Public Document Pack

Health and Wellbeing Board
Agenda

Tuesday, 25 November 2014
3.00 pm,
Committee Room 1 - Civic Suite
Civic Suite
Lewisham Town Hall
London SE6 4RU

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

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

Part 1

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

Health and Wellbeing Board Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Tuesday, 25 November 2014.

Barry Quirk, Chief Executive
Monday, 17 November 2014

Mayor Sir Steve Bullock (Chair)	London Borough of Lewisham
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
Rosemarie Ramsay MBE	Healthwatch Lewisham
Marc Rowland (Vice-Chair)	Lewisham Clinical Commissioning Group
Dr Danny Ruta	Public Health, London Borough of Lewisham
Brendan Sarsfield	Family Mosaic
Frankie Sulke	Directorate for Children and Young People
Susanna Masters	Lewisham Clinical Commissioning Group
Katrina McCormick	Public Health Lewisham
Sarah Wainer	
Martin Wilkinson	Lewisham CCG
Warwick Tomsett	
Ruth Hutt	Public Health

Andrew Billington	London Borough of Lambeth
Jacky Bourke-White	Age UK
Elizabeth Clowes	Lambeth integrated commissioning team
Henry Hobson	Age UK Lewisham and Southwark

MINUTES OF THE HEALTH AND WELLBEING BOARD

Tuesday, 23 September 2014 at 3.00 pm

ATTENDANCE

PRESENT: Mayor Sir Steve Bullock (Chair), Cllr Chris Best (Cabinet Member for Community Services), Aileen Buckton (Executive Director for Community Services, LBL), Elizabeth Butler (Chair, Lewisham and Greenwich Healthcare Trust), Dr Danny Ruta (Director of Public Health, LBL), Tony Nickson (Director, Voluntary Action Lewisham), Peter Ramrayka (Voluntary and Community Sector), Rosemarie Ramsay (Healthwatch Lewisham), Dr Marc Rowland (Chair of Lewisham Clinical Commissioning Group and Vice-Chair of the Health and Wellbeing Board), Brendan Sarsfield (Family Mosaic).

IN ATTENDANCE: Catherine Bunten (Policy Manager, Commissioning, Performance & Strategy, Children and Young People, LBL, representing Frankie Sulke), Carmel Langstaff (Service Manager, Strategy and Policy, Community Services, LBL), Susanna Masters (Corporate Director, Lewisham Clinical Commissioning Group), Mike Salter (Head of Medicine Management, Lewisham Clinical Commissioning Group), Sarah Wainer (Head of Strategy, Improvement and Partnerships, Community Services, LBL), Martin Wilkinson (Chief Officer, Lewisham Clinical Commissioning Group), Kalyan DasGupta (Clerk to the Board, LBL).

APOLOGIES: Apologies were received from Dr Simon Parton (Chair of Lewisham Local Medical Committee), Frankie Sulke (Executive Director for Children and Young People, LBL), Jane Clegg (Delivery, NHS SE England – South London Area, London Region).

The Chair welcomed Rosemarie Ramsay MBE as the new Chair of Healthwatch and representative of Healthwatch to the Health and Wellbeing Board.

1. Minutes of the last meeting and matters arising

1.1 The minutes of the last meeting (3 July 2014) were agreed as an accurate record.

1.2 The Board

1. Agreed that an Action Tracker would be tabled at future meetings.

2. Agreed that Food Poverty would continue to be on the Board's Work Programme.

2. Declarations of Interest

2.1 There were no declarations of interest.

3. Update on Revision of Lewisham Pharmaceutical Needs Assessment

3.1 Dr Danny Ruta (Director of Public Health, LBL) updated the Board on progress and planned timetable for revision of the Lewisham Pharmaceutical Needs Assessment (PNA).

3.2 The following points were highlighted:

- In order to fulfil its statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services in Lewisham, the Director of Public Health has convened a PNA steering group with representation from Lewisham Clinical Commissioning Group and the Local Pharmaceutical Committee (LPC).

- The group is in the process of updating the data collected for the previous PNA, and reviewing recent policy guidance and evidence.

- A visioning/stakeholder event is planned for late September/early October, after which priorities for the future development of pharmaceutical services will be generated, and these will inform the first draft revised PNA. This will be followed by a 60-day consultation between October and December 2014, and a final draft PNA will be produced for consideration by the Board in January 2015.

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

- GPs will be invited to the event.

- Pharmacists may wish to address loneliness as part of their overall remit because, as frontline service providers, they are likely to be directly aware of people experiencing such issues.

- HWB members expressed interest in visiting a community pharmacy. **DR to action.**

- Lewisham should also explore out-of-borough pharmaceutical services for examples of best practice.

- Public Health, the CCG, and the LPC should be invited, in addition to Healthwatch, to help the Board decide on the best model for pharmaceutical services in the borough.

3.4 The Board:

1. Noted the progress made and the planned timetable for completion of a revised PNA.

2. Agreed that the timetable should incorporate an optional visit to a community pharmacy.

4. Adult Integrated Care Programme Update

4.1 Susanna Masters (Corporate Director, Lewisham Clinical Commissioning Group) provided the Board with an update on Lewisham's Adult Integrated Care Programme (AICP) and in particular on the Better Care Fund (BCF) and Joint Commissioning Intentions.

4.2 The following points were highlighted:

- Susanna explained that, because of the Department of Health deadline, the BCF application had to be submitted before the 23 September 2014 HWB meeting. It was approved by the Health and Wellbeing Board's Chair and Vice-Chair.

- In developing the plan, Board members will ensure that it takes account of the Care Act and adequately addresses the needs of carers and the mental and physical health of service users. Members will also ensure that activity to reduce acute emergency admissions is feasible and realistic.

  This activity is currently underway and is being undertaken alongside the development of Lewisham's Joint Commissioning Intentions for health and care.

- Following the 19 September submission, it is now anticipated that feedback on Lewisham's revised plans will be provided by NHS England and the LGA by the end of October 2014.

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

- Elizabeth Butler requested sight of future bids in advance of submission to ensure full engagement of the Trust.

- The Performance Dashboard agreed at the last meeting will help monitor progress and offer reassurance, particularly with respect to reducing Emergency Admissions. Updates will be provided twice a year, with supplementary reports as required.

- It was confirmed that Lewisham had submitted plans for a 1.8% reduction in emergency admission for 2014-15.

- Lewisham will continue to learn from best practice models.

4.4 The Board:

1. Noted the activity in relation to the Better Care Fund.

2. Noted the updates provided on the Adult Integrated Care Programme.

3. Noted the work in progress in relation to the Joint Commissioning Intentions.

4. Agreed that supplementary performance reports may need to be submitted over and above the twice-yearly presentation of the Dashboard, to help the Board monitor progress in relation to the Adult Integrated Care Programme.

5. System Resilience Plans 2014-15 and Winter Funds

5.1 Martin Wilkinson (Chief Officer, Lewisham Clinical Commissioning Group) provided an update on progress of the development of the System Resilience plans for Lewisham, Greenwich and Bexley, in line with the System Resilience Guidance published by NHS England on 13 June 2014.

5.2 The report highlighted the following points:

- The key initiatives contained within the unscheduled care section of the plan cover demand and capacity analysis and action plans, enhancement of 7-day working, the development and implementation of a real-time data and predictive modelling tool, closer working with LAS to drive higher utilisation of Appropriate Care Pathways (ACPs), and the development of a standardised approach for rapid response / Joint Emergency Teams.

- System resilience plans are being refined following initial feedback from NHS England. Plans will be reviewed in September and October to ensure they are joined up across the system.

5.3 The Board noted the update on the development of the system resilience plans.

6. Voluntary and Community Sector Representative update

6.1 Peter Ramrayka (Voluntary and Community Sector representative) provided a summary of a consultation with a range of Lewisham's voluntary and community organisations regarding their needs and the work of the HWB, and conveyed their views on how they might contribute to the Board's ongoing activities.

6.2 The following issues were highlighted:

- The report focused on the organisations' responses to the nine priorities identified in the Board's Joint Strategic Needs Assessment and, in

particular, on hard-to-reach groups who might not be represented elsewhere in the system.

- The report discussed the steps being taken to involve the community and voluntary sector in issues discussed or due to be discussed by the HWB, to obtain its input.

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

- Reducing re-offending is a priority of the Safer Lewisham Board; this further highlights the need for joined-up working.

- Organisations had highlighted issues relating to their specific areas of work rather than broader strategic issues.

- There is a need to work with VAL's Health and Social Care Forum, to understand the issues and needs of the voluntary and community sector better.

- The HWB could improve communications on its activities. Loneliness could be used as a theme to reflect the strategic work undertaken by the HWB. A campaign on loneliness would make the issues and the provisions concrete.

6.4 The Board noted the Voluntary and Community Sector Representative update.

6.5 <u>Work Programme for the next meeting: 25 November 2014</u>

- Carmel Langstaff (Service Manager, Strategy and Policy, Strategy, Improvement and Partnerships, Community Services, LBL) distributed the Work Programme and members agreed to feed back any comments and suggestions.

- Carmel explained that future agendas could be smaller, given the new process, by which meetings will focus on strategic items requiring the input of members.

- It was suggested that the Work Programme feature as a standing item at the end of all future Board meeting agendas. This was agreed.

The Board agreed to include the Work Programme report and discussion as a standing final item in all future Board meeting agendas.

The meeting ended at 16:00 hrs.

#	MEETING REF	ACTION	LEAD/OWNER	ASSIGNED TO	DUE DATE	STATUS
1	3 July 2014	Housing and Health in Lewisham Martin Wilkinson to explore the case for investment further with Genevieve Macklin. It is suggested that the recommendations should be considered as part of the Adult Integrated Care Programme and the allocation of Winter Pressures resources.	Martin Wilkinson	Martin Wilkinson / Genevieve Macklin		Awaiting update.
2	3 July 2014	Voluntary and Community Sector Response to Poverty, with a Focus on Food Poverty 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 to 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.	Tony Nickson	Voluntary Action Lewisham	March 2015	Tony Nickson meeting colleagues in Public Health w/c 10 November 2014 to discuss joint action on a possible 'food summit' arising from our complementary presentations on Food Poverty at a previous meeting.
3	23 September 2014	Update on Revision of Lewisham Pharmaceutical Needs Assessment The timetable should include an optional visit for Board members to a community pharmacy.	Danny Ruta	Mike Salter	March 2015	The timetable has not been agreed to date.

HEALTH AND WELLBEING BOARD				
Report Title	Declarations of interest			
Contributors	Chief Executive – London Borough of Lewisham		Item No.	2
Class	Part 1	Date:	25 November 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	Adult Integrated Care Programme, Better Care Fund and Draft Joint Commissioning Intentions			
Contributors	Executive Director for Community Services and Chief Officer, Lewisham Clinical Commissioning Group		Item No.	3
Class	Part 1	Date:	25 November 2014	
Strategic Context	Please see body of report			

1. Purpose

1.1 This report provides Members of the Health and Wellbeing Board with an update on Lewisham's Adult Integrated Care Programme, the Better Care Fund and seeks comments on the draft Joint Commissioning Intentions for Integrated Care for 2015/16 and 2016/17.

2. Recommendations

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

- Note the updates provided on the Adult Integration Care Programme;
- Note the latest update on the Better Care Fund submission;
- Ensure the draft Joint Commissioning Intentions for Integrated Care reflect the priorities identified in the Joint Health and Wellbeing Strategy before public consultation commences; and
- Agree the process, set out in paragraph 8.14, for signing off the Board's formal opinion on the Commissioning Intentions and Operating Plan, prior to its publication.

3. 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 Future's priority outcome that communities in Lewisham should be 'Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing'.

3.3 The Health and Social Care Act 2012 placed a duty on Health and Wellbeing Boards 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 places a specific duty on the CCG to include the relevant Health and Wellbeing Board in the preparation of their commissioning plans and when making significant revisions to those plans. The Health and Wellbeing Board must be provided with a draft commissioning plan and the CCG must consult the Board as to whether it considers the plan takes proper account of the Health and Wellbeing Strategy. The Health and Wellbeing Board's opinion on the final plan must be published within the Operating Plan. Health and Wellbeing Boards can refer plans to NHS England if they do not think the joint Health and Wellbeing Strategy has been taken into proper account.

3.5 The Health and Social Care Act 2012 also requires Health and Wellbeing Boards to encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area.

3.6 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. Adult Integrated Care Programme (AICP)

4.1 The work of the Adult Integrated Care Programme is progressing steadily. As requested by members of the Board, this report provides a more detailed update on the Neighbourhood Model.

Neighbourhood Model

4.2 Neighbourhood Community Teams
The vision for the Neighbourhood Model is based around four Neighbourhood Community Teams (NCT), comprising Social Care staff and District Nurse staff, working together in neighbourhood offices. The composition of the teams has been agreed and the core teams have been established. Recruitment is currently taking place to fill any Social Care vacancies. Applications have closed and interviews will take place in November.

4.3 Aligned to GP practices, each neighbourhood team has direct access to other associated key services including Enablement care, Admission Avoidance Service, Hospital Discharge team and other therapies. These associated services are provided from two hubs covering the North and South of the borough. Each hub is linked to two NCTs giving each NCT direct access to the services within the hub. Adult

Mental Health Services are also aligned to the NCTs. The NCTs are also directly linked to the Community Connections team.

4.4 Work Force Development

To support the further integration and joint working within the NCT, a workforce development programme has been established. The programme includes a workshop on values and behaviours and the development of active learning sets which will act as the framework for developing staff in the neighbourhoods. The training on problem solving and case management will call on actual case work.

4.5 Office Accommodation

The initial plan was to co-locate all staff in the current premises occupied by District Nursing. Following assessment of the proposed sites, it has been confirmed that these sites could not accommodate the proposed number of additional staff. Officers are working with colleagues across LBL and the NHS to map the current estate and to identify suitable alternative accommodation for the NCTs.

4.6 IT Connectivity and Information Governance

Work continues to meet the IT requirements to support the NCTs. Using the service requirements of Kaleidoscope as a model for shared services, the IT and Information Governance (IG) departments of LBL and Lewisham and Greenwich NHS Trust are developing a shared solution for the neighbourhood offices.

4.7 In addition progress is being made on the development of Connect Care (the Virtual Patient Record) which will allow staff to share information across organisations. The first phase involving access to hospital records is due in March, with links to other health and social care information due subsequently.

4.8 In order to support information sharing and the integration of records, work is progressing on using NHS number as the unique identifier for Social Care records. Lewisham Council has met the requirements which will allow it to connect to the NHS network and cross-reference clients between the two systems.

5. Single Point of Access

5.1 The Single Point of Access has brought together the Social Care Advice and Information Team (SCAIT) and District Nursing Call Centre. The Single Point of Access will be located in Laurence House. A common assessment form has been developed and will be used to provide people with appropriate advice and information, to direct people to suitable services or, where necessary, to make referrals to the Neighbourhood Community Team for an assessment or review.

6. Information and Advice

6.1 The advice and information workstream has identified the mechanisms currently used by individuals to access information and advice. An options appraisal has been undertaken regarding the development of a comprehensive on line information and advice offer. The Adult Integrated Care Programme Board (AICPB) has agreed in principle to utilise Lewisham's website to develop an enhanced on line information offer subject to a detailed specification.

7. The Better Care Fund

7.1 Members will recall that the Better Care Fund (BCF) was announced as part of the 2013 Spending Round and that Lewisham submitted its BCF plan on 4 April 2014. Subsequently Ministers announced 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 to refine their plans during June and that further guidance would follow. This additional guidance and information was delayed until the last week in July and the first week of August. This guidance provided details of the process for revising and resubmitting the BCF plans.

7.2 The revised Lewisham BCF plan was submitted on 19 September 2014 and shared with members of the Health and Wellbeing Board at its last meeting on the 23 September – see Appendix A.

7.3 The updated BCF guidance in August stated that there would be a Nationally Consistent Assurance Review Process of all submitted plans performed by externally commissioned providers, all working to a common methodology which had been reviewed, approved and validated by external experts. The results of the review process will then be moderated and calibrated to develop a consistent national view of the status of local BCF plans. The individual assessment of each plan will be used alongside an assessment of the local delivery context in which a plan sits, to produce an approval rating. Plans will be either: approved; approved with support; approved with conditions; or not approved.

7.4 An initial review of all submitted plans has been undertaken. Early feedback received was generally positive with requests for some additional evidence to be provided. It is anticipated that formal feedback on Lewisham's revised plans will be provided by NHS England and the LGA by the end of October 2014.

8. Joint Commissioning Intentions for 2015/16-2016/17

8.1 The joint Commissioning Intentions for Integrated Care provide a framework for how commissioners intend to commission local health and care services for 2015/16 and 2016/17. The Adult Joint Strategic Commissioning Group (AJSCG) has been co-ordinating the development of the Joint Commissioning Intentions.

8.2 These joint Commissioning Intentions cover the whole of Lewisham's adult population with a particular focus on:

- frail and vulnerable people;
- adults with complex needs and disabilities;
- older people;
- people with long term conditions and/or mental health problems;
- people with alcohol problems;
- pregnant women.

8.3 The draft Joint Commissioning Intentions include the interface with children and young people's services that are commissioned by the health service. The Children and Young People's plan (2012–2015) - 'It's everybody's business' - sets out the strategic aims and the detailed priorities and plans for all agencies working with children and young people across Lewisham.

8.4 It is a single, two year plan with one set of priorities. This is the first time that the collective resources available to Lewisham Council (Adult Social Care and Public Health) and NHS Lewisham Clinical Commissioning Group (CCG) have been brought together. The aim is to use these resources, of nearly £490 million, to their best effect to reshape the advice, support and care services provided across health and social care, working together with our public and partners, to improve health and care and reduce health inequalities.

8.5 The draft Joint Commissioning Intentions for Integrated Care for 2015-16 and 2016-17 are shown at Appendix B. They summarise the significant challenges for Lewisham:

- People are living longer: 50% of ASC spend on services is for people aged 75+
- More people have one or more long term conditions, which now takes up 70% of the health service budget.
- Deprivation is increasing.
- Too many people die early from deaths that could be avoided by healthier life styles.
- People's experience of care is very variable.
- Services are under increasing strain due to rising demand, increasing costs and limited budgets.

- There is an affordability gap, which cannot be addressed by efficiency and productivity improvements only. This means the solution is to work together to change what we do and how we do it.

8.6 These challenges are common across all health and care systems as recently highlighted in NHS Five Year Forward view (October 2014) and the report of the London Heath Commission 'Better Health for London' (October 2014).

8.7 The approach in Lewisham to address these fundamental challenges is to commission person-centred care that through early intervention and integrated care pathways helps Lewisham residents – from birth and throughout life - to enjoy a good quality of life, to make choosing healthy living easier, and to support local people and neighbourhoods to do more for themselves and one another. The draft Commissioning Intentions set out how our population's physical, mental and social care needs will be better met through coordinated advice, support and care.

8.8 Only a limited number of six priorities have been proposed, of which five align with the Better Care Fund submission; the sixth relates to Children and Young People. These priorities are:

- Prevention and early intervention
- GP practices and primary care
- Neighbourhood community care for adults
- Enhanced care and support for adults
- Children and Young People's care
- Supporting Enablers

8.9 These proposed priorities build on and embed the work of previous health and care plans, including the Health and Wellbeing Strategy, which have been informed by the Joint Strategic Needs Assessment and the views of local people in Lewisham.

8.10 The draft Joint Commissioning Intentions require further work to ensure that they are written in plain English, readily accessible to Lewisham people and ask the most appropriate consultation questions. A readers panel has been set up to advise on the language and presentation of the Joint Commissioning Intentions and a short summary version of the Joint Commissioning Intentions will be produced as well for wide distribution.

8.11 The Joint Commissioning Intentions will be a public document for wider engagement with the public, local providers and other stakeholders. This further engagement is part of the ongoing dialogue with Lewisham residents and partners to shape the way integrated care will be provided in Lewisham.

8.12 An engagement programme and communication plan will be implemented during November – December 2014, to further test that the Adult Integrated Care Programme is focused on the right plans for action to deliver the maximum benefits to Lewisham people over the next two years. The engagement exercise then will inform the translation of the joint Commissioning Intentions into the Operating/Commissioning plans across health and social care and be secured in contracts for 2015/16.

8.13 Members of the Health and wellbeing Board are asked to review the draft Joint Commissioning Intentions for Integrated Care and to consider whether these draft Joint Commissioning Intentions have taken proper account of the joint Health and Wellbeing Strategy.

8.14 Legislation also requires that the formal opinion of the Health and Wellbeing Board on the Commissioning Intentions and Operating Plan is included in the published version. Officers recommend that, subject to the views of the Board on the final version of the Joint Commissioning Intentions and Operating Plan, a draft form of words is produced and circulated by email for members to sign off as the Board's formal opinion.

9. Financial Implications

9.1 There are no financial implications arising from this report. Any proposed activity or commitments arising from the Adult Integration Programme or the Joint Commissioning Intentions and Operating Plan will need to be agreed by the delivery organisation concerned and be subject to confirmation of resources. The funding available in future years will of course need to take account of any required savings or any other reduction in overall budgets and national NHS planning guidance, which is expected in late December 2014.

10. Legal implications

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

10.2 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.

10.3 The Health and Social Care Act 2012 places a specific duty on the CCG to include the relevant Health and Wellbeing Board in the preparation of their commissioning plans and when making significant revisions to those plans. The Health and Wellbeing Board must be provided with a draft plan and consulted as to whether it considers the plan takes proper account of the Health and Wellbeing Strategy. The Health and Wellbeing Board's opinion on the final plan must be published within the commissioning plan. Health and Wellbeing Boards can refer plans to NHS England if they do not think the joint Health and Wellbeing Strategy is being taken into proper account.

11. Crime and Disorder Implications

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

12. Equalities Implications

12.1 Although there are no specific equalities implications arising from this report, the draft commissioning intentions address current health and care inequalities as identified in the JSNA.

13. Environmental Implications

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

14. Conclusion

14.1 This report sets out the progress of the Adult Integrated Care Programme, the Better Care Fund submission and the draft joint Commissioning Intentions to date and invites members to note and agree any actions proposed within this report.

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

Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

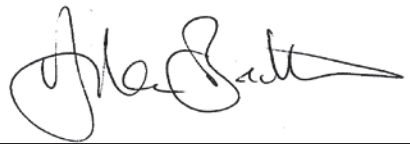
Local Authority	**LB Lewisham**
Clinical Commissioning Groups	**Lewisham Clinical Commissioning Group**
Boundary Differences	**None; local authority and CCG are co-terminous**
Date agreed at Health and Well-Being Board:	**Chair and Vice Chair approval action agreed by Board on 18/09/2014**
Date submitted:	**19/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£1.140m**
2015/16	**£21.114m**
Total agreed value of pooled budget: 2014/15	**£7.159m**
2015/16	**£21.842m**

b) Authorisation and signoff

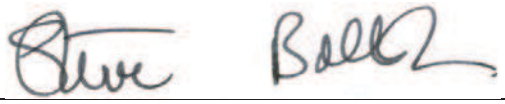
Signed on behalf of the Clinical	**Lewisham CCG**

Commissioning Group	
By	**Martin Wilkinson** 
Position	**Chief Officer NHS Lewisham Clinical Commissioning Group**
Date	**19/09/2014**

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	**Lewisham**
By	**Aileen Buckton** 
Position	**Executive Director for Community Services**
Date	**19/09/2014**

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	**Lewisham Health and Wellbeing Board**
By Chair of Health and Wellbeing Board	**Sir Steve Bullock** 
Date	**19/09/2014**

c) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
Lewisham Health and Wellbeing Strategy	Published in September 2013. Based on the JSNA evidence the board has identified nine priority outcomes for health and wellbeing in Lewisham, which highlights the commitment to integrated working. Health and Wellbeing Strategy
Pioneer Bid	Lewisham's expression of interest in becoming a Pioneer in health and social care integration outlining the history of integrated working in Lewisham and its plans to increase the scale and pace

	of integration.  Pioneer Expression of Interest.pdf
HWB Report – Integrated Adult Care Programme	The report outlined the vision for integrated care, covering all adults in Lewisham. The related PID provided more detail on the programme which seeks a step change in the way services are delivered, in patient experience and in performance and outcomes.
Joint Strategic Needs Assessment	The Joint Strategic Needs Assessment is an online information resource for everyone who commissions, provides or uses health, social or children's services in Lewisham. It also provides the evidence base for Lewisham's Joint Health & Wellbeing Strategy.
SEL Strategy	SEL Strategy
A Local Health Plan for Lewisham - NHS Lewisham CCG's Commissioning Strategy 2013-18	The CCG's Commissioning Strategy 2013-18 sets out the purpose, vision and understanding of the health needs of Lewisham residents and the plans to improve their health and wellbeing.
CCG Commissioning Intentions 2014/15 and 2015/16	NHS Lewisham CCG's Commissioning Intentions 2014/15 and 2015/16 is the framework for commissioning local health services over the next two years.
CCG Operating Plan 2014/15 and 2015/16	 Operating Plan.pdf
CCG Primary Care Development Strategy	 PC Development Strategy.pdf
Health and Wellbeing Performance Dashboard	 HWB Performance Dashboard.pdf
Case Study from Community Connections	Case Study

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our Vision
Better Health, Better Care and Stronger Communities in Lewisham

Lewisham is a diverse inner London borough with a growing population, projected to increase from 286,000 to 318,000 by 2021. Lewisham is the 15th most ethnically diverse local authority in England - 46% of the population are from black and ethnic minority groups. Around 26,000 residents are above 65 years of age and over 3,400 are aged over 85 years. This latter group is often the most complex and therefore bears a very high proportion of care costs.

The Index of Multiple Deprivation 2010 ranks Lewisham 31st of 326 districts in England and 9th out of 33 London boroughs. Small areas of the highest deprivation are found in Evelyn (the most culturally diverse ward in the borough) and Whitefoot and Bellingham (wards with the highest proportion of older people). People living in the most deprived wards have poorer health outcomes and lower life expectancy compared to the England average.

Social housing comprises just over a third of all households in the borough. The private rented sector, the fastest growing housing sector in the borough, comprises some 24% of all households. Lewisham has cheaper housing than other inner London boroughs and has high levels of poor condition, multi-occupancy private rentals and hostel accommodation which provide a home to groups of vulnerable or single people. There are nearly 40,000 one person households in Lewisham.

The Council and CCG have co-terminus borough boundaries with older residents accessing acute and community health care mainly from Lewisham and Greenwich NHS Trust and mental health care from South London and Maudsley Foundation Trust. Health and care work together in four geographical neighbourhoods as shown below.

Also we work in partnership across the South East London health economy as a whole, on the elements of our strategy that cannot be addressed at Borough level alone, or where there is common agreement that there is added value in working collectively.

GP Practices in Lewisham

North Lewisham 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

Central Lewisham Practices

12 Belmont Hill
13 Lewisham Medical Centre
14 Burnt Ash Surgery
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

South East Lewisham 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

South West Lewisham Practices

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

Lewisham's vision

Lewisham's vision is to deliver joined up and co-ordinated health and social care to all adults in the borough and to achieve:

- **Better Health – to make choosing healthy living easier** - providing people with the right advice, support and care, in the right place, at the right time to improve their health and wellbeing.

- **Better Care** - **to provide the most effective personalised care and support where and when it is most needed -** giving all adults control of their own care and supporting them to meet their individual needs.
- **Stronger Communities** – **to build engaged, resilient and self-directing communities** - enabling and assisting local people and neighbourhoods to do more for themselves and one another.

Our vision for integrated health and social care in Lewisham has both evolved and changed. The Council, CCG (Shadow)/PCT and the former Lewisham Healthcare Trust (acute and community service provider) agreed to develop and deliver an integrated health and social care model from November 2011. Our original approach was to focus on those with the most complex needs and, in particular, their access to health and social care services and their experience of admission into and out of the acute sector.

However it became evident that when undertaking the preparatory work for the Integrated Pioneer Bid in June 2013, that we required a more ambitious approach. We therefore decided to widen the scope of the integration programme to include all of Lewisham's resident adult population. This is reflected in our vision which now encompasses better health choices and making better use of resources in local communities which can support residents to self-care or self-manage their condition wherever possible.

The Lewisham adult integrated care programme has 10 workstreams. The 5 schemes outlined in this Better Care fund submission will help to quicken the pace and effectiveness of key elements of the programme.

Our achievements in 2012/13

- Readmission rates have improved - in Q1 2011/12, 15.6% patients were readmitted to hospital within 30 days of discharge. This reduced to 8.4% at Q4 2012/13. There are no or minimal delayed social care transfers of care month by month, whereas previous performance was in the bottom quartile.
- Patient/service users' satisfaction has improved significantly – see page 10.
- The level of unplanned hospitalisation for chronic ambulatory care sensitive conditions has reduced – see page 9.
- 87% of the people who were supported through Enablement Care Services were able to remain in the community at the end of the service provision.
- Although our older people population has risen, there has been a decrease in the numbers entering residential or nursing care. Therefore more people have remained in their own homes.

These achievements have been possible because of piloting work in the integration programme. In 2012/13 there has been a focus on streamlining discharge arrangements, improving our enablement offer and ensuring that our admission avoidance services works in a systematic and effective way. This work will be built on and incorporated into schemes 2, 3, and 4 of this Better Care Fund submission.

Feedback from our public indicated we needed to do more to change the whole system.

Barriers to improving health and care outcomes

Early feedback from local residents:

- Lack of organisational join-up, a lack of continuity between services, not knowing what opportunities are available and not having the time and space to consider which opportunities to access.
- Not knowing who to go to for help, advice or information.
- The complexity of the system
- The low take up of existing opportunities and activities provided within the community that support people's health and wellbeing.

Lewisham's approach to integration

Our approach to deliver successfully the transformation of health and social care is to encompass the whole adult population and widen the partnership to include a whole community approach to good health and well-being, whilst concentrating the clinical and professional core services where they could be used to greatest effect. Our approach is to commission person-centred care that can assist, through early intervention, in ensuring that residents living with long term conditions can have a good quality of life, others can help themselves to make choosing healthy living easier and assisting local people and neighbourhoods to do more for themselves and one another.

Lewisham's vision – key supporting principles:

The key support principles agreed by the Health and Wellbeing Board are:

Person centred:

- where the individual is supported and encouraged to take control of, and be responsible for, their health and wellbeing as far as they are able;
- where the individual is better equipped and uses their own skills to manage their own care and takes control in decision making; and
- where advice, support and care is co-ordinated around the whole person rather than on specific conditions and which gives the individual choice and control.

Use an outcome based approach to commissioning and delivery to ensure that advice, support and care is delivered earlier and more effectively resulting in:

- better quality and patient experience,
- improved health and care outcomes;
- a shift in resources to proactive, preventative care provided in the community;
- increased value for money.

Apply a population based approach using techniques of risk stratification, patient segmentation and evidence based care to ensure our collective, limited resources are most effectively used to meet the local health and care needs and challenges.

b) What difference will this make to patient and service user outcomes?

Our Ambition

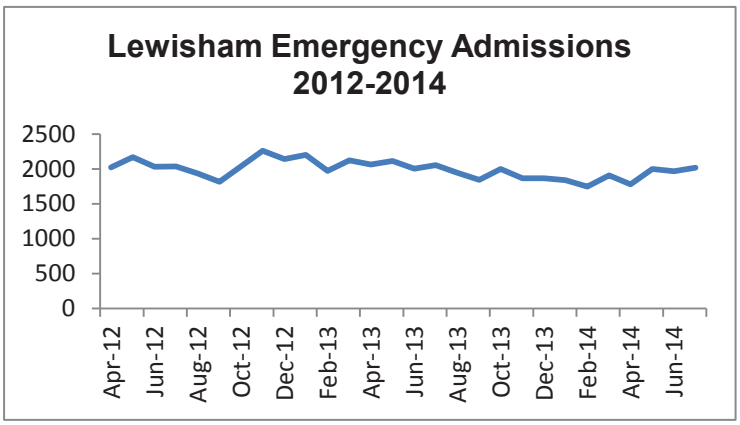
Our ambition is that all service users will feel more in control of their care, understand what services are available to them and know how to access urgent support. Users will receive person-centred support and care provided closer to home, when required, which is provided by joined up teams of staff, working proactively, so reducing the need to attend or be admitted to hospital in an emergency.

How Lewisham's advice, support and care will look in five years' time	
Better Health	• Access to clear and high quality, personalised information • Consistent messages and integrated campaigns which raise awareness and encourage people to take action themselves • Effective advice and support (including advice on benefits entitlement) that promotes healthy living and self-care

Better Care	• Professional support to individuals and carers to enable them to exercise choice and control in relation to their health and wellbeing.
	• A continuum of joined up, flexible community based care to effectively support, maintain and regain independence including:
	  ○ rapid delivery and installation of equipment, technology and housing adaptations
	  ○ Effective support within appropriate settings to enable people to recover quickly and to respond quickly to unexpected deterioration and other health or care emergencies or crises
	  ○ Intermediate tier of services to support people to stay at home :
	• shared approach to care management across health and social care including
	  ○ sharing of information, so that individuals tell their story only once
	  ○ single assessment and co-produced health and social care records and
	  ○ single reviews undertaken by trusted reviewers on behalf of health and social care whenever possible.

Stronger Communities	• Stronger resilient community networks working effectively to support people to live well and stay healthy • Effective links to community and neighbourhood support e.g. social networks to maintain recovery and independence • Activities and opportunities available locally to promote and support health and well being

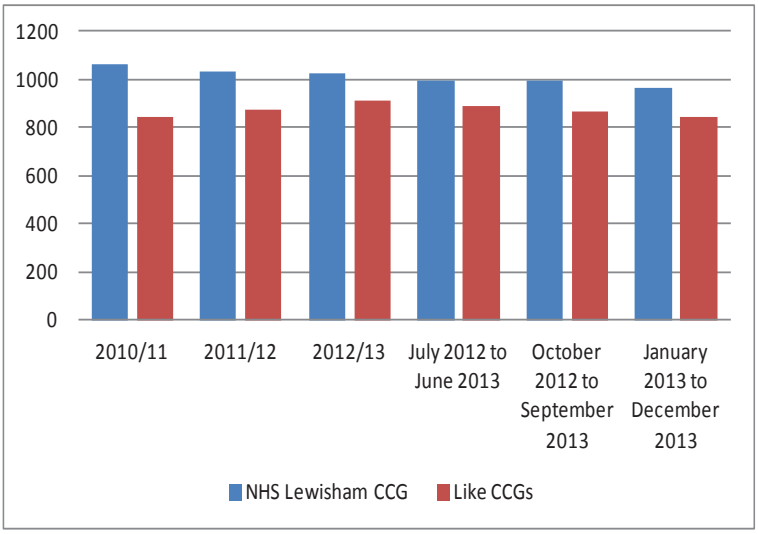
Our five year ambition is to change the way people can obtain advice care and support by providing more community based services, so reducing hospital emergency admissions. The graph below shows the trend for emergency admissions in Lewisham demonstrating some success in reducing admissions against an underlying local population growth of circa 2%. The partnership recognise further opportunities to address unnecessary admissions.



Our focus will therefore be on:

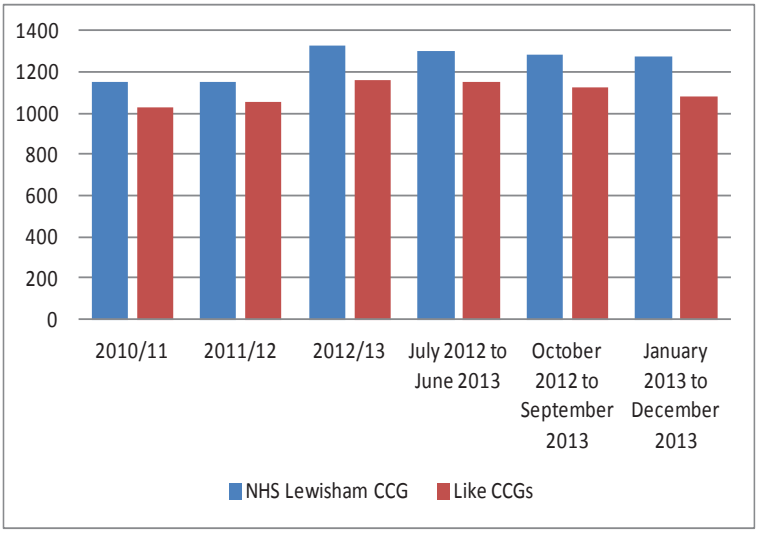
- Reducing unplanned hospitalisation for chronic ambulatory care sensitive conditions
- Reducing emergency admissions that should not usually be admitted to hospital
- Reducing emergency admissions for those over 65 years

Emergency Admissions – Unplanned hospitalisation for chronic ambulatory care sensitive conditions

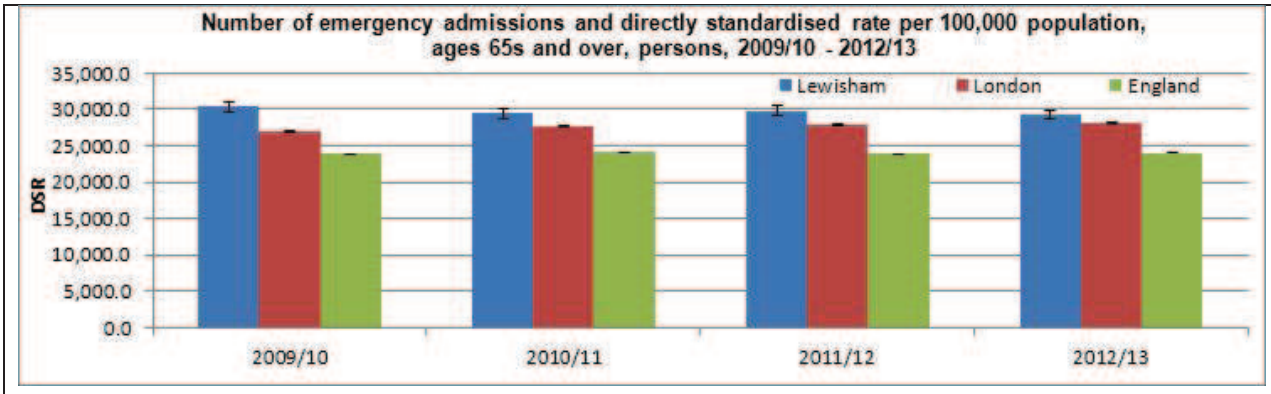


This indicator is concerned with reducing the amount of time people spend avoidably in hospital, through better and more integrated care in the community outside of hospital for nineteen 'ambulatory care sensitive condition.'[1] Currently the trend has been falling over time. But so have CCGs like Lewisham and there is still a 13% gap to achieve the average.

Emergency Admissions – Those that should not usually be admitted to hospital



This indicator is concerned with emergency admissions for conditions that should not usually be admitted to hospital. It is a directly standardised rate per 100,000 people registered. The trend has been falling over time since 2012/13. But so have CCGs like Lewisham and there is still a 15% gap to achieve the average.

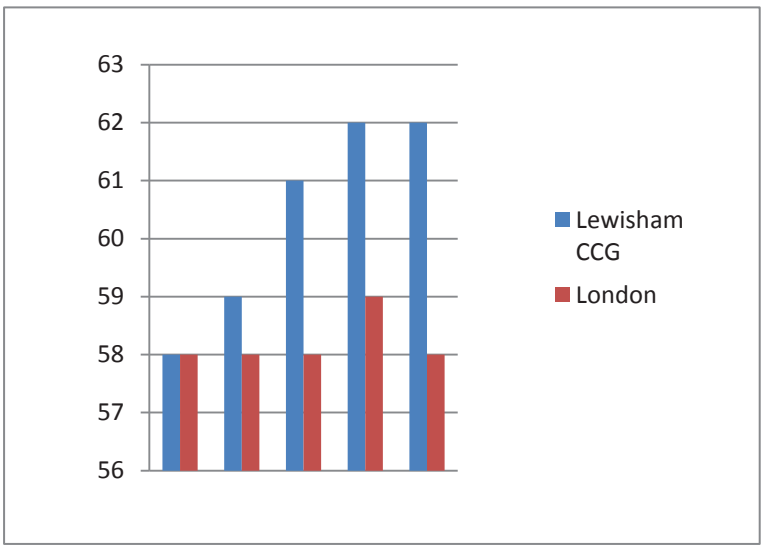


Lewisham has higher rates of emergency admissions rates for people over 65years in comparison to both London and England. In 2012/13 almost 8000 Lewisham people aged 65 years and over had an unplanned admission to hospital. The most common diagnosis for admission for the over 65 years was pneumonia, Urinary tract infections (UTI) and COPD.

