy's 'The Healthy NHS Board 2013, Principles for Good Governance' as the basis for its assessment.

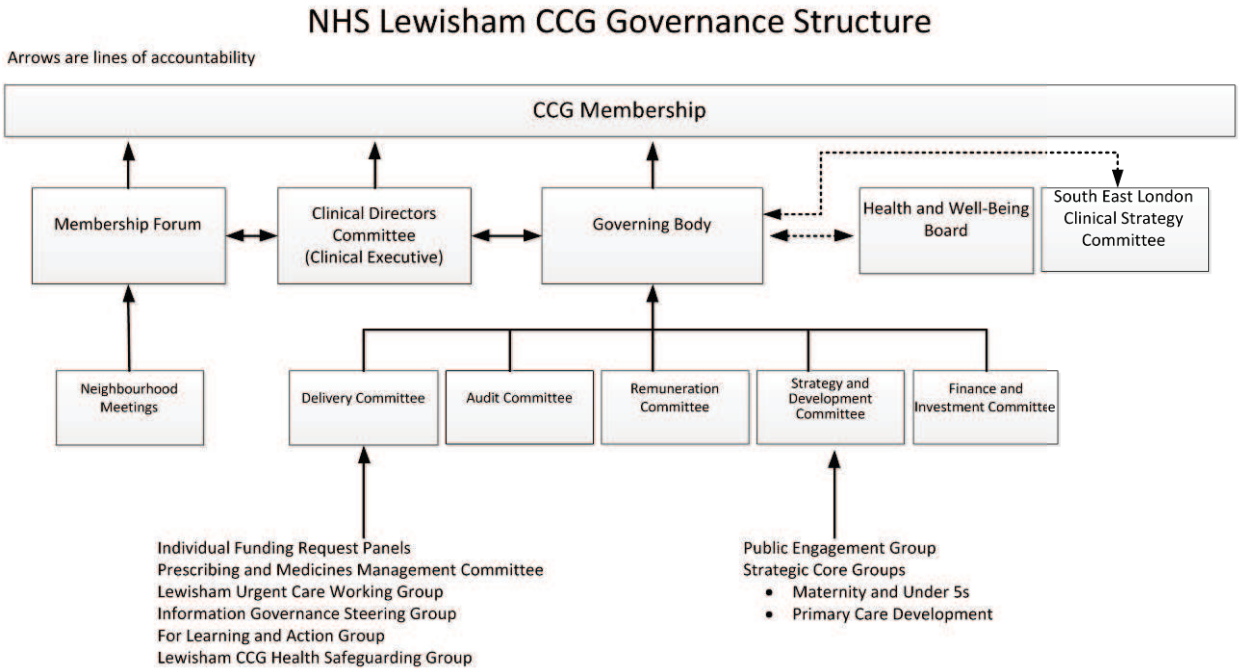
The members of the Governing Body assessed their collective and individual contributions to the leadership roles of formulating strategy, ensuring accountability, and shaping organisational

culture. The Governing Body reviewed how these roles are supported and informed by knowledge and understanding of the CCG's external context, information and intelligence, and engagement with patients and the public, the CCG membership, staff, and partners.

Recommendations for further development included ensuring greater clarity of the decision-making journey for recommendations that are made to the Governing Body, improving public involvement in Governing Body meetings held in public, greater use of clinical audit to support performance information, and reviewing its risk appetite.

In addition a shared committee was established with the other CCGs in South East London. The South East London Clinical Strategy Committee was established to develop a collaborative approach to commissioning decisions across South East London, particularly where these decisions impact on the populations of more than one CCG.

The CCG is a membership organisation with a federated structure. The organisational chart below shows the governance structures in place during the financial year ending 31st March 2014.



The chart indicates the inter-relationship between membership bodies on the left (the Clinical Directors' Committee, Membership Forum and Neighbourhood Meetings) and the key governance committees, headed by the Governing Body in the centre of the chart. The chart also shows the important links with our partner organisations including the Lewisham Health and Well Being-Board and the South East London Clinical Strategy Committee.

Clinical Directors Committee

The Clinical Directors Committee has been a standing Committee of Lewisham CCG, made up of the seven GPs elected to the Governing Body by the CCG members and included the Chief Officer. It has been the high level membership body to provide a formal connection, transacted through the Membership Forum, between the on-going business of the Governing Body and CCG member practices. It provided a vehicle in which the Clinical Directors sought and considered ideas, views and concerns from members and galvanised their support and participation to deliver the CCG's objectives.

During the year the work of the Clinical Directors Committee included:

- influenced the development of the CCG's strategic plans ensuring that the membership's views were incorporated
- promoted the CCG's strategic plans with the membership ensuring engagement, support and participation
- agreed plans for pathway redesign including for Chronic Obstructive Pulmonary Disease, heart disease, diabetes and asthma.
- discussed feedback from members about the quality of local services

There were eleven meetings of the Clinical Directors Committee during the year. All of the meetings were well attended and were quorate. The table below shows the members and attendance record. The Clinical Directors Committee was supported by the CCG management team, with appropriate attendance, as required

Members	Role	April	May	June	July	Aug	Sept	Oct	Nov	Jan	Feb	March
Dr Arun Gupta	Clinical Director	X	Y	Y	Y	Y	Y	Y	X	Y	Y	Y
Dr David Abraham	Senior Clinical Director	Y	X	Y	X	X	Y	Y	Y	Y	Y	Y
Dr Faruk Majid	Senior Clinical Director	Y	Y	Y	Y	Y	Y	X	Y	Y	Y	Y
Dr Helen Tattersfield*	Chair	Y	Y	Y	Y	Y	Resigned 1st September					
Dr Hilary Entwistle	Clinical Director	Y	Y	Y	Y	X	X	Y	Y	Y	Y	Y
Dr Jacky McLeod	Clinical Director	Joined 1st October						Y	X	Y	Y	Y
Dr Judy Chen	Clinical Director	Y	X	X	Y	X	Y	X	X	X	Y	Y
Dr Marc Rowland**	Clinical Director / Chair	X	Y	Y	Y	Y	Y	X	Y	X	X	Y
Mr Martin Wilkinson***	Chief Officer	Y	X	X	X	Y	X	Y	Y	X	X	Y

* Dr Helen Tattersfield resigned her post as Chair and member of the Clinical Directors Committee effective from 1st September.
** Dr Marc Rowland became Chair of the Clinical Directors Committee from 1st September, previously he had been a Clinical Director.
*** Deputies for Mr Martin Wilkinson included the Corporate Director (May and February), the Commissioning Director (June, September and January), and the Chief Financial Officer (July) Absences are normally agreed with the Chair as members are frequently required to attend other meetings.

Audit Committee
The committee was established to take an independent and objective view of the CCG's financial systems, compliance with laws and compliance with best practice in its arrangements for corporate governance.

During the year, the work of the Audit Committee included:

- induction, for which independent support was provided
- discussing the Internal Audit plan for 2013/14 and commenting on the reports of the reviews
- approving the Counter Fraud Work Plan for 2013/2014 and reviewing relevant policies

- reviewing the CCG's governance arrangements and the relationships between committees
- supporting the establishment of a Finance and Risk Working Group
- inquiring about the scope and range of clinical input into commissioning decisions which led to a CCG workshop to strengthen "clinical commissioning"
- approving the appointment of internal and external auditors
- scrutinising financial processes to learn lessons from elsewhere, such as from Croydon Primary Care Trust
- scrutinising and advising on the format and content of the Board Assurance Framework, including deeper dives into particular high risks.

There were four meetings of the Audit Committee during the year. The table below shows the members and attendance record. The Audit Committee was supported by the CCG management team, with appropriate attendance, as required. The Chief Financial Officer was in attendance at all the meetings.

Members	Role	July	Oct	Jan	March
Prof Ami David	Designated Nurse	Y	Y	Y	Y
Mrs Diana Robbins	Lay Member	Y	Y	Y	Y
Dr Faruk Majid	Senior Clinical Director	X	Y	Y	Y
Mr Ray Warburton	Lay Member	Y	Y	X	Y
Vacant*	Designated Secondary Care Doctor	X	X	X	X

* The Designated Secondary Care Doctor resigned her position at the CCG on the 1st June. A new Designated Secondary Care Doctor took up his post in April 2014.

Remuneration Committee

The Remuneration Committee has been responsible for approving the terms and conditions, remuneration and travelling or other allowances for Governing Body members, including pensions and gratuities in addition to the terms and conditions of employment for all employees.

During the year, the Remuneration Committee agreed levels of remuneration for Governing Body members.

There were two meetings of the Remuneration Committee during the year. The table below shows the members and attendance record. The Remuneration Committee was supported by the CCG management team, with appropriate attendance, as required. Due process was followed when conflicts of interest occurred during meetings.

Members	Role	30-May	27-Jun
Prof Ami David	Designated Nurse	Y	Y
Mrs Diana Robbins	Lay Member	Y	Y
Mr Ray Warburton	Lay Member	Y	Y
Dr Suparna Das*	Designated Secondary Care Doctor	Y	X

* Dr Suparna Das resigned her position at the CCG on the 1st June. A new Designated Secondary Care Doctor took up his post in April 2014

Strategy & Development Committee

The Strategy and Development Committee was established to set and maintain the CCG's strategic direction for commissioning and to develop formal strategic and operational plans for approval by the Governing Body.