Our five year ambition also is:

- To improve user experiences. Our intention is to increase the proportion of people who feel supported to manage their condition and achieve top quartile performance in this area.
- To increase the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (target 90%)
- To maintain low levels of delayed transfers of care from hospitals.

People Feel Supported with their Long-Term Conditions (GP Survey July 2014)



We will be measuring this through both the social care quality of life (ASCOF 1A) indicator and also the GP survey indicator measuring the percentage of people who report enough professional support to manage their long term condition (NHSOF 2.1).

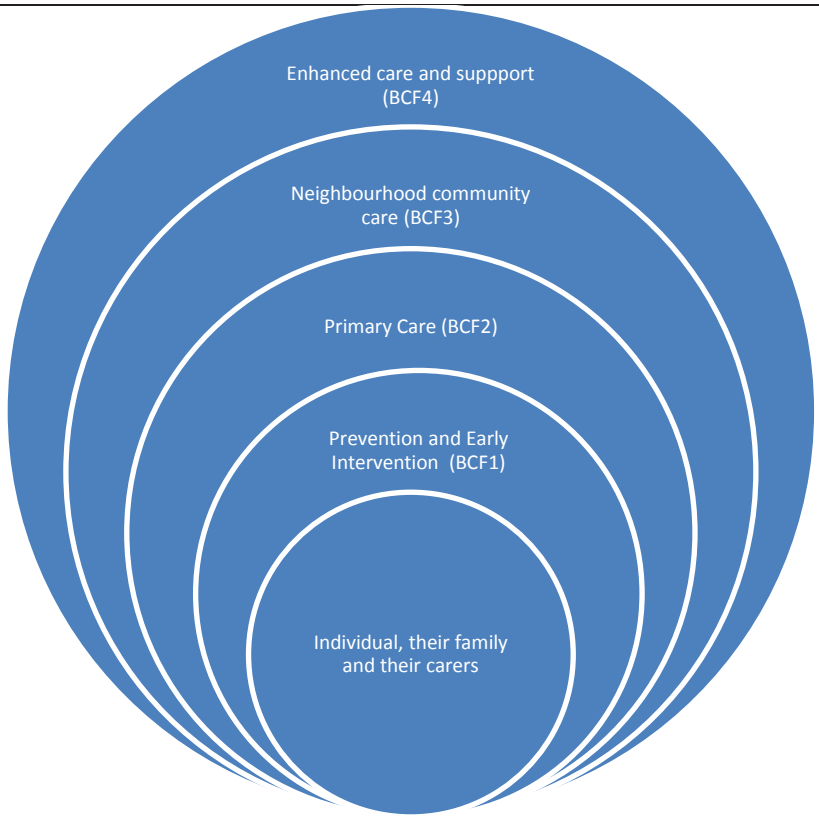
Our work is focused also on achieving improvements across a wider range of health and wellbeing indicators, as set out in the Health and Wellbeing Board's Performance Dashboard (see Section 1c - related documentation). This dashboard includes the above outcomes indicators specifically to measure the success of the Better Care Fund Plan.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

The Adult Integrated Care Programme "Better Health, Better Care and Stronger Communities" is focused on the redesign and reshaping of services to transform the way in which residents are encouraged and enabled to maintain and improve their own health and wellbeing, transforming the way in which local health and care services are delivered within the borough, and transforming the way in which people access and are connected to the assets that are available within their own communities and neighbourhoods.

The five schemes planned to accelerate the achievement of our overarching vision and the reduction in emergency admissions, supported with investment from the Better Care Fund are:

- **Prevention and Early Intervention (BCF 1)** – (1) develop a borough wide information and advice gateway, including specialist advice for carers. (2) Mainstream our Community Connections programme that supports development of community resources to support vulnerable adults. (3) It is also planned to develop further preventative services through a programme of targeting unnecessary hospital admissions for Falls, Dementia, UTI's and COPD.
- **Primary Care (BCF 2)** – to provide a strong primary care, focused on population based commissioning to deliver improved outcomes, working in partnership with patients and in collaboration with practices in neighbourhood community teams.
- **Neighbourhood Community Care (BCF 3**)- to support and care for people with long term physical and/or mental health conditions and vulnerable people, with their carers, families and communities to effectively manage their own care and maintain their independence.
- **Enhanced Care and Support (BCF 4)** – to refocus and redesign the current community based resource on supporting people to continue to live at home by preventing people requiring a hospital admission and delivery of enhanced co-ordinated services.
- **Supporting Enablers (BCF 5)** - to ensure that the necessary tools and infra-structure are in place to achieve the cultural changes and working practices required for effective integration.



BCF Scheme 1 - Prevention and Early Intervention

The Better Care Fund will be used to support service changes in the community to:

- provide a rationalised borough wide information and advice gateway, including specialist advice and signposting for carers. This information will support self-care and self- support and be the access point for care accounts.
- establish a single point of access to improve the coordination and provision of information and advice, with a single phone number for social care and health, it will provide more detailed information and advice, as well as triage referrals.
- support community networks by extension of Lewisham's Community Connections project. This connects people to local support and activities, reduces isolation, and improves wellbeing for patients/service users and carers.
- target preventative services and support to those cohorts of adults who are at high risk of hospital admissions from falls, dementia, UTI's and COPD. This will include low level equipment and telecare, minor housing improvements and handyperson schemes to support people to be able to stay in their own homes.

BCF Scheme 2 – Primary Care

The Better Care Fund will be used to support service changes in primary care to:

- increase the level of proactive, preventative care – 'every contact counts'; health checks, promoting immunisation and vaccination, to promote better health
- increase earlier identification, diagnosis and intervention for people over 75, diabetes, CVD, COPD, dementia and cancer, to improve health outcomes
- provide greater support to patient education and self-management of long term

conditions to increase individual choice and control

- ensure that patients have collaborative care plans working with neighbourhood community teams
- identify people who will benefit from continuity of care and ensure that they have a named professional accountable for their care

BCF Scheme 3 – Neighbourhood Community Care

The Better Care Fund will be used to support service changes in neighbourhood community care to:

- embed and enhance the effectiveness of the neighbourhood community teams which are aligned to GP clusters with the integration of mental health workers to co-ordinate both physical and mental health care. These multi-disciplinary teams have already brought together district nurses, all therapies, social workers and care workers. The functions of the neighbourhood teams are to provide
    - Preventative care through the early identification of risks and deterioration,
    - Admission avoidance using local multidisciplinary teams (MDTs) centred around person centred care and collaborative care plans
    - Support following hospital discharge to remain well and supported in the community
    - Short-term enablement support to enhance independent living skills
- take a shared approach to care management across health and social care including
    - sharing of information, so that individuals tell their story only once
    - single assessment and co-produced health and social care records and
    - single reviews undertaken by trusted reviewers on behalf of health and social care whenever possible

BCF Scheme 4 - Enhanced Care and Support

The Better Care Fund will be used to support service changes in neighbourhood community care to:

- provide additional community based support by responding rapidly to changes in circumstances and providing alternative services to acute hospital care, so maximising the opportunity for people to remain in their own home or within a community setting
- refocus and reshape existing community based care services that contribute to admission avoidance across Lewisham's health and care sector to improve their responsiveness, application and outcomes. This will include redesigning access to and pathways through such services. New approaches will be piloted over the winter period and where successful new contracts for services will be put in place from 15/16.
- review, develop and enhance support available to and within care homes to ensure that unplanned admissions from such settings can be reduced
- improve the structures around discharge planning and its associated services to reduce unnecessary delay and readmission. This covers assessments of need, home preparation services and night sitting services.
- streamline the process and application for the Disabled Facilities Grant to ensure

that it is used to best effect to maximise the benefits for residents working with housing services

BCF Scheme 5 – Supporting Enablers

The Better Care Fund will be used to support service changes in neighbourhood community care to**:**

- support delivery of the Virtual Patient Record, to provide health and care professionals with more complete information about a person's needs and to support and facilitate, amongst other things, joint assessments, joint care planning and swifter interventions
- develop the Adult Social Care System so that it aligns with the Virtual Patient Record and fulfils the Care Act requirements
- support the overall management of Lewisham's integration programme to ensure implementation is paced and mainstreamed and evaluations are undertaken and learning shared

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

In establishing the case for change in Lewisham, we have considered:

- **public health analysis of priorities emerging from our JSNA**
- **the views of our public and service users**
- **the current utilisation of health and social care services**
- **evidence on the most effective models of care and interventions**

Public Health analysis of trends and challenges

Lewisham's population of 282,000 (Mid-2012 population estimate) is projected to grow across all age groups over the next five years. In this period the largest will be in the 20-64 year old age group. The ethnic profile of those aged 20-64 will be increasingly diverse with a greater proportion of people from Black and Minority Ethnic groups. However, over the next fifteen years the greatest percentage increase will be in the 65+ age group. The ethnic profile of the older population which had been previously predominantly white will also change.

The main health risks for adults living in Lewisham are:

- the increasing numbers of people diagnosed with long term conditions and their management, in particular, Diabetes, COPD, CVD and hypertension. It is estimated that there are approximately 15,000 people in Lewisham with undiagnosed diabetes, CVD and COPD. Furthermore people from Black and Minority populations are diagnosed with some of these diseases such as diabetes

and CVD approximately ten years earlier than the white populations.

- The level of mental health needs for both common and severe mental illness is higher for adults in Lewisham than comparative boroughs.
- Lewisham is only identifying 52.9% of people with dementia; the low diagnosis of diagnosis is a national challenge; the national rate is only 53.3% (August 2014)

The main health risks for older people living in Lewisham are:

- the likelihood to have a long term condition increases with age, with over 50% of those aged 75+ have two or more long term conditions.
- dementia as it increases markedly with age. In 2012/13 it was estimated that possibly under half of all people with dementia are undiagnosed in Lewisham.
- accidental falls - the rate of emergency hospital admissions for accidental falls is significantly higher in Lewisham than the England average, at 3,367 per 100,000 in 2012/13

Further information is available from Lewisham's Joint Strategic Needs Assessment

Given this health profile, integrated care "an approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring services are well coordinated around their needs"[1] - has been deemed essential to meet the needs of our ageing population, transform the way care is provided for people with long-term conditions and enable people with complex needs to live healthy, fulfilling and independent lives. It has also indicated that we need to do more to enable people to self-care and self-manage.

The public's views of our service

Lewisham Healthwatch recently provided an overview of the key messages from Lewisham residents during 2013-14. Also we have had specific events to engage the public, a local Quality in Health and Social Care: A People's Summit was held in July 2014. These activities reinforce the findings from previous engagement activity and highlighted in particular the need for transparency and access to performance monitoring data, the need for personal, caring and responsive health and care services and the need for adequate time and information to support patient and user understanding of their role in decision making.

[1] Report to the Department of Health and NHS Future Forum from The King's Fund and Nuffield Trust

How to improve health and care outcomes

Recent feedback from local residents:

- **More information** – the public in Lewisham want greater information on:
  - how to access services and activities - specific references to knowing how to access services out of hours and weekends; more information knowing how a services are performing against standards
  - how to do more self-care and manage their own care; there is a strong willingness to self-manage and support for 'every contact counts'; people want more information about their medication and discharge information
  - how to get involved in communities activities.
- **Caring staff** – local users want competent staff who are courteous and compassionate and treat the person as an individual; who listen and keep the user carers(unpaid) and family members informed throughout the planning, care and treatment
- **Better Coordination of services** –Lewisham public strongly supported joined up health and social care (including involving and supporting the voluntary sector), specifically improving the coordination between district nurses, care workers and other agencies

Work on developing a SEL case for change to support the SEL commissioning strategy is in progress.

The current utilisation of health and social care services

Health and social services are under increasing strain to meet growing demands for health and social care and to contain escalating costs. There is clear evidence of this pressure locally:

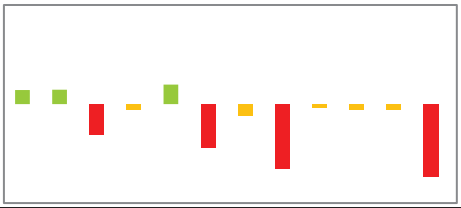
The variability in the quality of care across all services

- The high number of A&E attendances and pressure on urgent and emergency care services
- Increasing pressure on adult social care for community care packages when the adult social care is required to make a substantial contribution to the Council budget savings programme - a provisional savings target of £25m over this period (against a net budget of £80m).
- Increased longer waiting times for inpatient care

18 weeks Referral to Treatment Times have not met the NHS standard for seven months for Lewisham people – Graph opposite shows trend between April 2013 and July 2014

- Difficulties in accessing primary care services
- Increased waiting times for cancer care

Waiting times for cancer treatment within 62 days are becoming challenging - Graph opposite shows trend between July 2013 – June 2014



These challenges are likely to present the biggest challenges to affordability and sustainability over the next five years.

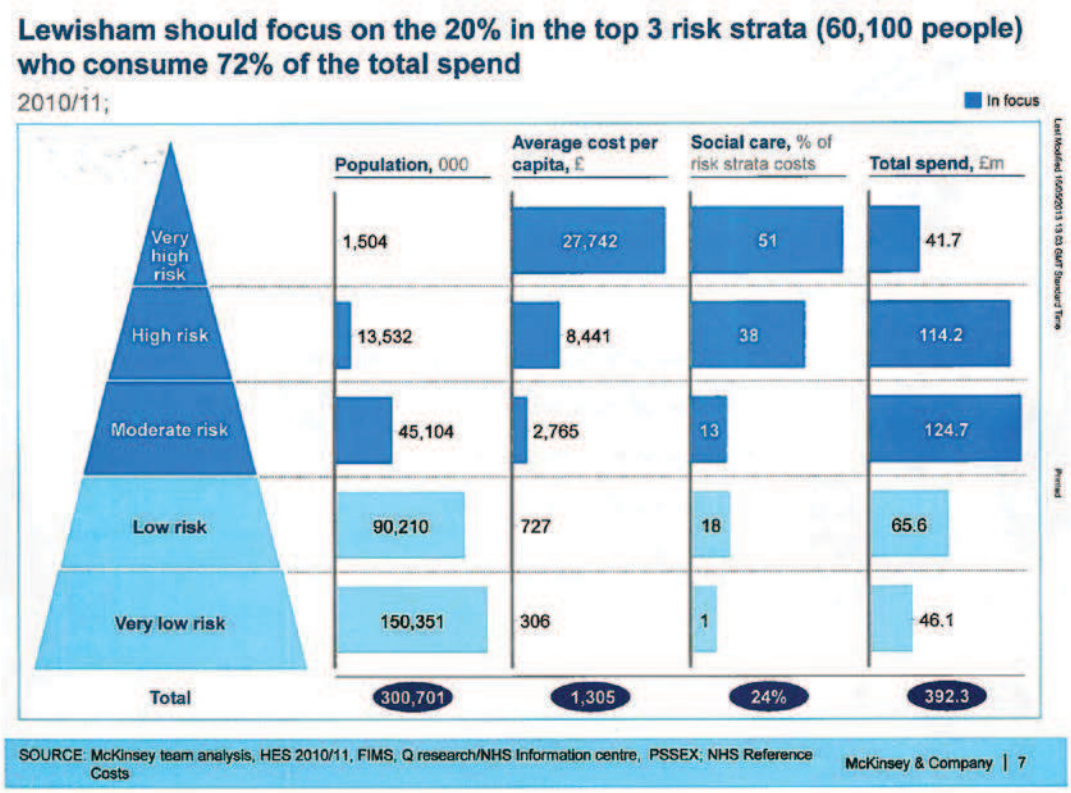
Overview of how the BCF will address Lewisham's key challenges

		Better Care Fund Schemes				
		Prevention and Early Intervention (BCF 1)	Primary Care (BCF2)	Neighbourhood Community Care (BCF 3)	Enhanced Care and Support (BCF 4)	Supporting Enablers (BCF 5)
Local Challenges – Need for Change	Reduction in emergency admissions	√	√√	√√	√√	√
	Improved patient experience for people with long term conditions	√√	√√	√√	√	√
	Increased proportion of older people who still at home after discharge from hospitals into reablement or rehabilitation	√	√	√√	√√	√
	Increased number of people with diagnosed long term conditions – including dementia	√√	√√	√	√	√

√√ Direct Impact
√ Indirect Impact

Our Better Care Fund Plan has also been informed by the conclusions of examination of use of resources using the high level risk stratification of the Lewisham registered population. It should be noted that this analysis used 2010/11 activity data and the former PCT costings, so include NHS England's commissioning costs for primary care and specialised services. With these caveats, the key conclusions are that

- Lewisham's population, who are categorised as very high risk and high risk categories with the highest demand, equate to about 5% of the population and accounts for 40% of the total health and care costs
- Lewisham's population, who are categorised as very high risk, high risk and moderate risk categories with high demands, equate to about 20% of the population and accounts for 70% of the total health and care costs



The above findings of our local risk stratification work very much mirrors the conclusions of the North West London Integrated Care pilot work (2012).[2]

A recent bed utilisation audit undertaken at the Lewisham Hospital has further supported our understanding of emergency admissions highlighting those patients that could have been managed through alternative arrangements rather than occupy an acute bed at the time of the survey.

Our intention is to transform the local health economy to support people to manage their own conditions at home, to keep well and remain out of hospital. Our intention is to re-balance the heath and care resource so that the highest demands and costs associated with small numbers of the population are reduced, to enable us to invest more resources in preventative advice, support and care for the whole community.

More detailed work is underway by GP Practices compiling a risk register of the top 2% of patients on their lists who are most vulnerable to a hospital admission. This register is also being compared to the top 2% indicated by the risk scores assigned by QAdmissions, which is a legally compliant risk stratification tool. Early findings indicate that there are some very high risk scores for patients who are not necessarily on the GPs' horizon as potentially high risk emergency care users. Also work is underway with community health services and adult social care to identify those at-risk patients on the practice-based 2% register against those known to other care providers.

Evidence on the most effective models of care and interventions

To inform both the development of our local strategies and plans and to contribute to the

[2] http://www.nuffieldtrust.org.uk/our-work/projects/north-west-london-integrated-care-pilot-evaluation

SEL strategy, a range of evidence and analysis has been collected and examined. This has included a review of available evidence on how to improve the care of people with long-term conditions[3] and Ambulatory Care Sensitive Conditions (ACSCs)[4]; the key messages and evidence review that was completed on *Frail older people in Lewisham* in August 2013[5]; and the evidence in two recent publications (2014)[6] [7] on what is required to improve the care of older people. In addition we have reviewed the evidence from *Evaluating Integrated and community based care*: *How do we know what works* published by the Nuffield Trust[8] 2013, the summary of findings from the Local Government Association Evidence Review 2013[9] and information and evidence from two tools available to support the work on Integrated Care.[10][11]

Our plan also reflects the case that has been made for the integration with adult social care. Lewisham's AICP takes account of the findings presented in the report on adult social care efficiency presented by the LGA which concludes that:

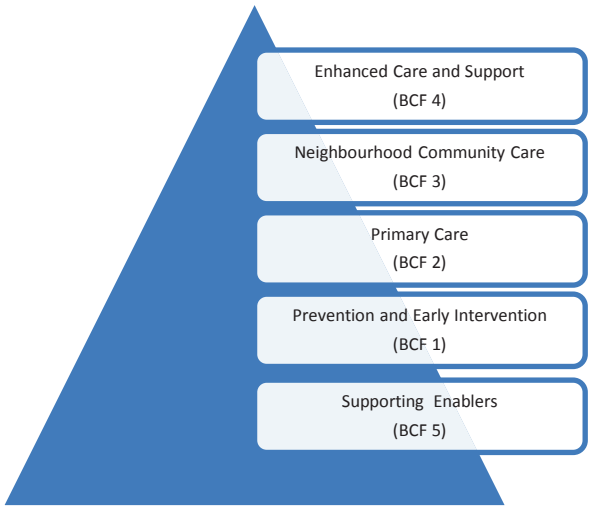
- Many people although not well enough to manage their own care when ill are likely, with the right help and treatment, to make a partial or full recovery.
- Giving a person care when they do not require it is costly and can accelerate their need for more care. When a person stops doing things to look after themselves, they are likely to deteriorate more rapidly.
- Enabling a person to get help when they need it but stopping that help when they have recovered is the most effective way of helping the person get the best outcomes.
- Old age, in particular, has 'ups and downs' in relation to ill health. It is important to gear services flexibly around both the better times and those times when a person may not be able to cope.[12]

[3] Long Term Conditions Compendium of Information Third Edition (2012) DH
[4] Emergency hospital Admission for ACSCs: identifying the potential for reduction (2012) The King's Fund
[5] Frail Older People In Lewisham. (2013) Ellen Pringle
[6] Better care for Older People-Working differently to improve care. (2014) Deloitte Centre for Health Solutions
[7] Making our health and social care systems fit for an aging population. (2014) The King's Fund
[8] Evaluating Integrated and community based care : How do we know what works? (2013) Nuffield Trust
[9] Integrating Care Evidence review (2013) Local Government Association
[10] Whole System Integrated Care and Support Toolkit: Local Government Association
[11] NHS England – Any town
[12] Adult Social Care Efficiency Programme – Interim Findings, Local Government Association, 2013

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Overview on how schemes fit together



The summary of the BCF programme below illustrates the high level key milestones by scheme for the delivery of the BCF. The project plan for each scheme can be found in annex 1.

Prevention and Early Intervention (BCF 1)	
Milestones	**Delivery Date**
Develop borough wide information and advice gateway, including specialist advice for carers: • Implement new web site including knowledge/information warehouse	Q4 2014/15
• Campaign to promote website and delivering training for front line professionals	Q4 2014/15
• The resources for the Carers Gateway and carers advice are part of the integration programme and are aligned to the BCF funding. These funds have already been pooled between health and social care and form part of the joint commissioning mainstream programme	Q4 2014/15
• Extend Community Connections preventative work within neighbourhoods	Q4 2014/15
Develop preventative programmes targeting unnecessary admissions for falls, UTI's and COPD: • Implement new falls pathway including referral guidelines	Q2 2015/16
• Implementing new falls assessment process and prescription tools.	Q2 2015/16

Primary Care (BCF 2)	
Milestones	**Delivery Date**
Launch of Lewisham Neighbourhood Primary Care Improvement Scheme (LNPCIS) to support collaborative practice working – specific focus on management of long term condition patients and self-management	Q2 2014/15
Interim review of LNPCIS outcomes to inform 15/16 approach	Q3 2014/15
4 primary care neighbourhood based networks formally established	Q4 2014//15
Extension of LNPCIS for further 12 months with continued focus on the management of long term condition patients and self-management	Q1 2015/16
Neighbourhood based networks across health and social care (incorporating	Q4 2015/16

primary care) integrated through the Adult Integrated Care Programme	

Neighbourhood Community Care (BCF 3)	
Milestones	**Delivery Date**
Extend access to primary care and community services and increased capacity for admissions avoidance	Q2 2014/15
Review model of carers assessments and support, including respite, in preparation for the implementation of the Care Act	Q3 2014/15
Improve discharge planning	Q3 2014/15
Continuation of Neighbourhood Facilitators and development of generic workers	Q4 2014/15
Integrate community mental health into neighbourhood model	Q1 2015/16
Further develop joint packages and joint care planning	Q1 2015/16

Enhanced Care and support (BCF 4)	
Milestones	**Delivery Date**
Develop a range of intermediate care tier services as alternative admission avoidance services	
• New approaches piloted and evaluated	Q4 2014/15
• Business case developed including a detailed analysis of bed needs and the additional support required at home and the benefits realised for additional investment	Q4 2014/15
• New contracts in place	Q2 2015/16
Redesign reablement and widen range of providers	
• Review completed	Q3 2014/15
• Redesign of enablement completed	Q4 2014/15
• Recommissioning of outcome based domiciliary care and non-nursing health related tasks completed	Q2 2015/16
• Develop community based provision for dementia patients to prevent unnecessary admissions	Q1 2015/16

Supporting Enablers (BCF 5)	
Milestones	**Delivery Date**
Social Care database development to include NHS number as main identifier. Renewal of Support and Maintenance Contract for social care database	Q4 2014/15
VPR Phase 1 complete. GP practices and Lewisham and Greenwich Healthcare Trust sharing wide range of care records. This will support better community care, improve admission avoidance and discharge planning	Q4 2014/15
VPR Phase 2 completed. Lewisham Social Care services sharing data with health partners. This will improve community care, GP and Social Care neighbourhood team working	Q2 2015/16
Self Assessment development on new referral tool embedded into Social Care IT System, with plan for development into development of the Care Account.	Q2 2015/16
AIC Programme completed	April 2018

b) Please articulate the overarching governance arrangements for integrated care locally

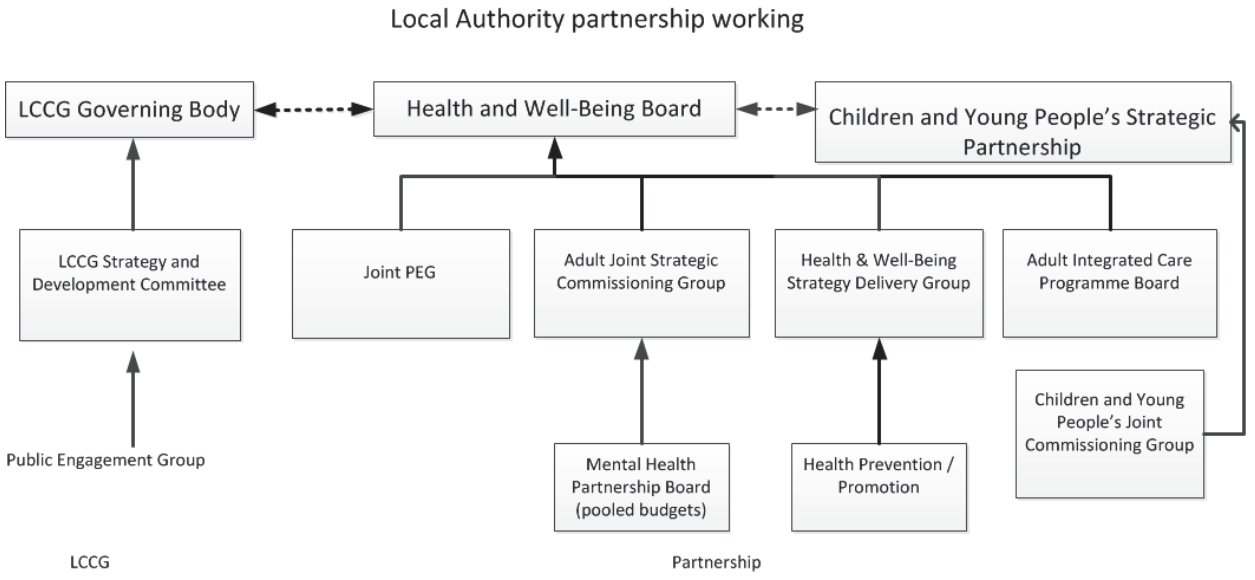
The following Boards ensure effective governance of Lewisham's Adult Integrated Care programme:

- Lewisham's Health and Well Being Board
- Adult Integrated Care Programme Board (AICPB)
- Individual Project Boards for each workstream/scheme

The Health and Wellbeing Board monitors the progress of the programme. To ensure that the progress of each individual workstream/scheme is more regularly assessed, the Health and Wellbeing Board is supported by the Adult Integrated Care Programme Board (AICPB).

The AICPB is accountable to the Health and Wellbeing Board for the delivery and evaluation of the Adult Integrated Care Programme. It has specific responsibility for overseeing the implementation, monitoring and evaluation of the programme and the activity within the Better Care Fund plan. It has representatives from the CCG, the Council and the NHS Trusts.

The AICPB sits alongside and works closely with Lewisham's Health and Wellbeing Delivery Group which ensures progress against the Health and Wellbeing Strategy Delivery Group, the Adult Joint Strategic Commissioning Group and the Joint Public Engagement Group.



c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Adult Integrated Care Programme Board (AICPB)

The Adult Integrated Care Programme Board (AICPB) has responsibility of overseeing the development and monitoring of the delivery of BCF plan and provides regular updates to the Health and Wellbeing Board. This is chaired jointly by the Chief Officer of Lewisham CCG and the Executive Director of Community Services, London Borough of

Lewisham (LBL). Board membership also includes the key stakeholders involved in taking forward the integration agenda including the Head of Housing of LBL and representatives from Lewisham and Greenwich NHS Trust and South London and Maudsley Foundation Trust.

The Adult Integrated Care Programme Board meets monthly and reviews the programme's action log, the risk register and the workstream activity to ensure appropriate progress is being made. Where delays or problems emerge, these are brought to the attention of the Board who decide on the most appropriate remedial action.

All decisions are recorded and circulated to key stakeholders, with regular progress reports to the Health and Wellbeing Board, including receiving the Health and Wellbeing Board's Performance Dashboard (see Section 1c - related documentation). This dashboard includes the indicators within the Better Care Fund Plan.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
BCF 1	Prevention and Early Intervention
BCF 2	Primary Care
BCF 3	Neighbourhood Community Care
BCF 4	Enhanced Care and Support
BCF 5	Supporting Enablers

5) RISKS AND CONTINGENCY

a) Risk log

It is recognised that the successful transformation of adult health and care involves high risks, however the potential benefits achievable are estimated to be significant for Lewisham's population. Thus the effective management of risk is viewed by all partners as of paramount importance.

The Better Care Fund Programme Risk Register was developed initially during the planning phase with stakeholders in February 2014. Since then the Risk Register has been refined to ensure that it captures all the risks that threaten the successful delivery of the Adult Integrated care Programme and that appropriate risk responses (mitigating action) have been identified to manage the identified risks.

It is a 'live' register and updated as necessary, but at a minimum it is reviewed by the AICPB on a monthly basis.

AICP Risk Register

Description of risk	Risk consequence	Current Risk Rating	Risk trigger	Risk response (mitigating action)	
				What have we done?	What will we do?
R1: Transformation: The service transformation required to achieve integration is not clearly defined.	Activity undertaken does not contribute effectively to achieving integration and changes happen in an uncoordinated and piecemeal fashion.	15 (5x3) RED	Monitoring of activity against overall programme plan. Scrutiny of monthly programme highlight report.	Specific workstream focused on managing the programme – worksteam 10. Workshop held for the Board to produce a detailed vision for the neighbourhood model. Outline programme plan produced.	Produce a detailed programme plan with key deliverables and timescales, showing the 'critical path' and interdependencies. Monitoring of workstream project plans to check alignment with programme plan. Workshop to be held for the Board to produce a detailed vision for intermediate care/ extra care / enablement. Communication and engagement plan to include sufficient and appropriate activities to ensure that workstream participants and service staff understand the programme and the new delivery models.
R2: Savings: (a) The Council and the LCCG do not make required savings (i) in terms of the required amount; and (ii) by the required time. Making savings in one area transfers pressures to other parts of the system. (b) The reinvestment required to pilot and	(a) If required savings are not achieved, and do not contribute to the required savings, the programme could be destabilised and be deemed ineffective. The Individual services covered by the programme may need to make savings in an unplanned and inefficient way. Making savings in one	20 (5x4) 15 (5x3) RED	Monitoring of overall programme plan against assumed and identified efficiencies. Scrutiny of monthly programme highlight report.	Robust ongoing scrutiny through existing governance arrangements - the AICPB, reporting to the Health and Wellbeing Board (and the Lewisham Future Board for Council savings). Established tight programme and project management arrangements.	Produce an overall programme plan with key deliverables and timescales, showing the 'critical path' and interdependencies. Undertake detailed financial mapping to align activity and spend and to assess the impact of proposed changes and new delivery models. Business Cases will be produced and approved for key schemes, identifying planned costs and benefits. Proposals within the Business Cases will be piloted to validate further the Business Case assumptions.

Description of risk	Risk consequence	Current Risk Rating	Risk trigger	Risk response (mitigating action)	
				What have we done?	What will we do?
implement new delivery models is not secured.	area might affect the achievement of savings in other areas if pressures are transferred to areas that are under resourced and trying the save money. (b) Lack of reinvestment may mean that the planned pace and scale of the programme is not realised and new models of delivery cannot be tested and evaluated.				Full evaluation of implications of the Care Act on programme resources.
R3: Reshaping / Redesigning services: The shift from acute to community services does not happen or happens, but in a way that does not allow for disinvestment from acute and mental health hospital based services.	Hospital based activity and capacity is not reduced and expected reductions in service requirements and spend across the wider system are not realised.	15 (5x3) RED	Schemes will be monitored against the benefit realisation plan to identify variances against plan.	Identified potential models and schemes which will be further evaluated and piloted.	Allocate resources based on where there is evidence that shift from acute to community services will be achieved and there will be a significant positive impact on improving outcomes and quality, based on approved Business Cases. Contractual levers will be used to incentivise reducing hospital demand and capacity. If target reductions in hospital activity are not met, contingency plans will be developed setting how the excess acute demand will be funded including risk share arrangements.
R4: Governance: Effective governance and leadership across all	Focus is on short term transactional benefits rather than long term transformation of the	10 (5x2) AMBER	Monitoring of overall programme plan against	Established a Board which fosters strong collaborative working to ensure commitment from all organisations and involves primary, community and secondary health and mental	Workshop for the Board to produce detailed vision for the neighbourhood model and for intermediate care/ extra care / enablement.

Description of risk	Risk consequence	Current Risk Rating	Risk trigger	Risk response (mitigating action)	
				What have we done?	What will we do?
organisations is not in place to give the programme sufficient momentum and to generate sustained and high levels of commitment.	whole system over five years and beyond. Improvements are not strategic, do not achieve longer term benefits and do not achieve the required system redesign.		key milestones, agreed outcomes and financial plans.	health providers; social care; and housing. Workshop held for the Board to produce a detailed vision for the neighbourhood model.	The Board will regularly scrutinise plans to ensure the focus remains on both quick wins and longer term strategic change.
R5: IT: An effective system for sharing information, data and resources is not developed.	Information, data and resources is not shared effectively and services are not significantly improved.	12 (4x3) AMBER	Monitoring of workstream plans against key milestones, agreed outcomes and financial plans. Specific focus on Workstreams 2,3,4,5 & 6	Specific workstream on IT systems and process – Workstream 6. Commitment to Virtual Patient Record secured across organisations in Lewisham. The Virtual Patient Record system has been procured and will be delivered by Orion Healthcare. Information Governance working group established and meeting regularly. Current information sharing arrangements, including the secure transfer of information via *egress*, between practitioners are continuing.	Agree and sign information sharing protocols for the transfer of information via the Virtual Patient Record. Roll out the Virtual Patient Record to practitioners (and ultimately, the public).
R6: Risks/ monitoring / evaluation: Risks are not properly identified, evaluation is not able to clearly attribute outcomes to the programme, peer learning is not sufficiently exploited.	Poor identification of risks will damage programme integrity and may negatively affect organisational reputation. Difficulty in being able to directly attribute positive outcomes to	9 (3x3) AMBER	Monitoring of overall Programme plans against key milestones, agreed outcomes and financial plans.	Clear process for identifying and managing risks has been developed. Board considers 'RED' programme risks quarterly. The overarching outcomes framework, supporting the BCF, is monitored on a quarterly basis by the Board.	New models will be developed on best available evidence. Key areas will be piloted to allow for the further gathering of evidence to inform investment decisions.

Description of risk	Risk consequence	Current Risk Rating	Risk trigger	Risk response (mitigating action)	
				What have we done?	What will we do?
	the programme (due to the interrelated nature of the programme which interfaces with wider health and social care changes such as those arising from Dilnott) may mean that the success of the programme is not visible to the Public and key stakeholders. It will not be possible to target resources appropriately due to the lack of evidence suggesting where investment should be made and services redesigned.			'Deep dives' on specific workstreams by the Board, to understand the learning and to share good practice, to complement the tight programme and project management arrangements covering individual workstreams. Regular Leads and Coordinators meetings bring together best practice and collaborative working across PH, LCCG and LBL to enhance competencies, skills and capacity.	
R7: Cultural change: The workforce does not move to a new way of working with shared values and behaviours.	The integration of services is not achieved.	15 (5x3) RED	Monitoring of workstream plans against key milestones, agreed outcomes and financial plans. Specific focus on Workstreams	Specific workstream focused on inspiring the workforce to develop a new common culture that will support new delivery models – worksteam 5. Successful bid to HESL to support cultural change (cognitive connections commissioned). Second bid to HESL to implement cognitive connections work also successful.	Using a 'bottom up' approach in involving staff to determine and design the changes required, as supported by the evidence on cultural change. Engagement plan to be developed with specific staff engagement events.

Description of risk	Risk consequence	Current Risk Rating	Risk trigger	Risk response (mitigating action)	
				What have we done?	What will we do?
			2,3,4,5 & 6.		
R8: Capacity: There is (a) insufficient capacity to manage and deliver the programme and (b) the workforce does not have the capacity to support the new model.	(a) The Programme does not achieve its outcomes within the agreed timeframe. (b) The workforce is not able to make effective contributions to improving the delivery and the integration of services.	15 (5x3) RED	Monitoring of workstream plans against key milestones, agreed outcomes and financial plans. Specific focus on Workstreams 2,3,4,5 & 6.	Specific workstream focused on managing the programme – worksteam 10. Four project managers being appointed (two at the CCG and 2 at the Council) to support the programme.	Planned phased approach to changing the workforce starting with the current neighbourhood teams.
R9: Capability: The current workforce does not have (and does not develop) the knowledge and skills required to support the new model.	The workforce is not able to make effective contributions to improving the delivery and the integration of services.	15 (5x3) RED	Monitoring of workstream plans against key milestones, agreed outcomes and financial plans. Specific focus on Workstreams 2,3,4,5 & 6.	Specific workstream focused on inspiring the workforce to develop – worksteam 5. Successful bid to HESL to support this work.	Planned phased approach to changing the workforce starting with the current neighbourhood teams. Using a 'bottom up' approach in involving staff to determine and design the changes required, as supported by the evidence on cultural change.
R10: Non-Statutory support: The programme does not utilise effectively	Statutory and public services remain the key providers of information, advice	15 (5x3) RED	Monitoring of overall Programme plan -	Investment in Community Connections made to support vulnerable adults and older people at a community level to prevent/reduce reliance on statutory services.	Development of a new model for information and advice to support self-care. Engagement plan to be developed with

Description of risk	Risk consequence	Current Risk Rating	Risk trigger	Risk response (mitigating action)	
				What have we done?	What will we do?
existing VCS assets, knowledge and capacity.	and support in relation to adult social care and vulnerable adults remain reliant on health and social care services.		specifically the quality measure of people having confidence to manage their own (LTC) condition.	Community Connections work aligned to workstream 7 (building stronger communities) and a strategic steer for project provided. Workshop to explore the redesign of community transport services grant funded by the Council has taken place.	specific VCS engagement events.
R11: Commissioning: It is (a) not aligned to the programme or (b) aligned but creates perverse incentives which increase costs.	(a) Contracts are agreed which do not support the programme. (b)The contracting mechanisms within the commissioning system incentivise increased intervention by organisations.	15 (5x3) RED	Monitoring of overall Programme plan - specifically the activity measure of avoidable emergency admissions.	Specific workstream on commissioning– Workstream 8.	Joint review of contract types, levers and risk sharing to inform 2015/16 contracts. Joint commissioning intentions for adults services in Lewisham including considerations of moving away from Payment by Results to outcomes based and /or value added commissioning approaches to incentivise providers to implement new ways to organise services around the user and carer.
R:12 Mental Health: Mental health services are not sufficiently integrated into the programme.	Lack of integration between community based mental health services and other health and care services means that holistic services centred on the user are not created.	12 (4x3) AMBER	Monitoring of workstream plans against key milestones, agreed outcomes and financial plans.	Involvement of SLaM on the Programme Board and in the early planning of workstreams.	Workforce development to improve generic understanding of physical and mental health needs and importance of integrate physical and mental health services. WS10 attendance at Mental Health Executive Board in October 2014.
R13: Communications: The effective involvement and buy-in of key stakeholders in	The integration of services is not achieved.	12 (4x3) AMBER	Monitoring of workstream plans against key milestones, agreed	Communications Plan has been developed covering initial activity including the programme launch, development of programme identity and key messages, stakeholder mapping and analysis, awareness-raising, and progress reporting.	Engagement plan to be developed with specific staff engagement events.

Description of risk	Risk consequence	Current Risk Rating	Risk trigger	Risk response (mitigating action)	
				What have we done?	What will we do?
delivering the programme's objectives is not secured.			outcomes and financial plans.	Communications Working Group established.	

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

In Lewisham we have a mature multi agency approach to our strategies and plans. Our BCF plans are in line with the CCG's 2 year operational plans and 5 year strategic plans and the joint Lewisham Adult Integration Programme; all of which have been considered by the CCG Governing Body and the Health and Well-being Board. Consequently the BCF plans are reflected in Lewisham and Greenwich NHS Trust's 5 year plans for acute and community services. Lewisham And Greenwich NHS Trust and South London and Maudsley NHS Foundation Trust are members of the Lewisham Adult Integrated Care Programme Board. NHS England, NHS Trust Development Authority and Monitor are currently triangulating commissioner and provider activity and financial plans; including risk identification, management and mitigation.

Our BCF plans indicate a shift of activity from hospital settings to community and home settings and an avoidance of unnecessary hospital admissions. This generates risk to all agencies and we will continue to develop plans and joint understanding of the impact of plans throughout 2014/15 and 2015/16 and align plans to the 2015/16 and 2016/17 contract rounds. Our BCF identifies a reduction in non elective admissions of 649 FCEs in 2015/16 (1.8%). This generates a reduction in CCG expenditure of £930k per annum and a corresponding reduction in NHS provider income. Our planned reduction in admissions is lower than the expectation in the national BCF guidance. In Lewisham there is an underlying 2% increase in the demand for admissions (broadly in line with population increases). We have had some success in holding this fairly flat through our local plans (e.g. QIPP) and effectively containing the population growth pressures. We know however that there are opportunities to improve further upon that from bed utilisation audits and comparisons of Lewisham performance in relation to conditions not normally resulting in admission or admissions for ambulatory care sensitive conditions. We are committed to managing the impact of our plans from a whole systems perspective.

The Council and CCG have well developed and formal joint commissioning structures underpinned by section 75 and section 256 agreements and exisiting risk arrangements. We will build on that history to ensure our governance arrangements for the BCF are robust and fit for purpose in design and in operation.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

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'.* Specifically the work of the Health and Wellbeing 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 and the delivery of the Health and Wellbeing strategy

Thus the Board scope of responsibilities is wide including adults and children's services and is responsible for encouraging and supporting the advancement of the integration agenda, as set out in the Health and Social Care Act 2012, alignment of plans and strategies, identifying inter-dependency and cross fertilisation of ideas. Its broad membership ensures that the key stakeholders for taking forward the integration are proactively involved, including the main acute, mental health and voluntary sector providers, NHS England and Lewisham Healthwatch.

Key inter-dependencies for BCF are the local housing strategy and personal budgets implementation:

Housing

The Lewisham older people's housing strategy has been developed with a focus on creating choice and meeting need by developing a continuum of housing provision. The development of three Extra Care housing schemes across the borough will provide further opportunity to support people to remain living in the community.

The schemes provide for a range of needs from low level support to more complex intervention. They will accommodate and provide support in areas where we are seeing a growth in the need for services, such as to support people who have dementia or where some monitoring or support during the night is required thus reducing the need for residential care.

Personal budgets.

Adult social care has developed an approach to self directed support that promotes the use of Direct payments. The administration and monitoring is currently provided by a dedicated team. Meeting needs in this way has provoked positive change in the provider market to ensure that services available are more person centred and can accommodate more choice. The borough has been a pilot site for Personal health budgets where the approach to person centred care is evolving.

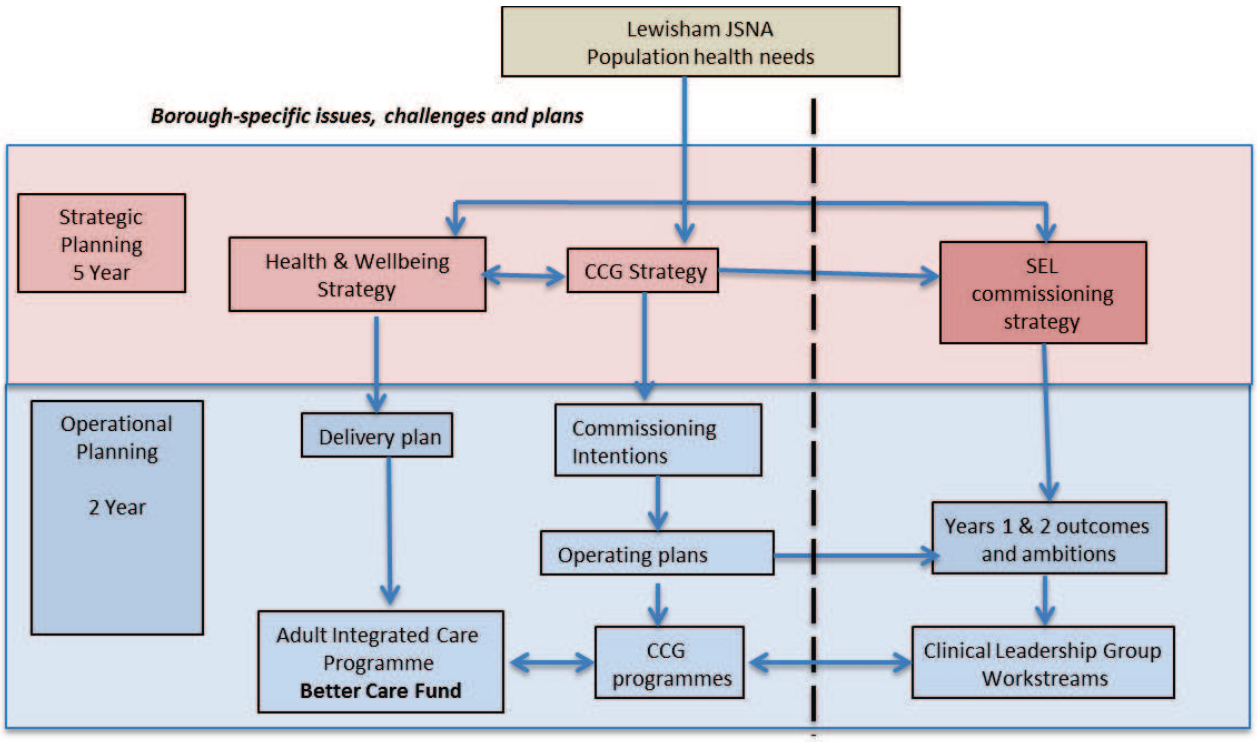
To help the Health and Wellbeing Board to deliver its key objectives, four supporting groups have been established: the Health and Wellbeing Strategy Delivery group, the Adult Integrated Care Programme Board (overseeing the BCF), the Adult Joint Strategic Commissioning Group and the Joint Public Engagement Group – see section 4 (c) for further details of the HWB's governance arrangement

The Adult Joint Strategic Commissioning Group is responsible for a number of important linked functions which underpin the BCF Plans for Action, including:

- the co-ordination of the joint commissioning intentions and plans across the Local Authority and Clinical Commissioning Group(CCG) on behalf of the Health and Wellbeing Board, ensuring that they align with other plans including South East London NHS Strategic Plan
- the management of the partnership agreements e.g. those under Section 75 of the NHS Act 2006. This includes identifying resources to meet joint strategic objectives and priorities agreed as part of these arrangements.

- the promotion of the effective use of resources. This will include formally agreeing respective contributions to pooled or aligned budgets, receiving financial reports on current performance of pooled budgets, providing oversight of the contracts register and agreeing the timetable for procurement; roll out of personal budgets
- the joint commissioning and procurement of quality services that achieve best value, in line the Adult Social Care Outcomes Framework, the Public Health Outcomes Framework and the NHS Quality, Innovation, Productivity and Prevention Framework (QIPP) and outcomes

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents



Lewisham's Health and Wellbeing Strategy 'Achieving a healthier and happier future for all' (2013) outlines the key health and wellbeing challenges Lewisham Borough faces as well as the assets, skills and services that are available locally to support people to stay healthy and be happier. It identifies two strategic themes for action over the next 10 years, which provides the foundation of our integration programme. These key strategic themes are:

- **Health prevention** - achieving a healthy weight; improving immunisation uptake; improving sexual health; preventing the uptake of smoking among children and young people and reducing the numbers of people smoking; reducing alcohol harm; improving mental health and wellbeing; increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years
- **Long term conditions** - 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's 5 year Strategic Plan (2013) was informed by Lewisham's Joint Strategic Needs Assessment (JSNA) and the Lewisham's Health and Wellbeing Strategy. The CCG's Strategic Plan identifies three strategic themes:

- Healthy Living for All –help people to live healthy lifestyles, make healthy choices and reduce health inequalities
- Frail and Vulnerable People - support and care for with dignity and respect
- Long Term Conditions – empower users with greater choice to manage their condition

The CCG's Commissioning Intentions and the CCG's Operating Plan set out the commissioning priority areas for 2014/15 -2015/16. The priority areas are cancer, maternity and end of life care and people with long term conditions including people with mental health problems. As a result of an ongoing dialogue with the public, the CCG's members and local stakeholders during 2013/14, it was concluded that the current way of providing and procuring services, with the expected increase in level and complexity of demand, would not provide the best quality of care for our priority areas and would not be affordable. So the challenge was we had to 'do things differently together' in primary and community care setting to achieve system wide change. These conclusions have been reiterated in the more recent South East London commissioning strategy.

The work of the Adult Integrated Care Programme and the Better Care Fund Plans for Action has taken forward the CCG's priorities for **all adult care** by focusing our collective effort on 'doing things differently' to transform way advice, support and care is provided in five different schemes:

- Prevention and Early Intervention - BCF Scheme 1
- Primary Care – BCF Scheme 2
- Neighbourhood Community Care – BCF Scheme 3
- Enhanced Care and support – BCF Scheme 4
- Enhanced Enablers – BCF Scheme 5

The CCG's Operating priorities which are not included within the Better Care Fund schemes are:

- integrated children's and adolescent services, for example CAMHs, which is being taken forward in partnership with the Lewisham Council's Children's and Young People's directorate
- the wider Primary Care strategy including addressing variation in care and accessibility of services in hours and out of hours. The work on primary care co-commissioning is being taken forward in collaboration with the other five CCG's in South East London as part of the South East London Strategy
- the management and redesign of urgent care services, including the operational resilience work co-ordinated by the Bexley, Greenwich and Lewisham Urgent Care working Group
- the development of maternity services, although the establishment of new community midwifery model has a link with the development of neighbourhood

community care

All the above priorities are included within the CCG's refreshed Strategic Plan and the draft joint Commissioning Intentions which are currently being developed.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

The CCG Primary Care Development Strategy provides the local framework to the delivery of proactive care, accessible care, coordinated care and continuity of care and is the basis of the BCF Scheme 2. Key enablers to support the delivery of this strategy are:

- A population based commissioning approach, based on the four neighbourhoods in Lewisham which are also being used as the basis for the integrated neighbourhood model (BCF scheme 3)
- Collaborative practice working to deliver population based services
- Reduction in variation across practices
- Lewisham Neighbourhood Primary Care Improvement Scheme (LNPCIS) to directly support practices to deliver in key clinical focus areas – this will follow on from the scheme launched in August 2014.

Primary care co-commissioning presents an opportunity to work in closer partnership with the NHS England the key commissioner for primary care. The potential to work more closely with NHS England is being explored by Lewisham CCG with the five CCGs in South East London to support the local work to improve quality of primary care, address health inequalities, and help to establish a sustainable health and care service. So primary care co-commissioning has the potential to support BCF scheme 2

The CCG already has a close working relationship with NHS England and is working with this commissioner in determining where additional services, established and funded through improvement initiatives can reasonably be included when the primary medical services contracts are reviewed. This will allow for simplifying contractual agreements with individual practices.

Lewisham CCG also is working with NHS England to determine the growing opportunities in delivering services through Community Pharmacy. This will be through contractual arrangements and encouraging closer partnership working with general practice in facilitating the development of comprehensive primary care based services.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Adult social care services continue to have a focus on the provision of preventative services and a range of personalised services that connect people to their communities and support them to live as independently as possible.

Lewisham is redefining its approach to manage the demand for Social care services by further developing information and advice, delivering preventative services and developing a new contract with service users and carers that recognises the importance and promotes self-management.

The focus on preventative services has been developed in partnership with health. These services provide a range of care and support that have reduced the need for acute care intervention. It is our intention to build on this capacity in order to divert people away from formal care packages when appropriate thereby reducing the pressure on demand for both health and social care resources.

The integrated service delivery model will ensure that both health and social care share key objectives for the future, such as reducing duplication and improving the experience for customers whilst protecting and valuing the functions of adult social care.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

The Adult Integrated Care Programme and the activity and funding aligned to the BCF schemes will help to support adult social care - through joint working and the amalgamation of roles and services - to streamline and improve service provision, reduce the need for high cost services, release efficiencies and improve user experience and outcomes.

To achieve efficiencies and to ensure that support and care is provided in a consistent and equitable way for all client groups, we will:

- Encourage people to take more responsibility for their own care and to use their existing resources, whether financial, social or otherwise, where appropriate, to achieve their stated outcomes. We will help people to help themselves by promoting and simplifying access to universal services and by linking them to support available to them within their own families and communities
- Develop the use of prevention and short term early intervention services which enable people to maintain and regain independence reducing people's need for and reliance on long term care and support
- Establish different delivery models through outcome based commissioning and market development - enabling people to have more control and choice through personal budgets and direct payments
- Implement an assessment model that takes account of personal assets and the contributions an individual can make to ensure their needs are met in ways which they prefer and choose for themselves
- Ensure all assessment and support planning staff and providers work with service users in ways that reduces dependency and promotes independence, ensures safety, and supports recovery

- Ensure the right level of support is offered in the most cost effective way according to a person's assessed eligible needs

Our plans seek to rebalance the overall health and social care spend, by shifting resources to proactive, preventative care provided in the community, so reducing the demand for acute and mental health bed.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The amount allocated from the BCF to protecting adult social care is £6.8m in 2014/15 and £10.3m in 2015/16. Additionally the BCF identifies £800k towards the council's Care Act implementation responsibilities

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

A Task and Finish Group has been established to implement the Care Act within the Adult Integrated Care Programme. The Group has oversight of activity undertaken by AICP workstreams to deliver the requirements of the Care Act to manage the complex set of interdependencies and prevent duplication. The Group is working with the leaders of the integrated social work functions to ensure compliance within the South London and Maudsley-led integrated mental health services. Areas that sit outside of existing structures are being co-ordinated directly by the Task and Finish Group and Care Act Project Manager.

Some of the key areas of activity to implement the Act are set out below:

Workforce Development:

- A training plan, based on national learning resources being developed by Skills for Care, will be implemented to ensure social work practice is compliant and supports the new approach to support planning.
- A learning and development plan for commissioners will ensure they have the skills and knowledge in place for the delivery of the Act.
- A communications plan will be delivered with key partners and stakeholders to provide information for staff aligned to adult social care, for example in Housing, NHS services and the voluntary sector.

In addition to the BCF funding, this activity will be resourced in part from the existing 2014/15 allocation towards Care Act implementation and through reprofiling existing budgets.

Carers Services:

Lewisham is developing its commissioning response to meet the new duties in preparation for the final statutory guidance. Using the recent DH model based on the Lincolnshire tool, Lewisham's additional recurring carers' costs were forecast at £844k per annum. These costs can only be met in part from reprofiling existing resources for carers which are set out elsewhere in the BCF. Activity will include:

- A new process for assessments will be developed to enable the Council to deliver the increased volume of carers' assessments anticipated.
- A new market of services will be developed for carers to meet needs under the national eligibility criteria and purchased using personal budgets.
- Respite care services will be provided to the cared-for person, and as such will sit on the client's personal budget not the carers. Local consultation will be undertaken regarding this change.

Assessment, Support Planning & Personalisation

We anticipate a significant increase in demand for assessment and support planning services from self-funders and are in discussion with DH around the modelling of costs. The tool initially forecast costs of £695k and it was anticipated that this would be revised downwards. However, as the DH model does not include one-off or recurring costs incurred during the BCF period relating to IT and informatics, system redesign, meeting needs not previously eligible or general increases in activity as people test their needs against the new eligibility criteria, we believe this remains a reasonable guide to annual cost pressures. Activity will include :

- IT systems are being reviewed to ensure they deliver compliant practice for 2015/16 and for 2016/17 when the Council will roll out Care Accounts.
- Support Planners, a new role in the system, will be in place following the restructure of Assessment and Care Management to deliver holistic 'asset based' approach to care and support planning.
- Resource Allocation Systems to generate indicative personal budgets for social care will be updated and in place for all client groups including carers.

v) Please specify the level of resource that will be dedicated to carer-specific support

Lewisham Council and Lewisham CCG each commission a range of services from voluntary and community sector partners designed to support carers; assessments, breaks, support. These services are currently aligned to the BCF as supplementary commitments without specifically forming part of the BCF in 2015/16.

Additionally the BCF includes voluntary services commissioned from grant funding of £250k (e.g. Community Connexions) as well as specific council commitments arising from the implementation of the Care Act 2014.

Further work will be undertaken in 2015 to review the full range of carers support services and integrate into the wider BCF plans.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Lewisham Council is required to make savings of £95m from its revenue budgets between 2014/15 and 2017/18. As the largest service area, adult social care is required to make a substantial contribution to this and has a provisional savings target of £25m over this period (against a base net budget of £80m). Although integrated working has already delivered efficiency savings and reshaped services, adult social care needs to meet the challenge of unprecedented financial pressures and, as mentioned previously,

needs to respond to increases in the level and complexity of demand and meet the new obligations introduced by the Care Act. These additional costs are set out Section 7 (iv).

As the majority (87%) of the Adult Social Care Net Budget is spend on the provision of care to individuals, either in their own homes or in community settings, the BCF plan recognises that the shift to proactive, preventative care provided in the community with the delivery of health provision closer to home could increase the pressure on this budget and will need to be recognised in our application of resources to community based working.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

A whole system approach to planning for 7 day services has been agreed by partners in Lewisham as well as working across the wider South East London economy. Lewisham is committed to improving 7 days a week access to urgent and emergency care services, and their supporting diagnostic services, so that they are delivered in a way that addresses equitable access, care and treatment whatever day someone is admitted or where appropriate discharge and support services are needed. Extended services also improve clinical outcomes, support our BCF outcomes metrics and provide for a better patient experience. Although 7 day services go beyond urgent and emergency care, the BCF focuses on this area.

Lewisham and Greenwich Trust has shared with local partners their detailed self-assessment and outline plans for the Lewisham Hospital site against the national 7 day clinical standards which have been submitted as part of the London Quality Standards programme. The 7 day services clinical standards have been published through the initial report of the NHS Services Seven Days a Week Forum (December 2013).
Local discussions have begun to assess community health and social care service provision across the levels of service provision suggested through NHS Improving Quality report 'NHS services – open seven days a week: every day counts' (Nov 2013) to ensure appropriate and financial sustainable services are delivered when needed and to identify those services where the BCF would support an integrated 7 days a week offer across local organisations. The CCG has registered its interest with NHSIQ in its 7 day service self-assessment toolkit to see how this could support our 7 day service integration planning.

Appropriate weekend working will be the initial focus for Lewisham services so that active acute care is delivered at weekends and so that community, mental health and social care services are available to deliver weekend support services as well as enabling safe discharge ensuring local urgent and emergency care services operate effectively and efficiently across the whole week. A series of weekend audits between acute, community and social care services in Q1 will help inform our planning for community based 7 day services as well as learning from 2013/4 winter schemes.

A local CQUIN has also been agreed as an additional incentive to transform the way services are provided and assist in the assessment of the current position in terms of 7 day working across acute and community services and develop a programme of

implementation that identifies areas to support admission avoidance and early discharge over 2 years.

As highlighted previously, we will ensure that appropriate social care and support services can be put in place out of normal office hours and at weekends to facilitate timely discharges from hospital. This will include resources being made available to undertake assessments at weekends and, during 14/15, introducing the ability to access enablement, home from hospital services and access to care packages of the weekend.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The NHS number is already used as the primary identifier between Lewisham and Greenwich NHS Trust acute services and social care services (ASC) provided by Lewisham Council. More work is underway to extend the use of the NHS number as the primary identifier across social care, primary care and the South London and Maudsley NHS Trust (SLaM)through the Adult Integrated Care Programme.

Lewisham healthcare providers (hospital, community and general practice) is working with a range of healthcare providers within the borough, hosted by Lewisham and Greenwich NHS Trust, to establish a Virtual Patient Record (VPR) which uses the NHS number as the prime identifier. The VPR has been rolled out within health organisations in Lewisham and work is underway to include SLaM and ASC as part of the database procurement process that will be completed by December 2015

Discussions are also under way with an expectation that by 2015/16, the VPR solution that has been procured by Lewisham and Greenwich NHS Trust, will include Greenwich providers of health and social care in.

Additionally, NHS Lewisham CCG has entered into a London wide Application Programming Interface (API) agreement via the introduction of the electronic patient care planning system, Coordinate My Care (CMC), for patients with life limiting conditions.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The systems we have and are seeking to establish are all based on Open APIs and Open Standards, as confirmed by our suppliers. As part of Scheme 5 we will be deploying these standards as we further integrate data, and as part of preparation for the Care Act we will explore data exchange with other authorities as necessary to ensure complete care records can be maintained when people with personal care records move to another authority.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

All partners are committed to appropriate IG controls and standards.

The Council has achieved compliance with the PSN framework which includes N3 code of connection. We are currently considering the best approach to establishing an RA for connection to the NHS spine for access to Patient Demographic Services.

The CCG was ranked 14th highest (out of 221) for the 2013/14 CCG IG toolkit scores and operates a comprehensive risk based approach to IG. Lewisham and Greenwich Trust identified some IG challenges in 2013/14 when the new organisation took control of Queen Elizabeth Hospital. A comprehensive action plan is in place and achievement of IG toolkit standards are expected for 2014/15.

Each organisation operates its own information governance, security, management and quality policies.

There is a commitment to developing joint information governance frameworks, building on the existing joint commissioning structures across the council and CCG, the joint provision arrangements across the council and Lewisham and Greenwich Trust and also associated with the local virtual patient record programme that is enabling health and social care partners in Lewisham to connect patient/client records.

These arrangements will cover applicable UK law, NHS Standard Contract requirements, IG Toolkit standards, professional clinical practice and in particular requirements set out in Caldicott 2.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

In June 2013 Mc Kinsey undertook a high level risk stratification of the Lewisham registered population using 2010/11 data. This showed that:

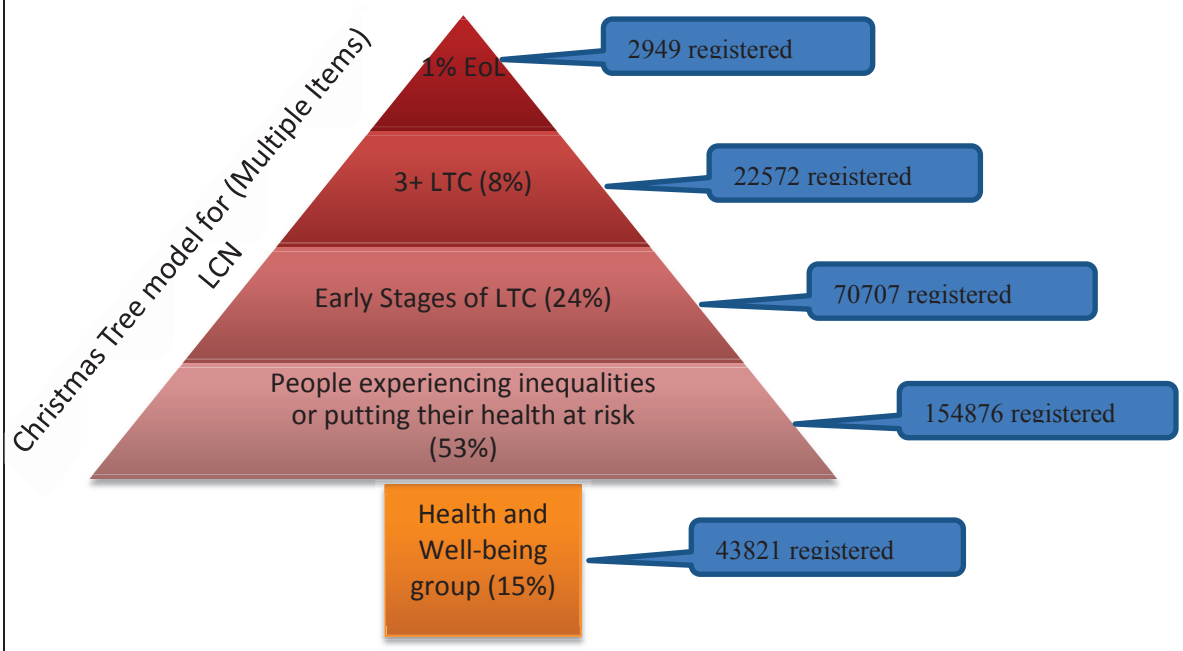
- Lewisham's population, who are categorised as very high risk and high risk with the highest demand, equate to about 5% of the population and accounts for 40% of the total health and care costs
- Lewisham's population who are categorised as very high risk, high risk and moderate risk categories with high demands, equate to about 20% of the population and accounts for 70% of the total health and care costs

The detailed analysis is shown at page 18.

Recently more detailed modelling work has been undertaken by South East London to further segment our population using the primary care data set. This modelling work identifies a similar size cohorts for the different risk categories as previous risk stratification work. About 9% of our population are people at the end of their life or with three or more long term conditions. People who are of moderate risk or are at early stages of long term conditions equate to a further 24% of the population.

We are exploring how best we can use this patient segmentation modelling tool at a neighbourhood level, recognising the limitations of the data, to support GP practices with their neighbourhood community teams to more effectively support people with long term conditions.

Lewisham CCG Practices – Risk Profile



Already GP Practices are compiling a risk register using QAdmissions of the top 2% of patients on their lists who are most vulnerable to a hospital admission. This work is being enhanced by the work underway with community health services and adult social care to match those at-risk patients on the practice-based 2% register against those known to other care providers.

Our ambition is to roll out this work incrementally to target all those patients in the high risk and moderate risk category (the top 10-15%) to improve their primary and community support and care so that hospital admissions are avoided.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

The joint process that is being introduced is that patients will be accurately identified through risk stratification (and other mechanisms), which includes criteria to identify early dementia and mental health issues. The patient is then proactively managed according to the level of their risk. In the controlled environment of care co-ordinated by the GP a single assessment is undertaken and then the person is streamed to one of these pathways:

- GP management with a care plan, including self-care
- Neighbourhood 's multi-disciplinary team management, co-ordinated by the GP, with a single care plan, including self –care
- Proactive Primary Care, co-ordinated by the GP, with a care plan and including self-management

The accountable lead professional is the patient's GP but the GP may choose to delegate this role to a more appropriate member of the multidisciplinary team. This will be clearly communicated to the patient so that the patient knows who to contact when they need to and can get timely decisions about their care

Collaborative care plans are delivered to all patients with an LTC, those identified as living with frailty syndrome and other complexity (including mental health and learning disabilities).

Collaborative care plans will be developed across the whole system for patients who are at risk of deterioration and subsequent hospital admission, involving the sharing of information and the common approach across the system.

Once the high risk patients are identified through the risk stratification process, the MDT (community, practice and social care staff and medicines management where appropriate) will assess the patient's needs and develop the care plan. Some of those higher risk or frailer patients will be part of a virtual ward and offered regular home visits, but most patients will be assessed and managed within the practice. The GP remains the overall lead for these patients and referrals to other health services including hospital services medical teams will be made by him/her.

Mechanisms are to be developed for sharing information across organisations through 'view only ' or download exchange, as well as access to portable web access for patients records and care plans. This will help to create an integrated approach to enable both health and social care professionals across the system to share care planning and self-management, which will reduce duplication and improve patient experience.

The intention is that there will be a single review undertaken by trusted reviewer on behalf of health and social care whenever possible.

Patient empowerment and training programmes to be developed (Health Foundation bid) plus GP and practice staff training. Community staff and social care staff will be undergoing supported learning in both joint care planning and complex team working/ dynamics as part of the community team integration programme (for which there is an action plan developed with an initial focus on neighbourhoods 1 and 2).

Project officers from both the LBL and LCCG have been assigned to lead on the community team integration process (with the action plan above) and this work is supported by the Workforce Development work steam on the Integration project Board.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

We are working towards achieving 4,000 care plans agreed with GPs, many of which will require next steps carried out by the MDT.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

The Lewisham Public Engagement approach is to develop, design and deliver meaningful engagement in Lewisham – in multiple ways to include the views and aspirations of as many people as possible. We are committed to responsive, open and transparent engagement and putting the views of public at the heart of everything we do. Through involving and engaging the public we believe we will be better able to commission high quality services that meet the health needs of our local population. Effective engagement will not only help to improve health outcomes, it will also help to make the best use of public money.

In developing Lewisham's Health and Wellbeing Strategy, the CCG's Commissioning Strategy and Intentions, we have demonstrated how the views expressed by local residents, including service users and their carers, have informed and influenced the key priorities for action and commissioning of specific services.

More recent engagement has focused on gathering views to improve existing services and to identify key priorities for the Adult Integrated Care Programme and has taken place through a Quality Summit, workshops, focus groups and a range of consultation meetings with service users and their carers, and through the Voluntary Sector's Health and Social Care Forum, working closely with Lewisham Healthwatch.

Our approach to engagement, fundamentally builds on existing community strength and infrastructures, resulting in us working with many voluntary organisations in Lewisham to contribute to the shaping our joint commissioning plans and the AICP including :

- Health and Social Care Forum – brings together voluntary and community sector service providers and services.
- Healthwatch Patient Reference Group Meetings - holds bimonthly thematic public discussions on such issues as Mental Health, Care.data Transfer and the South East London Strategy conversations.
- Voluntary Sector Compact Steering Group - provides the standard of frameworks that guides the Council and its partners to work well with the Voluntary and Community Sector.
- Community Connections Steering Group membership - comprises key third sector organisations to provide community development approaches to connect our residents to community and voluntary sector services and to assist well being

Focus Groups have been held with different specific community groups (reflecting our seldom heard and equalities protected characteristics groups) as part of developing the CCG's Commissioning Strategy and using 'Lewisham Life'; a quarterly magazine to reach every home in the borough.

As part of the Adult Integrated Care Programme to which the BCF aligns, a stakeholder

mapping exercise has been undertaken. This ensures that all key stakeholders are appropriately engaged with the individual workstreams and help to shape and redesign services. In addition, workstreams are using a range of existing fora, such as Lewisham's Positive Ageing Council and Local Assemblies, to engage with the public more widely.

Three voluntary sector members sit on the Health and Wellbeing Board. To support the Board in its engagement and consultation activity, a Joint Public Engagement Group has been established which brings together representatives from the voluntary sector and Lewisham Healthwatch, and officers from the CCG, Council and the acute trusts, to inform the integrated care agenda.

The Joint Public Engagement Group (JPEG) will continue to co-ordinate the public engagement work across Lewisham and to provide assurance to the Health and Wellbeing Board that effective engagement is being undertaken.

Currently joint commissioning intentions are being developed to take forward the adult integrated care programme from 2014/15 onwards. The joint Commissioning Intentions will be a public document for wider engagement with the public, local providers and other stakeholders. The joint Commissioning Intentions will set out the pace and scale of the changes Lewisham commissioners wants to see in the way in which specific services are commissioned to deliver our vision, 'Better Health, Better Care, Stronger Communities' and seeks 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.

An engagement programme and communication plan will be put in place during October – December 2014, to further test that the Adult Intergrated Care Programme is focused on the right priorities and actions to deliver the maximum benefits to Lewisham people over the next two years.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Lewisham established an Adult Integrated Care Programme in January 2014. The programme builds on the considerable work to join up services which began in 2011. It is a partnership between the Council (including Adult Social Care, Public Health, Housing and Cultural and Community Development) the CCG, Lewisham and Greenwich Healthcare Trust and South London and Maudsley NHS Foundation Trust.

During 2014, a series of multi-agency workshops have taken place bringing together stakeholders across health and social care, including local GPs, Lewisham and Greenwich Healthcare Trust, South London and Maudsley NHS Foundation Trust, Housing partners and the local voluntary sector. The aim of these workshops has been

to develop further the vision and ambition of specific aspects of the BCF programme and to co-produce the new delivery models of care. These workshops have included:

- Mapping key pathways (April 2014)
- Neighbourhood working (June 2014)
- Prevention of falls (August 2014)
- Information and advice – current and future provision (August 2014)

Lewisham partners have also been working across South East London through an integrated workstream of SEL CCG's Community Based Care Strategy to share learning and develop joint work where value can be added under the 'shared standards, local delivery' philosophy. This work is now being subsumed within the wider SEL CCG/NHS England development of a 5 year strategy.

For Lewisham and Greenwich NHS Trust and South London and Maudsley NHS Foundation Trust, the above engagement has been underpinned by our contractual relationship as two significant providers of local community, acute and mental health services. These joint contractual discussions have focussed on how to secure the transformational changes we jointly wish to deliver using the contractual levers, for example, CQUINs and outcomes- based service specifications, innovative risk sharing arrangements and the greater flexibilities within PbR now available to commissioners.

Also these contractual discussions have included agreeing the finance and activity levels as part of the CCG's overall contract, and in developing our two year Operational and five year Strategic Plans. The BCF is an integral element of these plans and has always been part of the CCG's QIPP planning with the Trust.

More recent work is being undertaken on a South East London basis to align the CCG/SE London CCGs' Plans with Lewisham & Greenwich's Five Year Plan.

So in conclusion the engagement with our local NHS Foundation Trusts and NHS Trusts on the BCF and the wider integration agenda has been at many different levels – at a strategic level, locally and across south east London, to develop a shared vision, at an operational level to redesign models of care and at a contractual level to secure agreed changes.

ii) primary care providers

Lewisham GPs have been engaged also at various levels in the development of the Better Care Fund submission.

The GPs elected to the CCG's Governing Body have been directly involved in the development of the BCF plan as members of the Health and Wellbeing Partnership, the Adult Integrated Care Programme Board and the Adult Joint Strategic Commissioning Group.

Clinical Directors, on behalf of the GP members, have been involved greatly in developing the vision, ambition and approach for each BCF scheme, with a specific focus on establishing strong primary care (BCF scheme 2) and neighbourhood community teams (BCF 3) in 2014/15. Also working with other colleagues across South East

London to develop the South East London strategy

The broader membership of the CCG has been engaged regularly through our Membership forum meetings and our four neighbourhood meetings. A particular focus for discussion has been how the future 'collaborative working' will be taken forward locally through population based commissioning;

At an individual GP level the changes to the General Medical Services (GMS) contract from April 2014 has supported the implementation of the underlying principles of the BCF - more proactive integrated and personalised care through:

- Ensuring that all people aged 75 and over have a named, accountable GP who is responsible for overseeing their care
- Introducing more systematic arrangements for risk profiling and proactive care management, under the supervision of a named GP, for patients with the most complex health and care needs
- Giving GP practices more specific responsibilities for helping monitor the quality of out-of-hours services for their patients and supporting more integrated working
- with out-of-hours services

Locally the Lewisham Neighbourhood Primary Care Improvement Scheme (LNPCIS) has directly supported practices to deliver in key BCF areas including:

- Long term conditions to ensure appropriate identification (through risk stratification) and management (supported by collaborative care planning) of these patients in Primary Care
- Prevention and early detection including cancer, health checks and immunisations
- Flu and pneumonia vaccinations to ensure high levels of population coverage
- Primary Care access to support reduced A&E attendances through 7 days, 8-8pm access and redirection from A&E
- End of life

iii) social care and providers from the voluntary and community sector

As with other key stakeholders social care and voluntary and community sector providers have been engaged with the BCF at various levels.

At a strategic planning level, Lewisham Council's Executive Director for Community Services is a member of the Health and Wellbeing Board and jointly chairs the Adult Integrated Care Programme Board. The Health and Wellbeing Board includes 3 representatives from the voluntary and community sector. The voluntary sector is also represented on the CCG Board. Both social care and voluntary sector providers have worked in partnership with the CCG to develop the South East London 5 year Strategic Plan.

Adult social care co-ordinated key multi agency activity (outlined in 8b i). Voluntary sector providers were involved in each workshop undertaken to further develop the vision and ambition of specific aspects of the BCF programme and co-produce the new delivery

models of care.

A Joint Public Engagement Group (JPEG) was established in March 2014 to support a more co-ordinated approach to communicating and engaging the wider voluntary and community sector about the BCF vision and aims. JPEG's membership includes representatives from Lewisham Healthwatch and Voluntary Action Lewisham. Engagement activity has also been undertaken with the voluntary and community sector through the Health and Social Care Forum co-ordinated by Voluntary Action Lewisham. The quarterly forum brings together voluntary and community organisations with an interest in health and social care.

Operationally, a consortium of voluntary and community sector providers delivers Community Connections, a key part of the neighbourhood modelproviding preventative and early intervention activity, building social capital and developing volunteering. An important element of the Community Connections project is the development activity with local community groups (see case study for Community Connections).

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The overall impact of CCG allocations and BCF and QIPP requirements over a five year period is already modelled within the operational planning submission made by the CCG for the 2014/15 planning round. Commissioner plans outline significant reductions in activity across all points of delivery within acute settings, along with an increase in delivery within community settings. The CCG is working closely with providers to ensure that this service shift is managed proactively, and aligned to Lewisham & Greenwich's NHS Trust's financial sustainability. Lewisham and Greenwich Trust is the provider of a wider range of community services in Lewisham and therefore a key player in delivering the shift.

Local provider plans are consistent with commissioner plans to the extent that both forecast a reduction in non-elective activity over the five year planning period. However, they are not fully consistent in that the provider has adopted a different approach to setting a baseline for activity, and is planning for a more modest reduction in non-elective activity. Consequently, a significant gap remains between provider and commissioner plans.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
1
Scheme name
Prevention and Early Intervention
What is the strategic objective of this scheme?
Scheme 1 has three strands. The advice and information workstream within the AICP will develop as part of a wider prevention programme: • Develop borough wide information and advice gateway, including specialist advice for carers • Extend our well established Community Connections programme to support development and use more effectively community resources to support vulnerable adults. • Develop preventative programmes targeting unnecessary admissions for falls, UTI's and dementia.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
1) We intend to implement an integrated information and advice model across Lewisham that will comprise the following elements: • A Care Act compliant, comprehensive, up to date website to enable people to plan their own care choices. • An information warehouse and directory of services, this will be used by Community Connections to make best use of our community based assets. This will assist effective support planning and the use of community resources which are both home and community based. • Telephone support (with a single number covering social care and health) • Advertising materials (leaflets, videos, magnets) and training for front line staff, to increase the impact of the 'every contact counts' campaign • Face to face support at a community level in libraries and community Hubs (Citizen Advice Bureau) • Development of a Carers' Gateway Service (Carers Lewisham) Adult social care alone received 12,000 contracts per year requesting information and advice. A detailed analysis has shown that over 50% could have been dealt with satisfactorily with a good information system. The new information gateway will look to reduce telephone calls by 50% that need to be answered and lay the foundation for self-assessment and self-management. The Technology to enable self-assessment will be

completed in 2016, although the information website will be available from 2015.

User groups will be working to build and test out the information and advice gateway to ensure that it is user friendly, empowering, encouraging self-management and takes a problem solving approach.

Telephone support, that sits behind the website, with a single phone number for social care and health, will provide more detailed information and advice, but will also undertake triage, filtering cases that do/don't require full assessment. To ensure the website is well used and the telephone support is appropriately used, we will ensure we have a good communications campaign. In addition, we will run training sessions for front line professionals, carers and the public on how to navigate the site.

The 2011 census found that there are approximately 22,000 carers living in Lewisham. It is expected that simplifying the pathway for identifying carers and linking them into services, will see a much greater proportion of carers in Lewisham supported to continue with their caring role. The Advice, Information and Prevention Service will be linked into the Neighbourhood Model to ensure that all carers, but especially of patients most at risk of hospital admission are offered ongoing support to avoid unplanned admissions to hospital or residential care.

The Carers' Gateway service will be a first port of call for carers support and most carers' needs should be dealt with by this service. The emphasis of the service will be to draw on community, social and personal strengths/assets to reduce need and risks. Following an initial screening, assessment goals and outcomes will be set with the carer and they will be encouraged to develop their own support plan and link in with universal services. If more complex needs are identified fuller assessments will be available for those seeking more intensive support.

2) The Community Connections project, a pilot preventative community development project,was funded by the council in 2013. The project is delivered by a consortium of voluntary sector organisations. It operates within works alongside the neighbourhood teams and has 3 core elements:

- Support Facilitators work to connect people at the threshold of requiring care services to existing opportunities in their communities.
- Community Development Workers work with the voluntary and community sector to develop new services to meet identified needs that encourage and enable people to stay independent for longer.
- Volunteer Co-ordinators create new opportunities for volunteering and connect individuals to these opportunities.