The committee established a number of sub groups to develop detailed operational plans, including public engagement.

There were six meetings of the Strategy and Development Committee during the year. The table below shows the members and attendance record. The Strategy and Development Committee was supported by the CCG management team, with appropriate attendance, as required.

Members	Role	04-Apr	06-Jun	01-Aug	07-Nov	02-Jan	06-Mar
Dr Arun Gupta	Clinical Director	Y	Y	Y	Y	Y	X
Mr Charles Malcolm-Smith	Head of Strategy & Organisation Development	Y	Y	Y	Y	Y	Y
Dr David Abraham	Senior Clinical Director	Y	Y	Y	Y	Y	Y
Mrs Diana Robbins	Lay Member	Y	Y	Y	Y	Y	Y
Dr Helen Tattersfield	Chair	Y	Y	X	Resigned 1st September		
Dr Marc Rowland	Clinical Director	Y	Y	Y	Y	Y	Y
Mr Martin Wilkinson*	Chief Officer	X	X	Y	Y	X	Y
Mrs Susanna Masters	Corporate Director	X	Y	Y	Y	Y	Y
Mr Tony Read	Chief Financial Officer	Y	X	Y	Y	X	X

*Deputies for Mr Martin Wilkinson included the Chief Financial Officer (April) and the Corporate Director (June and January).

During the year, the work of the Strategy and Development Committee included:

- developing the CCG 5-year strategic plan in alignment with the strategy of the Health and Well-Being Board
- developing a public engagement strategy
- working in partnership with the Local Authority for a joint bid for improved children's services
- developing a strategy to improve end of life care in nursing homes
- developing an integration strategy for adult services that was shortlisted for "Integrated pioneer" and was the basis for the allocation of the Better Care Fund.
- developing a Joint Carer's Strategy

Delivery Committee

The Delivery Committee was established to monitor the performance of commissioned health services in all aspects and to monitor delivery of the CCG's operational plans. The committee reviewed the CCG's position against key performance, quality and financial metrics, and identified mitigating steps where delivery was off-track.

The Delivery Committee established a number of subgroups to monitor performance against plans in detail and these included groups to monitor quality, information governance and risk management.

There were twelve meetings of the Delivery Committee during the year. The table below shows the members and attendance record. The Delivery Committee was supported by the CCG management team with appropriate attendance as required.

Members	Role	April	May	June	July	August	Sept	October	Nov	Dec	January	Feb	March
Ms Diana Braithwaite	Commissioning Director	Y	Y	Y	Y	Y	X	Y	Y	X	Y	X	X
Dr Faruk Majid	Senior Clinical Director	X	Y	Y	Y	Y	Y	Y	Y	X	Y	Y	Y
Dr Helen Tattersfield	Chair	Y	Y	Y	Y	Y	Resigned 1st September						
Dr Hilary Entwistle	Clinical Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	X
Dr Jacky Mcleod	Clinical Director	Joined 1st October						Y	Y	Y	Y	Y	X
Dr Judy Chen	Clinical Director	Y	Y	X	Y	Y	Y	Y	Y	X	Y	X	Y
Dr Marc Rowland	Clinical Director	Replaced Dr Tattersfield					X	Y	X	Y	X	Y	X
Mr Martin Wilkinson	Chief Officer	Y	Y	X	X	Y	X	Y	Y	Y	Y	X	Y
Mr Ray Warburton	Lay Member	Y	Y	Y	Y	Y	Y	Y	Y	X	X	Y	Y
Mr Tony Read	Chief Financial Officer	Y	X	Y	X	X	Y	Y	Y	Y	Y	Y	Y

During the year the work of the Delivery Committee included supporting and monitoring plans which:

- improved health promotion interventions for smoking cessation, alcohol use and healthy weight
- improved services for mothers and infants
- improved management of pressure sores
- improved management of long term conditions including respiratory disease, diabetes, heart failure and cardiovascular disease
- improved services for people with dementia
- improved GP referrals to hospitals
- improved governance and quality processes
- the Delivery Committee reviewed work that the CCG found particularly challenging during the year and recommended solutions. Such work included:
- where performance was below plan, such as:
    - recovery rates for psychological therapies
    - waiting times at accident and emergency services
    - 62-day wait from referral to first definitive treatment for cancer
    - 18 week referral to treatment targets in some service areas
    - 52 week waits at one provider
- where quality of services did not meet expected standards, such as
    - with aspects of community nursing services
    - with aspects of post natal care
    - with pressure sore management
    - with communications between services, particularly at discharge from hospital

The Risk Management Framework

In line with good practice, the CCG adopted a risk management process which has been designed to provide continuous identification, assessment, control, communication and

monitoring of risk with clear escalation processes. When faced by risks, the CCG takes a positive and controlled approach to risk management, acceptable to the Governing Body, as described below.

Risks to achieving the CCG's objectives and business plans were identified at project or programme board meetings, at assurance committees when inadequate or no assurances were given or at routine business meetings. Wherever a risk was identified the escalation route was the same.

Project and programme risks were assessed and managed at the project or programme management level. Where risks were considered to have an impact on the CCG's corporate objectives, these were escalated to the Risk Management Group. The role of the Risk Management Group has been to:

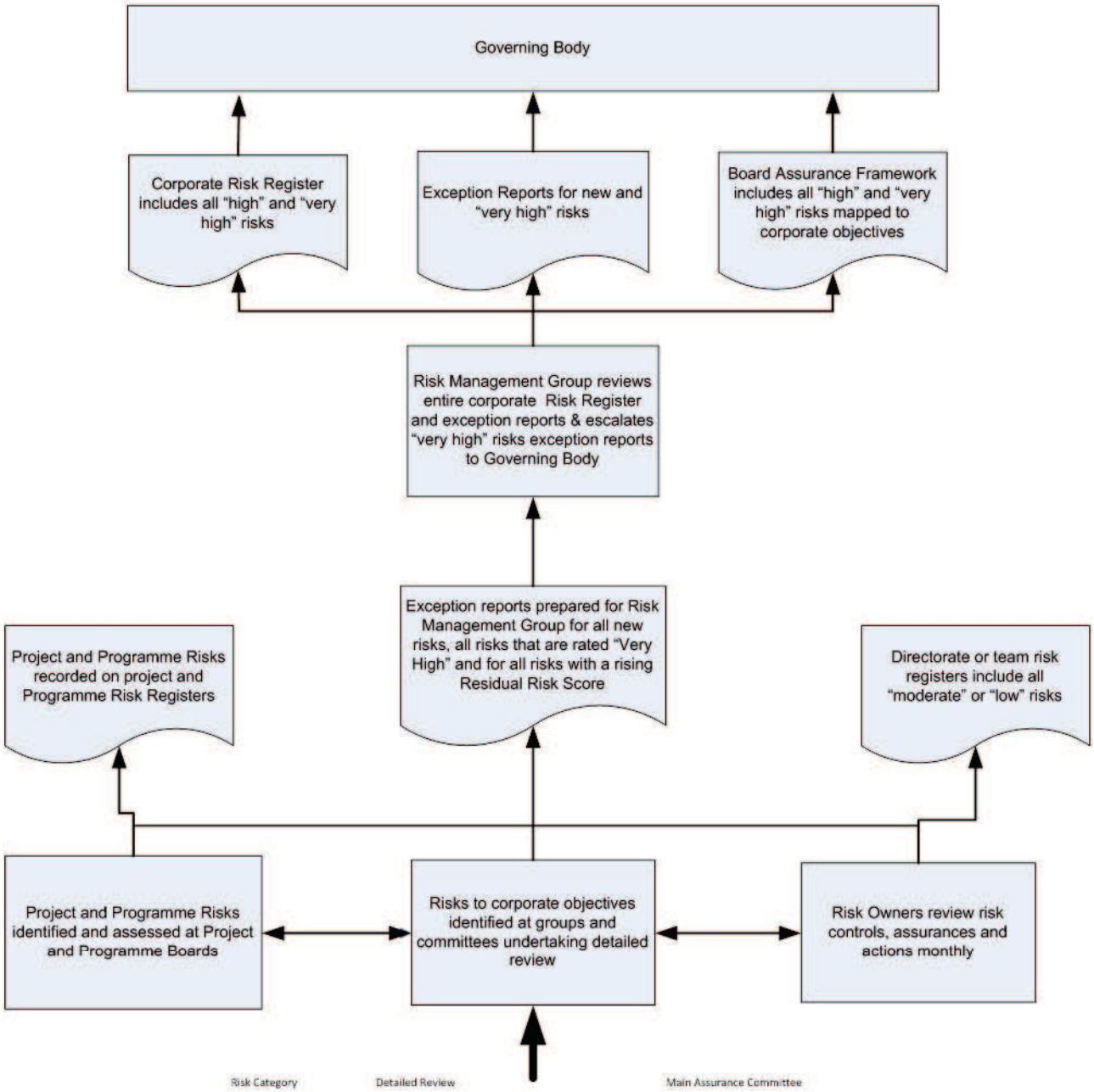
- review, evaluate and agree exception reports for new and amended risks and instruct that the Risk Register is updated accordingly.
- review and evaluate exception reports for new and "very high" risks and recommend these to the Governing Body
- review the risk register by scrutinising the existing controls and assurances ensuring that the register is an accurate summary of the risks to the organisation and recommend the Risk Register and the Board Assurance Framework to the Governing Body.