Performance data gathered to date indicates that the project is having a positive impact on the health and wellbeing of the target group. Additional resources will enable the pilot to be mainstreamed, enabling it to expand its reach. The project is aligned to Public Health's Health Improvement Team but there are opportunities to integrate further, for example in relation to brief interventions. Over 250 residents have been placed or supported through this scheme over the last 6 months.

Community Connections has established a database of services that is kept up to date. The "service directory" includes users reviews and referral mechanisms. This will be

integrated into the new borough wide Gateway to facilitate one point of access and improve access to localised neighbourhood services. This will be of particular help to GP's, health check referrers and other professionals.

3) A recent bed utilisation audit was undertaken in partnership with LGHT. This in conjunction with Social Care allocation analysis June/July 2014 indicates some prevalent long them conditions led to unnecessary admissions (Dementia, Falls and UTI's). This scheme will therefore develop a preventative programme for each of these conditions. The planning will take place from October 2014 to April 2015 and will include:

- Patient identification/risk stratification. This is to be piloted in Neighbourhood 1 from October 2014.
- Promote screening/early diagnosis as appropriate
- A multi-disciplinary action plan in each neighbourhood to be agreed.
- Implement the falls prevention pathway agreed in July 2014.

Our Public Health reports show that the number of people with 2 or more long term conditions rises in our 75+ population. In line with this, our emergency admissions rates rise for the same age group, for the highest diagnosis areas of Dementia, Falls and UTI's. Emergency admissions rates for falls in 2013/14 was 1427, 52.7% of the total 75+ admissions. Following on from this, this group of people also spend longer in hospital; this was substantiated by the recent UHL bed audit.

We intend to re-design and implement an evidenced based falls prevention pathway in line with NICE recommendations, and align funding to further investment in activities to reduce falls and in the rehabilitation and reablement of people following a fall. We will commission evidence based falls prevention interventions (e.g. strength and balance training) for individuals and groups identified as at medium and high risk of falls.

The plan is based on the following data:

The prevalence of falls based on the estimates given by the Department of Health (2009)[13] and applied to the local population.

	Percentage	Number
Number of 65+ **registered** in Lewisham (2014)		26,393
People over 65 falling each year	34%	8974
People over 65 falling twice or more each year	15%	3,959
People over 65 attending the Urgent Care Centre following a fall	5%	1,320
People over 65 sustaining fractures	3%	791
People over 65 sustaining hip fractures	0.8%	211

A review of provision and access to preventive services and equipment has identified significant potential to achieve far greater cost-effective utilisation of existing resources, but also potential to reduce demand on care and support services by extending provision of preventive services. This will be achieved through investment in minor housing improvements such as those achieved through "warm homes" and handyperson

[13] Prevention Package for Older People DH 2009 http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146

schemes, and investment in basic low level equipment to support and maintain health and wellbeing, such as telecare.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The council will provide the information and advice web resource, and will co-provide a telephone support service with Lewisham & Greenwich NHS Trust (community nursing component will be commissioned by Lewisham CCG). Face to face support (including training) at a community level will be commissioned by the council and provided by the voluntary sector (e.g. through the community connections project) and by trained front line staff across a range of providers (e.g. Libraries, pharmacies, GP practices).

The falls prevention pathway will be implemented through a partnership between the council, CCG and Lewisham and Greenwich NHS Trust, with additional community based interventions commissioned from the voluntary and community sector and private providers.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

An information and advice mapping exercise was undertaken with over 30 local stakeholders, and a separate exercise planned with members of the public. Benchmarking review of information and advice provided by other local authorities and a market analysis of website providers was undertaken. The selection and design of the integrated information and advice model was validated against Care Act requirements. The development of a falls prevention pathway was undertaken through a review of NICE guidance, analysis of local data and mapping of existing processes, and benchmarking against falls prevention pathways in other local authorities.

Further evidenced based used:

- Making best use of the Better Care Fund (The King's Fund)
- NICE clinical guideline NICE (2013). Falls: assessment and prevention of falls in older people. NICE clinical guideline 161 (December 2013)
- For the economic case for investing in falls prevention, see 'Fracture prevention services: an economic evaluation' (Department of Health, 2009)
- Campbell et al (2013), which evaluated the impact of Northamptonshire Crisis response service
- LGA Evidence Review: 'Integrated care evidence review, November 2013'
- Department of Health (2009). Fracture prevention services: An economic evaluation. London: The Stationery Office.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in

headline metrics below
The following benefits are planned: • Reduction in emergency admissions in falls UTI and COPD • Improved public satisfaction with greater information availability • People feeling more connected to their community • Improved patient experience for people with long term conditions
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
This scheme will be monitored and managed via the joint Adult Joint Integrated Care Programme Board and associated work streams and joint governance arrangements, with regular progress reports to the Health and Wellbeing Board, including the Health and Wellbeing Board's Performance Dashboard. This dashboard includes the indicators within the Better Care Fund Plan.
What are the key success factors for implementation of this scheme?
• Comprehensive advice and information database that receives excellent satisfaction feedback from the public and staff. • Channel shift of people now using various call centres to access information and advice. • Reduction in duplicate referrals to health and social care • Increase in the numbers of people supported by community schemes designed to address isolation and improve wellbeing. • Reduction in the people being admitted to hospital for Falls, Dementia, UTI's and COPD

Scheme ref no.
2
Scheme name
Primary care
What is the strategic objective of this scheme?
The Strategic aim is to provide strong primary care focused on delivering continuity of care which is proactive and co-ordinated and delivers improved outcomes, working in partnership with patients and in collaboration with other practices in neighbourhood community teams
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The primary care model of care is to provide care to the whole population registered with the GP practice - proactive, accessible, co-ordinated and continuity of care - which is set within the wider context of the CCG's draft Primary Care Development strategy. The specific focus for the Better Care fund scheme 2 is to support changes in series to improve continuity of care, which is proactive and co-ordinated: **Proactive Care** • Neighbourhood networks in Lewisham to ensure that every contact counts, seeing each contact with a patient as an opportunity to address preventative health needs, to provide brief interventions or to sign post the person to other services within the network. The information will be recorded on a virtual patient record. • Primary care to empower people to take responsibility for their own health, to remain healthy and to stay connected with their communities by being able to identify the kind of services that would be most beneficial to them. • Primary Care providers to ensure that their patients have a personal health plan to help them lead a healthier life style. This will be developed with patients including sign posting to appropriate supporting services. • Practices to work in partnership to improve public health outcomes, such as increasing the coverage of screening and immunisation across the population as a key preventative activity. **Co-ordinated care** • Practices to systematically identify people who will benefit from co-ordination of care and a care plan. • Patients to have collaborative care plans, working with the neighbourhood

community schemes that:

- will be co-designed with them
- set out agreed goals and improve self-management
- Can act as a patient passport with health services
- promotes a proactive, integrated, co-ordinated and holistic approach to patient care.
- Will be managed by a co-ordinator when necessary.
- Will be reviewed regularly or when needs change.

- Practices to utilise appropriate technology to share the care plan across organisations to allow for care to be delivered in a co-ordinated way. This will be supported by agreed policies and processes to safeguard patients information.

Continuity of Care

- Practices to identify people who would benefit from continuity of care. They will work with the patient and their carer to co design a care plan with the patient, and with their carer if appropriate.
- Practices to ensure good care by having a named skilled professional accountable for a person's care. The patient will be made aware of the role of this person and how to contact them.
- Co-ordinator to work with the named accountable professional to co-ordinate the co designed care plan and support the patient by navigating them through the system.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The commissioning landscape now enables a number of partners to commission services from primary care. These include NHS England who commission the core services from the primary care providers, the Local Authority who commission and contract a range of enhanced services from primary care providers, as well as Lewisham CCG who commission other enhanced services from primary care providers. It is therefore essential that commissioners work in partnership to ensure a comprehensive range of joined up services are developed and delivered to meet the needs of local people.

At a local level, all GP practices in Lewisham are members of the CCG. GP member practices work closely in local neighbourhood groupings to have clinically led discussions relating to common problems that are arising and to explore how local services can be improved and co-ordinated better, driving the commissioning agenda of the CCG as a whole.

The CCG already has a close working relationship with NHS England and will work with this commissioner in determining where additional services, established and funded through improvement initiatives can reasonably be contractualised when the primary medical services contracts are reviewed. This will allow for simplifying contractual agreements with individual practices.

There are plans to align local authority and CCG primary care commissioning to ensure that the uses of resources are optimised and services are delivered in an integrated way. This increased scope will ensure that the CCG is in a better position to commission services for the whole population which is outcomes based.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

- South East London Primary Care Strategy
- Emerging London GP Development Standards
- Blunt, I (2013) 'Focus on preventable admissions: trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013' Quality Watch, The Health Foundation, Nuffield Trust
- Purdy S (2010). Avoiding hospital admissions: what does the research evidence say? London: The King's Fund. Available at: www.kingsfund.org.uk/publications/avoiding-hospital-admissions (accessed on 19 December 2013).
- De Silva D (2011) Helping people help themselves: a review of the evidence considering whether it is worthwhile to support self-management. London: The Health Foundation

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduction in emergency admissions - It is planned that collectively the schemes identified in this programme will directly support reducing emergency admissions. Based on SUS activity and benchmarking against 'like CCGs' the CCG has estimated that savings could be made by reducing unplanned hospitalisation for chronic ambulatory care sensitive conditions for example Diabetes, COPD and Heart failure, which relates to the Primary Care (BCF Scheme 2) and the Neighbourhood Community Care (BCF Scheme 3)
- Reduction in A&E attendances
- Improved patient experience for people with long term conditions
- Increased proportion of older people still at home after discharge from hospitals into reablement or rehabilitation
- Maintain the current low level of delayed transfer of care
- Reduction in permanent admissions to residential homes

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Overall progress of implementing the Primary Care strategy will be monitored

through the CCG Developing Primary Care steering group and the CCG's Strategy and Service Development Committee

- The specific BCF scheme will be monitored via the joint Adult Joint Integrated Care Programme Board and joint governance arrangements, with regular progress reports to the Health and Wellbeing Board, including receiving the Health and Wellbeing Board's Performance Dashboard. This dashboard includes the indicators within the Better Care Fund Plan.
- The key performance indicators are also monitored by the CCG's Delivery Committee on a monthly basis together with the planned reductions in emergency admissions.

What are the key success factors for implementation of this scheme?

- GP Engagement
- Collaborative working amongst GP practices
- Primary Care workforce development
- Interoperability of IT
- Developing a cohesive strategy for estates to deliver services

Scheme ref no.
3
Scheme name
NEIGHBOURHOOD COMMUNITY CARE
What is the strategic objective of this scheme?

The integration programme in Lewisham has 10 workstreams as shown in section 1.3 (Pioneer Bid). These all have action plans, and the following work is in progress and will be completed by end of March 2015. This will provide the foundation of the integration model by April 2015.

- Single point of access/referral into all community based care and health services.
- Co-located multi-disciplinary teams in each of the 4 neighbourhoods (Social Workers, District Nurses, all Therapies, Healthcare Assistants, Mental Health Workers)
- Neighbourhood networks established with agreed ways of working with said neighbourhood teams, pharmacists, domiciliary care services, Community Connections and health trainers.
- One line of management/co-ordination in each neighbourhood, and protocols agreed for working arrangements with the relevant GP clusters.
- Risk stratification of patients completed.
- Contract agreement for Community Connections programme 2015/16, including new volunteer recruitment targets. (Provider consortium – Age UK, Volunteer Centre, Voluntary Action Lewisham.)
- Neighbourhood model established for carers gateway offer (Carers Lewisham)
- Neighbourhood advice points established (Citizen Advice Bureau)
- Neighbourhood patient/service users groups established (Voluntary Action Lewisham & Healthwatch)

The BCF scheme will therefore be able to sustain the above developments.

The strategic objective is for locally based multi-disciplinary teams to provided co-ordinated support and care for people with long term physical and/or mental health conditions and vulnerable people, with their carers, families and communities to effectively manage their own care, where possible and maintain their independence.

The drivers for this change are:

- The provision of care at scale but also at a sufficiently local level to be genuinely responsive to local need
- The provision of care according to need and not according to organisational structure (and therefore constraint)
- The provision of comprehensive, co-ordinated care, using connected patient information, to enable the quickest and smoothest delivery to the patient of all

health and social support requirements, with all relevant professionals working together

- Enhanced patient experience of services, including the confidence that all professionals involved in the care are working together towards the same agreed outcomes
- The delivery of healthcare for each patient, with full consideration of the social context in which it exists
- The engagement of the patient in their healthcare and their empowerment to support their own stabilisation, recovery and maintenance.
- More efficient use of resources, to generate savings that can be reinvested in enhancements and innovations
- The improvement of services through the delivery of proactive as well as responsive care, as part of a whole system strategy to identify patients at risk of deterioration and hospital admission

Overview of the scheme

The aim of the Neighbourhood Community Care scheme is to establish a system-wide network of health, social care and voluntary sector professionals, based around neighbourhood community teams, into which GPs, community services and the local hospital can refer, via a single point of access. Also the aim is for the neighbourhood community teams to have a shared approach to care management across health and social care to underpin the multi-disciplinary team work.

The single point of access team will triage all referrals and ensure that the request is forwarded to the relevant neighbourhood's Care Co-ordinator. The Co-ordinator will refer the patient details to the most appropriate professional in the team (who will act as the patient's keyworker) and organise the relevant MDT meetings, tracking that the next steps have been carried out and ensuring that any further care is enlisted from the wider network. This will be carried out in close liaison with the referring GP practice or hospital team, and will incorporate prioritisation strategies according to identified risk and complexity.

The development of the neighbourhood network model will be supported by Project Managers, who will liaise with all stakeholder teams to help unblock operational issues and escalate problems requiring strategic input.

The majority of referrals to the neighbourhood network will be for patients identified as at risk through the GP practice risk stratification initiative, comprising mainly of the elderly (especially those living with frailty syndrome), those with one or more long-term conditions (LTCs) and those whose social context is not conducive to optimal mental and physical health.

The risk stratification initiative will be expanded incrementally until a system-wide process for identifying patients at risk is in place, in which a common assessment can be made at every entry-point to the system so that patients are uniformly risk assessed and enter into the relevant pathway for their type and level of risk.

The scheme will focus on key segments of the top 10 - 15% of the adult population deemed to be at very high risk, high risk or (some) at moderate risk. Segmentation initiatives will identify where this spend is concentrated and how pathways can be improved to reduce it and improve the patient's journey back to optimum mental, physical and social health.

The neighbourhood community teams will provide:

- Preventative care through the early identification of risks and deterioration,
- Admission avoidance using local multidisciplinary teams (MDTs) centred around person centred care and collaborative care plans
- Support following hospital discharge to remain well and supported in the community
- Short-term enablement support to enhance independent living skills

Underpinning the delivery of neighbourhood support via the neighbourhood community teams is a shared approach to care management, supported by:

- single assessment on behalf of health and social care, whenever possible
- collaborative care plan, in which the patient is encouraged and empowered to become a full partner in the decision-making process about the health and social care support that they receive and in which the full range of necessary health, social care and voluntary sector professionals collaborate to work towards common outcomes for the patient.
- a more targeted approach to conditions such as UTI's will be addressed by bringing together other staff such as Health Care Assistants, Domiciliary Care Staff and Nurse Prescribers, to be able to identify early and deal with low level conditions that could escalate and result in hospital admission.
- sharing of information, so that individuals tell their story only once
- single reviews undertaken by trusted reviewers on behalf of health and social care, whenever possible

Disabled Facilities Grants (DFGs) is relevant to Disabled people who want to remain as independent as possible within their own home. It provides access to funding for adaptations to the homes of owner occupier disabled people. The grants are given as a result of a statutory duty imposed by legislation that is administered by the local authority.

The scheme is ongoing and the way it is delivered is very prescriptive due to the legislative basis. The potential for change therefore is limited. Disabled Facilities Grants provide adaptations to enable a disabled occupant to access their dwelling and use of all facilities within it. This prevents the need for people to be supported in more institutional settings and meets the Outcomes of promoting independence and wellbeing..

The service is quite unusual in that the authority is both the commissioner and the providers of the service. This cannot be changed due to the statutory nature of the service. Similarly, the involvement of the Occupational Therapists who assess individuals from the local authority is a statutory requirement.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Within the framework of the Adult integrated Care Programme (via the Adult Joint Integrated Programme Board) in Lewisham, the various system partners (London Borough of Lewisham Council, Lewisham & Greenwich NHS Trust, SLAM, Lewisham CCG and the Voluntary Sector) will contribute to the scheme as follows: • BCF will fund the adult social care component of the neighbourhood teams. • Lewisham & Greenwich NHS Trust will fund the community nursing component of the neighbourhood teams. • SLAM will fund the neighbourhood-based mental health teams who will work closely with the neighbourhood teams. • BCF will fund the Care-Coordinators and Project management costs. • Lewisham CCG will provide the risk stratification investment.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
• North West London Integrated Care Programme (Bardsley et al 2013) • Evaluating integrated and community-based care (Nuffield Trust 2013) • Integrated Case Management (Halton PCT) • Poteliakhoff E, Thompson J (2011). Emergency bed use: what the numbers tell us. London: The King's Fund. • Integrated care value case toolkit (LGA) • Making best use of the Better Care Fund (The King's Fund) • NHS England, Transforming participation in health and care 2013,
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
See part 2.
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
It is planned that collectively the schemes identified in this programme will directly support the reducing emergency admissions. Based on SUS activity and benchmarking against 'like CCGs' the CCG has estimated that savings could be made by reducing unplanned hospitalisation for chronic ambulatory care sensitive conditions for example Diabetes, COPD and Heart failure, which relates to the Primary Care (BCF Scheme 2) and the Neighbourhood Community Care (BCF Scheme 3)

Based on SUS activity and benchmarking against 'like CCGs' the CCG has estimated that savings could be made by reducing other emergency admissions using effectively the neighbourhood community teams (BCF Scheme 3) and increasing admissions avoidance via the Enhanced Care and Support (BCF Scheme 4)

In addition the following benefits are planned:

- Reduction in A&E attendances
- Improved patient experience for people with long term conditions
- Increased proportion of older people who still at home after discharge from hospitals into reablement or rehabilitation
- Maintain the current low level of delayed transfer of care
- Reduction in permanent admissions to residential homes

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

This scheme will be monitored and managed via the joint Adult Joint Integrated Care Programme Board and associated work streams and joint governance arrangements, with regular progress reports to the Health and Wellbeing Board, including the Health and Wellbeing Board's Performance Dashboard. This dashboard includes the indicators within the Better Care Fund Plan.

The key performance indicators and the planned reductions in emergency admissions. are also monitored by the CCG's Delivery Committee on a monthly basis Patient and public feedback about their experience of co-ordinated local care:

- GP feedback about the coherence of the neighbourhood teams
- Development of robust Key Performance Indicators to include;
    - admissions avoided through risk stratification, care planning and co-ordinated local care
    - re-admissions avoided through enablement and supported discharge
    - enhanced patient experience of health and social care
    - patients that feel confident to self-manage their long term condition
    - GP Quality Alerts about the services individually and about the neighbourhood teams as a coherent body and delayed discharges

What are the key success factors for implementation of this scheme?

- Engagement and culture change across wider health economy: GPs, community and adult social care teams
- Workforce development, recruitment and retention
- 'Physical' co-location of neighbourhood teams
- Integrated ICT tools and systems
- Development of contracting mechanisms to commission for outcomes to deliver the model across all commissioners

Scheme ref no.
4
Scheme name
Enhanced Care and Support
What is the strategic objective of this scheme?

The strategic objective is to refocus and redesign the current community based intermediate tier of services to better provide enhanced care to support people to continue to live at home by preventing people requiring an unplanned hospital admission and ensuring effective structured discharge to avoid re-admission

Whilst the primary focus within this scheme is on admission avoidance and a rapid response team (RRT) to prevent admissions as far as possible, elements of this scheme will also seek to improve the structures around discharge planning and its associated services.

We will be reviewing the existing community based care services that contribute to admission avoidance across Lewisham's health and care sector and by developing and enhancing those services improve their responsiveness, application and outcomes. This will include redesigning access andpathways through such services. New approaches will be piloted over the winter period and where successful, new contracts for services will be put in place from 15/16.

Taking the case for change there is a clear rationale for our approach of:

- Provide better coordinated person centred care.
- Have measurable improvement in outcomes for our target populations.
- Support care closer to home (right place, right support, right time).
- Actively support the health and care needs of carers.
- Promote independence, health and wellbeing for all Lewisham people.
- Develop a health and care system based on the needs of local people not organisations.
- Ensure the system is safe, effective, efficient, affordable and sustainable.

We will deliver this by:

- Empowering and equipping our Workforce with the skills to deliver coordinated care.
- Connecting systems and people with up to date information.
- Ensuring we have quality buildings providing multi agency support and care.
- Creating a movement for social change, engaging with the whole of Lewisham's population, to provide a new paradigm for how people view their health.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

This scheme aims to bring together all the elements of care which contribute towards avoiding admissions and the provision of support closer to home. This will be achieved in part through targeting resources to maximise the impact.

Enhanced services will provide a cohesive and seamless service to the patients. This will include:

Admissions Avoidance Service (AAS)

The scheme will expand the existing AAS ensuring that the correct professionals are working within a multi-disciplinary team to cover a seven day a week service. This service will also provide a Rapid Response aspect within 2 hours and this is being linked in with the newly developed Appropriate Care Pathways (ACPs) that are being developed. We have just launched the Falls ACP and will shortly be launching both COPD and Diabetes ACP going forward. Also AAS covers assessments of need, home preparation services and night sitting services.

The AAS service is based both within the community to pick up patients who require a "Step Up" response and also within our acute provider within ED, 'Step Down' to support discharge. In addition to this we have commissioned a small number of recuperative beds where patients can stay for up to 72 hours within the acute setting, in order to prevent an acute admission. Following this they either go home with no care, home with care or to bed based rehabilitation.

We will expand the AAS further, after we have undertaken health economic modelling to ensure we have the right service to meet the needs of our population.

Clinical Nurse Specialists

Over winter we are piloting Clinical Nurse Specialists (CNSs) for Asthma and Diabetes working in ED at weekends, to support the patients in NOT being admitted, if they can be cared for at home. We currently already have this for COPD. Again these links to the development of ACPs going forward. The nurses will pick patients up both within ED and via LAS/ACP to prevent an admission. If successful these roles will form part of the admission avoidance service going forward.

Single Point of Access

We will shortly have in place a "single point of access" in order to enhance our admission avoidance services linked to the development of community networks (Scheme 3). There will also be a single referral form for all professionals to use in order to streamline the process of referrals. We already have mechanisms in place within the acute setting to identify those patients that are "medically fit" for discharge but that require enablement or rehabilitation and provide supportive discharge to that cohort of patients, releasing acute capacity and delivering care at home or bed based for rehabilitation if appropriate.

Rehabilitation Beds

Lewisham currently has 22 beds for rehabilitation (intermediate care) within a Care Home

and the scheme will support the expansion to 25 beds over the next few months to be fully in place by April 2015. There is also the capacity for this service to take a small number of "Double Handed" patients for up to 14 days prior to starting on a rehabilitation programme for up to 6 weeks. These beds are in addition to the community service that supports patients at home with a rehabilitation programme, again for up to six weeks. However, with further health economic modelling, the CCG will be able to determine and define the type of rehabilitation beds and extra care housing required in order to support patients.

Enablement Service

To support effective admissions avoidance and discharge of patients the Enablement Services will need to be enacted. These include the above and the use of intermediate care /rehabilitation service, both bed based and community based at Brymore

Development of a Virtual Ward

The CCG are currently developing in partnership with Lewisham & Greenwich Trust an acute GP visiting service as part of the AAS, to identify those patients earlier in the day who are at risk of an admission and maintain them at home with support from community services. This would then become a virtual ward going forward. This will not only support discharging patients sooner, but will also support the AAS going forward in preventing acute admissions.

Ambulatory Care Unit

Lewisham and Greenwich NHS Trust together with commissioners are also working on the development of an Ambulatory Care Unit and are part of the National Programme for the Ambulatory Emergency Care Network for this year. Again this will support admissions avoidance going forward as this team will be able to access the ACU thus preventing an unnecessary admission.

This scheme also links to the planned development of extra care housing which is a key part of Lewisham's Housing Strategy. Funding from the BCF will be used to ensure that the provision of additional support services is available within these settings.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- The AAS services and the supportive discharge services are predominantly commissioned by Lewisham LCCG with additional funding from the London Borough of Lewisham (LBL).
- LBL also funds the Enablement Services.
- LBL is coterminous with LCCG and has a strong track record of working together. The services are then commissioned from Lewisham and Greenwich NHS Trust and LBL.
- We are also working closely with the voluntary sector across a variety of areas.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme

- to drive assumptions about impact and outcomes

- AAS Pilot: Lewisham CCG this scheme (AAS) as an initial pilot in 2013/14, which demonstrated averted admissions (approximately 20 per month).
- Rapid Response teams at front end of A&E; Sutton and Merton PCTs.
- Early Supported Discharge: (National Audit Office 2010)
- Making best use of the Better Care Fund (The King's Fund)
- Oliver D, Foot C, Humphries R (forthcoming). Making our health and care services fit for an ageing population. London: The King's Fund.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

See Part 2.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Based on SUS activity and benchmarking against 'like CCGs' the CCG has estimated that savings could be made by reducing other emergency admissions using effectively the neighbourhood community teams (BCF Scheme 3) and increasing admissions avoidance via the Enhanced Care and Support (BCF Scheme 4)

In addition the following benefits are planned

- Reduction in A&E attendances
- Improved patient experience for people with long term conditions
- Increased proportion of older people who still at home after discharge from hospitals into reablement or rehabilitation
- Reduction in delayed transfer of care
- Reduction in permanent admissions to residential homes

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

This scheme will be monitored and managed via the joint Adult Joint Integrated Care Programme Board and associated work streams and joint governance arrangements, with regular progress reports to the Health and Wellbeing Board, including the Health and Wellbeing Board's Performance Dashboard. This dashboard includes the indicators within the Better Care Fund Plan.

The key performance indicators are also monitored by the CCG's Delivery Committee on a monthly basis and the planned reductions in emergency admissions. The scheme will be fully evaluated to ensure they meet the Key Performance Indicators (KPIs) in place. The outcome evaluation will determine if we proceed to fully commission or change the model. KPIs will include;

- the numbers of patients supported via enablement

- the numbers of admissions avoided
- numbers of patients supported via rehabilitation in the Care Home
- numbers of patients supported via rehabilitation in their own homes.
- numbers of reduced care packages following enablement.
- numbers of reduced care home placements following enablement.
- numbers of patients accessing enablement services.
- numbers of emergency admissions from care homes
- numbers of adaptations for homes and use of equipment at home
- Patient experience of health and social care.
- Increased numbers of patients supported to live independently.
- Number of patients that feel confident to self-manage their long term condition.

We will also be collecting data of the developing ACPs to identify the numbers of patients with an avoidable admission effectively using the ACPs.

We have effective patient feedback from bed base rehabilitation but need to ensure that this in place across all community services to ensure a positive user experience.

What are the key success factors for implementation of this scheme?

- Development and ensuring right skill mix/competencies for all staff across health and social care.
- Engagement and culture change within acute setting and teams.
- Development of contractual mechanisms for all providers.
- Ensuring the whole system has appropriate alternatives to an acute setting.

Scheme ref no.
Scheme 5
Scheme name
Supporting Enablers
What is the strategic objective of this scheme?
The strategic objective is to ensure that the necessary tools are in place to achieve the cultural changes and working practices required for effective integration. This includes data sharing between social care and health to provide professionals with more complete information about a person's needs and to support and facilitate, amongst other things, joint assessments, joint care planning and swifter interventions. The Adult Social Care Database and associated systems will be developed so that they align with the Virtual Patient Record and fulfil Care Act requirements. The scheme also includes the overall management of Lewisham's integration programme to ensure progress is maintained.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Data Sharing Close working in partnership with Lewisham and Greenwich Healthcare Trust (LGT) has resulted in the development of a Virtual Patient Record (VPR). The initial phase saw a tender let to Orion Healthcare to provide a technical solution from Feb/Mar 2015. This includes a Master Patient Index, In/Outpatient activity including discharge summaries, lab results, radiology, PACS, immunisations, Community referrals and GP detailed care records. The next phase, planned for July 2015, will add birth and antenatal data, endoscopy, GP Out of Hours service data, Community Care Plans and medications. Following this, work will start on adding Mental Health data, social care data (children and adults) and data from opticians, pharmacists and dentists. The project will impact on all 280,000 residents of the borough, and the adult social care element will link the records of about 4-5,000 active and recently active users. Information Governance arrangements will be required to ensure there is compliance and that data is only shared on the basis of informed consent of the patient/ service user. Following this, records from all the necessary systems will be linked securely through N3, using the NHS number as a common identifier, to build a comprehensive health and social care picture for each person. **IT Systems** As part of the Adult Integrated Care Programme, a project team is working on developing

a new support and maintenance contract with our existing Adult Social Care Database and finance software providers.

A number of enhancements to the system are being procured to address the integration programme and the Care Act. This includes using connectivity Application Programme Interfaces (APIs) and software tools to support data exchange, NHS number loader and Demographic Batch System lookup software using N3 code-of-connection as well as FACE assessment tools for personal budget and support planning.

Also being introduced is a Londonwide product called CarePlace.org, which helps find providers of adult social care, and MySupportBroker, which works with vulnerable adults to make the best use of their personal budget.

Additional software will be required to support self-assessment, possibly purchased from our current Social Care finance software provider. This will impact the approx. 100-200 users of these systems across health and social care, with potentially more once VPR is established.

Self Assessments

As part of our drive to improve access to information and advice, ensuring that we have electronic tools where people can self-assess and refer into Health and Social care is key to give further choice and control to our patients/service users. Both the Care Act and our integration programme focus on the most cost effective way of delivering service provision, which will maximise the use of all available resources including online assessments. In Lewisham we will be looking to develop in the first instance, tools to support the dialogue around referral and start the process towards either council funding or applying for care accounts.

Adult Integrated Care Programme

A small element of the scheme includes the programme management capacity necessary to ensure delivery of all the projects. This is a complex programme and requires consideration of the fit between local and national priorities, including the need to deliver high quality services in the context of significantly reduced resource levels.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Data Sharing

Lewisham and Greenwich Healthcare Trust (LGT) has taken the lead, and have already procured Orion through Insight as the provider of the VPR and Nautilus as an implementer. Strong programme management arrangements are in place, including a board representing all parties to ensure compliance, to deliver the various phases of the project. Highlight reports are used to monitor progress, with exception reporting and use of a regularly reviewed risk register.

IT Systems

LB Lewisham is the lead organisation, but as part of the Adult Integrated Care

Programme, the project is monitored closely by a board comprising health and social care representatives. In addition, there is a project delivery team to ensure different aspects of work are joined-up and support each other, tracking the interdependencies and making essential links to drive the project forward. Procurement is from a number of providers, in some instances through sub-contracts. So LiquidLogic are main database suppliers, but through them Oxford Computer Consultants (OCC) supply Social Care finance software. Other providers include CarePlace and MySupport Broker.

Self Assessments

Lewisham has established a Care Act task and finish team to deliver the required changes. The requirements are split into the workstreams, which are led by a named Manager(s). These workstreams feed back into the Integration Programme Board.

Adult Integrated Care Programme

Work is being undertaken by all partners involved in the programme. This includes CCG, LBL and LGT and SLaM.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The projects are designed to support and facilitate other schemes, so the focus is on establishing an infrastructure that ensures frontline professionals have all the information they need to make fast, accurate diagnosis of both medical and social care needs. In addition, systems will need to support reporting, planning and commissioning to ensure that services are reviewed and developed to ensure cost-effective, high quality care is provided at the right point to minimise or eliminate long-term support needs.

As already confirmed – project management arrangements are strong and well monitored plans exist for delivery.

Work has been undertaken with frontline staff and managers across Lewisham to identify key gaps in knowledge and work on the VPR in particular is intended to provide as much information as possible, subject to the necessary information governance protocols. In addition, systems have been demonstrated and tested with staff to ensure suitability in terms of interface and useability.

A cost/benefit analysis has been developed to ensure that all organisations taking part in the Virtual Patient Record project will receive suitable benefits that will offset the costs of deployment. Some will be immediately cash-releasing, but many may involve cost avoidance or quality improvements.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme contributes to the success delivery of other BCF schemes so will contribute to the delivery of the following benefits:

- Reduction in Emergency Admissions
- Improved patient experience for people with long term conditions
- Increased proportion of older people who still at home after discharge from hospitals into reablement or rehabilitation
- Maintain the current low level of delayed transfer of care
- Reduction in permanent admissions to residential homes

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

This scheme contributes to the other BCF schemes and has clear deliverables within the associated projects.

What are the key success factors for implementation of this scheme?

The scheme will require a number of IG and technical hurdles to be overcome. Evidence from other areas demonstrates that success is achievable, but local requirements will need to be considered carefully by the delivery teams to ensure that all parties keep pace with the required activity to deliver within expected timescales.

Other key success factors are the capacity and capability of the workforce to utilise fully the potential of VPR.

ANNEX 2 – Provider commentary

NHS England / LGA guidance for completing the "Provider commentary" in Annex 2 below

One of the key changes is that we are asking all areas to ensure they have shared their planned non-elective activity reductions with their relevant providers. In particular, we are looking for acute providers to submit commentary explicitly stating whether they recognise the emergency admissions activity reductions and agree with them. We do not expect providers to sign-off BCF plans, but we do expect to see evidence of provider engagement. A template is provided in annex 2 which should be shared with acute providers for commentary and should be submitted alongside the BCF plans in September.

Although we only require explicit written commentary from acute providers to be submitted alongside the BCF plans, you may wish to conduct a similar exercise with out-of-hospital providers to ensure they are prepared for any impact of planned emergency admissions reductions.

A good provider commentary will:

- Confirm detailed and meaningful provider involvement in the development of the
- plans, from the major acute providers locally
- Demonstrate clear alignment between the overarching BCF plan and the provider plans
- Provide triangulation to provide reassurance that the projected reductions in planned emergency activity are feasible
- Confirm that providers are implementing their own risk management and action plans to respond to the planned change in activity
- Demonstrate a shared understanding of the critical path to successful delivery
- Articulate local risks and cross reference with the risk log in Section 4

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Lewisham
Name of Provider organisation	Lewisham & Greenwich NHS Trust
Name of Provider CEO	Tim Higginson
Signature (electronic or typed)	Tim Higginson

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	24,329 (all providers)
	2014/15 Plan	24,840 (all providers)
	2015/16 Plan	24,272 (all providers)
	14/15 Change compared to 13/14 outturn	2.1%

	15/16 Change compared to planned 14/15 outturn	-2.3%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	N/A
	How many non-elective admissions is the BCF planned to prevent in 15-16?	459

*** Note: These above figures do not match the part two spreadsheet as the above figures are planned figures for 2014/15 and 2014/16 whereas the part two spreadsheet figures are Q4 2013/14 to Q3 2014/15 and Q4 2014/15 to Q3 2015/16.**

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Lewisham and Greenwich NHS Trust support the planned reductions of non-elective admissions targeted through the BCF, integrated in a wider programme of pathway change aimed to keep people out of hospital.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	N/A
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Lewisham and Greenwich NHS Trust are working with partners to reduce demand on A&E and inpatient admissions which is over our capacity at this time, and this reduction in non-elective admissions is entirely consistent with our own service objectives.

Lewisham

NHS
Lewisham
Clinical Commissioning Group

Draft Joint Commissioning Intentions for Integrated Care

2015-16 and 2016-17

Updated: 28th October 2014

Version 12

Contents

1. Executive summary

This document sets out our draft Joint Commissioning Intentions for Integrated Care. It is a framework for how we intend to commission local health and care services for 2015/16 and 2016/17. It covers the whole of Lewisham's adult population with a particular focus on:

- frail and vulnerable people;
- adults with complex needs and disabilities;
- older people;
- people with long term conditions and/or mental health problems;
- people with alcohol problems;
- pregnant women.

The draft Joint Commissioning Intentions includes the interface with children and young people's services that are commissioned by the health service. The Children and Young People's plan (2012–2015) - 'It's everybody's business' - sets out the strategic aims and the detailed priorities and plans for all agencies working with children and young people across Lewisham.[1]

It is a single plan with one set of priorities. This is the first time we have brought together the collective resources available to Lewisham Council (Adult Social Care and Public Health) and NHS Lewisham Clinical Commissioning Group (CCG). We aim to use these resources, of nearly £490 million, to their best effect to reshape the advice, support and care services provided across health and social care, working together with our public and partners, to improve health and care and reduce health inequalities.

It sets out how our population's physical, mental and social care needs will be better met through coordinated advice, support and care. Our approach is to commission person-centred care, that through early intervention and integrated care pathways helps Lewisham residents – from birth and throughout life - to enjoy a good quality of life, to make choosing healthy living easier, and to support local people and neighbourhoods to do more for themselves and one another.

It is an ambitious commissioning plan. We believe that by transforming systems and organisations we will be able to respond effectively to the following significant challenges facing health and social care in Lewisham:

- people are living longer.
- more people have one or more long term conditions.
- deprivation is increasing.
- too many people die early from deaths that could have been prevented by healthier lifestyles.
- people's experience of care is very variable.
- services are under increased strain due to a rising level of demand and limited resources.

[1] http://www.lewisham.gov.uk/myservices/socialcare/children/Documents/CYPP2012-15.pdf

- people's expectation of services and the cost of services are increasing.
- there is an affordability gap which cannot be addressed by efficiency and productivity improvements only.

We have chosen six priorities which align with the Better Care Fund submission:

1. prevention and early intervention(section 5.1)
2. GP practices and primary care (section 5.2)
3. Neighbourhood community care for adults (section 5.3)
4. Enhanced care and support for adults (section 5.4)
5. Children and young people's care (section 5.5)
6. Supporting enablers (section 5.6)

The proposed action plans for these priorities will allow us to achieve our ambition and are realistic and feasible to deliver within the expected resources.

These proposed priorities build on and embed the work of previous health and care plans (see box below) all of which have been informed by our Joint Strategic Needs Assessment[2] and the views of local people in Lewisham.

Relevant Lewisham Strategic and Operational Plans
• Health and Wellbeing Strategy • Children's and Young People's Plan 2012-2015 • CCG's Commissioning Strategy 2013-18 • Last Years CCG's Commissioning Intentions 2014/15 – 2015/16 • CCG's Operating Plan 2014/15-2015/16 • Draft south east London commissioning strategy The relationship between these different plans is shown at Appendix A

A financial gap remains between the draft action plans, as set out in these draft Commissioning Intentions, and the resources we expect to have for the next two years. Given these significant challenges, these draft joint Commissioning Intentions are part of a continuing journey of planning, engaging, prioritising and reviewing how best we use our joint resources, of nearly £490 million, to provide quality care with improved health and care outcomes for all in Lewisham. It is part of our ongoing dialogue with the Lewisham people and partners together to determine the way integrated care will be provided in Lewisham. We remain committed to fully engage in an open and transparent way with the public and our providers to discuss the way we can best meet the serious challenges that face statutory health and social care organisations in Lewisham

We know we can find local solutions to the significant challenges we face, today and in the future, by continuing to:

[2] www.lewishamjsna.org.uk and see Glossary of Terms, Appendix F

- work in partnership with Lewisham residents.
- work effectively with the CCG's member practices, both as local commissioners and providers of services.
- work collectively with other CCGs and NHS England, across the south east London health economy as a whole, on the elements of our strategy that cannot be addressed at a Lewisham borough level alone.
- work collaboratively with our local providers, including voluntary and community organisations, to support them to integrate care across organisational boundaries and respond effectively to our commissioning expectations as set out in section 6.

Thus, it is vitally important that we the local health and care commissioners, the CCG's members, Lewisham residents and local providers continue to work together to effectively reshape future health and care systems and organisations locally in Lewisham.

Aileen Buckton
Executive Director for Community Services
London Borough of Lewisham

Dr Danny Ruta
Director of Public Health,
London Borough of Lewisham

Dr Marc Rowland
Chair,
NHS Lewisham CCG

Martin Wilkinson
Chief Officer,
NHS Lewisham CCG

2. Who we are

NHS Lewisham Clinical Commissioning Group (CCG) and the London Borough of Lewisham (LBL) are responsible for commissioning (planning, buying and monitoring) the majority of health and care services in Lewisham. LBL and Lewisham CCG have co-terminus boundaries.

Residents access acute and community health care mainly from Lewisham and Greenwich NHS Trust and mental health care from South London and Maudsley Foundation Trust. Health and care work together in four geographical neighbourhoods as shown at Appendix B.

NHS Lewisham Clinical Commissioning Group (CCG) is a membership organisation made up of the GP practices in the borough. NHS Lewisham CCG commissions most of the healthcare services for Lewisham residents, including:

- hospital care
- rehabilitation care
- urgent and emergency care
- most of community health services
- mental health
- learning disability services

NHS England commission primary care services such as GPs, pharmacists, dentists and opticians and some other specialist services.

London Borough of Lewisham (LBL) commissions and in some areas provides a wide range of services including:

- adult social care, community and cultural services, public health
- children's social care - targeted and early intervention services for children and young people
- housing and homeless
- education; environment and waste
- planning economy and regeneration
- finances for payment of council tax and benefits

Health and Wellbeing Board – NHS Lewisham CCG and the London Borough of Lewisham work in partnership with other stakeholders[3], as members of Lewisham's Health and Wellbeing Board. The Health and Wellbeing Board is a statutory committee of the London Borough of Lewisham (LBL). It promotes greater integration to improve health and wellbeing in Lewisham and produces the joint strategic needs assessment (JSNA). The Council, the CCG and partners use this information to develop strategies to meet the identified needs of Lewisham people. The Health and Wellbeing Board oversees the Adult Integrated Care Programme, and works alongside the Children and Young People's Strategic Partnership to deliver the priorities in the Children and Young People's Plan:

[3] Health and Wellbeing Board's membership – see Glossary of Terms, Appendix F

- The Children and Young People's Strategic Partnership (CYPSP) brings together all organisations working with and for children and young people in Lewisham, so that services are well placed to deliver our vision that - 'Together with families, we will improve the lives and life chances of the children and young people in Lewisham'.

- The Adults Integrated Care Programme (AICP)[4] covers all adults in Lewisham. It is a whole system approach covering most services and activities across the health and care sector, including public health. It is aligned with universal services such as Supporting People, housing, employment, adult education, culture and leisure and is underpinned by joint commissioning, local pooled budgets (section 75 agreements)[5] and Better Care Funding.

South East London - the six CCGs in south east London are working together with NHS England commissioners (specialised services and primary care), the six London Boroughs and the public to deliver 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. There is a public consultation process underway for the south east London commissioning strategy[6] - 'Our Heathier South East London. Appendix A shows how the different strategic plans fit together.

[4] Adult Integrated Care Programme – see Glossary of Terms, Appendix F
[5] Section 75 Agreements – see Glossary of Terms, Appendix F
[6] http://www.lewishamccg.nhs.uk/get-involved/improving-south-east-Londons-health-services-together/Documents/SEL%20Strategy%2020%20June%202014.pdf

3. Our vision for health and care in Lewisham

Lewisham's vision is to deliver joined up and co-ordinated health and social care to all residents in the borough.

Our overall ambition for adults is for adults to be more in control of their care, to understand what services are available to them and know how to access urgent support. People who use services experience person-centred support and care provided closer to home by joined up teams of staff, working proactively, to reduce the need to attend or be admitted to hospital in an emergency.

Our vision for adult health and care in Lewisham

Better Health – to make choosing healthy living easier - providing people with the right advice, support and care, in the right place, at the right time to improve their health and wellbeing.

Better Care - to provide the most effective personalised care and support where and when it is most needed - giving all adults control of their own care and supporting them to meet their individual needs.

Stronger Communities – to build engaged, resilient and self-directing communities - helping local people and neighbourhoods to do more for themselves and one another.

Our overall ambition for children and young people is that together with families, we will improve the lives and life chances of the children and young people in Lewisham. We will target support to the children, young people and families who need it most, intervening early so that their needs do not escalate and outcomes are improved. We will achieve this through effective joint commissioning and the better alignment of resources across different agencies to deliver the partnership's shared outcomes across health, social care and education.

Our vision for children and young people is underpinned by three shared values:

We will put children and young people first every time.

We will have the highest aspirations and ambitions for all our children and young people.

We will make a positive difference to the lives of children and young people.

4. Local challenges

Local challenge in Lewisham:

- changes in our population's health and social care needs
- Lewisham residents' views of their service is that greater improvement is required
- performance of our current services
- financial position over the next two years

4.1 Population trends and health and social care needs

Key population and ethnicity profile change

Lewisham is a diverse inner London borough with a growing population, projected to increase from 286,000 to 318,000 by 2021. Lewisham is the 15th most ethnically diverse local authority in England - 46% of the population are from black and ethnic minority groups. Lewisham's population is relatively young, with one in four aged under 19 years.

Lewisham's population is projected to grow across all age groups over the next five years. In this period the largest will be in the 20-64 year old age group. The ethnic profile of those aged 20-64 will be increasingly diverse with a greater proportion of people from black and ethnic minority groups.

However, over the next fifteen years the greatest percentage increase will be in the 65+ age group. The ethnic profile of the older population which had been previously predominantly white will also change.

Challenge – people are living longer

Around 26,000 residents in Lewisham are above 65 years of age and over 3,400 are aged over 85 years. In 2012/13 almost 8000 Lewisham people aged 65 years and over had an emergency admission to hospital. The most common diagnosis for admission for those aged over 65 years was pneumonia, urinary tract infections (UTI) and COPD

There have been improvements in the health of Lewisham residents. However Lewisham people still have significantly worst health outcomes than the rest of London and England.

Challenge – more people have one or more long term conditions

The likelihood of having a long term condition, including dementia increases with age; over 50% of those aged over 75 are likely to have two or more long term conditions. Long term conditions account for £7 of every £10 spent on health and care in England.

Deprivation

Deprivation is increasing in Lewisham. The Index of Multiple Deprivation 2010 ranks Lewisham 31st of 326 districts in England and 9th out of 33 London boroughs.

Challenge – increasing deprivation

People living in the most deprived wards have poorer health outcomes and lower life expectancy compared to England's average

The areas of the highest deprivation are found in Evelyn (the most culturally diverse ward in the borough) and Whitefoot and Bellingham (wards with the highest proportion of older people). Even within wards there can be very wide and potentially increasing variation in the wellbeing and life chances experienced by residents.

Mortality

Life expectancy has been improving. The life expectancy at birth was 76.7 years for women and 72.3 years for men in 1991-93; in 2008-10 it had increased to 81.3 years and 78.8 years respectively, however, for both men and women life expectancy remains lower than the England average. Also there are even greater differences in life expectancy rates in different wards within the borough. Life expectancy is 6.6 years lower for men and women in the most deprived areas of Lewisham than in the least deprived areas.

Challenge – too many people die early from deaths that could have been prevented by healthier lifestyles

Cancer is now the main cause of death (28.3%), followed by circulatory disease (28.1%), respiratory disease (13.8%) and dementia (9%) in Lewisham.

A fifth (21%) of Lewisham population smoke, which is more than the national average. About a third of adults in the borough are overweight or obese, compared to just under a quarter in England as a whole. Lewisham also has a high level of childhood obesity - over 25% of Reception children and 37% of Year 6 are overweight or obese. Alcohol related harm is significant and increasing in Lewisham.

The main health risks by age group	
Children • premature delivery • low birth weights of babies • high levels of obesity • exposure to toxic stress • the level of child poverty in Lewisham is significantly worse than the England average • the rate of family homelessness is also worse than the England average	**Young people** • mental health issues, often as a consequence of exposure to toxic stress during early development • sexual ill-health - high levels of teenage pregnancy and rates of sexually transmitted infections (STIs) • high levels of obesity • tobacco, alcohol and cannabis use also adversely affect young people's health in Lewisham
Adults • increasing numbers of people diagnosed with long term conditions and their management, in particular, diabetes, COPD, CVD and hypertension • level of mental health needs for both common and severe mental illness is significantly higher for adults in Lewisham than comparative borough • Lewisham is only identifying 52.9% of people with dementia; increasing the low diagnosis is a national challenge • high levels of drug and alcohol misuse	**Older people** • the likelihood of having a long term condition increases with age, with over 50% of those aged 75+ having two or more long term conditions. • dementia as it increases markedly with age and the level of diagnosis is low (see Adults section) • accidental falls - the rate of emergency hospital admissions for accidental falls is significantly higher in Lewisham than the England average, at 3,367 per 100,000 in 2012/13

Further information is available from Lewisham's Joint Strategic Needs Assessment.[7]

4.2 Lewisham residents' views of our service

There has been an ongoing dialogue with the people of Lewisham and local providers about our proposed commissioning priorities and plans through a wide programme of engagement, including the Quality Summit[8], joint workshops on integrated care[9], focus groups[10], online surveys [11]as well as a range of consultation

[7] http://www.lewishamjsna.org.uk/
[8] Quality in Health and Social Care – a People's Summit – 29th March 2014
[9] Joint Integrated Workshops have been held to map care pathways; review information and advice and develop neighbourhood community vision during 2014

events. We have worked closely with Lewisham Healthwatch and with the many voluntary organisations and community groups in Lewisham to capture the views of local people about their local services, which are summarised at Appendix C.

This engagement work has confirmed that the people in Lewisham support the key priorities of the Adult Integrated Care Programme including:

- individuals making choices and decisions for themselves -which requires better information to support people to have greater confidence to make choices and take control of the management of their own care.
- individuals looking after themselves more and a willingness to self-manage their health and wellbeing – but again this requires better information and advice which is personalised and access to the right support.
- better co-ordination and joined up health and care services which includes the voluntary sector.
- personalised care which is holistic – where the user of the service is in control, supported with individual care planning and shared decision making.

This engagement work has confirmed that further improvements are required in local services. Lewisham Healthwatch recently provided an overview of the key messages from Lewisham people during 2013-14, which was reinforced at the People's Quality Summit in March 2014, as summarised in the box below:

How to improve health and care outcomes -

Summary feedback from local residents:

- **More information** – Lewisham residents want greater information on:
  - how to access services and activities - to know how to access services out of hours and weekends; more information on how services are performing against standards
  - how to do more self-care and manage their own care; there is a strong willingness to self-manage and support for 'every contact counts'; people want more information about their medication and discharge information
  - how to get involved in community activities.
- **Caring staff** – local people who use services want competent staff who are courteous and compassionate and treat the person as an individual; who listen and keep the user, carers and family members informed throughout the planning, care and treatment
- **Better coordinated services** – Lewisham residents strongly supported joined up health and social care, specifically improving the coordination between district nurses, care workers and other agencies

Source: Healthwatch Lewisham (July 2014); People's Quality Summit (March 2014)

[10] Focus Groups with different specific groups (reflecting our seldom heard and equalities protected characteristics) as part of developing the CCG's Commissioning Strategy

[11] Online survey of the CCG's Commissioning Intentions – January 2014

The above views of Lewisham residents have informed the development of the proposed implementation plans for 2015/16 and 2016/17 as summarised in Section 5.

See Appendix C for more information which shows the Lewisham people have informed the development of specific action plans for 2015/16 and 2016/17.

4.3 Performance of our services

We have seen improvements in services already during 2013/14 with the alignment of acute and community health and care teams and the pilot of an integrated multi-disciplinary team in one neighbourhood:

- people with long term conditions feel more supported.
- emergency admissions for chronic conditions have reduced.
- 87% of the people who were supported through Enablement Care Services were able to remain in the community at the end of the service provision.
- although our older people population has risen, there has been a decrease in the numbers entering residential or nursing care. Therefore more people have remained in their own homes also the number of emergency admissions has reduced for people over 65 years.
- mothers who smoke at time of delivery has decreased from 8.7% in March 2012 to 4.4% in March 2014. This is significantly lower than the average in England at 12%.
- the number of Looked After Children (LAC) who have completed annual health assessments rose from 80.9% in March 2012 to 92.8% as at August 2014, and 100% of Looked After Children aged 0-4 have had annual health checks.
- percentage of LAC who received intervention for substance misuse is 100%, exceeding the target of 80%.

There are many examples of excellent services in Lewisham; but we have not succeeded in rolling out best practice and innovation uniformly across the borough, and some unacceptable variation in services and outcomes remains, for example:

- the NHS Constitutional standard that Lewisham residents should start their consultant led treatment within a maximum of 18 weeks from GP referral for non-urgent conditions is not being met fully – in August 2014 the overall performance was 89%.

- some Lewisham people have difficulty in accessing primary care services.

- a high proportion of children in Lewisham are not being vaccinated, especially the uptake of the pre-school booster and the MMR2 by the age of five remain below target.

Challenge – people's experience of care is very variable

Reduce the current variation in the quality of care and experience for all Lewisham residents

Given the rising pressure on health and care services, we need to ensure that a consistent high quality care is provided within the finite resources.

Challenge – increasing pressure on services

Maintain high quality services which are safe when services are under increased strain due to a rising level of demand and limited resources

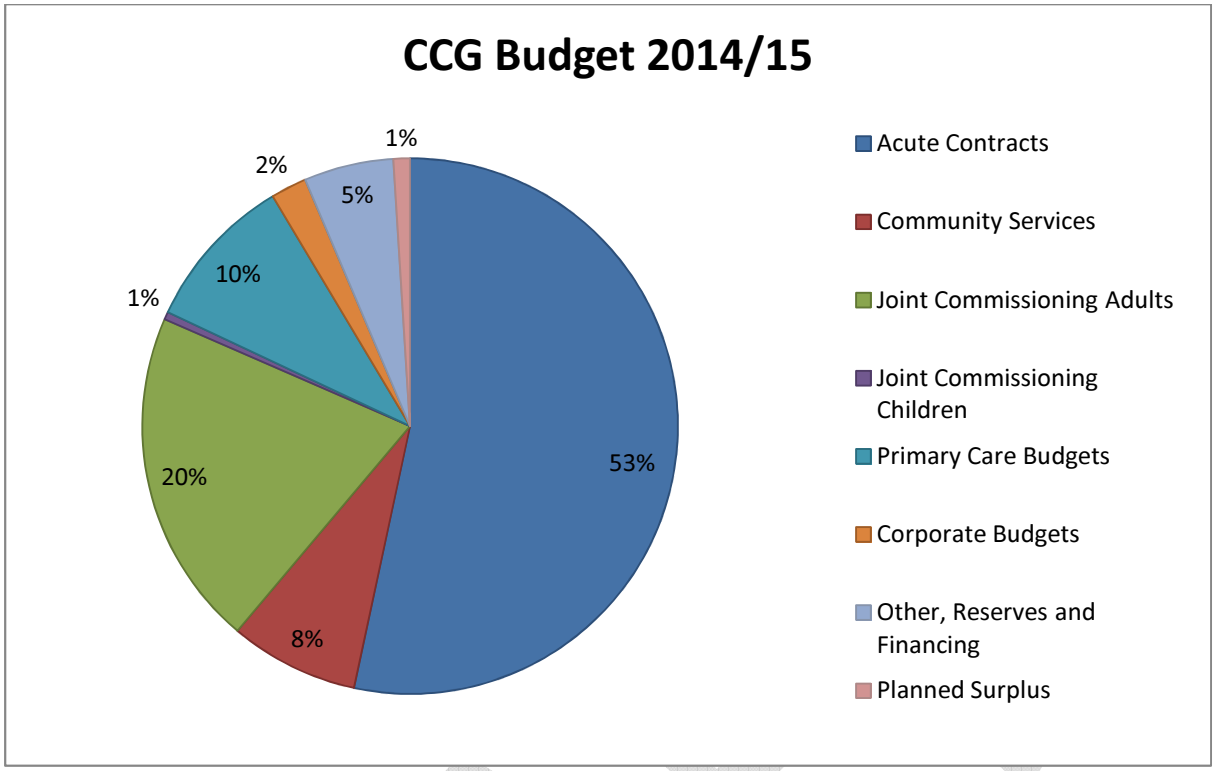
The cost of providing care is getting more expensive. The health service can now treat illnesses that previously were undiagnosed or were simply untreatable. People with more complex conditions can be supported in the community due to better drugs, equipment and skilled staff. It is good that more people are receiving health and care, but we cannot afford to keep treating more and more people. We need to work together to improve the performance of some services, but also provide services in a different way in the future.

Challenge – rising expectations of people and increasing cost of services

The cost of delivering health and care services is increasing - we need to work together to improve the performance of some services, but also provide services in a different way in the future.

4.4 Financial position over the next two years

NHS Lewisham Clinical Commissioning Group (CCG) receives around £384m (2014/15) to commission most of the healthcare services in Lewisham which we allocate as follows:



53% of the CCG's budget is spent on acute hospital care equivalent to £205 million.

If NHS Lewisham CCG continues to commission in the same way as today it will result in the CCG facing a funding gap between projected spending requirements and resources available of around £27.5 million between 2015/16 and 2016/17.

NHS Lewisham CCG	2014/15 (this year)	2015/16 (year 1)	2016/17 (year 2)
Net spend budget	£377.826 million[12]	£391.633 million	£398.595 million
Savings required	£9.990 million	£13.557 million	£13.964 million

Source: NHS Lewisham CCG's Governing Body March 2014

This estimate is made taking into account current expected productivity improvements and the expected annual out-turn expenditure in line with contracts, and assumes that the health budget will remain protected in real terms and is based on national guidance[13].

Lewisham Council has a net spend budget of £268 million in 2014/15. It needs to make £85 million savings over the next three years due to reduced government

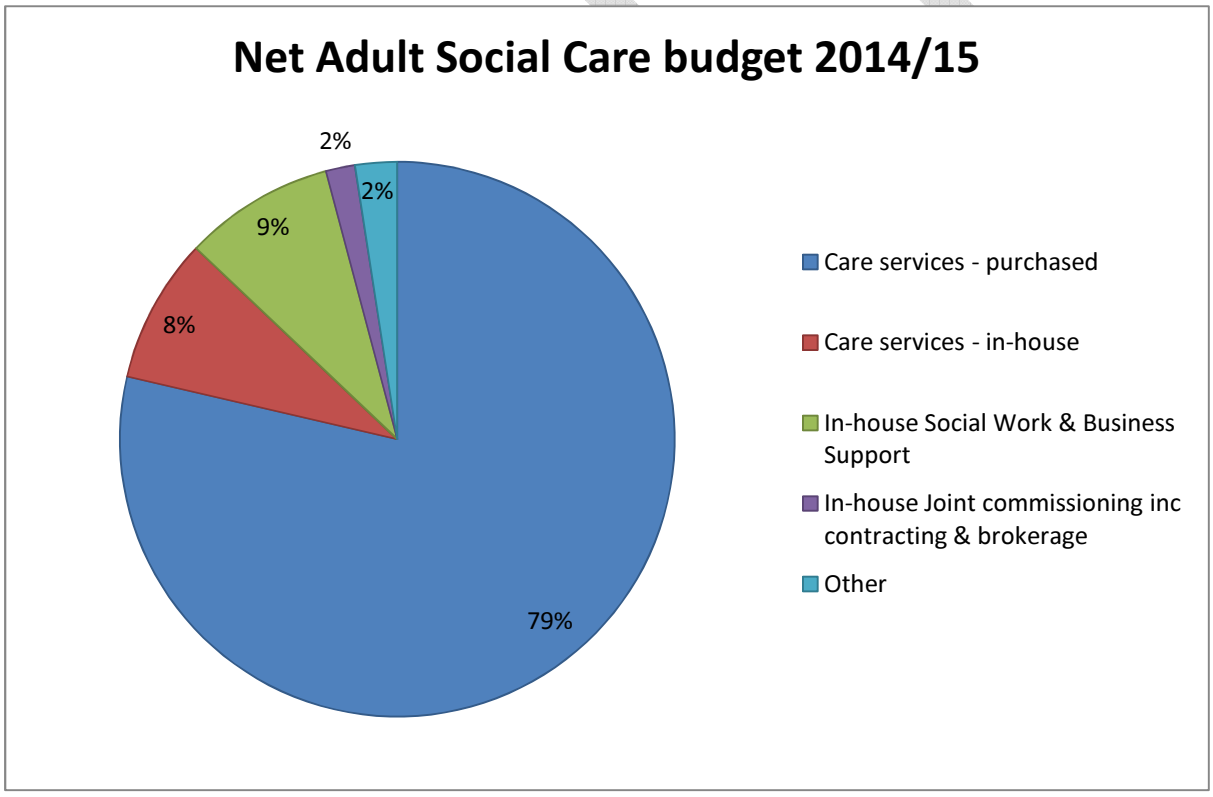
[12] As at March 2014, since then additional budget adjustments have been made.
[13] 'Everyone Counts: Planning for Patients 2014/15 - 2018/19' – see Glossary of Terms – Appendix F

funding – as shown below. The Council is engaging with Lewisham residents on how these savings can be made as part of the 'Lewisham's Big Budget Challenge'[14]

Lewisham Council	2014/15 (this year)	2015/16 (year 1)	2016/17 (year 2)
Savings required	£39.0 million	£26.0 million	£20.0 million

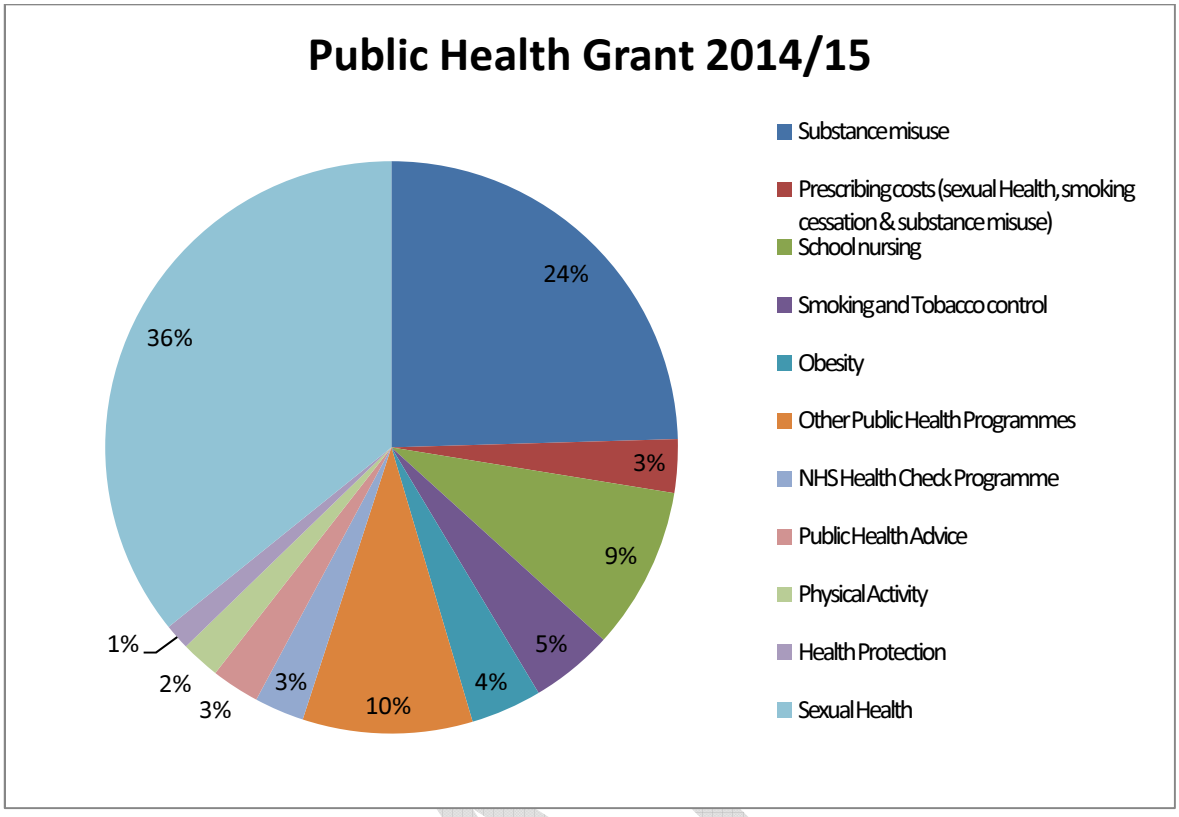
Source: Healthier Communities Select Committee, 21st October 2014, item 5, Lewisham Futures Programme

Lewisham Council's Adult Social Care (ASC) has a net budget of £84.57 million. The majority (87%) of the ASC's budget is spent on the provision of care to individuals, either in their own homes or in community settings – as shown below. As the largest service area, adult social care will be required to make a substantial contribution to the Council savings programme over the next two years.



Lewisham Council's Public Health budget is £20 million in 2014/15. It is currently a 'ring fenced budget' so this money has to be invested in Public Health. The main areas of Public Health expenditure are

[14] http://www.lewisham.gov.uk/getinvolved/influence/Pages/The-Lewisham-Big-Budget-Challenge.aspx



Integrated care has delivered some efficiency savings and reshaped some services already. But improved productivity and efficiency savings alone will not be sufficient action to address the significant financial pressures and to respond to increases in the level and complexity of demand.

Challenge – affordability gap

Greater efficiency and productivity improvements will not be sufficient to address the significant financial challenges Lewisham faces.

This means the solution is to work together to change what we do and how we do it.

5. Proposed commissioning priorities and plans for 2015/16-2016/17

This section describes the six proposed commissioning priorities for 2015/16-2016/17 to deliver integrated care across Lewisham, which is centred around the individual, their family and their carers:

1. prevention and early intervention(section 5.1)
2. GP practices and primary care (section 5.2)
3. Neighbourhood community care for adults (section 5.3)
4. Enhanced care and support for adults (section 5.4)
5. Children and young people's care (section 5.5)
6. Supporting enablers (section 5.6)

5.1 Prevention and early intervention

Our aim for prevention and early intervention
To connect people to services and communities across the borough to promote wellbeing; where people recognise their personal strength and abilities as well as those of their families, friends and communities. To encourage people to stay independent longer and to find creative solutions to individual and collective challenges.

What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for Prevention and Early Intervention is to:

- establish a Single Point of Access to improve the coordination and provision of information and advice, borough wide, with a single phone number for social care and health, to provide more detailed information about services available and advice on how to stay healthy.

- provide a borough wide information and advice gateway to provide specialist advice and signposting for carers. This information will support self- help and self-care and be the access point for care accounts, as required by the Care Act 2014.

- promote healthy life styles to support Lewisham people to have greater engagement in and control of their own health and care by**:**

- improving the provision and access to preventative services, low level equipment and rehabilitation and reablement of people following a fall, to reduce the number of falls.

- increasing the support to people to enable them to stay in their own homes by investing in minor housing improvements such as those achieved through “warm homes” and handyperson schemes, low level equipment and telecare.

- integrating health improvement services with the neighbourhood community networks so that interventions and services can facilitate and support life style and behaviour changes - to reduce smoking, alcohol and drug misuse; promote mental and emotional wellbeing healthy eating, exercise and cancer screening - through making ‘every contact count’.

- extend Lewisham’s Community Connections project to connect people to local support and activities, reduce isolation and improve wellbeing for the people who use services and carers.
- Children and Young People:

  - promote emotional wellbeing of our young people through delivery of our Headstart programme and submission to The Big Lottery for further work in 2015.
  - implement the expansion of health visitors and transfer of responsibilities to Local Authorities.
  - reduce preventable childhood illness by promoting the uptake of infant and child vaccinations and a wider model of intervention.

5.2 GP practices and primary care

Our aim for GP practices and primary care
To provide strong GP practices and primary care[15] focused on delivering continuity of care which is proactive, co-ordinated and accessible to deliver improved outcomes, working in partnership with patients and in collaboration with other practices and neighbourhood community teams.

What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for GP practices, working with neighbourhood community teams, supported by local improvement funding, is to:

[15] Primary Care services includes GP practices, community pharmacists, general dental practitioners and optometrists

- increase the level of proactive, preventative care focused on 'every contact counts'; health checks, promoting immunisation and vaccination, to promote better health.
- increase earlier identification, diagnosis and intervention for people over 75 - diabetes, Cardiovascular-disease (CVD), chronic-obstructive pulmonary-disease (COPD), dementia and cancer, to improve health outcomes.
- provide greater support to patient self-management of long term conditions, to increase individual choice and control.
- ensure that patients have collaborative care plans, identify people who will benefit from continuity of care and ensure that these people have a named professional accountable for their care.
- reduce variation in care between GP practices by supporting GP practices:
  - make appropriate outpatient referrals by improving the pathways of care and evaluating the Referral Support Service pilot[16].
  - effective medication reviews and prescribing of medicines.
  - address quality standards, diagnosis and management of disease as highlighted in neighbourhood population profiles.
  - improve the patient's experience with better access in hours and out of hours and continuity of care, using the information gained from the public about the barriers to accessing GP services.
  - support NHS England's consultation on the London draft standards and specifications for primary care.
- improve the quality and accessibility of urgent care by redesigning current services, like 'walk in centres' [17], to make them simpler to navigate, with a common specification and with the roll out of NHS 111 In Lewisham working with neighbouring CCGs.
- enhance access to Mental Health Specialist advice and support to primary care via neighbourhood link workers and consultants supporting the seamless and effective transition of individuals with mental health needs into primary care.
- support specialist provision within primary care to provide enhanced treatment for drug and alcohol problems with a particular focus on increasing and higher risk drinkers.
- support the implementation of End of Life - "One Chance to Get it Right" and the opportunities of better care with Coordinate My Care.
- take forward the potential opportunities of primary care co-commissioning including developing the appropriate governance arrangements, working collaboratively across south east London.

[16] Referral Support Service – see Glossary of Terms – Appendix F
[17] Walk in centres in Lewisham - see Glossary of Terms – Appendix F

- support GPs to continuously improve the quality of services they provide by implementing an education and training programme.
- increase the co-ordination of care working with the wider primary care team – with community pharmacists for minor illnesses, general dental practitioners and optometrists.

5.3 Neighbourhood community care for adults

Our aim for neighbourhood community care for adults
To provide co-ordinated support and care, by locally based multi-disciplinary teams, for people with long term physical and/or mental health conditions and vulnerable people, with their carers, families and communities to effectively manage their own care, where possible, and maintain their independence.

What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for Neighbourhood Community Care is to:

- embed and enhance the effectiveness of the Neighbourhood community teams which are aligned to General Practice (GP) clusters with the integration of mental health workers to co-ordinate both physical and mental health care. These multi-disciplinary teams have already brought together district nurses, all therapies, social workers and care workers. The core neighbourhood community teams are linked with the wider neighbourhood community network. The functions of the neighbourhood community teams are to provide:
  - preventative care through the early identification of risks and deterioration.
  - admission avoidance using local multidisciplinary teams (MDTs) centred around person centred care and collaborative care plans.
  - support following hospital discharge to remain well and supported in the community.
  - short-term enablement support to enhance independent living skills.
  - joint medication policy and medication reviews to optimise the use of medication.
  - increase people's confidence and motivation to manage their condition by extending peer support and self-management.
  - provision of 'hub' services for drug and alcohol misusers in the community.
- Take a shared approach to care management across health and social care, including:
  - same approach to risk stratification to identify those people at higher risks of a deterioration in their health.
  - sharing of information, resulting in individuals only having to tell their story once.

- single assessment and co-produced health and social care records.
- single reviews undertaken by trusted reviewers on behalf of health and social care whenever possible.
- personal budgets are offered to all to adults and children who are eligible for NHS Fully Funded continuing healthcare.

- workforce training to ensure that all staff have the appropriate capability, capacity and engagement to ensure an equitable service for all users of services, including strengthening working practices through leadership and supervision to heath and care staff who work in people's homes and in isolation.

- realignment of care packages for people with learning and/or physical disabilities to meet their needs in the most cost effective way. This will include potentially taking forward preliminary work to develop new integrated personal commissioning for people with complex needs, working with people who use these services, their families and the voluntary sector.

- give equal status to mental health with physical health, by enhancing the range of community mental health services and interventions that are tailor-made to the needs of individuals and their aspirations for long term recovery and provide support to reduce relapse and need for hospital re-admission.
- support the development of Lewisham's Maternity Care Model to promote normalised child birth and improve continuity of care for mothers.
- review of current services and procurement approaches for community based services:

  - review community health services to ensure that the delivery of these services are fully integrated with the neighbourhood community teams and to identify areas for potential future market testing, which is likely to include diabetes, pressure ulcer and tissue viability services.
  - Review acute services to ensure that the delivery of these services are fully integrated across health and social care to identify areas for potential innovative contractual models which is likely to include the care pathway for musculoskeletal[18], direct access physiotherapy, dermatology and cardiology.
  - review of talking therapies services in the borough to inform future service development.
  - review mental health voluntary contracts to increase the opportunity for community support for people with mental health problems and reducing the reliance on secondary care services.

[18] MSK – Musculoskeletal - see Glossary of Terms Appendix F

5.4 Enhanced care and support for adults

Our aim for enhanced care and support for adults
To refocus and redesign the current community based intermediate tier of services to better provide enhanced care to support people to continue to live at home and to prevent people requiring a hospital admission and ensuring effective structured discharge to avoid re-admission.

What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for enhanced care and support is to:

- provide additional community based support by responding rapidly to changes in circumstances and providing alternative services to acute hospital care, to maximise the opportunity for people to remain in their own home or within a community setting.
- refocus and reshape existing community based care services that contribute to admission avoidance across Lewisham's health and care sector to improve their responsiveness, application and outcomes. This will include redesigning access to and pathways through such services. New approaches will be piloted over the winter period and, where successful, new contracts for services will be put in place from 2015/16 with a focus on enhancing 'step up' facilities[19].
- review, develop and enhance support available to and within care homes to ensure that unplanned admissions from such settings can be reduced.
- improve the structures around discharge planning and its associated services to reduce unnecessary delay and readmission. This covers assessments of need, home preparation services and night sitting services.
- streamline the process and application for the Disabled Facilities Grant to ensure that it is used to best effect to maximise the benefits for residents working with housing services.
- work in partnership with Housing – to deliver alternative service models to support people to live longer in the community
    - Implement new model for extra care housing including remodelling existing sheltered assets developed jointly with Lewisham Homes
    - Explore alternative models of housing and support for vulnerable groups including people with learning disabilities and mental health problems
- review and evaluate the implementation of the adult Mental Health model to ensure that it is improving outcomes for services users and reducing the reliance on bed based care.
- improve continuing healthcare (CHC) processes for assessment and case management by:

[19] Community Based 'Step up' services – see Glossary of Terms Appendix F

- reviewing the CHC process from checklist/referral to decision making in order to improve processes.
- reviewing placement activity (AQP via spot purchasing vs home care packages) in order to identify current trends and projections for future demand.
- developing a joint funding policy with the London Borough of Lewisham for patients who do not meet the eligibility criteria for NHS Fully Funded Continuing Care but have significant health care needs.

- recomission our nursing home contracts to ensure that we have access to sufficient high quality cost effective which offer choice to service users and their families.

- review the provision of specialist continuing care services for older adults with severe mental health problems to ensure that these specialist services are commissioned in the most clinically appropriate and cost effective way.

- End of Life – to ensure the NHS London Strategic Clinical End of Life Network Guidance on Commissioning Intentions is implemented locally
- Neuro-rehabilitation to ensure that Lewisham residents have access to a range of neuro-rehabilitation services including specialist bed based, currently commissioned by NHS England, lower acuity bed based services, slow stream rehabilitation and community based neuro-rehabilitation

- re-commission the existing domiciliary care framework to move from a model which delivers care in a 'time and task ' approach to one which focuses on delivering outcomes which are important to individuals and their families'.
- explore the opportunities for supporting people who have both physical and mental health problems and who need a hospital admission by developing a different model of care between acute care and mental health focusing on rapid assessment and discharge planning (RAID).

5.5 Children and young people's care

Our aim for children and young people's care
To provide integrated care pathways that provide high quality support – with choice and control for children, young people and their families at the right time, in the right place for all our children and young people, ensuring that needs do not escalate.

What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for Children's and Young People is to:

- shape the development of regional health service provision through the south east London Clinical Commissioning Strategy – ensuring that our existing areas of good practice are emphasised and replicated.
- deliver high quality and integrated care pathways in the community to ensure that all children receive excellent and complementary care from different services, partners and providers - including children's community nursing, school nurses, therapies, and special needs nursing.
- develop the process and mechanisms through which to deliver personal health budgets to children, including those with Education, Health and Care Plans.
- secure high quality community health services through re-modelled and effective service delivery with commissioned providers, including school nurses, therapies, and special needs nursing.
- Commission a new drug and alcohol treatment service for Children and Young People up to the age of 25

5.6 Supporting enablers

Our aim for supporting enablers
To ensure that the necessary tools and infra-structure are in place to achieve the cultural changes and working practices required to support integrated care, including public communication and engagement, Information Technology, commissioning tools, estates utilisation

What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for Supporting Enablers is to:

- improve the communication with the public to promote system wide change in the way advice, support and care is provided.
- implement a joint workforce development plan to support the ambition of integrated care and the proposed action plans set out in the Commissioning Intentions:
  - new ways of working, - different skill mix, new generic roles; new competencies.
  - different relationship with patients - a cultural change in the relationship with people who use our services and carers supporting empowerment and independence.

- maximise the potential of technological advances to support people who use our services and professionals, specifically the delivery of Connect Care[20], to provide health and care professionals with more complete information about a person's needs and to support and facilitate, amongst other things, joint assessments, joint care planning and swifter interventions.
- use different commissioning, procurement and contractual tools to secure the potential benefits of integrated care:
  - sharing of risks and incentives between commissioners and providers;
  - joint procurement.
  - the opportunities of Payment by Results (PbR)[21] flexibilities.
  - the commissioning of support service using the opportunities to buy from the Commissioning Support Lead Provider Framework[22].
- provide programme support for Adult Integrated Care Programme[23] to ensure implementation is paced and mainstreamed and evaluations are undertaken and learning shared
- better utilisation of our collective estates by statutory and voluntary organisations – to work with providers to undertake a review of estates in Lewisham Borough to maximise their effective.

[20] Connect Care – see Glossary of Terms, Appendix F
[21] Payment by Results - see Glossary of Terms, Appendix F
[22] Commissioning Support Lead Provider Framework – see Glossary of Terms, Appendix F
[23] Adult Integrated Care Programme - see Glossary of Terms, Appendix F

6. Commissioners' ambition for 2015/16 and 2016/17

6.1 Commissioner's ambition for Lewisham residents

As commissioners we intend to bring together the collective resources available to Lewisham Council (Adult Social Care and Public Health) and NHS Lewisham Clinical Commissioning Group (CCG), of nearly £490 million, to use them to the maximum benefit to support people to live well in all aspects of their lives. Our ambition is to achieve better outcomes than we do now for Lewisham residents by:

- making choosing healthy living easier - providing people with the right advice, support and care, in the right place, at the right time to improve their health and wellbeing and help people live independently.

- providing the most effective personalised care and support where and when it is most needed, so giving all adults control of their own care and supporting them to meet their individual needs.

- helping to build engaged, resilient and self-directing communities - enabling and assisting local people and neighbourhoods to do more for themselves and one another.

6.2 Commissioners' ambition for system wide change

Our ambition is to deliver the six system wide changes across health and social care, summarised below, working together with the people of Lewisham and partners, to achieve improved health and care and reduced inequalities.

Commissioners' ambition for system wide change in 2015/16 and 2016/17
1. Commission advice, support and care services for the **whole population** using techniques of risk stratification, patient segmentation and evidence based care to ensure our collective, limited resources are most effectively used to meet the local health and care needs and challenges. 2. Use an **outcome based approach** to commissioning to ensure that advice, support and care is person centred and delivered earlier and more effectively resulting in: • consistent high quality of care and patient experience whenever and wherever care is provided. • reduced variation and inequalities in health and care outcomes. • increased focus on proactive, preventative care. 3. Work in **partnership with Lewisham residents** to empowering users of services to help reshape their services to achieve better outcomes. 4. **Shift the focus of resources** to invest in joined up primary care, social care and

community care, for both physical and mental health, so that people receive the support they need when they need it and to reduce the growth in demand for acute (hospital based) services.

5. **Spend our collective resources wisely** to deliver better outcomes and avoid waste by working collaboratively with current and future providers to develop the local market and to identify the procurement approach most suitable to achieve and secure the above system wide transformation.

6.3 Commissioners' ambition for all providers

We wish to commission from a wide range of statutory, voluntary and independent sector providers to support us to deliver the proposed priorities and plans as set out in these Commissioning Intentions and to transform systems and organisations to deliver integrated advice, support and care across Lewisham.

We want to work in partnership with all our local providers to support them to embed, within their organisations, systems and processes to ensure that users of the service views are listened to and acted on in order to achieve continuous improvement in the quality of care, which is proactive, self-monitoring and managed - as an effective organisational response to the Francis recommendations[24] and the Winterbourne View report[25].