"Risk owners" at Director or senior manager level were assigned to all risks and risk owners have been responsible for identifying controls and actions to mitigate risks to target levels. Controls have included the development of policies, for example for the management of personal confidential data, mandatory training programmes, in safeguarding and fraud prevention, and the development of strategies and action plans to mitigate risks to achieving our corporate objectives. All this information has been collated over the year in the Board Assurance Framework which is discussed at the meetings of the Governing Body.

The management of risk is the duty of all staff, inclusive of the reporting of incidents and near-misses in accordance with the policies and procedures in place. All managers are accountable for the day-to-day management of risks within their areas of responsibility, ensuring assessments are undertaken and risk registers updated with action plans as appropriate regularly updated. Directors are responsible for providing risk management leadership and sponsorship across the CCG.

The chart below illustrates how risks have been identified and escalated through the organisation to the Governing Body. The bottom of the chart includes a table which shows the type of risk, shown here as the "risk category," the committee or work group where detailed review of the risk and controls took place and the main assurance committee that held oversight of the risk. The main body of the chart shows how risks are escalated to the Governing Body.

Lewisham CCG Risk identification and Escalation Process



Risk Category	Detailed Review	Main Assurance Committee
Change / Transition	Programme Management Meeting	Delivery Committee
Clinical and Quality	Clinical Quality Review Groups	Delivery Committee
	Public Engagement Group	
	Core Contract Meetings	
	Patient Safety Advisory Group	
	NHS Lewisham CCG Health Safeguarding Group	
	Pharmacy and Medicines Management Committee	
	For Learning and Action Group	
Environmental	Senior Management Team	Delivery Committee
Financial	Finance and Risk Group	Delivery Committee
Governance	Senior Management Team	Delivery Committee
Information Governance	Information Governance Steering Group	Delivery Committee
Information Management & Technology	Senior Management Team	Delivery Committee
Operations	Senior Management Team	Delivery Committee
Partnership and Contractual	Core Contract Meetings	Delivery Committee
People	Senior Management Team	Delivery Committee
Reputation	Patient Engagement Group	Delivery Committee
	Senior Management Team	
Strategic	Strategy and Development Committee	Delivery Committee (in year)
		Health and Well Being Board

The Assurance Framework is a key process for the identification and control of risks, and is designed to provide the CCG with assurance that the organisation is effectively managing, or

has plans in place designed to manage risks that may threaten the achievement of the organisation's corporate objectives which are reviewed annually.

The Assurance Framework ensures:

- a comprehensive method is established for the effective and focussed management of the principal risks to meeting the CCG's objectives.
- the Governing Body is confident that its principal objectives can be achieved.
- strategic controls are in place to manage those risks.
- the Governing Body is satisfied with assurance that the controls are effective and risks are managed appropriately.
- positive assurances are identified along with gaps in controls and/or assurances.

The risk controls in place, enable the CCG to determine whether the risks are being managed effectively through:

- policies, procedures and guidelines.
- education, training and staff development.
- equipment and facilities.
- staff competency.
- induction programme.
- any other measures deemed necessary.

The Assurance Framework has been improved and developed during the year following discussions with the Audit Committee and Governing Body members. Improvements have included work to identify gaps in assurance, providing more details of evidence of assurance and adding greater details of planned mitigation actions. The CCG has also responded positively to in-year recommendations from Internal Audit.

Equality Impact Assessments (EIA) are a core part of policy, strategy and project development within Lewisham CCG. The NHS Lewisham CCG Policy on Policies ensures that there is a regulated approach to the development of policies and procedural documents and a requirement for all policy and procedural documents developed by the CCG and for the CCG to describe how they meet the Public Sector Equality Duty.

EIA training has been provided to facilitate understanding behind the principles and practical application of the assessments. Support, guidance and tools are provided by the Equality and Diversity team on an on-going basis. The team has supported the CCG to assess a wide range of areas including strategies, policies, commissioning plans and QIPP projects.

As a key partner, Healthwatch Lewisham provided a representative voice of patients from the many diverse communities in Lewisham into our risk management processes. Their involvement in the CCG structure included membership of our Public Engagement Group, our For Learning and Action Group, which reviewed 'quality' in respect of patient safety, clinical effectiveness and patient experience of the services we commissioned for our population, and membership of the Clinical Quality Review Groups for Lewisham and Greenwich NHS Trust and for the South London and Maudsley NHS Foundation Trust.

As representatives of local people, Healthwatch Lewisham has added a valuable voice of local people. A significant recent initiative driven by the CCG in partnership with our partners including Healthwatch Lewisham, was the delivery of a large public listening event 'Quality in Health and Social Care; A People's Summit', which attracted 100 residents to discuss quality, aspirations and expectations with service providers listening to understand the patient voice. Learning from this public event will inform our approach to risk management for 2014/15 as well as our wider commissioning responsibilities.

The Clinical Commissioning Group Internal Control Framework

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation.

The CCG's Information Governance Framework has been reviewed and reiterated during 2013/14. This is so that our Information Governance Framework reflects appropriately the implications of the Health and Social Care Act 2012 and the NHS Constitution.

The CCG's Information Governance Framework is established as a key and integral part of the CCG's Risk Management Assurance Framework. The Information Governance Framework requires review, decision making and directions at senior level governance forums such as the Governing Body and the Delivery Committee.

A Senior Information Risk Owner (SIRO) role that is accountable for leading the information risk culture and approach of the CCG has been put in place in line with NHS requirements. The Chief Financial Officer of the CCG fulfils the SIRO role.

The Senior Information Risk Officer (SIRO) is responsible for:

- Understanding how the strategic business goals of the CCG may be impacted by information risks: acting as an advocate for information risks on the Board and in internal discussions.
- Ensuring the Board is adequately briefed on information risk issues.
- Overseeing the development of an Information Risk Policy, and a strategy for implementing the policy within the CCG's Information Governance Framework.
- Reviewing the annual information risk assessment to support and inform the Annual Governance Statement.
- Taking ownership of risk assessment processes for information risks, supported by the Information Governance Manager, Information Security Lead, Records Manager and the Caldicott Guardian.
- Reviewing and agreeing action in respect of identified information risks.

- Providing a focal point for the resolution and/or discussion of information risk issues.

A separate Caldicott Guardian role is also now established to act as the conscience of the organisation regarding confidentiality and privacy matters affecting individual persons and to avoid a potential conflict of interest with the organisational responsibilities of the SIRO. The Director of Nursing fulfils the Caldicott Guardian role.

Support from the Lay Member for Governance helped assure that the requirements of the Information Governance Toolkit were achieved.

A developing governance model of Information Asset Owners and Information Asset Administrators and the South London Commissioning Support Unit provide assurance, support and expertise to the SIRO and Caldicott Guardian.

Both officers and the supporting governance model satisfy the requirements of NHS Information Governance policy as demonstrated by the achievement of Level 3 assurances on the NHS Information Governance Toolkit requirements that relate to the Information Governance accountability requirements for CCG's.

Risk Based Approach to Information Governance
The CCG's developmental approach to Information Governance is being taken forward through a risk based Information Governance approach.

The CCG recognises that culture is a strong influence and determinant of fair, proportionate and cost effective information risk decision-making outcomes.

The CCG therefore addresses the human element factor of information risk as a core part of its information risk approach. It has ensured the uptake of Information Governance Training by at least 95% of its staff. The SIRO has in addition undertaken additional strategic information risk management training.

As part of its risk based Information Governance approach, the CCG utilises the online NHS Information Governance Toolkit to assess and demonstrate its capacity and capability to satisfy the rapidly evolving information risk issues that relate to the handling of information.

The CCG has in its first year as a fully established statutory organisation satisfied the requirements of the Information Governance Toolkit and achieved an overall score of eighty per cent (80%). This was the highest score in South London, second best in London and 14th best in England.

The CCG has procured an information risk organisational development information risk management product to engage with and support staff and the CCG in iterating risk assessments regarding the CCG's flows of information and where its information assets are held.

Pension obligations
As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality, diversity & human rights obligations
Control measures are in place to ensure that the clinical commissioning group complies with the required public sector equality duty set out in the Equality Act 2010. These include policy commitments and mandatory staff training.

Sustainable development obligations
We are developing plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

We will ensure the clinical commissioning group complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

We are also setting out our commitments as a socially responsible employer.

During 2013/14 the CCG Governing Body agreed a policy for sustainable development and the first phase of our Sustainable Development Management Plan which sets out a 36 year vision to reduce our carbon footprint by 80%.

Risk assessment in relation to governance, risk management & internal control

The CCG's Risk Assessment Framework as set out in the Risk Management Strategy is based on the National Patient Safety Advice (NPSA) guidance and aligned to the adopted internationally recognised AS/NZS 4360:1999 guidelines which provides a model for identifying, assessing and controlling risks. Further information on how the CCG manages the principles of Risk Management, can be found under the Risk Management Framework section above.