We would like to work together with our providers to support them to use the opportunities to develop services that help people to live well in all aspects of their lives and to have strong, effective leadership at every level throughout the organisation, to lead the cultural change in the way in which care is delivered across the health and care system

Finally, we are keen to demonstrate to Lewisham residents that not only do we commission services that provide good value for money and are efficient and effective, but also 'add value' and are financially sustainable.

Commissioners' ambition for all local providers in 2015/16 and 2016/17

1. Continuous improvement in quality of care for all – "getting the basics right every time" monitored and reported publicly:

- **Safety** – have robust systems in place to protect people from abuse and avoidable harm, with an open culture to learn when mistakes do occur.
- **User experience** – develop robust systems to find out about the experiences of all people who use our services, including those who are unlikely to complain or voice their views, triangulated with other quality information.
- **Effectiveness** – have a programme of audits to test that advice, support and care achieves good outcomes, promotes good quality of life and is based on the best

[24] Francis Report – see Glossary of Terms, Appendix F
[25] Winterbourne View report – see Glossary of Terms, Appendix F

available evidence; working towards real time information.

- **Workforce** – ensure care is provided by staff who are caring, compassionate and understand the importance of language and cultural differences; staff who are supported to be confident, engaged, motivated, knowledgeable and properly skilled; staff who have shared values and are empowered to be innovative, creative and to learn.

2. Strong leadership at every level throughout the organisation to support the culture and practice in the way in which care is delivered across the health and care system:

- **Person centred** – where the 'person is in control'; the professional is focused on the total needs of the individual, which empowers the individual to be independent, make informed choice and take control; a behavioural change in the relationship between the person and the professional.
- **Proactive, preventative care focused on better outcomes and reducing inequalities** provided in the community setting, supporting health and wellbeing.
- **Provided in cooperation and collaboration** with other professions and coordinated across organisations (health, social care and the voluntary sector) so that it is seamless to the user, supported by Connect Care[26].
- **Co-produced with people who use the services and the public**, with specific consideration to engage with people from protected characteristics, to proactively reduce inequalities of access and outcomes.
- **Supports learning and innovation**.

3. Added Value

- **Increasing value for money** – demonstrate good value for money, efficiency and effectiveness compared to similar services and avoid waste.
- **Move towards an integrated performance management approach** that focuses on improving 'value', for example, by using a scorecard of outcome metric that relate to safety and effectiveness, patient experience and costs.
- **Develop financially sustainable services** working with commissioners.

[26] Connect Care – see Glossary of Terms, Appendix F

7. Measuring the benefits of integrated care

We wish to use the National Voice "I statements"[27] to make sure that we are measuring what Lewisham residents consider to be the most important benefits to achieved by joined up, integrated care. We want to work with the people of Lewisham to build on the initial work undertaken as part of the CCG's Annual General Meeting (AGM) – see table below – as a basis for further engagement.

Summary of the prioritised "I statements" from NHS Lewisham CCG AGM
• I have an understanding and know what is in my Care Plan • I have the information, and support to use it, that I need to make decisions and choices about my care and support • I have the information, and support to use it, that helps me manage my condition • I tell my story once • I want to be involved in discussions and decisions about my care, support and treatment • I know in advance where I am going, what I will be provided with and who will be my main point of professional contact • Taken together, my care and support help me to live the life I want to the best of my ability. Source: National Voices A narrative for person-centred coordinated ('integrated') care - 'I statements' 2012

Also we will use the NHS, Public Health and Adult Social Care outcomes frameworks and the local communities' feedback to measure success. The majority of these measures are included within the Health and Wellbeing Board Performance Dashboard which is monitored by the Health and Wellbeing Board on a regular basis – See Appendix D.

[27] National Voice 'I Statements' – see Glossary of Terms, Appendix F

8. Engagement process

This draft Joint Commissioning Intentions for Integrated Care sets out our proposed priorities and accompanying draft action plans for local services for 2015/16 and 2016/17, which commissioners consider are most feasible and realistic within the collective, expected resources and best addresses the local challenges we face in Lewisham.

These joint Commissioning Intentions and proposed action plans, however, only partially address the financial challenges that face Lewisham health and care system. A 'financial gap' still remains. The exact size of the remaining 'gap' is difficult to determine precisely, but it will become clearer in January 2015 when it is expected that further national guidance will be available.

The challenge continues:

A financial gap still remains between the proposed action plans as set out in these draft joint Commissioning Intentions and the collective resources we expect to have for the next two years

Therefore it is vitally important that the Council, CCG's members, the public and local providers continue to work together to effectively reshape future health and care systems and organisations locally in Lewisham. Only together will we be able to make sure that the local health and care services are financially sustainable.

We are committed to build on our good communication and engagement to date and to engage fully with you, the public and our providers, to discuss openly and transparently the way we can best meet the serious challenges that face the statutory health and social care sector, to find jointly local innovative solutions. We are putting in a place a programme of engagement events, working with Lewisham Healthwatch, to seek your views and comments during the November and December 2014.

We would welcome your views on the following three issues:

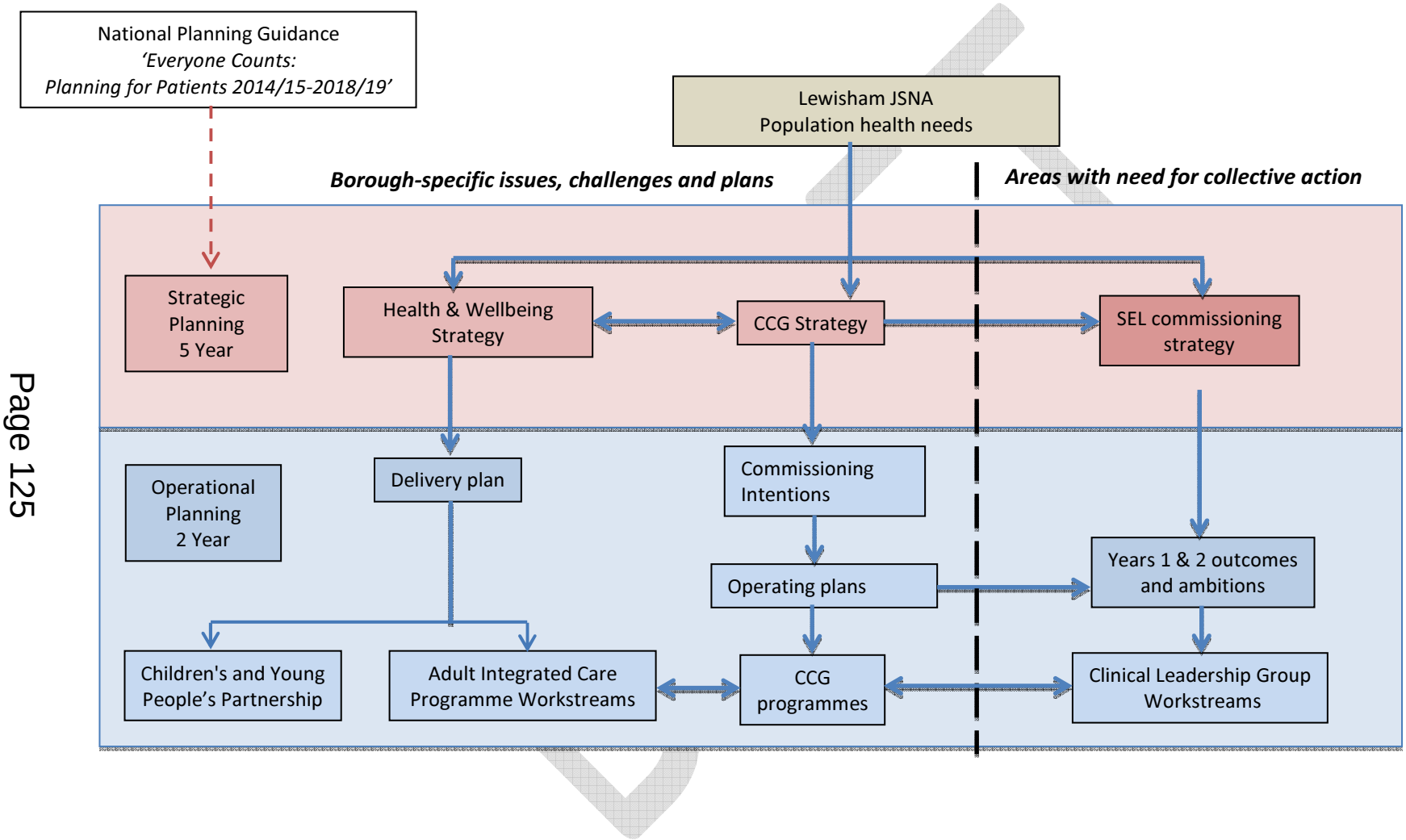
Three engagement Issues
1. Are these the best action plans to deliver the priorities within the limited resources available, for 2015/16 and 2016/17, as set out in section 5? 2. Do you agree that the most important 'I Statements' for us to achieve as a result of joined up, integrated care are those set out in section 7? Or are there other important issues you wish to highlight, from the Lewisham Healthwatch and the Quality Summit summary (section 4.2) 3. Do you support the commissioners' ambition for whole system and providers

changes, as set out in section 6?

Discuss with communications how best to phrase these engagement questions

Please contact XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX with your views before 31st December 2015.

APPENDIX A


National Planning Guidance
'Everyone Counts:
Planning for Patients 2014/15-2018/19'
Lewisham JSNA
Population health needs
Borough-specific issues, challenges and plans
Areas with need for collective action
Strategic Planning 5 Year
Health & Wellbeing Strategy
CCG Strategy
SEL commissioning strategy
Operational Planning 2 Year
Delivery plan
Commissioning Intentions
Operating plans
Years 1 & 2 outcomes and ambitions
Children's and Young People's Partnership
Adult Integrated Care Programme Workstreams
CCG programmes
Clinical Leadership Group Workstreams

GP Practices in Lewisham

North Lewisham 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

Central Lewisham Practices

12 Belmont Hill
13 Lewisham Medical Centre
14 Burnt Ash Surgery
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

South East Lewisham 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

South West Lewisham Practices

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

APPENDIX C

How the views of Lewisham people have an impact on developing the action plans for 2015/16 and 2016/17

Priority	Local service Issues	Public Feedback on local issues	Action planned to be implement during 2015/16 and 2016/17
Prevention and Early Intervention	Information and advice on staying healthy and well.	Strong view that individuals should be making choices and decisions for themselves. This requires better information to give people confidence to make choices and take control of the management of their own care. Clear and consistent information to support health promotion and self-management in appropriate format	Establish a Single Point of Access to improve the coordination and provision of information and advice, borough wide with a single phone number for social care and health, to provide more detailed information about services available and advice on how to stay healthy
	Information and advice on accessing services	Improve the information about accessing services - how to access services out of hours and weekends especially about changes to access to GP out of hours and emergency services;	
	Information and advice on accessing community activities	Want to be able to find out how to get involved in communities activities and co-produce new services;	Extend Lewisham's Community Connections project to connect people to local support and activities, reduce isolation and improve wellbeing for service users and carers.
	Access to performance data about local services	More information about how services are performing which is transparent and easy to access	Commissioners' Ambition for all Local Providers to work in partnership with all local providers to support them to embed, within their organisations, systems and processes to ensure a continuous improvement in quality of care for all – "getting the basics right every time" - monitored and reported publicly

	Health Promotion - general	Strong support for 'every contact counts' ethos; strong willingness to self-manage (eg health trainers);	Integrating health improvement services with the neighbourhood community networks so that interventions and services can facilitate and support life style and behaviour changes - to reduce smoking and alcohol misuse; promote mental and emotional wellbeing healthy eating, exercise and cancer screening - through making 'every contact count'
	Health promotion – mental health	There should be increased awareness about mental health and more done to prevent the onset of mental health;	
General Practice and Primary Care	General Practice - access	Primary Care access continues to be difficult and frustrating, particularly telephone access and for certain groups of the population including carers, young persons, older people and people who do not speak English as a first language;	Reduce variation in care between GP practices by supporting GP practices to improve the patient's experience with better access in hours and out of hours and continuity of care, using the information gained from the public about the barriers to accessing GP services. Support GPs to continuously improve the quality of services they provided by implementing an education and training programme
	General Practice - quality	Improve the continuity of care from general practice Improve the service and communication from practice staff	
	Wider Primary Care - quality	Positive feedback about community pharmacy and the services it provides	Increase the co-ordinating care working with the wider primary care team – with community pharmacists, general dental practitioners and optometrists
Neighbourhood Community Care	Community based care – quality	Improve the quality of district nurses and social work provision; Better coordination between district nurses, care workers and other agencies; Poor experience for mental health users; seem to	Embed and enhance the effectiveness of the Neighbourhood community teams which are aligned to General Practice (GP) clusters with the integration of mental health workers to co-ordinate both physical and mental health care, linked with the wider neighbourhood community network

		be not treated with the same priority as people with physical health needs	Give equal status to mental health with physical health, by enhancing the range of community mental health services and interventions that are tailor made to the needs of individuals and their aspirations for long term recovery and provide support to reduce relapse and need for hospital re-admission
	Integrated community based care	Strong support for better co-ordinated, joined up health and social care including involving and supporting the voluntary sector; but need to make sure that person who uses the service understand who is responsible;	
	Community based care – personalised	Lewisham residents want personalised care across all settings which is holistic – with individual care planning, shared decision making and patients in control; Service users want greater empowerment by being given more information about their care and medication without use of technical language; Adequate time and information needs to be given to support patient understanding and role in decision making;	Implement a shared approach to care management across health and social care including: - Same approach to risk stratification to identify those people at higher risks of a deterioration in their health - sharing of information, so that individuals tell their story only once - single assessment and co-produced health and social care records - single reviews undertaken by trusted reviewers on behalf of health and social care whenever possible - personal budgets to adults and children rolled out to those who receive continuing healthcare
Enhanced Care and Support	Enhanced care and support - quality	Reduce the variability of quality of care provided in hostels and care homes;	Review, develop and enhance support available to and within care homes to ensure that unplanned admissions from such settings can be reduced.
	Enhanced care and support - Inequality	Emerging concerns about equity and equality for some specific groups eg HIV, Substance Misusers, people living in hostels, people in care	Undertake an equalities impact assessment of our joint Commissioning Intentions for Integrated care

		homes, Vietnamese speakers and parents of children with complex needs	
	Enhanced care and support – discharge planning	Users, carers (unpaid) and family members want better inclusion in care planning and process and discharge planning Improve the discharge particularly for vulnerable groups eg hostel residents and mental health patients	Improve the structures around discharge planning and its associated services to reduce unnecessary delay and readmission. This covers assessments of need, home preparation services and night sitting services
Children's and Young People		Positive feedback continues about Lewisham's birthing unit (Ref 1) Young people want to engage with health dialogues to influence services and make sure their needs are understood Mental Health services – improve the access to MH and CAHMs; Greater focus on the transition (16-25 years)	

Public's future expectations		Users experience of care is variable and could be made better Strong desire for improved communication from staff - with improved interpersonal skills, where staff are caring, courteous and compassionate; service users are treated with dignity and respect and listened to	Commissioners' Ambition for all Local Providers to work in partnership with our local providers to support them to embed, within their organisations, systems and processes to ensure continuous improvement in quality of care, which is proactive, self-monitoring and managed: to have strong, effective leadership at every level, throughout the organisation, to lead the change in the culture and practice in the way in which care is delivered across the health and care system.

APPENDIX D

Key Performance Indicators to measure progress

Improved health and care outcomes - to improve outcomes and reduce the gap of equality of opportunities:

- Potential years of life lost from causes amenable to healthcare
- Life expectancy at birth – including inequality in life expectancy at birth
- Premature mortality - under 75 Mortality Rates from CVD, cancer, respiratory disease, Lung Cancer, serious mental illness
- Infant Mortality (under I years)
- Children in Poverty (Under 16s)

Prevention and Early Intervention

- Low birth weight of all babies
- Uptake rates of Immunisation for infants and children
- Cancer screening coverage - breast cancer, cervical cancer, bowel cancer
- Proportion of physically active and inactive adults
- Uptake of Influenza vaccine in those over 65 years of age
- Number of practitioners skilled in identifying those at risk from alcohol harm and delivering brief interventions
- Smoking
    - Level of smoking in the population (18+)
    - 4 week smoking quitters
    - Number of 11-15 year-olds who take up smoking
    - Number of children in smoke free homes
    - Smoking at time of delivery
- Mental Health
    - Level of Serious Mental Illness, dementia, depression in the population
    - Suicide rates
- Sexual Health
    - Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24
    - Level of diagnosed HIV infection in the population
    - Percentage of people presenting with HIV at a late stage of infection(Legal Abortion rate for all ages
    - Teenage conceptions

Better User Experiences

- Long Term Conditions - increase the number of people who feel supported to manage their condition;
- Patients with Long-Term conditions actively engaged in self-care
- Primary Care Access - ease to speak to someone on the phone – CCG Dash Board
- Friends and Family test- hospitals, maternity, GPs mental health and communities – CCG Dash board
- Breastfeeding Prevalence 6-8 weeks

- Self-reported well-being - people with a low happiness score
- Proportion of people using social care who receive self-directed support, and those receiving
- direct payments
- End of life – people dying in their usual place of residence – CCG Dash board

Changes in the way people can obtain advice care and support – provide more community based services and reduce unnecessary hospital admissions

- Reduction in avoidable emergency admission using three measures:
    - Reducing unplanned hospitalisation for chronic ambulatory care sensitive conditions
    - Reducing emergency admissions that should not usually be admitted to hospital
    - Emergency readmissions within 30 days of discharge from hospital
    - unplanned hospitalisation for asthma, diabetes and epilepsy in children
    - emergency admissions for children with lower respiratory tract infection
    - Alcohol related admissions
- Increase in the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Delayed transfers of care from hospitals
- Improved access to psychological therapists – CCG Dash Board
- Two week wait referrals for cancer services
- Early diagnosis of cancer

Appendix E

How will we know we have achieved out ambition of integrated care – National Voices "I Statements"

Category	"I" Statement
Overall	I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.
Goals and outcomes	All my needs as a person are assessed.
	My carer/family have their needs recognised and are given support to care for me.
	I am supported to understand my choices and to set and achieve my goals
	Taken together, my care and support help me live the life I want to the best of my ability.
Care Planning	I work with my team to agree a care and support plan.
	I know what is in my care and support plan. I know what to do if things change or go wrong.
	I have as much control of planning my care and support as I want.
	I can decide the kind of support I need and how to receive it.
	My care plan is clearly entered on my record.
	I have regular reviews of my care and treatment, and of my care and support plan.
	I have regular, comprehensive reviews of my medicines.
	When something is planned, it happens.
	I can plan ahead and stay in control in emergencies.
	I have systems in place to get help at an early stage to avoid a crisis.
Communication	I tell my story once.
	I am listened to about what works for me, in my life.
	I am always kept informed about what the next steps will be.
	The professionals involved with my care talk to each other. We all work as a team.
	I always know who is coordinating my care.
	I have one first point of contact. They understand both me and my condition(s). I can go to them with questions at any time.
	I have the information and support to use it, that I need to make decisions and choices about my care and support.
	I have information, and support to use it, that helps me manage my conditions.
	I can see my health and care records at any time. I can decide who to share them with. I can correct any mistakes in the information.

Information	Information is given to me at the right times. It is appropriate to my condition and circumstances. It is provided in a way that I can understand.
	I am told about the other services that are available to someone in my circumstances, including support organisations.
	I am not left alone to make sense of information. I can meet/phone/email a professional when I need to ask more questions or discuss the options.
Decision making	I am as involved in discussions and decisions about my care, support and treatment as I want to be.
	My family or carer is also involved in these decisions as much as I want them to be.
	I have help to make informed choices if I need and want it.
	I know the amount of money available to me for care and support needs, and I can determine how this is used (whether it's my own money, direct payment, or a 'personal budget' from the council or NHS).
	I am able to get skilled advice to understand costs and make the best use of my budget.
	I can get access to the money quickly without over---complicated procedures.
Transitions	I can get access to the money quickly without over---complicated procedures.
	When I move between services or settings, there is a plan in place for what happens next.
	I know in advance where I am going, what I will be provided with, and who will be my main point of
	I am given information about any medicines I take with me – their purpose, how to take them, potential side effects.
	If I still need contact with previous services/professionals, this is made possible.
	If I move across geographical boundaries I do not lose me entitlements to care and support.
Emergencies	I could plan ahead and stay in control in an emergency.
	I had systems in place so that I could get help at an early stage to avoid crisis.

Appendix F

Glossary of Terms

Adult Integrated Care Programme

Lewisham's Adult Integrated Care Programme (AICPB) builds on work undertaken within the borough since November 2011 to develop and deliver an integrated health and social care model. This work brought together teams of district nurses, all therapies, social workers and care workers. Building on this, further integration took place through the establishment of multi-disciplinary teams to align with GP neighbourhoods. Subsequently, members of the Health and Wellbeing Board agreed to increase the scale and pace of integration.

Better Care Fund

The Better Care Fund (BCF) was announced as part of the 2013 Spending Round and is a core element of the 'Everyone Counts' planning guidance. The national policy guidance stated that 'the Government will introduce a £3.8 billion pooled budget for health and social care services, shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people, with the resultant reduction in unnecessary hospital admissions and inappropriate lengths of stay.

Care Act (2014)

The Care Act has created a single law that makes it clear what kind of care people should expect. The Care 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 help people navigate the system and make the best choices

Commissioning Support Lead Provider Framework

NHS England has developed a new framework agreement for commissioning support services – the Lead Provider Framework – that enables CCGs, NHS England and other customers to source some or all of their commissioning support needs, ranging from back office support services to more bespoke services that support local and large scale transformational change projects.

Chronic conditions

Chronic conditions require ongoing management over a period of years and cover a wide range of health problems, such as heart disease, diabetes and asthma. These

conditions require a complex response over an extended time period that involve coordinated inputs from a wide range of health and care professionals and access to essential medicines and monitoring systems.

Connect Care
Connect Care, previously known as the Virtual Patient Record, allows patient information to be shared across organisations. It pulls together patient data from acute, community and primary care providing organisations in Lewisham with a read only record at the point that clinical decisions are made.

Enablement care services
Enablement is about helping people become more independent and improve their quality of life. It focuses on helping patients relearn how to do everyday tasks, such as making a meal, getting out of bed and personal care for themselves rather than having someone else doing the tasks for them.

Everyone Counts: Planning for Patients 2014/15 - 2018/19 (December 2013)
Everyone Counts is planning guidance from NHS England that outlines the ambition, priorities and financial planning requirements for the NHS in England.

Francis Report (2013)
The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013 (The Francis Report) chaired by Robert Francis QC made 290 recommendations to the Secretary of State for Health to improve patient safety in the NHS. All NHS organisations have been required by NHS England to respond to the "Francis Report" and to publish an action plan detailing how the recommendations will be implemented.

Health and Wellbeing Board
Health and Wellbeing Boards bring together key leaders from the NHS, public health, adult social care, children's services and Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health. Its main functions are to undertake a Joint Strategic Needs Assessment, develop the Joint Health and Wellbeing Strategy and encourage integrated health and social care.

Integrated Personal Commissioning (September 2014)
NHS England, the Local Government Association, Think Local Act Personal and the Association of Directors of Adult Social Services are formally inviting health and social care leaders to help build a new integrated and personalised commissioning approach through an Integrated Personal Commissioning (IPC) programme which will, for the first time, blend comprehensive health and social care funding for individuals, and allow them to direct how it is used.

Lewisham's Joint Strategic Needs Assessment
Our Joint Strategic Needs Assessment pulls together information about local health and social care needs and is a vital tool to help us plan future services. It explores how Lewisham compares with other areas locally, regionally and nationally. It also

examines what services we are currently providing, what works well and what could be improved.

MSK
MSK is shorthand for Musculoskeletal. MSK disorders cover any injury, disease or problem relating to our muscles, bones or joints.

National Voice "I statements"
"I" statements are indicators for measuring people's experience of integrated care and support. National Voices developed these statements through consultations with patient and user organisations, and from patient experience indicators. They tested and refined them in two workshops involving system leaders, patients, people who use services, carers and patient organisations.

NHS 111
NHS 111 is a new national service aimed at making it easier to access local NHS healthcare services in England. People can dial 111 when they need medical help fast but it's not a 999 emergency. NHS 111 is available 24 hours a day, 365 days a year. At the moment, NHS 111 is being rolled out in different parts of England but is not fully 'live' in Lewisham, Lambeth and Southwark.

NHS Constitution (2013)
The NHS constitution brings together in one place details of what staff, patients and the public can expect from the National Health Service. It also explains what you can do to help support the NHS, help it work effectively, and help ensure that its resources are used responsibly.[28]

Payments by Results
Payments by Results (PbR) is the payment system in England under which CCGs pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs. PbR currently covers the majority of healthcare in hospitals. For example, £119 for an outpatient attendance in obstetrics or £5,323 for a hip operation.

Referral Support Service
Lewisham's Referral Support Service is a two year pilot to support the GP referral process from referrer to the patient's first outpatient appointment. It offers patients a choice of location, date and time for their appointment, using the electronic referral system 'Choose and Book'.

Section 75 Agreement
An agreement made under section 75 of National Health Services Act 2006 between a local authority and an NHS body in England. Section 75 agreements can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised.

[28] www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf

'Step up' and 'step down' services
'Step up' is a short term provision of up to six weeks provided to prevent an admission into a hospital bed. 'Step down' is a provision to speed up discharge from a hospital bed by helping the patient to return to their own home.

Walk in Clinics in Lewisham
The New Cross GP Led Walk-in Centre is a medical practice whose services are available to all, whether they are registered as a patient or not. Patients are able to walk-in, sign in at reception and see the next available clinician. The service offered to patients using the walk-in centre is limited to immediate or same day treatment only and is not suitable for on-going treatment for chronic conditions.

Winterbourne View Report (2012)
The report sets out steps to respond to failings following the abuse revealed at Winterbourne View hospital. The report lays out clear, timetabled actions for health and local authority commissioners working together to transform care and support for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging.

HEALTH AND WELLBEING BOARD				
Report Title	Lewisham Community Connections – interim evaluation and update			
Contributors	Lewisham Community Connections Adult Social Care		Item No.	4
Class	Part 1	Date:	25 November 14	
Strategic Context	Community Connections contribute to the aims set out in the Health and Wellbeing Strategy to provide integrated health and social care services across sectors including the voluntary and community sector.			
Pathway	The Health and Wellbeing Board considered the voluntary and community sector contribution to health and social care integration at its meeting on 25 March 2014.			

1. Purpose

1.1 This report provides members of the Health and Wellbeing Board with a summary of the interim evaluation of the Community Connections project. It focuses on the element of the project delivered by a consortium of voluntary sector providers, led by Age UK Southwark and Lewisham.

2. Recommendations

Members of the Health and Wellbeing Board are recommended to:

2.1 Note the Community Connections Interim Evaluation report.

2.2. Agree the areas for further work and development highlighted in the Interim Evaluation report.

2.3 Consider whether there are other ways in which the Community Connections project could contribute to meeting the strategic priorities of the Health and Wellbeing Board.

3. Strategic Context

3.1 The aims and outcomes of Lewisham Community Connections are about enabling older people and vulnerable adults to sustain their independence, to be integrated in their community and to reduce their reliance on statutory service provision. Therefore the Community Connections project makes a strategic contribution toward Shaping our future –Lewisham's Sustainable Community Strategy and in Lewisham's Health and Wellbeing Strategy.

3.2 Community Connections also has the potential to assist in the implementation of the Care Act 2014 in Lewisham.

4. Background information

4.1 In November 2013 Lewisham Council funded a Consortium led by Age UK Lewisham and Southwark (AUKLS) to deliver Community Connections (CC) for an 18 month programme.

4.2 CC is a preventative community development programme aimed at supporting any vulnerable adult in Lewisham who may benefit from services to improve their social integration and wellbeing. Individuals are supported through person centred plans to identify their skills and interests as well as what is important to them. Individuals are then matched to relevant groups and organisations in their local area. The project aims to support 1,200 individuals in the initial 18 month period.

4.3 CC also works with local community based organisations to assist in their development and capacity building. This is key to the overall success of the work to ensure that there are strong and sustainable organisations, networks and activities in place so that individual older people and vulnerable adults can access the support and activities they are looking for. The project aims to be in contact with160 groups, forums and organisations, including planned development work with 40 community groups, in the initial 18 month period.

4.4 The CC team are employed by AUKLS and Lewisham Disability Coalition, but are located with Adult Social Care in Lawrence House.

4.5 The recruitment and support of volunteers for the CC project is led by Volunteer Centre Lewisham under a separate contract.

4.6 An interim evaluation report was commissioned in October 2014 to look at progress and impact of the first 10 months work.

5. Key findings from interim evaluation report

5.1 The project has started successfully, and is well known across the borough.

5.2 CC brings together information about community resources that were previously unknown to health and social care.

5.3 515 individuals have been referred to the project between November 2013 and September 2014.

5.4 86% of service users report an increase in their wellbeing following support from CC. However further work will be needed to monitor sustainability in reducing social isolation.

5.5 Volunteer Centre Lewisham launched a new Befriending Service on 1st October in response to needs identified by CC.

5.6 Development visits have taken place with 160 community groups and organisations in Lewisham and detailed development plans in place with 27 community groups.

5.7 Further work is need to monitor the impact of CC input on use of statutory health and social care services, such as number of visits to GP, frequency and length of hospital admissions, reduction in falls etc.

5.8 CC's work has identified gaps in community resources and support, including access to affordable and accessible transport, need for range of befriending and support schemes.

5.9 Currently there are low numbers of referrals from health services, particularly GPs/primary care. There is a need to look at ways that make it easier for GPs or practice staff to refer, such as including referral form on NHS record system. The project is working well with the Falls Prevention Service and this could inform work with other health teams.

5.10 The CC Community Development Workers are an underused resource for GP practices and Patient Participation Groups to involve patients and to refer individuals for community support and services.

5.11 There is a need to review outputs and outcomes from Community Development Work to ensure a consistent approach across all neighbourhoods.

5.12 Explore options for further development of this model to increase referrals, and expand scope of support and information available such as Social Prescribing, introduction of SAIL (Safe and Independent Living) checklist in Lewisham.

6. Financial implications

6.1 None

7. Legal implications

7.1 None

8. Crime and Disorder Implications

8.1 None

9. Equalities Implications

9.1 There are no specific equalities implications arising from this report or

10. Environmental Implications

10.1 None

11. Conclusion

11.1 This report sets out the progress of the element of the Community Connections project delivered by a consortium of voluntary sector providers, led by Age UK Southwark and Lewisham. It highlights CC's contribution to the development of integrated health, social care and community services in the borough, and invites members to note and agree the areas for further development detailed in the interim evaluation report.

12. Background Documents

Community Connections Interim Evaluation Report October 2014

If you have any difficulty in opening the link above 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:

Lewisham Community Connections – Interim Evaluation Report

October 2014

Julia Shelley, Independent Consultant

1. Introduction

In November 2013 Lewisham Council funded a Consortium led by Age UK Lewisham and Southwark to deliver Community Connections (CC). Community Connections is a preventative community development programme aimed at supporting any vulnerable adult in Lewisham who may benefit from services to improve their social integration and wellbeing. Individuals are supported through person centred plans to identify their skills and interests as well as what is important to them. Individuals are then matched to relevant groups and organisations in their local area.

Community Connections also works with local community based organisations to assist in their development and capacity building. This is key to the overall success of the work to ensure that there are strong and sustainable organisations, networks and activities in place so that individual older people and vulnerable adults can access the support and activities they are looking for.

Community Connections is seen as playing a key role in increasing integration of health, social care and community based services, and in working in the borough's four cluster areas.

This report aims to review Community Connections progress over the first 10 months of its work looking at the activities that have been carried out, the numbers of individuals and organisations that have engaged with the service, and the impact and benefits for them.

The original bid had included a proposal for a full project evaluation led by Goldsmiths College. However the final funding agreed did not allow for this, therefore Age UK Lewisham and Southwark (AUKLS) have commissioned this report which is based on the activity monitoring data, survey data collected from participants by the project team and interviews with consortium/delivery partners and stakeholders.

This report will form the basis for a paper to Lewisham Health and Wellbeing Board to:

i. inform the Board of Community Connections progress;
ii. engage partners in discussions about the ongoing development of the project;
iii. highlight issues raised that affect Health and Wellbeing Partners in the borough.

2. Project outline

The original consortium, which consisted of Age UK Lewisham and Southwark, Carers Lewisham, VAL, Lewisham Disability Coalition, Sage Educational Trust, submitted a grant application to Lewisham Council in June 2013. Following discussions with the Community Connections Consortium and with Volunteer Centre Lewisham (VCL) the project was established in November 2013 for an 18 month programme.

VCL are responsible for the recruitment and placement of volunteers as part of the CC initiative and report separately on their activities and outcomes. However there is close working between the CC team and VCL to ensure a co-ordinated approach

The CC programme started in November 2013 aiming to support 1,200 individuals and 40 community organisations over the 18 months.

The project has a team of 9 staff, a Team Leader, 4 FTE Community Support Facilitators, and 4 FTE Community Development Workers. A part time administrator has recently joined the team. All staff are located within Lewisham Council offices at Lawrence House in Catford.

The original bid envisaged that staff would be employed by different organisations in the Consortium. However due to the closure of one key partner since the start of the project (Sage Educational Trust) now AUKLS are the employer for all staff apart from one CSF who is employed by Lewisham Disability Coalition.

Community Support Facilitators – receive referrals, work with individuals to develop a person centred plan to identify their skills and interests as well as what is important to them. Individuals are then matched to relevant groups, organisations and activities in their local area. Each CSF is allocated to one of the four cluster areas in the borough. Their role with individuals is time limited with the aim of assisting people to identify their needs, to find solutions and put in place ongoing activities and support.

Community Development Workers are also allocated to one of the four cluster areas. They work closely with the CSFs to understand the gaps and priorities in each area as identified through individual plans. They are then able to work with local groups and centres to sustain and develop services, and assist with capacity building and creating opportunities. The aim is to strengthen community resources offer to local people.

2.1 Governance

The CC Consortium members meet monthly to monitor development and progress of the project and to consider extending the consortium membership as part of considering development of additional projects.

The CC Steering Group also meets on a monthly basis to review and monitor progress. The membership of the steering group includes Lewisham Council, the CCG, VAL, VCL and Healthwatch Lewisham which enables the group to assist with extending networks, providing information on additional opportunities and identifying local resources and activities.

2.2 Establishing and launching Community Connections

The first staff came into post in November 2013, and following a brief induction period, were immediately at work to promote and publicise CC, receive and assess referrals,

develop and implement Person Centred Plans for individuals and development plans with community organisations. The team needed to promote and introduce the service to ensure a steady flow of referrals. They also set up systems and processes for referrals and delivery of the project, which have continued to evolve over the life of the project. It took some weeks for the office and IT hardware and systems to be established so the team could function to full capacity.

This all meant that at first referrals came in slowly and systems and processed were developed gradually. However it is clear that the team dealt effectively with these challenges. Council officers and others report that the Community Connections service has established itself well, is widely known about in the borough, and has a growing reputation as a responsive and effective service.

The CC team has also benefited from being located with the Council's Adult Social Care office. This has enabled closer working and an understanding of the role of CC, so council staff are confident in making referrals and ongoing communication is good.

3. Support for individuals – review of activity and impact

CC received 515 referrals between November 2013 - September 2014 (11 months). 463 are active or completed cases, 52 are currently on the waiting list.

The total target for referrals over 18 months is 1,200, and if this was to be achieved evenly over the length of the project, CC would have expected to have received 733 referrals by this stage. Therefore in order to meet the original target of 1,200 the team are seeking and planning for approximately 100 referrals each month for the next 7 months.

As the project has become better known more widely and there is evidence of its success the number of referrals has increased. However there is more work to do to ensure that referrals come from a wider range of sources as the table below shows. In particular the team have identified the scope to increase the number of referrals from primary care.

Referral sources:

Adult Social Care	54.55%	GP practices	7.44%
Community Matron	0.83%	Community organisations	5.79%
NHS enablement	5.79%	Self referrals	1.65%
LINC/ LATT	8.26%	Community mental health	2.48%
Physiotherapists	9.92%	Admissions avoidance	3.31%

To date the majority of referrals have come through social care rather than health, and the low number coming from GP practices is of particular concern. There are many older people and vulnerable adults who may not be engaged with other services, but who do have contact with their GP practice. Older people have often seen their GP practice as a place to go for help and advice of all kinds, not purely related to health. The Community Development Team have worked to build links in different ways with various practices in the borough, but overall there are still few referrals being made. Therefore it should be a priority to explore ways to continue to raise awareness of CC across all practices and to make the referral process as straightforward as possible for GPs and other practice staff.

This would include looking at whether it would be possible for the GPs to make referrals directly through their own IT system, as has been achieved in other areas of London.

Referrals can come in batches so for example there was a rush of referrals following the recent "Techy Tea Party" in September which have yet to be fully allocated.

The project has also learnt that some individuals are looking for signposting and information rather than ongoing support and development of a personal support plan. The referral system has been updated in response to this to ensure that there is a fast track response to those clients, so that people who only require a brief intervention and are able to make their own arrangements are not kept waiting for signposting.

Who is being referred?

CC is for all older and vulnerable adults in the borough. To date the breakdown of referrals across the population is:

Age		Gender		Religion	
18-30	7.02%	Male	39.0%	Christian	70.76%
31-40	7.02%	Female	60.8%	Hindu	1.72%
41-50	9.21%	Transgender	0.02%	Islam	3.93%
51-60	13.60%			Buddhist	0.74%
61-70	11.40%			Other	1.72%
71-80	23.90%			None	17.94%
81+	27.85%			Undisclosed	3.19%

Ethnicity			
Asian or Asian British (Indian)	2.09%	White British	47.67%
Asian or Asian British (Other)	0.93%	White Irish	2.09%
Black or Black British (African)	10.23%	White Mixed (White & Asian)	0.70%
Black or Black British (Caribbean)	23.26%	White Mixed (White & Black African)	0.47%
Black or Black British (Other)	3.95%	White Mixed (White & Black Caribbean)	1.16%
Other Ethnic Group	1.63%	White Mixed (White & Other)	0.23%
Chinese	0.23%	White Other	3.72%
Turkish Cypriot	0.70%	Undisclosed	0.93%

This demonstrates that CC is reaching across the different communities in the borough, however it would be useful to do further analysis of the data to see how this relates to area of need or disability. Over 60% of service users are over 60 so the project is reaching older people as planned. This is significantly higher than the percentage of older people in the population.

Feedback from the team and council staff is that many of the referrals have higher levels of need than had originally been anticipated, but the data collected is not able to confirm this. Issues raised by the CC team around higher levels of need are focussed on requirements for accessible and affordable transport, support for individuals with dementia, day long activities rather than short classes, suitable activities for individuals who need higher levels of care or who are not able to travel on their own, or who are housebound.

Impact:

The aim of CC is to help increase people's sense of wellbeing and reduce their isolation. There are also more specific aims about reducing the numbers of GP visits and hospital admissions. At this stage the information and feedback collected from service users has focused on their wellbeing and isolation.

All service users are asked to complete a wellbeing questionnaire at the start of their involvement with CC, and again when their case is closed. I have looked at a sample of 66 cases that have been completed since the project began.

All participants were asked to rate their responses to the following questions:

1. Are you seeing your friends as often as you want to?
2. Do you see your family as often as you want to?
3. Do you feel safe in your home
4. Do you take part in activities you enjoy?

86% reported an improvement in their overall wellbeing following their support from CC, 8% reported no change and 6% reported a reduction in their wellbeing.

The project is probably less able to have an impact on questions 1 and 2. The area where CC has most to offer is in offering information and access to a range of activities. In response to question 4. 79% reported an increase in activities they enjoyed. 21% stayed at the same level of enjoyment but they were mostly people who already had a positive response to this question at the time of their initial assessment.

The average length of time CC worked with the people in this survey was 14 weeks, against an initial target of a six week input. These users were part of the project before the new fast track stream came into operation so this may impact on future working times. It is clear that it is not always possible to work quickly with people to explore what activities and support they are looking for and to put these in place. However as the project establishes longer term working relationships with community services, and resources are developed through the community work support, the Community Support Facilitators will be able to suggest activities and support more quickly.

The shortest length of work with an individual in the sample was 4 weeks, but this was a younger person with a learning disability who already leads a busy and active life and was only seeking assistance with identifying employment and training opportunities.

The longest period of those in the sample was 31 weeks which was a woman with a learning disability who lives independently but was inactive and lonely. With the assistance of CC facilitator she has taken up volunteering opportunities and other new activities and fed back that she was a lot more confident, and felt able to sustain her new activities.

The team have identified that there are people who need an ongoing period of support and assistance to overcome their fears about going out more, or joining clubs or activities. The proposed volunteer Befriending Service that will be hosted by VCL, will look at recruiting volunteers to provide shorter term support in this area, as well as others who offer a longer term befriending relationship.

Case Study: Harry's Story

Harry lives with his daughter who became his full-time carer a couple of years ago due to him suffering from a rare disease known as Pseudomyxoma peritonea (PMP), which is a form of cancer and has similar principal traits to those of Parkinson's in the way that it effects his physical form. Harry undergoes dialysis three times a week which therefore takes up most of his time and leaves him tired and exhausted. His free time was spent in front of his TV watching whatever was on.

Community Connections supported Harry and his daughter in their home where his hobbies, interests and needs were identified and matched to community services. Harry told the Community Connections worker on that first visit that he felt tired all the time and unmotivated to do anything, though he did want this to change.

A number of options were discussed such as the Parkinson's Group as well as the Rehab Exercise Class at the Ringway Centre which involves exercises he can do from a seated position. Harry attends these groups regularly and is now more motivated to maintain his own wellbeing.

Case study: Alice's Story

Alice was referred to the project by her sister, Sarah who described Alice as lonely and depressed.

Friendship Fridays, a local lunch and activity group was identified as a manageable start to increasing Alice's engagement with the community. Although initially nervous, Alice attended the group with a CC support facilitator to assist with increasing her confidence.

Since then, Alice attends the club every Friday and also assists with the set up of activities after the lunch club. Alice is now also taking the bus alone to go shopping and visiting her sister, Sarah, something she had previously not felt confident to do. Sarah is delighted with the positive change in Alice.

Alice now wants to help others in the same position by becoming a volunteer and has registered with Volunteer Centre Lewisham.

4. Support for community organisations: review of activity and impact

The targets and achievements for development work with community organisations:

	18 months total	Completed by end Sept
Development visits	160	160
Development plan for individual organisation	40	27 action plans agreed with and signed off by the community organisation and CC.
Launch event	1	1

The development visits include a wide range of groups and organisations and provide the team with information about what is available in the community, what additional resources and capacity may be needed.

The Community Development Worker role includes offering information about good practice, funding opportunities, making links and connections between projects, and maximising use of community resources.

Community Connections held a launch event in March 2014 which was attended by representatives of over 30 organisations working in the borough. The team facilitated workshops on Reaching Vulnerable Adults; Transport options; Volunteering.

The CDW team also attends a wide range of neighbourhood and borough wide forums and meetings. The purpose of attending these meetings is to:

a) tell groups and individuals about Community Connections, including seeking referrals for individual support;
b) make contact with community groups who may benefit from individual development work;
c) build connections between community groups, health and social care services to contribute to better integrated provision.

Some examples of the impact of Community Development Work:

Africa Advocacy Foundation (AAF) provides advice, support, training and advocacy for people of African descent, particularly those affected by long term health conditions. AAF currently runs 2 regular groups in Lewisham for vulnerable adults living with Mental Health difficulties or HIV.
The Community Connections project identified introduced AAF to The Reader, an organisation that delivers shared reading groups where members of the group read a chosen text aloud and discuss the themes, ideas and characters together. The Reader groups use literature to help people explore their own feelings and personal experiences within a safe context.
Bringing together the Reader and AAF was huge success. 19 people signed up to be part of the AAF Reader group starting in October. This will provide a new opportunity for people with long term health conditions to socialise and meet new people as well as spark self-reflection and expression.

Ageing Well Fun Club (AWFC) runs every Monday afternoon, bringing together a group of older people in New Cross to chat, to drink tea and to do arts and crafts activities together. On the day I attended the group were being taught how to do decoupage by an arts and crafts instructor. There was a friendly, bubbling atmosphere. One volunteer who had appointed himself as DJ was playing music from a stereo in the corner.

I met Muriel, the chair, who was struggling to keep up with all the admin work needed on top of organising the weekly activities and applying for funding to keep activities running. Over the course of the afternoon I helped Muriel to identify some specific areas that she felt she and the club needed support with. These included:

- Monitoring demographics of members and service users
- Finding ways to deliver more health-related activities to members
- Help learning to use computer software (eg Microsoft Word)
- Applying for funding
- Completing Annual Charity Return

We agreed a plan for this work and I put her in touch with other contacts in the borough and also ensured she had an invitation to the "Techy Tea Party" at the House of Commons.

By October we have completed the annual Charity Return, introduced two new regular users to the groups, successfully applied for additional funding and the groups AGM will look at future plans, including hoping to open for a second day each week.

Community Connections at South Lewisham Group Practice

Community Connections worked together with the Patient Participation Group (PPG) at South Lewisham Group Practice to organise and pilot a Health and Wellbeing Market Place event for patients to showcase some of the groups and organisations available to them in the area. Initially this was to be for SLGP patients only; however, due to the great response this was opened up subsequently to the local residents also.

The PPG group designed a poster and publicised the event, where 20 organisations had stalls.

The event was held on a Saturday morning in March and there was positive feedback from both visitors and stall holders. The PPG are now in the process of organising a mini market place every Friday morning during open surgery hours at SLGP, with 1 or 2 stalls each time. Again the stallholders will be from groups and organisations serving the Lewisham area, including Community Connections, and provide information and advice on what is available in the area.

South Lewisham Group Practice is now one of the local practices who regularly refer individuals for support from Community Connections.

5. Community Connections - Summary of achievements and impact:

- Successful start-up
- Full staff team in post, co-located with council teams
- Raised profile across borough, held launch event, established website and social media communications
- Bringing together information about community resources that were previously unknown to health and social care
- Built links and contributing to range of neighbourhood forums and groups.
- Received 515 referrals from a range of social care, health and community providers

- 86% of service users report an increase in their wellbeing following support from CC
- Volunteer Centre Lewisham launched a new Befriending Service on 1st October in response to needs identified by CC
- Development visits to 160 community groups and organisations in Lewisham
- Detailed development plans in place with 27 community groups.

6. Areas for further work and development:

- Impact monitoring – particularly in relation to impact on use of health and social care services
- Monitoring longer term impact for service users
- Continue to identify gaps in resources and services
- Balance of expectations, targets and resources – need streamlined systems and process, consistency of approach
- Increase level of referrals from health services, particularly GPs/primary care. Look at IT systems that make it easier for GPs to refer.
- Further develop Community Development Worker liaison with GP practices and Patient Participation Groups to support practices to refer individuals for community support and services
- Explore possibilities for introduction of Social Prescribing in Lewisham
- Consider development of SAIL (Safe and Independent Living) checklist in Lewisham
- Continue to develop work with Falls Prevention Service
- Review role and membership of the Consortium
- Look at how CC can contribute to the introduction of the Care Act 2014 in Lewisham
- Continue to develop and streamline referrals and assessment process to enable team to respond within agreed timeframes
- Review outputs and outcomes from Community Development Work to ensure a consistent approach across all neighbourhoods.

Lewisham Community Connections Interim Evaluation Report commissioned by Age UK Lewisham and Southwark.

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Thanks to the Community Connections team for their assistance and input

October 2014

HEALTH AND WELLBEING BOARD			
Report Title	**Health and Wellbeing Board Performance Dashboard**		
Contributors	Director of Public Health	Item No.	5a
Class	Part 1	Date:	25 November 2014
Strategic Context	Please see body of report		

1. Purpose

This report provides members of the Health and Wellbeing Board with an update on performance 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 note performance as measured by health and care indicators set out in the attached dashboard at Annex A, and by progress in delivering the actions within the Health & Wellbeing Strategy Delivery Plan.

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.

4.3 The Health & Wellbeing Strategy Implementation Group has recently received an update on delivery progress based on actions in the Health & Wellbeing Strategy Delivery Plan. The Group uses RAG ratings to assess progress, where Green is good, Amber is fair, and Red is poor.

4.4 The Implementation Group provides an assurance mechanism for the Board that enables discussion with leads for underperforming areas and for plans to be put in place to address this, and where appropriate escalate to Board. The update shows the majority of actions rated as green. All other actions that were rated amber or red were judged by the Implementation Group to have plans to address them. The Implementation Group will monitor the action plans closely to ensure that effective progress is being made. It is anticipated that the progress being made in delivery of the Strategy will translate into improvement in Health & Wellbeing Board Dashboard Indicators in 2015.

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.

5.3 <u>Overarching Indicators of Health & Wellbeing</u>

Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare has significantly reduced in Lewisham and we are now very similar to England. Delayed Transfer of Care rate and average days of delays has not significantly changed.

5.5 <u>Priority Objective 1: Achieving a Healthy Weight</u>

There has been no updated data since the last report.

5.6 <u>Priority Objective 2: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years</u>

There has been no update since the last report.

5.7 Priority Objective 3: Improving Immunisation Uptake

No Significant change in uptake ofD4 at 5 years, D3 at 1 year, MMR at 2 years and MMR2 at 5 years. Uptake of HPV has decreased significantly during 2013/14.

5.8 Priority Objective 4: Reducing Alcohol Harm

Alcohol related admission rate is increasing and is statistically similar to England, but higher than London.

5.9 Priority Objective 5: Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking

Smoking quit rate is decreasing but is higher than London and England. Smoking status at time of delivery is slightly increasing but the percentage is still less than half that of London and England (SATOD)

5.10 Priority Objective 6: Improving mental health and wellbeing

There has been no update since the last report.

5.11 Priority Objective 7: Improving sexual health

Chlamydia Diagnosis rate is improving and we are significantly higher than England. Legal abortion rate is going down but the rate is significantly higher than London and England.

5.12 Priority Objective 8: Delaying and reducing the need for long term care and support

Rate of new admissions to long term care is decreasing, but is higher than London and below England. The percentage of older people (65+) still at home 91 days after discharge from hospital into rehabilitation and reablement services has not changed significantly. It is still lower than London but higher than England.

5.13 Priority Objective 9: Reducing the number of emergency admissions for people with long term conditions

Avoidable emergency admission rate is reducing but still significantly higher than England and London. Emergency admission rate for acute conditions that should not usually require hospital admission is decreasing but is still significantly higher than London and England. Emergency readmission rate within 30 days of discharge seems to be increasing and it is significantly higher than England. Reviews of Adult Social Care clients is decreasing but is still higher than England and London.

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. Summary and Conclusion

Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare has significantly reduced in Lewisham. Delayed Transfer of Care rate and average days of delays has not significantly changed. There has been no change in uptake of childhood immunisations, but HPV has decreased significantly. The alcohol related admission rate is increasing and smoking quit rate is decreasing (although still performing better than London). Rate of new admissions to long term care is decreasing, but the percentage of older people (65+) still at home 91 days after discharge from hospital has not changed significantly. The avoidable emergency admission rate is reducing and the emergency admission rate for acute conditions that should not usually require hospital admission is decreasing. The emergency readmission rate seems to be increasing and reviews of Adult Social Care clients is decreasing. No updates are available for other indicators.

A review of Lewisham's Health & Wellbeing Strategy Delivery Plan shows that good progress is being made in implementing the strategy, with the majority of actions rated as green, and all other actions that were rated amber or red judged to have plans to address them. It is anticipated that this will translate into improvement in Health & Wellbeing Board Dashboard Indicators in 2015.

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

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 Metrics 2014/15

		Frequency	Latest Period of Availability	Previous Available Period (Lewisham)	Latest Available Period (Lewisham)	Lon	Eng	England Benchmark	Direction from Previous Period	Data Source
	Overarching Indicators									
1a	Life Expectancy at Birth (Male)(yrs)	Annual	2010-12	*77.6*	78.2	79.7	79.2	sig high	↑	PHOF 0.1i
1b	Life Expectancy at Birth (Female)(yrs)	Annual	2010-12	*82.3*	82.6	83.8	83	sig high	↑	PHOF 0.1ii
2	Children in poverty (%)	Annual	2011	*31.7*	30.5	26.5	20.6	sig high	↓	PHOF 1.01
3	Under 75 from CVD mortality (DSR)	Annual	2010-12	*96.7*	91.0	83.1	81.1	sig high	↓	NHSIC - P00400/ PHOF 4.04i
4	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (DSR)	Annual	2011-13	*2102*	2027	1890.2	2023.5	similar	↓	NHSOF 1A - ONS (CCG 1.1 DSR)- P01559
5a	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				↑	PHOF 0.2iii
5b	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				↑	PHOF0.2iii
6	Infant Mortality (%)	Annual	2010-12	*4.8*	4.9	4.2	4.3	similar	↑	P00723/CHIMAT Profile 2014
7	Low Birth Weight of all babies (%)	Annual	2012	*8.3*	8.4	7.9	7.3	sig high	↑	P00455/CHIMAT Profile 2014
8	Proportion of people using social care who receive self-directed support, and those receiving direct payments (Crude rate per 100,000)	Annual/Qtr**	2013/14	*55.5*	69.4	67.5	62.1	-	↑	ASCOF(1C)- NHSIC -P01509
9	Delayed transfers of care from hospital (crude rate per 100,000)	Annual/Qtr**	2013/14	*4.9*	4.7	6.9	9.7	-	↓	ASCOF 2C- NHSIC - P01516
10	Average Days of Delay (crude rate per 100,000)	Annual/Qtr**	2012/13	*103.7*	105.5				↑	BCF - Local Data - LPI264 (PPLUS)
	Priority Objective 1: Achieving a Healthy Weight									
11	Excess weight in Adults (%)	Annual	2012/13	-	61.2	57.3	63.8	similar	N/A	PHOF 2.12
12a	Excess weight in Children - Reception Year (%)	Annual	2012/13	*24.8*	25.0	23.0	22.2	sig high	↑	PHOF 2.06
12b	Excess Weight in Children- Year 6 (%)	Annual	2012/13	*40.4*	38.3	37.4	33.3	sig high	↓	PH NCMP Profiles
13	Breastfeeding Prevalence 6-8 weeks(%)	Annual/Qtr	2014/15 Q1 (Prov)	*70.8*	74.8			sig high	↑	PHOF 2.06; 2014/15 Q1 Local data - validation criteria not met
14a	% of physically active and inactive adults - Active adults	Annual	2012	*57.8*	54.3	57.2	56.0	similar		PHOF 2.13i
14b	% of physically active and inactive adults - Inactive adults	Annual	2012	*25*	29.2	27.5	28.5	similar		PHOF 2.13ii
	Priority Objective 2: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years									
15a	Cancer screening coverage - breast cancer (%)	Annual/Qtr	2013	*65.1*	66	68.6	76.3	sig low	↑	PHOF 2.20i
15b	Cancer screening coverage - cervical cancer(%)	Annual/Qtr	2013	*75.6*	77.5	74.1	78.3	sig low	↑	HSCIC
15c	Cancer screening coverage - bowel cancer (%) - 60% Target	Monthly/Qtr	May-14	*45.6*	43.5	45.8		-	↓	S.E London Bowel Cancer Screening centre (Available in Local Cancer Dashboard)
16	Early diagnosis of cancer (%)	Annual	2012	-	39.9	-	41.6		N/A	PHOF 2.19 – experimental statistics
17	Two week wait referrals (number per 100,000 population)	Annual	2013		2273		2166			Cancer Toolkit GP Profiles
18	Under 75 mortality from all cancers (DSR)	Annual	2010-12	*169.4*	159.9	139.1	146.5			NHSIC - P00381/ PHOF 4.05i
	Priority Objective 3: Improving Immunisation Uptake									
19	Uptake of the first dose of Measles Mumps and Rubella vaccine (MMR1) at two years of age	Qtr	2014/15 Q1	*88.3*	85.5	86.8	92.4	low	↓	PHOF 3.03viii/ Local Imms Cover Data
20	Uptake of the second dose of Measles Mumps and Rubella Vaccine (MMR2) at five years of age	Qtr	2014/15 Q1	*69.5*	70.8	79.9	88.5	low	↑	Local Immunisation cover data
21	Uptake of the third dose of Diptheria vaccine (D3) at one year of age	Qtr	2014/15 Q1	*88.9*	90	88.6	93.9	low	↑	Local Immunisation cover data
22	Uptake of the fourth dose of Diphtheria vaccine (D4) at five years of age	Qtr	2014/15 Q1	*76.2*	76.2	77.3	88.6	low	→	Local Immunisation cover data
23	Uptake of Human Papilloma Virus (HPV) vaccine in girls in Year 8 in Lewisham Schools	Annual/Qtr	2013/14	*84.8*	78.2				↓	Local Immunisation cover data
24	Uptake of Influenza vaccine in those over 65 years of age	Annual/Qtr	2013/14	*68.2*	70.2	62.8			↑	Local Immunisation cover data
	Priority Objective 4: Reducing Alcohol Harm									
25	Alcohol related admissions (ASR per 100,000 pop)	Annual*	2012/13	588	614	554	637	similar	↑	PHOF 2.18
26	Number of practitioners skilled in identifying those at risk from alcohol harm and delivering brief interventions (Local source)	Annual Local*	Nov-13 to Aug-14		384					LBL

Health and Wellbeing Performance Metrics 2014/15

		Frequency	Latest Period of Availability	Previous Available Period (Lewisham)	Latest Available Period (Lewisham)	Lon	Eng	England Benchmark	Direction from Previous Period	Data Source
	Priority Objective 5 : Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking									
27	Under 75 Mortality from Respiratory (DSR per 100,000 pop)	Annual	2010-12	*40.9*	38.6	32.6	33.5		↓	PHOF 4.07i
28	Under 75 Mortality from Lung Cancer (DSR per 100,000 pop)	Annual	2012	*23.57*	23.04	24.06	24.2		↓	NHS Indicator Portal - P00512
29	Smoking Prevalence(%)	Annual	2012	*22.6*	21.4	18	19.5			PHOf 2.14
30	4 week smoking quitter (crude rate per 100,000)	Annual/Qtr	2013/14	*821*	751.0	656.0	688.0		↓	HSCIC
31	Number of 11-15 year-olds who take up smoking (%)	Every 2-3 years	2010		9%					SHEU Survey (to be completed)
32	Number of children in smoke free homes (%)	Every 2-3 years	2010		57%					SHEU Survey (to be completed)
33	Prevalence of Smoking in 15 year olds (proxy: % Never smoked at all - Yr8 and Yr10 children)	Every 2-3 years	2010		74%					SHEU Survey (to be completed)
34	Smoking at time of delivery (%)	Annual/Qtr	2014/15 Q1	*5.2*	5.4	11.9	11.8		↑	HSCIC
	Priority Objective 6: Improving mental health and wellbeing									
35	Under 75 mortality rates for those with serious mental illness (DSR per 100,000 pop)	Annual	2011/12	*845.7*	839.8	-	1,274.8	sig low	↓	NHSOF 1.5
36a	Prevalence of SMI (%)	Annual	2012/13	*1.2*	1.2	1.0	0.8	-	→	QOF
36b	Prevalence of Dementia (%)	Annual	2012/13	*0.3*	0.3	0.4	0.6	-	→	QOF
36c	Prevalence of Depression (%)	Annual	2012/13	*10.4*	5.3	4.4	5.8	-	↓	QOF
37	Suicide rates (DSR per 100,000 pop)	Annual	2010-12	*7.1*	7.5	7.5	8.5	similar	↑	PHOF 4.10
38	Self-reported well-being - people with a low happiness score	Annual	2012/13	*15.0*	10.2	10.3	10.4	similar	↓	PHOF 2.23iii
	Priority Objective 7: Improving sexual health									
39	Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24 (crude rate)	Annual	2013	*4186*	3480	2179	2016	sig high	↓	PHOF 3.02i/3.02ii (NCSP & CTAD)
40a	People presenting with HIV at a late stage of infection(%) or	Annual	2011-13	*50.9*	46.1	40.5	45	similar	↓	PHOF 3.04
40b	Prevalence of diagnosed HIV infection per 1,000 among persons aged 15 to 59 years (crude rate)	Annual	2012	*7.94*	8.18	5.69	2.14	sig high	↑	PHE SH Profile
41	Legal Abortion rate for all ages (crude rate per 1000 women)	Annual	2013	*27.4*	27.6	22.8	16.6	sig high	↑	ONS Abortion Stats
42	Teenage conceptions (Rate per 1,000 15-17 Yr olds)	Annual	2012	*39.9*	42.0	25.9	27.7	sig high	↑	PHE Sexual Health Profile
	Priority Objective 8 – Delaying and reducing the need for long term care and support.									
43	social care related quality of life (%)	Annual	2013/14	*18.3*	18.6	18.4	19	-	↑	ASCOF 1A (P01507)
44	Rate of new admissions by older adults to long term care (crude rate per 100,000)	Annual/Qtr	2013/14	*612.9*	527	509.4	668.4	-	↓	ASCOF2A (P01514) (BCF)
45	% older people (65+) still at home 91 days after discharge from hospital into rehabilitation/reablement services	Annual/Qtr***	2013/14	*86.5*	86.9	88.9	81.9		↑	ASCOF 2B
	Priority Objective 9: Reducing the number of emergency admissions for people with long term conditions									
46	Rate of avoidable emergency admissions (Std rate per 100,000 pop)	Annual/Qtr***	2013/14(Prov)	*1027.6*	940.9	734.6	780.9	sig high	↓	BCBV / NHS Comparators/CCGOF 2.6
47	% people able to manage effectively their own long term condition at home	Annual	2013/14(Prov)	*62.3*	61.1	59.7	65.1		↓	NHSOF 2.1 (BCF)
48	Reviews of Adult Social Care Clients (cumulative % since Apr)	Annual/Qtr	2014/15 Q1	*77.9*	70.7	69.8	66.6		↓	BCF/Local Data - AO/D40 PPLUS
49	Health-related quality of life for people with long-term conditions	Annual	Jul 12 - Mar 13	*0.7*	0.7	0.7	0.7		↑	CCGOF 2.1
50	Emergency admissions for acute conditions that should not usually require hospital admission (DSR rate per 100,00 Pop)	Annual	2013/14(Prov)	*1324.8*	1279.4	991.0	1164.7	sig high	↓	CCGOF3.1
51	Emergency Readmissions within 30 days of discharge (ISR rate per 100,000 pop)	Annual	2013/14	*11.96*	12.73		11.78	sig high	↑	NHSOF3b

Health and Wellbeing Performance Metrics 2014/15

	Frequency	Latest Period of Availability	Previous Available Period (Lewisham)	Latest Available Period (Lewisham)	Lon	Eng	England Benchmark	Direction from Previous Period	Data Source

Key

sig high -signficantly higher than England; sig low - significantly lower than England
similar - statistically similar to England
DSR - Directly Standardised Rates
ASR - Age Standardised Rates
ISR - Indirectly standardised Rates
Lew - Lewisham; Lon - London; Eng - England

Statistically Better than England
Statistically Similar to England
Statistically 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
Annual* - Indicators not updated due to NO HES updates
Q - Financial Quarters

Boroughs (Bromley, Bexley, Lambeth, Southwark , Greenwich and Lewisham) from London Bowel Screening Hub
Annual/Qtr** - Only Local Data available both quarterly and annually
Annual /Qtr*** - 2013/14 Q3 emergency admission rates are available on BCBV metrics for each Ambulator Care Sensitive (ACS) condition.
Local Ad-hoc - Bowel Screening data only available for all 6 South East London

HEALTH AND WELLBEING BOARD				
Report Title	Reducing Emergency Admissions for people with Long Term Conditions – Lewisham CCG Progress Report			
Author	Lewisham Clinical Commissioning Group		Item No.	5b
Class		Date:	25 November 2014	
Strategic Context	Priority 9: Reducing Emergency Admissions for people with Long Term Conditions.			

1. Purpose

1.1 The purpose of this report is to provide an update on the progress against the objectives for key priority area 9 in the Health and Wellbeing Strategy; Reducing Emergency Admissions for people with Long Term Conditions. The focus of the report will be on the objectives and actions identified in the delivery plan of the Health and Wellbeing Strategy delivered by Lewisham Clinical Commissioning Group. This work on long term conditions is now encompassed within the Adult Integrated Care Programme.

2. Recommendation/s

Members of the Health and Wellbeing Board are recommended to note Lewisham Clinical Commissioning Groups progress against the delivery plan.

3. Policy Context

3.1 The Health and Social Care Act 2012 establishes 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. Health and wellbeing board members will collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future.

3.2 In line with Lewisham's Sustainable Community Strategy priority to create a 'Healthy, active and enjoyable borough where people can actively participate in maintaining and improving their health and wellbeing', the Health & Wellbeing Board has developed a ten year Health & Wellbeing strategy. The strategy sets out the improvements and changes that the Board, in partnership with others, will focus on to achieve our vision of;

Achieving a healthier and happier future for all

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

In taking forward action to achieve our vision we have three overarching aims;

I. ***To improve health*** – by providing a wide range of support and opportunities to help adults and children to keep fit and healthy and reduce preventable ill health.
II. ***To improve care*** – by ensuring that services and support are of high quality and accessible to all those who need them so that they can

regain their best health and wellbeing and maintain their independence for as long as possible.

III. ***To improve efficiency*** – by improving the way services are delivered; streamlining pathways; integrating services so ensuring that services provide good quality and value for money.

4. Long Term Conditions Programme

4.1 Lewisham Clinical Commissioning Groups 5 year (2013 – 2018) Commissioning Strategy: *A Local Plan for Lewisham* and subsequent priorities are aligned to the Health and Wellbeing Strategy. More so this is particularly apparent for long term conditions;

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

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

4.2 The long-term conditions work stream is delivered through the CCGs Quality Innovation, Productivity and Prevention (QIPP) programme. The QIPP programme is the national initiative that aims to make the NHS work more efficiently so that there are more funds available for treating patients. Delivering a successful QIPP programme will be crucial to ensuring that the CCG is using its resources in the most efficient way to enabling it to meet its vision for better health and best care.

4.3 In 2014/15 the number of emergency admissions across all acute providers in Lewisham continues to show a downward trend in comparison to 2013/14. More over for specific long-term conditions; Heart Failure, Chronic Obstructive Pulmonary Disease (COPD) and Diabetes there has been a reduction in the number of emergency admissions by 6.9% for Q1 2014/15 in comparison to the same period in 2013/14. Emergency Admissions for COPD saw the largest fall for the same period in Q1 2014/15 by 8.5%.

4.4 This report provides an update on the actions against each of the 4 deliverables underpinning *Priority 9* attributed to Lewisham CCG;

(i) *Implementing the key principles for treatment and care for all people with long term conditions; Risk Stratification, Integrated Care Teams and Self-Care. the key principles for treatment and care for all people with long term*

(ii) *Encouraging GPs to identify undiagnosed COPD, Diabetes and CVD (hypertension, atrial fibulation, arrythmia, heart failure, CHD) among their patients*

(iii) *Providing support, training and development to primary care in the management of long term conditions*

(iv) *Redesign of all key LTC pathways*

4.3 Implementing the key principles for treatment and care for all people with long term conditions; Risk Stratification, Integrated Care Teams and Self-Care. the key principles for treatment and care for all people with long term

4.3.1 Neighbourhood Community Team (NCT)

4.3.2 The Neighbourhood Community Teams (NCT) are forming the basis of integrated health and social care and the CCG are working collaboratively with partners to deliver this programme. The team consists of health, primary care and adult social care professionals based in four neighbourhood locations in order to enable comprehensive and co-ordinated proactive care to be delivered to at-risk patients. These patients are being referred to their NCT in order to;

(i) have their health and social care needs stabilised to slow down, reduce or prevent any deterioration that could lead to an otherwise avoidable hospital admission
(ii) be intensively supported following discharge from hospital in order to prevent relapse and subsequent re-admission

4.3.3 Locations with adequate capacity for these and mental health teams have been proposed and are being discussed with relevant estates representatives.

4.3.4 Referral to the teams will be via a 'Single Point of Access', where appropriate triage and workflow mapping will be carried out to ensure that the patient's most urgent needs are prioritised but with all other needs being met before "discharge" back to the GP.

4.3.5 The NCTs are a pillar of the Better Care Fund approach to integrated care and exist on a continuum with risk stratification and care planning: identification cannot be divorced from proactive care that stabilises the patient's risk status. The overarching ethos of the NCT approach is that patients only tell their story once in order that seamless support will be delivered to them by the appropriate team of health, primary and social care professionals working closely together to deliver the same agreed goals with the patient.

4.3.6 For additional detail on progress on delivering and embedding the NCT please refer to the Adult Integration Programme update.

4.3.7 Risk Stratification and Care Plans

4.3.8 LCCG has supported GP practices to deliver the National Unplanned Admissions Enhanced Services (ES). More so 40 of the 41 GP practices have used the Risk Stratification Tool to identify 2% of the cohort and agreed in excess of 5000 care plans for those patients identified as being most at risk of an avoidable hospital admission. A significant proportion of these patients will be referred for proactive support from health and social care professionals in Neighbourhood Community Teams (NCT) – with GPs coordinating the delivery of the care for the patient.

4.3.9 The CCG is currently conducting a review of the care plans to determine the following;

(i) The types of patients selected by the practices for proactive care e.g. long- term condition, age and history of falls etc.
(ii) How selection of at risk patients using clinical experience differs from the risk score assigned to patients using the Risk Stratification Tool.

(iii) The extent to which those selected by GP practices as being most at risk differs from Adult Social Care caseloads.

4.3.10 The planned outcomes from these analyses are as follows;

(i) The standardisation of clear pathways for different types of patients to reduce variation across the borough in the proactive care offered to them.
(ii) The identification of patients not naturally assumed by GPs and nurses to be at high risk of an avoidable hospital admission i.e. those outside of age and long term condition risk, in order to enhance practice learning.
(iii) The commissioning opportunities which arise from the comparative analysis.

4.3.11 The longer term risk stratification strategy, now a component of the integrated care programme – seeks to identify common approaches to the stratification of risk across the whole system and to develop successively more sophisticated patient segmentation initiatives and the subsequent care pathways.

4.3.12 **Collaborative Care Plans**

4.3.13 The CCG implemented a successful pilot with a small number of practices. Consequently, GP practices are being supported to deliver Collaborative Care Planning through the Lewisham Neighbourhood Primary Care Improvement Scheme.

4.3.14 By the end of 2014/15, in excess of 80 GPs and Nurses will have undertaken the training for the Year of Care approach to Collaborative Care Planning. This approach incorporates;

(i) Motivational interviewing technique, which seeks to support the patient to become an equal partner in discussions and decisions about their care: the patient as expert about themselves, the clinician as expert about conditions.
(ii) An 'informed' patient ethos, with the patient being educated about tests and results prior to their consultation to encourage two way discussion and the promotion of self-care and self-management.

4.3.15 The CCG is working closely with the NHS Year of Care Team to expand this approach from its initial focus on Diabetes to be applicable to all long term conditions.

4.4 Encouraging GPs to identify undiagnosed COPD, Diabetes and CVD (hypertension, atrial fibulation, arrythmia, heart failure, CHD) among their patients

4.4.1 Health Checks

4.4.2 As part of a collaborative programme commissioned by Public Health and delivered by the CCG, a structured programme to support practices to increase the numbers of health checks, increased smoking cessation and improving immunisations was delivered in 2013/14. This involved developing toolkits and supporting aids and information for GP practices. All GP practices were visited by the CCG facilitator team; using a standardised toolkit, there were structured discussions around improving delivery of the Health Checks programme. Best practice was shared and recommendations were fed back to Public Health; commissioners for NHS Heath Checks.

4.4.3 The collaborative programme between the CCG and Public Health has been extended into 2014/15 with a continued focus on NHS Health Checks. CCG facilitators will be undertaking follow up practice visits between November and December 2014 to consider progress since the first round of visits and feedback any new recommendations to improve the uptake and impact of the Health Checks programme.

4.4.4 Lewisham Neighbourhood Primary Care Improvement Scheme (LNPCIS)

4.4.5 Aligned to the Lewisham CCG Primary Care Strategy and building on previous schemes designed and managed by the CCG, the LNPCIS has been structured to support a reduction in emergency admissions with a specific focus on long term conditions. It also directly supports practices to work collaborative together to deliver the elements of the scheme.

4.4.6 The scheme supports GP practices in 'neighbourhoods' to work together to improve the quality and reduce variation in the delivery of services and care to patients with diabetes, COPD, hypertension and cancer. There is also a focus on driving up seasonal flu and pneumococcal vaccination coverage rates across neighbourhoods to directly impact on reducing emergency admissions in these areas.

4.4.7 The CCG intends to extend the scheme into 2015/16 carrying forward the same themes and with a continued focus on directly supporting reductions in emergency admissions.

4.5 Providing support, training and development to primary care in the management of long term conditions

4.5.1 Protected Learning Time Events (PLTs)

4.5.2 Lewisham CCG is committed to providing protected learning time for GP practices to support continual two way dialogue between the CCG and its constituent members. The annual programme of PLTs supports delivery of the CCGs commissioning intentions and priorities. The CCG funds medical cover to enable all staff from GP practices to attend the monthly sessions. PLTs encourage clinicians, GPs, nurses, practice staff and other key stakeholders to be briefed on current intervention, pathways and exchange ideas and examples of best practice.

4.5.3 Previous PLTs in 2014/15 have included sessions on Falls and Mental Health. In October 2014, the PLT session examined alternative care settings and pathways to acute emergency admissions. The PLT session explored what other interventions could be implemented by individual GP practices, at neighbourhood level and borough-wide initiatives, which would further support patients and reduce admissions. Consequently, the CCG is developing action plans and will be updating members via its dedicated GP Interactive Portal (GPi).

4.5.4 Health Education South London (HESL)

4.5.5 The CCG submitted a number of bids to Health Education South London (HESL) and received a total of £630,700 for the following schemes for primary care;

- Medicines Optimisations Education and Training Scheme (MOETS)
- Mutually Agreed Outcomes
- Primary Care Customer Service
- Workforce Development for Integrated Adult Care

- Lay educators for Type 2 diabetes
- Practice Nurse development
- Telephone consultation and triage skills

4.5.6 The schemes began implementation in March/April 2014 and are due to run until March 2015. The MOETS scheme began in December 2013. All the projects are on track to deliver their objectives.

4.5.7 The Practice Nurse Development project has undertaken an audit of practice nurses in Lewisham, asking nurses to complete a self-assessment form and then following up with an observational visit. A total of 63 practice nurses took part in the observations and the report is currently being drafted. The report will make recommendations on improving the quality and profile of general practice nursing. As a part of this project, the CCG also purchased a web-based toolkit called HeART. The toolkit enables practice nurses to log all of training and education, undertake appraisals and personal development plans as well as producing their portfolio – this will support Nursing Medical Council (NMC) revalidation requirements, which comes into effect in 2015.

4.6 Redesign of all key LTC pathways

4.6.1 Diabetes

4.6.2 The Lewisham Diabetes Clinical Network Group supported by the CCG, (which has with representation from patients, providers, commissioners and public health) continued work to build on the objectives outlined in the Lewisham CCG Diabetes Strategy, which was first launched in 2012. Core work streams for 2014/15 include;

4.7.1 *Improving access to structured education programmes*
DESMOND is the acronym for Diabetes Education and Self-Management for On-going and Newly Diagnosed. It is part of a school of patient education for people with diabetes, developed by a number of NHS Organisations. The CCG commissions DESMOND via its integrated community contract with Lewisham & Greenwich Trust. Enabling patients to 'self-refer' to DESMOND is currently being rolled out across Lewisham after a successful pilot in 2013/14. Marketing of the initiative will include pharmacies, leisure centres and leisure centres.

4.7.2 The CCG funded a dedicated administrator post to the DESMOND team to support proactive patient contact and follow-up, reducing the numbers of patients that do not attend and improving the quality of audit data. These benefits are already being realised within the team.

4.7.3 Taster sessions of the DESMOND course have been delivered to community pharmacists and others to promote understanding of the course. It has also invited health care professionals to join patients on the course and this has been very well received by the first GP registrars to sign up.

4.7.4 *Redefining Diabetes Community Services*
Lewisham CCG commissions Diabetes services as a part of the integrated community contract with Lewisham & Greenwich Trust and the service Is delivered by the Community Diabetes Team. The service redesign and improvements are supported by a CCG Diabetes Patient Focus Group.

4.7.5 The Community Diabetes Team conducted an audit of patient feedback from 2012/13 courses, which was very well received as a poster and was presented at the Diabetes UK Professional Conference 2014. The findings

were used to inform changes in the programmes approach and a re-audit is planned for the end of 2014/15. This is positive example of how patient feedback used to inform service design.

4.7.6 The CCG are redefining the specifications for the diabetes community services team, which includes delivery of Collaborative Care Plans for all patients in 2014/15.

4.7.7 The CCG Diabetes Patient Focus Group has joined their opposite groups in Lambeth and Southwark to discuss their experiences of insulin prescribing and management. This will inform the work of South London Health Improvement Network aimed at improving insulin prescribing and management.

4.7.8 In response to issues raised around insulin prescribing habits, an audit was conducted by the CCG Prescribing Team that resulted in the development of a local Insulin and Devices visual aid assist clinicians in prescribing choices. This has been very positively received by clinicians.

4.7.9 The referral pathway for Foot Services has been revised to reflect national guidance. Training events for primary care clinicians have been delivered and presentations were made to services users at a recent Diabetes UK event.

4.7.10 The CCG with joint commissioning colleagues has commenced work on scoping models for providing psychological support for people with diabetes and other LTCs whose complex needs are currently outside the scope of currently commissioned models.

4.7.11 Chronic Obstructive Pulmonary Disease (COPD)

4.7.12 In 2013/14 Lewisham CCG delivered a successful Diabetes Community Champion programme in partnership with Diabetes UK and it is this experience and learning that is being utilised to develop a similar programme with the British Lung Foundation for COPD. This year the CCG will be emulating the success of this programme by commissioning a 12 month pilot to increase awareness of COPD and its risk factors to those who are directly at high risk and its complications. The volunteers recruited will work at grassroots level to deliver pertinent messages and signposting to the community and increase the uptake of self-management for people with COPD via the structured education programme; LEEP (Lung Exercise and Education Programme).

4.7.13 From December 2014 Lewisham CCG, in partnership with Healthwatch Lewisham, will be delivering the Community Champion pilot for people with COPD.

4.7.14 Asthma

4.7.15 Lewisham CCG ran an event for people living with asthma, which involved patients, carers and their family members. The event provided local people with an opportunity to share experiences and make suggestions that could help improve how adults with asthma are cared for and supported. Clinical teams involved in caring for people with asthma discussed ways people can manage asthma and the support available to improve their health. Patients' advised about their expectations from practice nurses, the importance of clear information to support with managing their condition and the need for an Asthma Support Group.

4.7.16 The learning from this event supported the CCGs workshop for Practice Nurses; where new prescribing guidelines and skills development were

provided. At the Practice Nurse Forum, the CCG provided practice nurses with up to date equipment (including Spirometers) to support with the management and diagnosis of Asthma.

4.7.17 As a part of the Protected Learning Time (PLT) sessions the CCG will be running a Respiratory event for GP practices in November 2014. The session will support with consolidating the pathway.

4.7.18 The CCG has signed up for the National Review of Asthma Deaths, which goes live in April 2016 and the Asthma Standards Framework.

4.7.19 **Proactive Primary Care (PPC)**

4.7.20 PPC aims to instigate a shift from acute to chronic care using a suite of activities that build on current primary and community care practices, extending it in an evidence-based way through implementation of the following;

- Telephone calls by *Motivational Callers* to identified patients at risk of future use of A&E and subsequent admissions.
- Interventions through ready access to appropriate healthcare professionals and local organisations.
- Support and training for patients in self-care and decision-management to promote a “continuous healing relationship”. Patients develop skills to become active, informed participants in their healthcare.
- Development of communication pathways between primary, community, secondary and voluntary care agencies.
- Befriending by local voluntary agencies.

4.7.21 The CCG successfully applied for NHS London Innovation funding to support a Proactive Primary Care pilot for a GP practice based model. The work and evaluation is being shared with NHS England, which has replaced NHS London Innovation.

4.7.22 The project is supported by ‘Motivational Callers’ who are non-clinical practice staff. The callers received training in empathetic and considered listening skills and are provided with a software programme that supports the calls and enables them to appropriately advise and sign post patients.

4.7.23 The expectation is to evaluate the health and wellbeing outcomes of the patients contacted by telephone on 3 separate occasions, using a structured calling script, accompanied by a set of evaluation questions. Practices representing all four Neighbourhoods took part in this pilot project.