As a new organisation, established on 1st April 2013, all the risks to the CCG, including those impacting our governance, risk management and internal control were identified within the year. Workshops were held at the beginning of the year to identify key risks and to identify and implement controls. The risks facing the new organisation were rated high, as controls were un-tested, there was no historical assurance and there was a level of uncertainty in the new health landscape in Lewisham.

The Governing Body rated four principle risks with a very high residual risk score at the beginning of the year, these included:

- failure to achieve adequate Information Governance Standards
- the development and implementation of appropriate policies and mandatory training for all staff ensured that this risk was mitigated during the year
- claims for NHS Funded Continuing Health Care affecting financial plans
- in year financial reserves were sufficient to mitigate this risk
- transfer of Specialist Commissioning will not be cost neutral to the CCG
- in year financial reserves were sufficient to mitigate this risk
- failure to safeguard adults
- the appointment of designated safeguarding staff and mandatory training for all staff ensured that this risk was mitigated during the year.

The establishment of the governance committees and groups described above have provided the Governing Body with assurance over the wide range of business risks.

Review of economy, efficiency & effectiveness of the use of resources

In year monitoring of performance against our plans has been carried out by our Delivery Committee which includes ensuring that projects and programmes are delivering economic and effective services. During the year the Delivery Committee established a Finance and Risk Group to take an overview of capital expenditure and to scrutinise the management of financial risk. In addition, the CCG Audit Committee during the year has taken an independent view of

the CCG's financial management. The Audit Committee is attended by our colleagues in Internal Audit and External Audit and reports to the Governing Body.

Review of the effectiveness of governance, risk management & internal control

As Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.

Capacity to handle risk
To develop our capacity to manage risk a workshop was held with Governing Body members at the beginning of the year to describe and review the CCG's risk management processes. The Audit Committee review the Board Assurance Framework and risk management report at its meetings and give advice on potential improvement.

Our Risk Management Group has been chaired by the CCG's Chief Officer and is attended by directors and senior managers. The role of the group is described above. All of our key risks have been "owned" by a senior manager who are responsible for ensuring that controls are effectively implemented and appropriate actions are taken.

Our risk owners are supported by the Head of Integrated Governance and provided with monthly support to review their risks and mitigation plans. Training has been provided to staff at all levels in risk management processes and in how to use the CCG's risk management software.

Review of effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

The *Board Assurance Framework* itself provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and Risk Management Group and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Clinicians and management have worked in partnership to ensure the effectiveness of our systems of internal control. Following challenge at the Delivery Committee, management and clinicians worked together to align the governance processes that form the CCG's system of internal control with the commissioning cycle. The key activities of the commissioning cycle were scheduled for the appropriate committees in a new system of forward planning, management responsibilities were clarified and terms of reference of committees were updated.

The Governing Body and Audit Committee have also provided regular feedback on the completeness and effectiveness of our systems of internal control via their comments and feedback on the completeness of the Board Assurance Framework. For example, the Head of Integrated Governance met members of the Audit Committee early in the year. Control and assurance gaps were identified; existing controls and assurances were reviewed and the distinction between controls and evidence of their effectiveness was clarified.

Internal Audit also provided helpful advice and recommendations during the year and the details of these audits are described below.

An Internal Audit review of risk and governance good practice, noted that:

- a review of committee papers found that sufficient information is provided to allow them to discharge their duties
- there is a good balance between allowing the Governing Body and sub-committees to fulfil their scrutiny roles and their decision-making responsibilities with agendas giving priority to those items which require a decision.
- the CCG is able to demonstrate that its membership structure, required number of meetings and quorum for each committee is largely consistent with NHS England guidance
- the CCG has an established Risk Management policy that outlines how risks should be scored in terms of likelihood and impact (consequence) and the Corporate Risk Register and Board Assurance Framework show the controls/assurance the CCG has obtained against each risk
- appropriate training is provided to staff, tailored to reflect their involvement in the risk management process including one-on-one sessions with risk owners
- the CCG demonstrates its commitment to maintaining an awareness of the level of risk around its corporate objectives by placing the Risk Management and BAF update as a standing item at the beginning of the agenda of each Governing Body meeting.
- the Conflicts of Interests policy clearly sets out what is expected of CCG employees and members. The register of interest is reviewed at the start of each Governing Body/sub-committee meeting to help ensure the CCG is operating transparently in its business dealings. The policy is also updated annually to ensure it is complying with good practice.

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control.

The Head of Internal Audit concluded that:

Head of Internal Audit Opinion on the effectiveness of the system of internal control for the year ended 31 March 2014

Roles and responsibilities

The Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The Assurance Framework should bring together all of the evidence required to support the AGS.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the CCG's risk management, control and governance processes (i.e. the system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the CCG. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and CCG led Assurance Framework. As such, it is one component that the Governing Body takes into account in making its AGS.

A further component will be the assurances provided on the operation of the systems of internal control the service organisations which provide financial services on behalf of the CCG during 2013-14 as follows:

- NHS South London Commissioning Support Unit (KPMG);
- NHS Shared Business Service (Grant Thornton); and
- McKesson: NHS Electronic Staff Records (PwC).

Assurances on the operation of these systems will be provided by ISAE3402 Service Auditor Reports issued by the internal auditors of these organisations.

The Head of Internal Audit Opinion

The purpose of our HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the system of internal control. This Opinion will in turn assist the Governing Body in the completion of its AGS, and may also be taken into account by the Care Quality Commission or other regulators to inform their own conclusions.

Our opinion is set out as follows:

- Overall opinion;
- Basis for the opinion; and
- Commentary.

Our overall opinion is that:

Substantial assurance can be given that there is a generally sound system of internal control on key financial and management processes. These are designed to meet the CCG's objectives, and controls are generally being applied consistently.

The basis for forming our opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
- An assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas.

Commentary

The commentary below provides the context for our opinion and together with the opinion should be read in its entirety.

Context for our opinion

Our opinion covers the full year 2013-14 and is based on the seven reviews during the year.

The design and operation of the Assurance Framework and associated processes

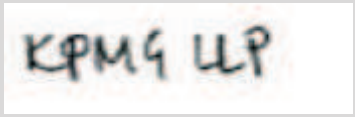
Overall our review found that the Assurance Framework in place is founded on a systematic risk management process and does provide appropriate assurance to the Governing Body. The review we have completed in this area has highlight areas for improvement that we believe could strengthen the process currently in place, although do not hinder out ability to issue an overall substantial assurance opinion. We will follow up recommendations raised during 2013-14 period.

The range of individual opinions arising from risk-based audit assignments, contained within risk-based plans that have been reported throughout the year.

We have provided one 'adequate' opinion during 2013-14 in relation to children and adult safeguarding. A 'requires improvement' opinion was provided on the following reviews: budgetary control/scheme of delegation, governance and risk management, acute contract management and performance reporting.

We have not given a rating to the data protection report completed by LAC. A preliminary review was completed earlier in the year but reported late in the year and so did not reflect the progress made by the CCG during the year. All recommendations raised from the review were implemented by the CCG on a timely manner.

No significant issues remained outstanding as at the year end which would impact upon our opinion.



KPMG LLP
Chartered Accountants
London
23 May 2014

The role of Internal Audit is to support the CCG by conducting appraisals of all internal controls, as identified through the Internal Audit Plan for the year, assessing their effectiveness and recommending improvements.

Following the review of a number of areas as identified in the CCG's Internal Audit Plan for 2013-14, the CCG has accepted a number of recommendations for development which are tracked by the Audit Committee to ensure implementation. The following areas have been subject to review, with further detail provided on areas which have resulted in limited assurance:

Governance and Risk Management
The CCG's governance and risk management arrangements are reviewed regularly, but following an assessment by our Internal Auditors, a number of areas were highlighted for improvement to develop and enhance our approach.

- ensure completeness of Minutes/Action Log identified through meetings.
- creation of Forward Plans for committees
- completeness of information on BAF and Corporate Risk Register Reporting
- allocate actions from the Francis Action Plan to responsible individuals for implementation
- completeness of BAF information
- review quorate criteria in committees' Terms of Reference
- improve robustness of Assurance Levels
- ensure web links stated within Constitution are relevant and correct
- review Declarations of Interest to ensure consistency and ensure it is up to date.

Acute contract management
The CCG accepted five recommendations for improvement following an assessment of the arrangements in relation to acute contract monitoring:

- agree a Service Level Agreement between the South London Commissioning Support Unit and the CCG
- reschedule the timing of the Delivery Committee
- establish greater contact with the South London Commissioning Support Unit
- include the provision of Community Contract performance
- maintain a log for action reporting and monitoring

Claims and performance management
Whilst highlighting areas for improvement, the Internal Auditors provided an overall adequate level of assurance regarding NHS South East London's claims and performance management processes which enable early challenge and resolution with providers.

Safeguarding children and adults
Following a review of the established arrangements regarding the safeguarding of children and adults at the CCG, an overall adequate level of assurance was concluded with respect to the CCG's discharge of responsibilities regarding safeguarding.

However, our Internal Auditors identified some areas for improvement to enhance the arrangements and ensure they reflect the requirements of NHS England.

Performance Reporting
In line with the CCG's anticipated level of assurance, our Internal Auditors concluded that the established arrangements for performance reporting at the CCG required improvement.

To enable the CCG to understand and review its performance and the performance of its providers to ensure it is operating effectively. Recommendations for development related to:

- development of a Performance Reporting Framework.

- report and monitor of the Outcomes Framework to the Delivery Committee.
- improve the format of the Integrated Performance Report.
- review the content of the Integrated Performance Report to ensure consistency before it is submitted to the Delivery committee.

Budgetary control and scheme of delegation
As expected, following a review of the design and operation of budgetary control and the scheme of delegation during the early part of the financial year, the Internal Auditors highlighted a number of areas for improvement to ensure greater robustness and appropriate decision making. Recommendations for development related to:

- improving the content of the Integrated Performance/Finance Reports.
- review the scheme of delegation to ensure decisions have been allocated to the appropriate committee/individual
- ensure consistency in the terms of reference for committees and the schedule of delegated matters
- develop a budget setting policy / procedure notes
- review authorised limits of approval for officers to ensure consistency with the limits described in the schedule of delegated matters
- develop a process to ensure decisions made by committees/individuals are commensurate with their delegated responsibility.

The CCG has responded positively to the recommendations from all of the Internal Audit reviews and are implementing resultant action plans.

Data quality

In line with the need to know principles set out in the Caldicott 2 Information Governance Review Report, the CCG ensures that information presented to the Governing Body and other governance forums does not identify individuals and is fully anonymised.

Senior Management diligently reviews information to be set out in governance and decision making information prior to consideration and presentation to the relevant governance forums.

The quality of information that the Governing Body and other governance forums receive to consider and direct decision making is also assured through the service level specification arrangements with the South London Commissioning Support Unit and the use of contractual arrangements with the commissioned providers.

Business-critical models

The Macpherson Report on the review of quality assurance (QA) of Government Analytical Models set out the components of best practice in QA making eight key recommendations.

In 2013/14, Lewisham CCG, working with other commissioners in South East London, began to develop the South East London Commissioning Model; a business critical analytical tool in modelling and appraising the impact of proposed changes in the local health economy over the next five years.

The development of the model follows the principles set out in the Macpherson report with an identified Senior Responsible Officer (a CCG Director of Commissioning), supported by a clear Governance Structure. The technical review group, chaired by the Bromley CCG Chief Financial Officer, draws upon multi-disciplinary specialist experience from all stakeholders, responsible for developing and using the model as well as providing quality assurance and peer review. This group is responsible for ensuring that there are effective processes underpinning the model, including appropriate guidance, documentation and training, as well as sharing best practice across disciplines and organisations.

The QA framework in place for this model will be used for all future business critical models.

Data security

We have submitted a satisfactory level of compliance with the information governance toolkit assessment.

Data security breaches
The Caldicott 2 Information Governance Review Report published in May 2013 advised a stronger focus on the scope of what constitutes a data breach to include any breach of the eight (8) principles of the Data Protection Act

The CCG has not recorded any breaches requiring rnvestigation and or further escalation during 2013/14.

Discharge of statutory functions

During establishment, the arrangements put in place by the clinical commissioning group and explained within the *Corporate Governance Framework* were developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

In light of the Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

Last, but not least, the CCG takes due account of the NHS Constitution and strives to uphold its values.

Conclusion

In conclusion I confirm that no significant internal control issues have been identified.

Mr Martin Wilkinson
Chief Officer
5th June 2014

Data entered below will be used throughout the workbook:

Entity name:	NHS Lewisham Clinical Commissioning Group
This year	2013-14
This year ended	31 March 2014
This year commencing:	1 April 2013

CONTENTS Page Number

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF NHS LEWISHAM CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS Lewisham Clinical Commissioning Group

for the year ended 31 March 2014 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure , the Statement of Financial Position, the Statement of Changes in Taxpayers ' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the NHS Commissioning Board with approval of the Secretary of State

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes; and
- the section on pay multiples and related narrative notes.

This report is made solely to the members of NHS Lewisham Clinical Commissioning Group in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Clinical Commissioning Group (CCG)'s members and the CCG as a body, for our audit work ,for this report, or for opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities ,the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the CCG; and the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report which comprises the Member Practices' Introduction, Strategic Report, Members' Report, Remuneration Report, Statement of Accountable Officer's Responsibilities and Governance Statement to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition , we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on regularity

In our opinion, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on the financial statements

In our opinion the financial statements :

• give a true and fair view of the financial position of NHS Lewisham CCG as at 31 March 2014 and of its net operating costs for the year then ended; and
• have been prepared properly in accordance with the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State.

Opinion on other matters

In our opinion:

• the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the NHS Commissioning Board with the approval of the Secretary of State;and
• the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financ ial statements .

Matters on which we report by exception

We report to you if:
• in our opinion the governance statement does not reflect compliance with NHS England's Guidance;
• we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made,a decision involving unlawful expenditure,or is about to take, or has taken, unlawful action likely to cause a loss or deficiency ; or
• we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

Conclusion on the CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report any matters that prevent us being satisfied that the audited body has put in place such arrangements.

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance issued by the Audit Commission in October 2013. We have considered the results of the following:

- our review of the Governance Statement ; and

- the work of other relevant regulatory bodies or inspectorates , to the extent that the results of this work impact on our responsibilities at the CCG.

As a result, we have concluded that there are no matters to report.

Certificate

We certify that we have completed the audit of the accounts of NHS Lewisham CCG in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Susan M. Exton
Director
for and on behalf of Grant Thornton UK LLP, Appointed Auditor

Grant Thornton House
Melton Street Euston Square London
NW1 2EP
5 June 2014

Statement of Comprehensive Net Expenditure for the year ended 31 March 2014

	Note	2013-14 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	4.1	**3,961**
Other costs	5	**375,454**
Other operating revenue	2	**(3,747)**
Net operating costs before interest		**375,668**
Other operating revenue		**-**
Other (gains)/losses		**-**
Finance costs		**-**
Net operating costs for the financial year		**375,668**
Net (gain)/loss on transfers by absorption		
Net operating costs for the financial year including absorption transfers		**375,668**
Of which:		
Administration Costs		
Gross employee benefits	4.1	**2,886**
Other costs	5	**3,624**
Other operating revenue	2	**(115)**
Net administration costs before interest		**6,395**
Programme Expenditure		
Gross employee benefits	4.1	**1,075**
Other costs	5	**371,830**
Other operating revenue	2	**(3,632)**
Net programme expenditure before interest		**369,273**

Other Comprehensive Net Expenditure	2013-14 £000
Impairments and reversals	**-**
Net gain/(loss) on revaluation of property, plant & equipment	**-**
Net gain/(loss) on revaluation of intangibles	**-**
Net gain/(loss) on revaluation of financial assets	**-**
Movements in other reserves	**-**
Net gain/(loss) on available for sale financial assets	**-**
Net gain/(loss) on assets held for sale	**-**
Net actuarial gain/(loss) on pension schemes	**-**
Share of (profit)/loss of associates and joint ventures	**-**
Reclassification Adjustments	
On disposal of available for sale financial assets	**-**
Total comprehensive net expenditure for the year	**375,668**

Reconciliation of Cash Drawings to Parliamentary Funding	2013-14 £000
Total cash received from DH (Gross)	**325,878**
Less: Trade revenue from DH	
Less:/(Plus): movement in DH working balances	**(372)**
Sub total: net advances	**325,506**
(Less)/plus: transfers (to)/from other resource account bodies	
Plus: cost of Home Oxygen Therapy	**320**
Plus: cost of drugs reimbursement (central charge to cash limits)	**29,135**
Parliamentary funding credited to General Fund	**354,961**
Adjustment for Partially Completed Spells	**(1,618)**
Net Funding	**353,343**

Statement of Financial Position as at 31 March 2014

	Note	31 March 2014 £000
Non-current assets:		
Property, plant and equipment		-
Intangible assets		-
Investment property		-
Trade and other receivables		-
Other financial assets		-
Total non-current assets		-
Current assets:		
Inventories		-
Trade and other receivables	17	**6,516**
Other financial assets		-
Other current assets		-
Cash and cash equivalents	20	**38**
Total current assets		**6,554**
Non-current assets held for sale		-
Total current assets		**6,554**
Total assets		**6,554**
Current liabilities		
Trade and other payables	23	**(27,264)**
Other financial liabilities		-
Other liabilities		-
Borrowings		-
Provisions	30	**(1,162)**
Total current liabilities		**(28,426)**
Total Assets less Current Liabilities		**(21,872)**
Non-current liabilities		
Trade and other payables		-
Other financial liabilities		-
Other liabilities		-
Borrowings		-
Provisions	30	**(453)**
Total non-current liabilities		**(453)**
Total Assets Employed		**(22,325)**
Financed by Taxpayers' Equity		
General fund		**(22,325)**
Revaluation reserve		-
Other reserves		-
Charitable Reserves		-
Total taxpayers' equity:		**(22,325)**

The notes on pages 5 to 40 form part of this statement

The financial statements on pages 1 to 40 were approved by the Governing Body on 3 June 2014 and signed on its behalf by:

Accountable Officer
Martin Wilkinson

Statement of Changes In Taxpayers Equity for the year ended 31 March 2014

	Note	General fund	Revaluation reserve	Other reserves	Total reserves
		£000	£000	£000	£000
Changes in taxpayers' equity for 2013-14					
Balance at 1 April 2013		-	-	-	-
Transfer of assets and liabilities from closed NHS Bodies as a result of the 1 April 2013 transition		-	-	-	-
Transfer between reserves in respect of assets transferred from closed NHS bodies		-	-	-	-
Adjusted CCG balance at 1 April 2013		-	-	-	-
Changes in CCG taxpayers' equity for 2013-14					
Net operating costs for the financial year		(375,668)	-	-	**(375,668)**
Net gain/(loss) on revaluation of property, plant and equipment		-	-	-	-
Net gain/(loss) on revaluation of intangible assets		-	-	-	-
Net gain/(loss) on revaluation of financial assets		-	-	-	-
Total revaluations against revaluation reserve		-	-	-	-
Net gain (loss) on available for sale financial assets		-	-	-	-
Net gain (loss) on revaluation of assets held for sale		-	-	-	-
Impairments and reversals		-	-	-	-
Net actuarial gain (loss) on pensions		-	-	-	-
Movements in other reserves		-	-	-	-
Transfers between reserves		-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure		-	-	-	-
Reclassification adjustment on disposal of available for sale financial		-	-	-	-
Transfers by absorption to (from) other bodies		-	-	-	-
Transfer between reserves in respect of assets transferred under absorption		-	-	-	-
Reserves eliminated on dissolution		-	-	-	-
Net Recognised CCG Expenditure for the Financial Year		(375,668)	-	-	**(375,668)**
Net funding		353,343	-	-	**353,343**
Balance at 31 March 2014		**(22,325)**	**-**	**-**	**(22,325)**

Statement of Cash Flows for the year ended 31 March 2014

	Note	2013-14 £000
Cash Flows from Operating Activities		
Net operating costs for the financial year		**(375,668)**
Depreciation and amortisation		**-**
Impairments and reversals		**-**
Other gains (losses) on foreign exchange		**-**
Donated assets received credited to revenue but non-cash		**-**
Government granted assets received credited to revenue but non-cash		**-**
Interest paid		**-**
Release of PFI deferred credit		**-**
(Increase)/decrease in inventories		**-**
(Increase)/decrease in trade & other receivables	**17**	**(6,516)**
(Increase)/decrease in other current assets		**-**
Increase/(decrease) in trade & other payables	**23**	**27,264**
Increase/(decrease) in other current liabilities		**-**
Provisions utilised		**-**
Increase/(decrease) in provisions	**30**	**1,615**
Net Cash Inflow (Outflow) from Operating Activities		**(353,305)**
Cash Flows from Investing Activities		
Interest received		**-**
(Payments) for property, plant and equipment		**-**
(Payments) for intangible assets		**-**
(Payments) for investments with the Department of Health		**-**
(Payments) for other financial assets		**-**
(Payments) for financial assets (LIFT)		**-**
Proceeds from disposal of assets held for sale: property, plant and equipment		**-**
Proceeds from disposal of assets held for sale: intangible assets		**-**
Proceeds from disposal of investments with the Department of Health		**-**
Proceeds from disposal of other financial assets		**-**
Proceeds from disposal of financial assets (LIFT)		**-**
Loans made in respect of LIFT		**-**
Loans repaid in respect of LIFT		**-**
Rental revenue		**-**
Net Cash Inflow (Outflow) from Investing Activities		**-**
Net Cash Inflow (Outflow) before Financing		**(353,305)**
Cash Flows from Financing Activities		
Net funding received		**353,343**
Other loans received		**-**
Other loans repaid		**-**
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		**-**
Capital grants and other capital receipts		**-**
Capital receipts surrendered		**-**
Net Cash Inflow (Outflow) from Financing Activities		**353,343**
Net Increase (Decrease) in Cash & Cash Equivalents	**20**	**38**
Cash & Cash Equivalents at the Beginning of the Financial Year		**-**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		**-**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**38**

Notes to the financial statements

NHS Lewisham Clinical Commissioning Group was constituted under the Health and Social Care Act 2012, and came into being on 1 April 2014.

This is a new organisation. Previous assets and liabilities of Lewisham Primary Care Trust transferred to other organisations under a Transfer Order on behalf of the Secretary of State for Health from that date. Under the terms of the Act our principal activities are the commissioning and monitoring of health services, for the population of Lewisham, defined as patients registered with GPs who are on Lewisham's performers list.

We carry out our operations from Cantilever House, Eltham Road, London SE12 8RN.
All references to the "Clinical Commissioning Group" and the "CCG" means NHS Lewisham Clinical Commissioning Group.

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2013-14* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the *Manual for Accounts* permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group (NHS Lewisham CCG) are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

In accordance with the Directions issued by NHS England comparative information is not provided in these Financial Statements.

1.1 Going Concern

These accounts have been prepared on the going concern basis.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Acquisitions & Discontinued Operations

Activities are considered to be ‘acquired’ only if they are taken on from outside the public sector. Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another.

1.4 Movement of Assets within the Department of Health Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.
For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

1.5 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

Notes to the financial statements

In the application of the clinical commissioning group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

NHS Lewisham CCG exercised critical judgement in respect of prescribing accruals (see Note 23).

1.5.2 Key Sources of Estimation Uncertainty

The following are the key estimations that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

NHS Lewisham CCG had no material key sources of estimation uncertainty.

1.6 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to NHS Lewisham CCG of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time NHS Lewisham CCG commits itself to the retirement, regardless of the method of payment.

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in NHS Lewisham CCG's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

1.8 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenses and liabilities in respect of grants are recognised when NHS Lewisham CCG has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.9 Property, Plant & Equipment

Notes to the financial statements

NHS Lewisham CCG had no Property, Plant and Equipment in 2013-14.

1.10 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 The Clinical Commissioning Group as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.10.2 The Clinical Commissioning Group as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group's net investment outstanding in respect of the leases.
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.11 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of NHS Lewisham CCG's cash management.

1.12 Provisions

Provisions are recognised when NHS Lewisham CCG has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

- Timing of cash flows (0 to 5 years inclusive): Minus 1.90%
- Timing of cash flows (6 to 10 years inclusive): Minus 0.65%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.80%

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when NHS Lewisham CCG has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 Clinical Negligence Costs

Notes to the financial statements

The NHS Litigation Authority operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group.

1.14 Non-clinical Risk Pooling

NHS Lewisham CCG participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.15 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.16 Financial Assets

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.1 Loans & Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Notes to the financial statements

1.17 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.18 Value Added Tax

Most of the activities of NHS Lewisham CCG are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Foreign Currencies

NHS Lewisham CCG's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.20 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.21 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2013-14, all of which are subject to consultation:

- IAS 27: Separate Financial Statements
- IAS 28: Investments in Associates & Joint Ventures
- IAS 32: Financial Instruments – Presentation (amendment)
- IFRS 9: Financial Instruments
- IFRS 10: Consolidated Financial Statements
- IFRS 11: Joint Arrangements
- IFRS 12: Disclosure of Interests in Other Entities
- IFRS 13: Fair Value Measurement

The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year.

1.22 The accounting arrangements for balances transferred from predecessor PCTs ("legacy" balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. The impact of the legacy balances accounted for by the CCG is disclosed in note 1.2 to these financial statements. The CCG's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 30 to these financial statements."

2 Other Operating Revenue

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Recoveries in respect of employee benefits	**-**	-	-
Patient transport services	**-**	-	-
Prescription fees and charges	**548**	-	548
Dental fees and charges	**-**	-	-
Education, training and research	**357**	49	308
Charitable and other contributions to revenue expenditure: NHS	**-**	-	-
Charitable and other contributions to revenue expenditure: non-NHS	**-**	-	-
Receipt of donations for capital acquisitions: NHS Charity	**-**	-	-
Receipt of Government grants for capital acquisitions	**-**	-	-
Non-patient care services to other bodies	**2,842**	66	2,776
Income generation	**-**	-	-
Rental revenue from finance leases	**-**	-	-
Rental revenue from operating leases	**-**	-	-
Other revenue	**0**	-	0
Total other operating revenue	**3,747**	**115**	**3,632**

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the General Fund.

3 Revenue

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
From rendering of services	**3,747**	**115**	**3,632**
From sale of goods	**-**	**-**	**-**
Total	**3,747**	**115**	**3,632**

Revenue is totally from the supply of services. The clinical commissioning group receives no revenue from the sale of goods.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	2013-14 Total	Total Permanent Employees	Other	Total	Admin Permanent Employees	Other	Total	Programme Permanent Employees	Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	**3,125**	2,768	357	**2,186**	2,104	82	**939**	664	275
Social security costs	**325**	325	-	**266**	266	-	**59**	59	-
Employer Contributions to NHS Pension scheme	**406**	406	-	**329**	329	-	**77**	77	-
Other pension costs	**-**	-	-	**-**	-	-	**-**	-	-
Other post-employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Other employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Termination benefits	**105**	105	-	**105**	105	-	**-**	-	-
Gross employee benefits expenditure	**3,961**	**3,604**	**357**	**2,886**	**2,804**	**82**	**1,075**	**800**	**275**
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	-	-	**-**	**-**	**-**	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	**3,961**	**3,604**	**357**	**2,886**	**2,804**	**82**	**1,075**	**800**	**275**
Less: Employee costs capitalised	**-**	-	-	**-**	-	-	**-**	-	-
Net employee benefits excluding capitalised costs	**3,961**	**3,604**	**357**	**2,886**	**2,804**	**82**	**1,075**	**800**	**275**

4.1.2 Recoveries in respect of employee benefits

	2013-14 Total	Permanent Employees	Other
	£000	£000	£000
Employee Benefits - Revenue			
Salaries and wages	-	-	-
Social security costs	-	-	-
Employer contributions to the NHS Pension Scheme	-	-	-
Other pension costs	-	-	-
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Total recoveries in respect of employee benefits	**-**	**-**	**-**

4.2 Average number of people employed

	2013-14 Total	Permanently employed	Other
	Number	Number	Number
Total	**53**	48	5
Of the above:			
Number of whole time equivalent people engaged on capital projects	**-**	-	-

4.3 Staff sickness absence and ill health retirements

	2013-14 Number
Total Days Lost	162
Total Staff Years	53
Average working Days Lost	3

	2013-14 Number
Number of persons retired early on ill health grounds	**-**
Total additional Pensions liabilities accrued in the year	**-**

Ill health retirement costs are met by the NHS Pension Scheme

Where the clinical commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS Pension Scheme.

4.4 Exit packages agreed in the financial year

2013-14	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	1	818	**1**	**818**
£10,001 to £25,000	-	-	-	-	**-**	**-**
£25,001 to £50,000	-	-	-	-	**-**	**-**
£50,001 to £100,000	-	-	-	-	**-**	**-**
£100,001 to £150,000	-	-	-	-	**-**	**-**
£150,001 to £200,000	-	-	-	-	**-**	**-**
Over £200,001	-	-	-	-	**-**	**-**
Total	**-**	**-**	**1**	**818**	**1**	**818**

	Departures where special payments have been made	
	Number	£
Less than £10,000	-	-
£10,001 to £25,000	-	-
£25,001 to £50,000	-	-
£50,001 to £100,000	-	-
£100,001 to £150,000	-	-
£150,001 to £200,000	-	-
Over £200,001	-	-
Total	**-**	**-**

Analysis of Other Agreed Departures

	Other agreed departures	
	Number	£
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	1	818
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval*	-	-
Total	**1**	**818**

Contractual payments in lieu of notice relates to one payment of £818 for annual leave due at date of termination.
These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.
The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

4.5 Pension costs

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.
Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

• Members can purchase additional service in the Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

5. Operating expenses

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Gross employee benefits			
Employee benefits excluding governing body members	3,437	2,362	1,075
Executive governing body members	524	524	-
Total gross employee benefits	**3,961**	**2,886**	**1,075**
Other costs			
Services from other CCGs and NHS England	**7,746**	2,631	5,115
Services from foundation trusts	**134,126**	-	134,126
Services from other NHS trusts	**165,434**	-	165,434
Services from other NHS bodies	**19**	-	19
Purchase of healthcare from non-NHS bodies	**23,773**	-	23,773
Chair and lay membership body and governing body members	**103**	103	-
Supplies and services – clinical	**-**	-	-
Supplies and services – general	**669**	389	280
Consultancy services	**374**	32	342
Establishment	**1,117**	76	1,041
Transport	**5**	4	1
Premises	**3,251**	154	3,097
Impairments and reversals of receivables	**-**	-	-
Inventories written down	**-**	-	-
Depreciation	**-**	-	-
Amortisation	**-**	-	-
Impairments and reversals of property, plant and equipment	**-**	-	-
Impairments and reversals of intangible assets	**-**	-	-
Impairments and reversals of financial assets	**-**	-	-
· Assets carried at amortised cost	**-**	-	-
· Assets carried at cost	**-**	-	-
· Available for sale financial assets	**-**	-	-
Impairments and reversals of non-current assets held for sale	**-**	-	-
Impairments and reversals of investment properties	**-**	-	-
Audit fees	**103**	103	-
Other auditor's remuneration			
· Internal audit services	**-**	-	-
· Other services	**-**	-	-
General dental services and personal dental services	**-**	-	-
Prescribing costs	**35,956**	-	35,956
Pharmaceutical services	**-**	-	-
General ophthalmic services	**-**	-	-
GPMS/APMS and PCTMS	**728**	-	728
Other professional fees excl. audit	**399**	98	301
Grants to other public bodies	**-**	-	-
Clinical negligence	**-**	-	-
Research and development (excluding staff costs)	**-**	-	-
Education and training	**142**	34	108
Change in discount rate	**-**	-	-
Other expenditure	**1,509**	-	1,509
Total other costs	**375,454**	3,624	371,830
Total operating expenses	**379,415**	**6,510**	**372,905**

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

6.1 Better Payment Practice Code

Measure of compliance	2013-14 Number	2013-14 £000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	4,336	21,879
Total Non-NHS Trade Invoices paid within target	4,123	21,263
Percentage of Non-NHS Trade invoices paid within target	95.09%	97.18%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	2,225	313,940
Total NHS Trade Invoices Paid within target	2,136	310,897
Percentage of NHS Trade Invoices paid within target	96.00%	99.03%

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2013-14 £000
Amounts included in finance costs from claims made under this legislation	-
Compensation paid to cover debt recovery costs under this legislation	-
Total	-

7 Income Generation Activities

The Clinical Commissioning Group does not undertake any income generation activities.

8. Investment revenue

The clinical commissioning group had no investment revenue as at 31 March 2014.

9. Other gains and losses

The clinical commissioning group had no other gains or losses as at 31 March 2014.

10. Finance costs

The clinical commissioning group had no finance costs as at 31 March 2014.

11. Net gain/(loss) on transfer by absorption

The clinical commissioning group had no net gains or losses on transfer by absorption as at 31 March 2014.

12. Operating Leases

Following the Health and Social Care Act 2012, all leases were transferred to NHS Property Services or Lewisham and Greenwich NHS Trust.

Lewisham CCG is recharged by NHS Property Services and Community Health Partners for the costs of its staff accommodation at Cantilever house and running costs of some buildings from which community health services are provided.

There are no formal agreements in place between NHS Property Services and the CCG or Community Health Partners and the CCG. Recharges in 2013-14 were based on the budget transfers to those organisations from the former Lewisham PCT, which were agreed by the CCG's officers. In 2013-14 Lewisham CCG paid NHS Property Services £1,479K and Community Health Partnership £1,679k. As there are no contracts in place there are no defined future contractual payment obligations.

13 Property, plant and equipment

NHS Lewisham CCG had no property, plant and equipment as at 31 March 2014 or during 2013-14.

14 Intangible non-current assets

NHS Lewisham CCG had no intangible non-current as at 31 March 2014 or during 2013-14.

15 Investment property

The Clinical Commissioning Group had no investment property as at 31 March 2014.

16 Inventories

The Clinical Commissioning Group had no inventories as at 31 March 2014

17 Trade and other receivables

	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	4,025	-
NHS receivables: Capital	-	-
NHS prepayments and accrued income	2,315	-
Non-NHS receivables: Revenue	58	-
Non-NHS receivables: Capital	-	-
Non-NHS prepayments and accrued income	99	-
Provision for the impairment of receivables	-	-
VAT	19	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-
Interest receivables	-	-
Finance lease receivables	-	-
Operating lease receivables	-	-
Other receivables	(0)	-
Total	6,516	-
Total current and non current	6,516	
Included above:		
Prepaid pensions contributions	-	

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring of them is considered necessary.

17.1 Receivables past their due date but not impaired

	2013-14 £000
By up to three months	278
By three to six months	17
By more than six months	268
Total	563

£399k of the amount above has subsequently been recovered post the statement of financial position date.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2014.

17.2 Provision for impairment of receivables

	2013-14 £000
Balance at 1 April 2013	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-
Adjusted balance at 1 April 2013	-
Amounts written off during the year	-
Amounts recovered during the year	-
(Increase) decrease in receivables impaired	-
Transfer (to) from other public sector body	-
Balance at 31 March 2014	-

18 Other financial assets

The clinical commissioning group had no other financial assets as at 31 March 2014.

19 Other current assets

The clinical commissioning group had no other current assets as at 31 March 2014.

20 Cash and cash equivalents

	2013-14 £000
Balance at 1 April 2013	**-**
Net change in year	**38**
Balance at 31 March 2014	**38**
Made up of:	
Cash with the Government Banking Service	**38**
Cash with Commercial banks	**-**
Cash in hand	**-**
Current investments	**-**
Cash and cash equivalents as in statement of financial position	**38**
Bank overdraft: Government Banking Service	**-**
Bank overdraft: Commercial banks	**-**
Total bank overdrafts	**-**
Balance at 31 March 2014	**38**
Patients' money held by the clinical commissioning group, not included above	**-**

21 Non-current assets held for sale

The clinical commissioning group had no non-current assets held for sale as at 31 March 2014.

22 Analysis of impairments and reversals

The clinical commissioning group had no impairments or reversals of impairments recognised in expenditure during 2013-14.

23 Trade and other payables

	Current 2013-14 £000	Non-current 2013-14 £000
Interest payable	-	-
NHS payables: revenue	10,559	-
NHS payables: capital	-	-
NHS accruals and deferred income	2,336	-
Non-NHS payables: revenue	1,437	-
Non-NHS payables: capital	-	-
Non-NHS accruals and deferred income	12,428	-
Social security costs	44	-
VAT	-	-
Tax	56	-
Payments received on account	-	-
Other payables	404	-
Total	27,264	-
Total payables (current and non-current)	27,264	

Non NHS accruals includes a sum of £6,218k in respect of prescribing for two months outstanding invoices from the Prescription Pricing Authority, due to the time lags in their processing of this information. This is in common with other CCG's treatment of this issue.

24 Other financial liabilities

The clinical commissioning group had no other financial liabilities as at 31 March 2014.

25 Other liabilities

The clinical commissioning group had no other liabilities as at 31 March 2014.

26 Borrowings

The clinical commissioning group had no borrowings as at 31 March 2014.

27 Private finance initiative, LIFT and other service concession arrangements

The clinical commissioning group had no private finance initiative, LIFT or other service concession arrangements that were excluded from the Statement of Financial Position as at 31 March 2014.

28 Finance lease obligations

The clinical commissioning group had no finance lease obligations as at 31 March 2014.

29 Finance lease receivables

The clinical commissioning group had no finance lease receivables as at 31 March 2014.

30 Provisions

	Current 2013-14 £000	Non-current 2013-14 £000
Pensions relating to former directors	-	-
Pensions relating to other staff	-	-
Restructuring	151	453
Redundancy	106	-
Agenda for change	-	-
Equal pay	-	-
Legal claims	-	-
Continuing care	870	-
Other	35	-
Total	1,162	453

Total current and non-current

	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Restructuring £000s	Redundancy £000s	Agenda for Change £000s	Equal Pay £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Total £000s
Balance at 1 April 2013	-	-	-	-	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the April 2013 transition	-	-	-	-	-	-	-	-	-	-
Adjusted balance at 1 April 2013	-	-	-	-	-	-	-	-	-	-
Arising during the year	-	-	604	106	-	-	-	870	35	1,615
Utilised during the year	-	-	-	-	-	-	-	-	-	-
Reversed unused	-	-	-	-	-	-	-	-	-	-
Unwinding of discount	-	-	-	-	-	-	-	-	-	-
Change in discount rate	-	-	-	-	-	-	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	-
Balance at 31 March 2014	-	-	604	106	-	-	-	870	35	1,615
Expected timing of cash flows:										
Within one year	-	-	151	106	-	-	-	870	35	1,162
Between one and five years	-	-	453	-	-	-	-	-	-	453
After five years	-	-	-	-	-	-	-	-	-	-
Balance at 31 March 2014	-	-	604	106	-	-	-	870	35	1,615

Restructuring provisions relate to the costs of the formation of new NHS organisations following the dissolution of South London Healthcare NHS Trust, payable over 4 years.

Redundancy provisions relate to employees under notice of redundancy at 31 March 2014. These will be payable in 2014/15 unless alternative NHS employment is confirmed and commences prior to the termination dates.

Continuing care provisions (£870k) relate to new continuing care claims in 2014/15 (£717k) and claims relating to periods of care before the establishment of the CCG (£153k) that are excluded from the £1561k that has been accounted for by NHS England. NHS Lewisham Clinical Commissioning Group retains legal responsibility for all NHS continuing healthcare payments relating to Lewisham patients accounted for by NHS Lewisham Clinical Commissioning Group and NHS England

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with Lewisham CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of Lewisham CCG at 31 March 2014 is £1,561k.

Other provisions include NHS Lewisham Clinical Commissioning Group's share of potential redundancy liabilities relating to an employee of NHS Southwark Clinical Commissioning Group, engaged on work on behalf of all South East London CCGs.

There are no legal claims currently lodged with the NHS Litigation Authority.

31 Contingencies

The clinical commissioning group had no contingent liabilities or contingent assets as at 31 March 2014.

32 Commitments

32.1 Capital commitments

The clinical commissioning group had no contracted capital commitments not otherwise included in these financial statements as at 31 March 2014.

32.2 Other financial commitments

The clinical commissioning group had no non-cancellable contract (which were not leases, private finance initiative contracts or other service concession arrangements) as at 31 March 2014.

33 Financial instruments

33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the clinical commissioning group's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the clinical commissioning group's internal auditors.

33.1.1 Currency risk

The clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The clinical commissioning group has no overseas operations. The clinical commissioning group therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

Because the majority of the clinical commissioning group's revenue comes parliamentary funding, the clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33.1.3 Liquidity risk

The clinical commissioning group is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament. The clinical commissioning group draws down cash to cover expenditure, from NHS England, as the need arises. The clinical commissioning group is not, therefore, exposed to significant liquidity risks.

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss'	Loans and Receivables	Available for Sale	Total
	2013-14 £000	2013-14 £000	2013-14 £000	2013-14 £000
Embedded derivatives	-	-	-	-
Receivables:	-	-	-	-
· NHS	-	4,025	-	4,025
· Non-NHS	-	58	-	58
Cash at bank and in hand	-	38	-	38
Other financial assets	-	(0)	-	(0)
Total at 31 March 2014	-	4,121	-	4,121

33.3 Financial liabilities

	At 'fair value through profit and loss'	Other	Total
	2013-14 £000	2013-14 £000	2013-14 £000
Embedded derivatives	-	-	-
Payables:	-	-	-
· NHS	-	12,895	12,895
· Non-NHS	-	13,865	13,865
Private finance initiative, LIFT and finance lease obligations	-	-	-
Other borrowings	-	-	-
Other financial liabilities	-	-	-
Total at 31 March 2014	-	26,760	26,760

34 Operating segments

The clinical commissioning group and consolidated group consider they have only one segment: commissioning of healthcare services.

35 Pooled budgets

The clinical commissioning group was not party to any pooled budget arrangements during 2013-14.

36 NHS Lift investments

The clinical commissioning group had no NHS LIFT investments as at 31 March 2014.

37 Intra-government and other balances

	Current Receivables	Non-current Receivables	Current Payables	Non-current Payables
	2013-14 £000	2013-14 £000	2013-14 £000	2013-14 £000
Balances with:				
· Other Central Government bodies	19	-	101	-
· Local Authorities	-	-	-	-
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	236	-	500	-
· NHS Trusts and Foundation Trusts	6,104	-	12,395	-
Total of balances with NHS bodies:	6,340	-	12,895	-
· Public corporations and trading funds	-	-	-	-
· Bodies external to Government	157	-	14,268	-
Total balances at 31 March 2014	6,516	-	27,264	-

38 Related party transactions

Details of related party transactions with individuals are as follows. Each individual was a member of the CCG's Governing Body for part or all of the year 2013-14 and is either a partner or a salaried GP within a Lewisham GP practice.
The table below records payments to and amounts owed to the GP practice for the provision of healthcare services.

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Oakview Family Practice (Dr Helen Tattersfield - CCG Chair April to September 2013)	55		0	
Jenner Practice (Dr Marc Rowland - CCG Clinical Director April to August 2013; CCG Chair from September 2013)	78		0	
Morden Hill Surgery (Dr David Abraham -CCG Senior Clinical Director)	148		3	
Hilly Fields Medical Centre (Dr Faruk Majid -CCG Senior-Clinical Director)	30		0	
Rushey Green Group Practice (Dr Judy Chen -CCG Clinical Director)	142		10	
Woolstone Medical Centre (Dr Hilary Entwistle - CCG Clinical Director)	32		5	
South Lewisham Group Practice (Dr Arun Gupta - CCG Clinical Director and Dr Simon Parton - CCG Advisory Governing Body Member)	99		11	
Vale Medical Centre (Dr Jacqueline McLeod - CCG Clinical Director from October 2013)	36		0	

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

• NHS England;
• NHS Foundation Trusts (e.g. Guy's and St. Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, South London and Maudsley NHS Foundation Trust);
• NHS Trusts (e.g. Lewisham and Greenwich NHS Trust);
• NHS Litigation Authority; and,
• NHS Business Services Authority.

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the London Borough of Lewisham in respect of services for people with learning disabilities.

39 Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the clinical commissioning group.

40 Losses and special payments

The clinical commissioning group had no losses and special payments cases during 2013-14.

41 Third party assets

The clinical commissioning group held no third party assets as at 31 March 2014.

42 Financial performance targets

Clinical commissioning groups have a number of financial duties under the NHS Act 2006 (as amended). The clinical commissioning group's performance against those duties was as follows:

	2013-14 Maximum	2013-14 Performance	Duty Achieved?
Expenditure not to exceed income	383,159	379,416	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	Yes
Revenue resource use does not exceed the amount specified in Directions	379,410	375,668	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	Yes
Revenue administration resource use does not exceed the amount specified in Directions	7,160	6,395	Yes

43 Impact of IFRS

Accounting under IFRS had no impact on the results of the clinical commissioning group during the 2013-14 financial year.