4.7.24 The CCG has teamed up with the London School of Economics who have evaluated the pilot. The outcomes from the pilot will inform future commissioning intentions.

5. Financial implications

There are no implications arising from this report. The long-term conditions programme supporting the reduction in acute emergency admissions is a part of the CCG QIPP 2014/15 programme.

6. Legal implications

There are no specific legal implications. Members of the Board are reminded that under Section 195 Health and Social Care Act 2012, health and wellbeing boards are under a duty to encourage integrated working between the persons who arrange for health and social care services in the area.

7. Crime and Disorder Implications

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

8. Equalities Implications

Lewisham CCG conducted Equalities Impact Assessments on core programmes including Risk Stratification and Collaborative Care Plans.

9. Environmental Implications

There are no specific environmental implications arising from this report.

10. Conclusion

The report provides an update on the progress towards the objectives and outcomes to date on reducing emergency admission for people with long term conditions. However, it is important to note that for the CCG in delivering its Commissioning Intentions and QIPP for 2014/15 reducing emergency admissions is and will continue to be a key priority. 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.

11. Contacts

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HEALTH AND WELLBEING BOARD				
Report Title	Update on the Cancer priority outcome in the Health and Well Being Strategy			
Contributors	Katrina McCormick, Deputy Director of Public Health		Item No.	5c
Class	Part 1	Date:	25 November 2014	
Strategic Context	Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years is one of the nine priority areas in Lewisham's Health and Wellbeing Strategy.			
Pathway				

1. Purpose

The purpose of this report is to provide an update on the progress towards achieving the outcome of Lewisham's Health and Wellbeing Strategy, Priority Area 2: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years in the Health and Wellbeing Strategy.

It also provides an overview of cancer in Lewisham as it is the first time that the Board has received a report on cancer .

1.1 The report highlights the following:

a) Cancer is now the main cause of death of people in Lewisham. However, mortality from cancer for all ages and for those aged under 75 has decreased in Lewisham as it has in London and England.

b) There has been little change in breast cancer screening coverage in Lewisham, although it remains above the coverage achieved by Lambeth and Southwark, but below the national target.

c) There has been a slight decrease in the uptake of bowel cancer screening. Lewisham is one of 4 CCG in South London (including Lambeth, Greenwich and Richmond) that has seen a slight decrease in uptake as of May 2014, out of the 12 CCGs in South London.

d) The coverage of the cervical screening programme for the prevention of cancer improved in Lewisham in 2012-13. Although Lewisham does not meet the national target of 80% coverage, there is an upward trend in improvement and coverage is above that of Lambeth and Southwark.

e) Survival for most cancer types is improving. This progress can generally be attributed to faster diagnosis and advances in treatment. However, there is still scope for improvement and some cancers have shown very little improvement. The one year survival rate for all cancers is lower in Lewisham compared to London and England.

f) A range of activity has been undertaken to promote early diagnosis of cancer by the Local Authority, Lewisham CCG , the Community Health Improvement Team and community and voluntary organisations.

g) Lewisham CCG has successfully secured funding from Macmillan to employ a GP Cancer lead. One of the main aims is to provide primary

care leadership particularly on cancer awareness and early diagnosis, and the role of primary care in increasing uptake of cancer screening.

2. Recommendation

Members of the Health and Wellbeing Board are recommended to:

2.1 Note and comment on the content of the report.

3. Policy Context

3.1 Increasing the number of people who survive colorectal, breast and lung cancer is one of the 9 priorities in the Lewisham's Health and Wellbeing Strategy .

3.2 Reducing inequality is one of the two principles informing Lewisham's Sustainable Community Strategy and increasing the number of people who survive cancer supports its priority of healthy, active and enjoyable- where people can actively participate in maintaining and improving their health and well-being.

4. Background

Cancer affects everyone. Over 250,000 people in England are diagnosed with cancer every year and around 130,000 die from the disease. Currently, about 1.8 million people are living with and beyond a cancer diagnosis. The Government Report "Improving Outcomes: A Strategy for Cancer" published in 2011 highlighted that despite improvements in survival and mortality in recent decades, cancer outcomes in England remain poor when compared with the best outcomes in Europe. Although improvements have been made in the quality of cancer services, a significant gap remains in both survival and mortality rates. If England was to achieve cancer survival rates at the European average, then 5,000 lives would be saved every year. If England was to achieve cancer survival rates at the European best, then 10,000 lives would be saved every year. A range of actions were identified and included the following:

- reduce the incidence of cancers which are preventable, by lifestyle change;
- improve access to screening for all groups and introduce new screening programmes where there is evidence they will save lives and are recommended by the UK National Screening Committee;
- achieve earlier diagnosis of cancer, to increase the scope for successful treatment – diagnosis of cancer at a later stage is generally agreed to be the single most important reason for the lower survival rates in England;

4.1 This report covers progress towards achieving the improvements and outcomes of the key priority area 2; Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years 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, with an emphasis on screening and early diagnosis. This work is undertaken in partnership with the CCG, NHS England, Local Acute Trusts , the voluntary and community sector and by individuals. The objectives in the delivery plan reflect the work of a number of strategies and plans, these include the CCG Clinical Commissioning Strategy 2013-2018 and the Cancer Commissioning Strategy for London

4.2 For this key priority the Health and Wellbeing Strategy wants to achieve the following:

- Support residents of Lewisham to achieve and maintain a healthy lifestyle.
- Reduce the rate of premature mortality of cancer in Lewisham .
- Increase the coverage of cancer screening programmes (Breast, Bowel and Cervical) in Lewisham.
- Increase the awareness of professionals and communities of the early signs and symptoms of common cancers.
- Reduce the incidence of cancer in Lewisham.

4.3 Performance in relation to achieving and maintaining a healthy lifestyle is not reported here as it is reported in the separate reports to the Board on the three priority outcomes Promoting Healthly Weight, Reducing Alcohol Harm and Reducing smoking prevalence and uptake among young people.

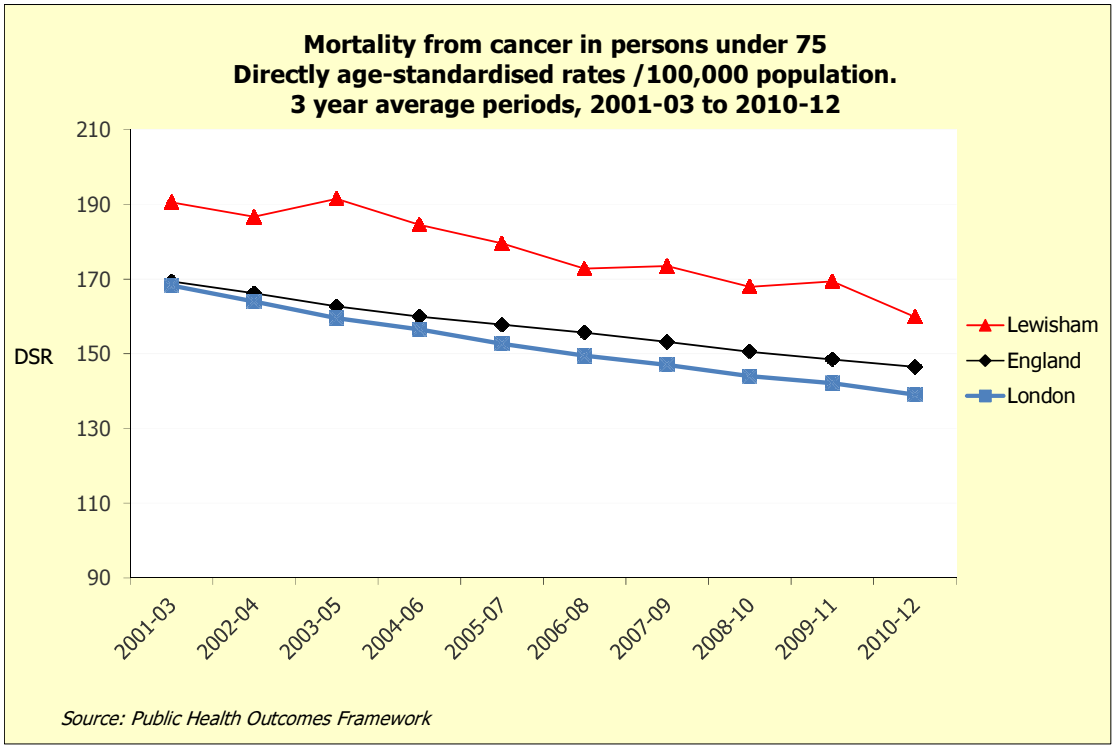
5. Performance

5.1 **Reduce the rate of premature mortality of cancer in Lewisham**

Cancer is now the main cause of death of people in Lewisham, 32% of all deaths in 2013/14 which equalled 463 deaths. Lung, Prostate and Bowel are the main cause of cancer deaths in males. Lung, Breast and Bowel are the main cause of cancer deaths in females.

Mortality from cancer for all ages and for those aged under 75 has decreased in Lewisham as they have done in London and England (Figure 1) . However the mortality rate in Lewisham for those aged under 75 is higher than London and England and this remains statistically significantly different.

Figure 1: Premature Mortality from Cancer, Lewisham, London England 2001-03 to 2010-12.



Smoking is by far the most important risk factor for cancer responsible for 19% of all new cancer cases nationally in 2010 equating to approximately one in five cancers[1]. Ninety per cent of lung cancers are associated with smoking. Lewisham has a significantly higher mortality rate for Lung cancer (47.1 per 100,000) compared to the England average 38.3 per 100,000 in 2009-11.

There are around 19,000 extra deaths from cancer, per year, in England because mortality rates are higher in more deprived groups for most cancers. Lung cancer has by far the largest number of excess deaths because of socio-economic variation (9,900 deaths)[2].

5.2 Increase the coverage of cancer screening programmes (Breast, Bowel and Cervical) in Lewisham.

Since the implementation of the Health and Social Care Act 2012 , NHS England has the responsibility for commissioning cancer screening services.

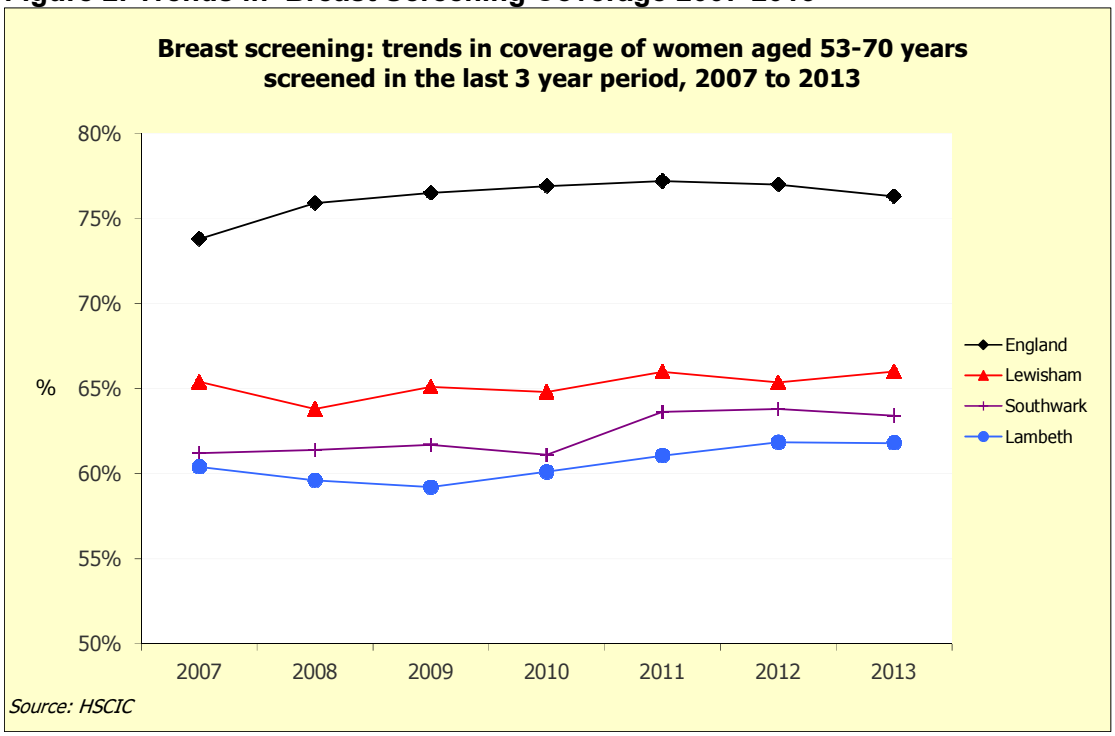
5.2.1 Breast Screening

Data on Breast Screening performance is provided by the Health and Social Care Information Centre with the most up-to date data being for 2013.

[1].http://www.cancerresearchuk.org/cancer–info/cancer stats/types/lung/riskfactors/lung-cancer-risk-factors

[2] http://www.cancerresearchuk.org/cancer-info/cancerstats/mortality/socio-economic-variation/#Excess

Figure 2: Trends in Breast Screening Coverage 2007-2013



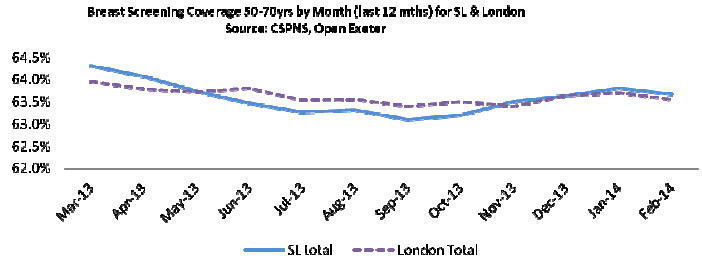
More recent data presented to the London Cancer Screening Board is provided on a South London CCG basis. The Breast Screening Provider for South East London is Kings Health Care.

Breast screening coverage data
South London (SL) CCG 50-70yrs
Trend charts : Last 12 months

NHS England

Overall slight decrease in coverage rates for SL

Breast Coverage Trends	50-70yrs											
SL	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14
NHS Bexley CCG	73.3%	73.4%	73.8%	73.9%	73.5%	73.9%	73.8%	73.3%	73.1%	73.0%	72.6%	72.3%
NHS Bromley CCG	71.4%	71.2%	71.3%	71.6%	71.8%	71.7%	71.5%	71.7%	71.9%	72.4%	72.8%	73.2%
NHS Croydon CCG	63.9%	63.4%	61.9%	60.8%	59.9%	60.1%	60.3%	60.4%	60.5%	61.0%	61.0%	60.7%
NHS Greenwich CCG	62.3%	61.8%	61.0%	60.5%	60.8%	61.0%	61.6%	62.6%	63.4%	64.0%	64.4%	64.7%
NHS Kingston CCG	63.7%	62.8%	60.6%	58.5%	56.9%	55.2%	53.6%	53.4%	54.4%	54.7%	54.6%	55.9%
NHS Lambeth CCG	57.8%	58.0%	57.8%	57.9%	57.8%	57.9%	57.8%	58.0%	58.3%	58.5%	58.3%	58.2%
NHS Lewisham CCG	60.7%	60.8%	60.7%	60.4%	60.9%	61.2%	60.5%	61.0%	61.5%	61.7%	62.0%	61.8%
NHS Merton CCG	64.7%	64.8%	64.0%	63.6%	62.7%	62.4%	60.9%	62.7%	62.9%	61.2%	62.4%	62.3%
NHS Richmond CCG	64.3%	64.7%	64.8%	64.4%	64.3%	65.0%	65.0%	63.9%	65.0%	65.0%	65.0%	64.5%
NHS Southwark CCG	60.6%	60.5%	60.6%	60.2%	60.4%	60.6%	60.3%	60.5%	60.5%	60.5%	60.2%	60.0%
NHS Sutton CCG	70.0%	69.6%	69.2%	69.3%	68.5%	68.2%	68.1%	68.4%	68.2%	67.5%	67.5%	66.9%
NHS Wandsworth CCG	57.0%	56.3%	57.0%	57.9%	58.7%	59.0%	60.0%	58.5%	58.9%	59.4%	59.7%	59.3%
SL total	64.3%	64.1%	63.7%	63.5%	63.3%	63.3%	63.1%	63.2%	63.5%	63.6%	63.8%	63.7%



There has been little change in the coverage of breast screening in Lewisham over the past six years despite a range of initiatives to promote the uptake. These include telephoning women that have missed their appointment to offer them an opportunity to make a further appointment; the production and distribution of a resource pack to primary care to support them to promote cancer screening programmes, the production of a video by local women for Black African and Black Caribbean communities to promote breast screening.

To support an increase in coverage of breast screening NHS England have negotiated with the screening provider a number of CQUINS. These include: when a woman does not attend their appointment they will be sent another invitation with a timed appointment, reminder letters are sent to women in regard to their appointment and women will be sent a text of their appointment time.

5.2.2 Bowel Screening.

The London Bowel Cancer Screening hub is based at St Mark's Hospital and it operates the national call and recall system to send out faecal occult blood (FOB) test kits, analyse samples and despatch results .The hub is responsible for coordinating the programme in London and works with six local screening centres. The South East London Screening centre is based at Lewisham Hospital and King's College Hospital. The screening centre provides endoscopy services and specialist screening nurse clinics for people receiving an abnormal result. It is also responsible for referring those requiring treatment to the appropriate hospital multidisciplinary team (MDT).

To support an increase in uptake in bowel cancer screening the Health Promotion Specialist based at the screening centre held a range of promotion sessions in the community and attended the Lewisham GP Neighbourhood Forums to inform and promote bowel screening.

The NHS offers bowel scope screening to all men and women aged 55. Bowel scope screening is an examination called 'flexible sigmoidoscopy'' which looks inside the lower bowel. The aim is to find any small growths called 'polyps', which may develop into bowel cancer if left untreated. Bowel scope screening is an addition to the existing NHS Bowel Cancer Screening Programme. This will be implemented in Lewisham from January 2015.

More recent data presented to the London Cancer Screening Board is provided on a South London CCG basis below.

Slight increase in SLs % Uptake in May 2014

SL area team : Bowel screening uptake data by month
60-69yrs from Jun 2013 to May 2014

NHS England

SL	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
NHS Bexley CCG	66.9%	50.9%	46.8%	53.6%	47.6%	44.4%	48.4%	59.5%	55.7%	56.6%	49.6%	53.7%
NHS Bromley CCG	61.6%	55.6%	56.8%	55.7%	53.5%	53.9%	47.6%	61.7%	50.3%	51.9%	53.4%	54.2%
NHS Croydon CCG	49.8%	42.4%	48.0%	44.5%	39.1%	43.7%	48.1%	51.3%	49.0%	52.7%	47.6%	47.8%
NHS Greenwich CCG	54.0%	42.1%	40.7%	43.9%	38.1%	37.4%	38.9%	50.3%	44.1%	44.4%	51.9%	46.4%
NHS Kingston CCG	55.0%	50.2%	49.5%	44.7%	42.5%	46.8%	51.5%	57.5%	54.2%	50.7%	50.2%	54.8%
NHS Lambeth CCG	43.8%	34.3%	37.4%	35.6%	33.8%	30.8%	35.3%	40.7%	39.3%	41.0%	39.3%	38.9%
NHS Lewisham CCG	49.2%	36.9%	35.8%	42.9%	34.6%	32.8%	38.9%	46.1%	43.5%	47.4%	45.6%	43.5%
NHS Merton CCG	46.7%	44.3%	47.2%	45.4%	39.6%	40.8%	45.7%	51.7%	50.8%	54.1%	47.6%	48.5%
NHS Richmond CCG	57.5%	51.6%	52.1%	47.3%	48.1%	47.5%	52.2%	58.8%	53.4%	59.1%	54.5%	54.3%
NHS Southwark CCG	41.1%	36.4%	32.7%	37.3%	34.3%	31.6%	37.2%	39.5%	36.1%	39.1%	39.9%	44.1%
NHS Sutton CCG	51.9%	53.5%	53.1%	50.0%	48.1%	46.4%	48.5%	54.6%	55.2%	56.4%	52.2%	52.7%
NHS Wandsworth CCG	45.3%	41.2%	41.2%	36.4%	37.7%	36.7%	44.6%	48.0%	48.1%	47.6%	43.9%	45.2%
SL total	52.2%	44.8%	45.3%	45.1%	41.5%	41.3%	44.8%	52.4%	48.3%	50.3%	48.1%	48.9%
London Total	48.1%	43.7%	42.5%	41.0%	40.6%	39.5%	43.1%	48.6%	48.7%	47.9%	47.7%	45.8%

Please note : Data is subject to change, as each month the data is refreshed, therefore the figures may increase.

A slight increase in % uptake for May 2014 of 0.8%. Greenwich reported a decrease in % uptake of 5.5% in May 2014 compared to April 2014. Bexley reported an increase in % uptake of 4.1%. Lambeth is furthest from the national target with a % uptake of 38.9%.

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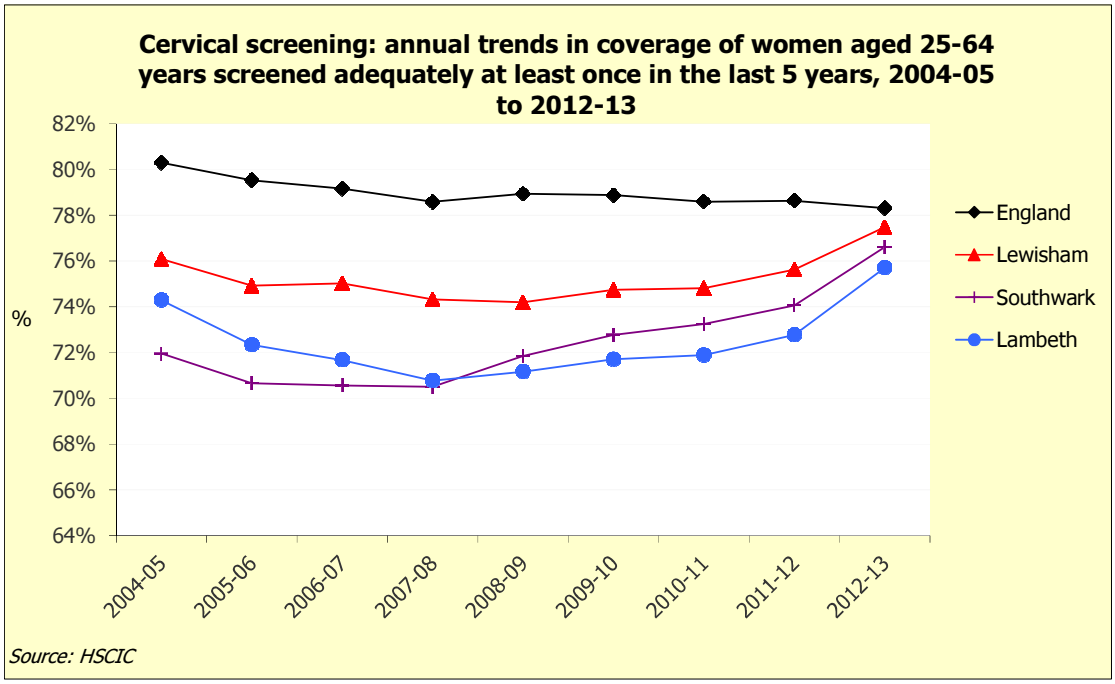
5.2.3 Cervical Screening

Cervical screening is a method of preventing cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer in a woman's cervix
Screening primarily takes place in a woman's GP surgery, some women have a smear taken in a sexual health clinic.
Screening coverage data provided by the Health and social care information centre is shown in Figure 3 .

Figure 3: Cervical screening trends in coverage Lewisham Southwark, Lambeth and England 2004-05 to 2012-13



The coverage of the cervical screening programme in Lewisham improved in 2012-13, although Lewisham does not meet the national target of 80% coverage. It is believed that the improved position is primarily due to the list validation exercise that has been carried out across South East London since 2012. There is concern that the numbers of younger women aged 25-29 being screened has declined. Research[3] is currently underway to find the more effective interventions to increase the uptake in this age group.

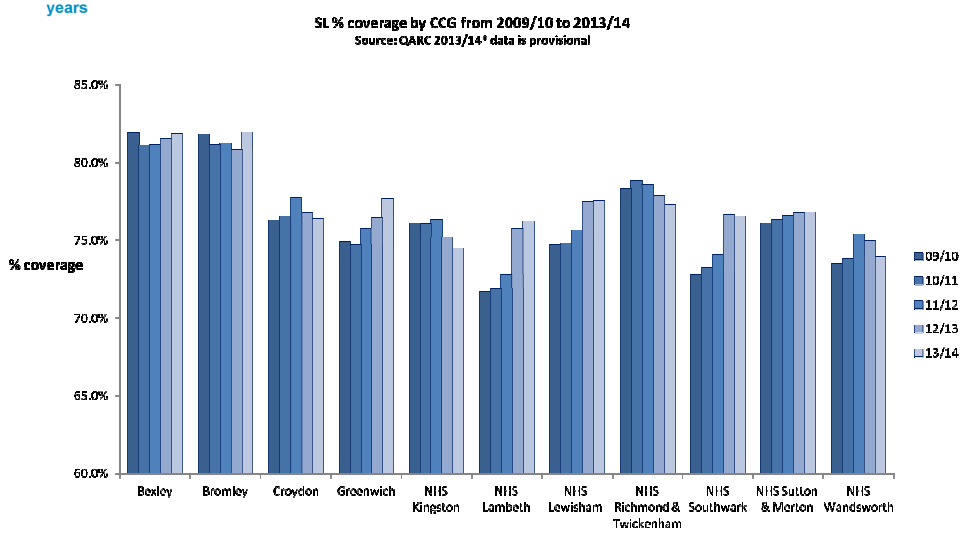
The implementation of the Human Papillomavirus (HPV) triage as part of the Cervical Screening Programme was rolled out in Lewisham from January 2013.

More up to date chart provided by NHS England .

[3] Strategies to increase cervical screening uptake at first invitation (STRATEGIC) http://www.nets.nihr.ac.uk/projects/hta/0916401

Cervical screening coverage data
CCG Trend charts for SL 25-64yrs for the past 5 years
Source: QARC 2013/14* data is provisional

5 CCGs decreased in % coverage in 13/14 compared to 12/13
A gradual increase in performance from Greenwich, Lambeth and Southwark over the past 5 years



9

One of the key issues known to affect the uptake of screening services in South East London is that of population mobility, people moving and not informing their GP surgery of their new address and thus do not receive their invitation.

5.4 Commissioning Intentions for Cancer Screening in South East London 2015/16.

The following are proposed by NHS England

- Split of South East London Breast Screening service into Kings (Lambeth Southwark) and Lewisham, Bexley, Bromley and Greenwich.
- Review configuration of breast screening services in London with plans to identify best option and re-commission in 16/17.
- Bowel cancer screening roll-out in prisons (Belmarsh).
- Develop cervical screening co-commissioning model for London (jointly with CCGs and providers) .

6. Increase the awareness of professionals and communities of the early signs and symptoms of common cancers.

Early detection of cancer greatly increases the chances for successful treatment. There are two major components of early detection of cancer: education to promote early diagnosis and screening.

Recognizing possible warning signs of cancer and taking prompt action leads to early diagnosis. Increased awareness of possible warning signs of cancer, among doctors, nurses and other health care providers as well as among the general public, can have a great impact on the disease.

6.1 Actions to improve early diagnosis

A range of activity has been undertaken to promote early diagnosis by the Local Authority, Lewisham CCG , the Community Health Improvement Team and community and voluntary organisations.

"Be clear on Cancer" campaigns run by Public Health England have been promoted. The Be Clear on Cancer campaign in 2013-2014 have included:

- Be alert to symptoms of lung cancer- July until mid-August 2013

- Breast Cancer in women over 70- February to March 2014
- Prostate cancer pilot, 20 October – 23 November, 2014
- Blood in Pee- 13 October to 23 November 2014

Lewisham CCG has successfully secured funding from Macmillan to employ a GP Cancer lead, one of the main aims is to provide primary care leadership in Lewisham particularly cancer awareness and early diagnosis, and the role of primary care in increasing uptake of cancer screening. Currently the CCG is recruiting to this post. The CCG clinical facilitators will be working with the GP, once in post to promote screening and early diagnosis in primary care.

The Lewisham CCG Neighbourhood Primary Care Improvement Scheme (2014/15) has invested funding to reduce variation in delivery of cancer services in primary care. The initial focus seeks to understand the differences in cancer referrals and ensures that clinical discussions are held with the GP Cancer Lead to draw on good practice and spread learning. It is anticipated that these discussions will identify the issues that should be prioritised in the future.

6.2 Outcomes

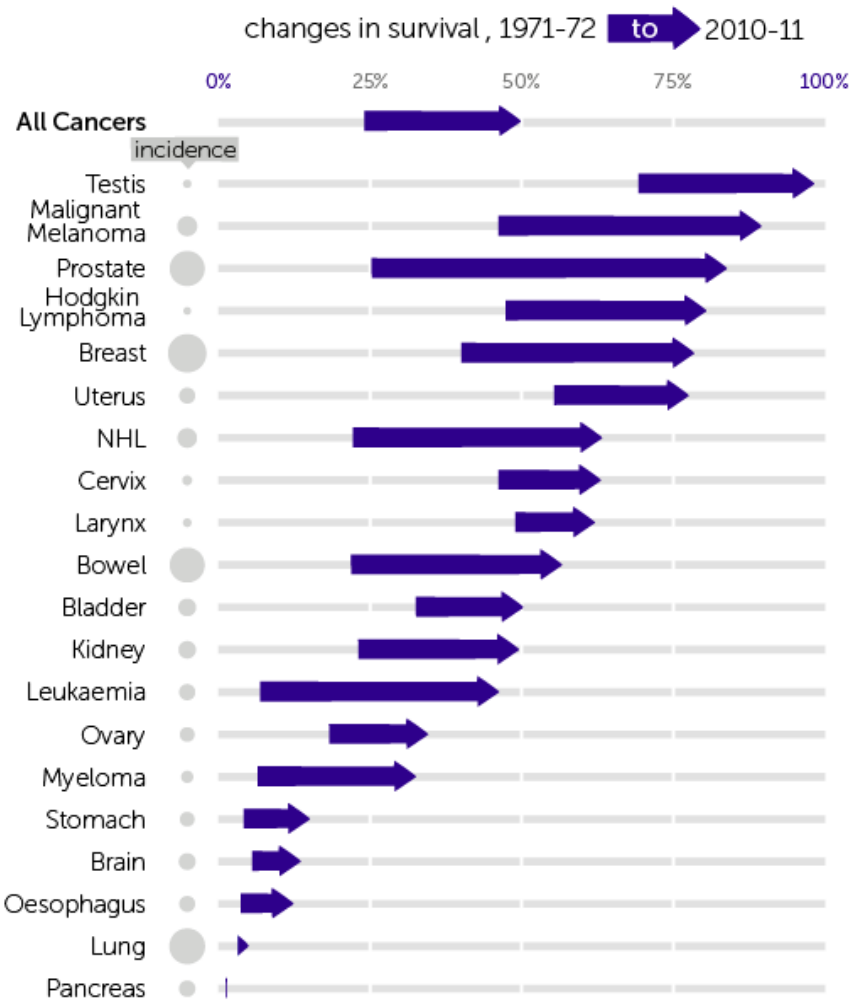
Survival for most cancer types is improving (Figure 5). This progress can generally be attributed to faster diagnosis and advances in treatment. However, there is still scope for improvement and some cancers have shown very little improvement since the early 1970s. Increasing cancer survival remains a major priority of Improving Outcomes: A Strategy for Cancer.

Prostate cancer has shown the largest improvement in age-standardised ten-year net survival since the early 1970s, from 25% in 1971-1972 to 84% in 2010-2011 (an absolute survival difference of almost 60 percentage points). However, interpretation of survival trends for prostate cancer is made difficult as the types of prostate cancer diagnosed have changed over time due to PSA testing. The next largest increases in ten-year survival are for malignant melanoma, non Hodgkin lymphoma and leukaemia, with absolute survival differences of 43, 41 and 39 percentage points, respectively, between 1971-1972 and 2010-2011.Bowel Cancer and female breast cancer have also shown large improvements in survival over the last forty years, with absolute survival differences of 35 and 38 percentage points, respectively. between 1971-1972 and 2010-2011.

There has been very little improvement in age-standardised ten-year net survival since the early 1970s for the four lowest surviving cancers in men and women: cancers of the brain, oesophagus and lung have all shown absolute increases of less than 10% percentage points since 1971-1972, whilst pancreatic cancer has had no change[4].

[4] http://www.cancerresearchuk.org/cancer-info/cancerstats/survival/common-cancers/

Fig 5: Age-Standardised Ten-Year Net Survival Trends, Adults (Aged 15-99), Selected Cancers, England and Wales, 1971-2011



Breast is for female only. Laryngeal is for male only

Ten-year survival for 2005-2006 and 2010-2011 is predicted using an excess hazard statistical model
Survival for bowel cancer is a weighted average derived from data for colon (C18) and rectum cancer (C19-C20, C21.8)

Please include the citation provided in our Frequently Asked Questions when reproducing this chart:
http://info.cancerresearchuk.org/cancerstats/faqs/#How

Figures 6 and 7 illustrate the improvement in one year survival rates in Lewisham compared to London and England for the period 1996-2011.

Figure 6: One year survival all cancers 1996-2011

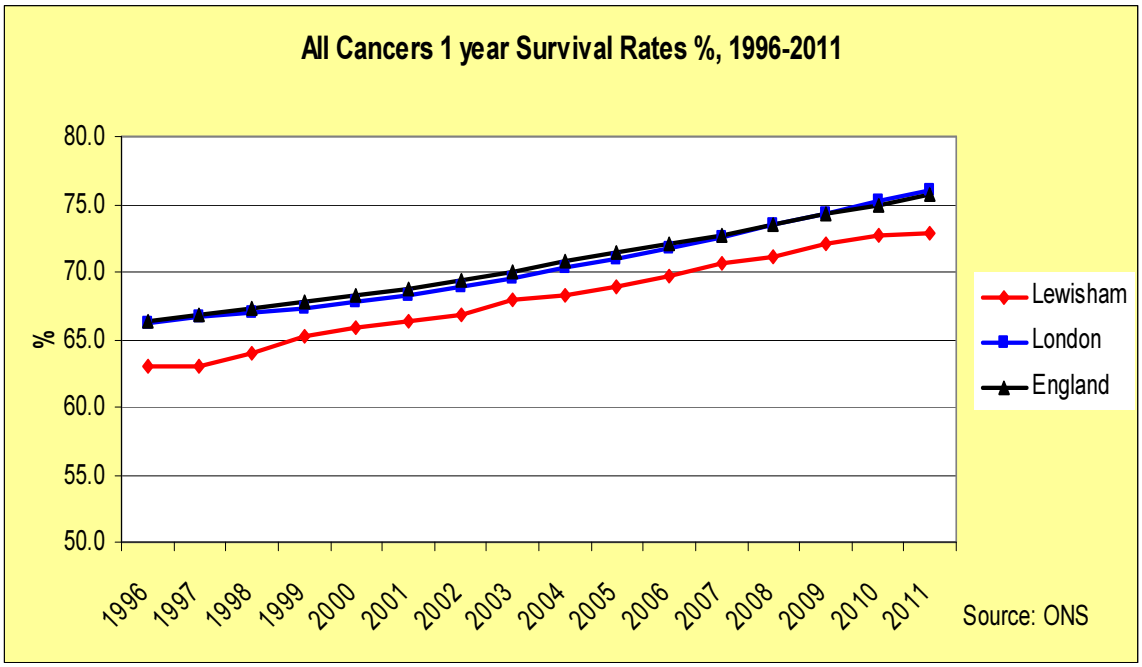
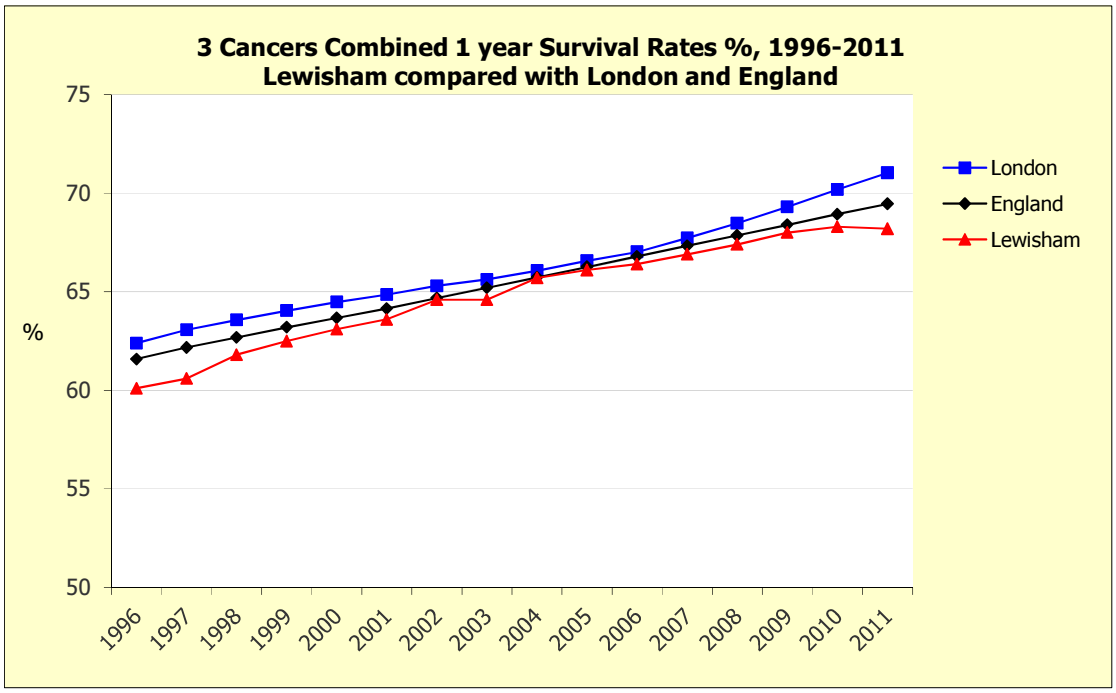


Figure 7: One year survival three cancer combined (breast colon and lung) Lewisham, London and England



7. Cancer Waiting Times

The focus is on GP referral to treatment time for which the constitutional standard is that 85% of patients start their treatment within 62 days. This standard has been

missed in London. Current rolling year performance for the CCG as a commissioner is now 79.6%, which is below the amber threshold. The three Trusts in South East London have had visits from the Cancer Waiting IST in the early part of the 2014 and they committed to delivering the recommendations by September 2014, so that this standard would be met in Quarter 3. Reviews from each Trust have shown that most actions have been met.

8. Financial implications

8.1 There are no specific financial implications arising from this report; all activities continue to be delivered within the existing budgets.

9. Legal implications

9.1 There are no specific legal implications. Members of the Board are reminded that under Section 195 Health and Social Care Act 2012, health and wellbeing boards are under a duty to encourage integrated working between the persons who arrange for health and social care services in the area.

10. Crime and Disorder Implications

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

11. Equalities Implications

11.1 Cancer is associated with socio-economic status with higher level of cancer mortality found among more deprived groups. Cancer prevalence increases with age for both men and women.

12. Environmental Implications

12.1 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 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	Lambeth, Southwark and Lewisham Sexual Health Strategy and Consultation			
Contributors	Ruth Hutt, Consultant in Public Health, LB Lewisham Elizabeth Clowes, Assistant Director, Commissioning, LB Lambeth Andrew Billington, Senior Commissioning Manager, LB Lambeth		Item No.	6
Class	Part 1	Date:	25 November 2014	
Strategic Context	Sexual Health is a Health and Wellbeing board priority. Services are commissioned in partnership with Lambeth and Southwark through a tri-partite arrangement.			
Pathway	An update on Sexual Health was submitted to the 28 January 2014 Health and Wellbeing Board			

1. Purpose

1.1 This report summarises the contents of the Lambeth, Southwark and Lewisham Sexual Health Strategy, which was launched in April 2014 for a period of consultation, including presentation at boroughs' relevant scrutiny or health committees.

1.2 The strategy is based on a public health needs assessment, covers analysis of investment and service delivery and makes recommendations regarding a direction of travel for shifting investment from clinic-based services to community provision and prevention and promotion.

1.3 The strategy has been developed with input from stakeholders, and consultation has included engagement with Clinical Commissioning Groups (CCGs) and specific focus groups with young people, MSM (men who have sex with men) and black and ethnic minority groups.

2. Recommendation/s

Members of the Health and Wellbeing Board are recommended to:

2.1 1) Review the responses to the public consultation on the Lambeth, Southwark and Lewisham Sexual Health Strategy

2) Agree the Lambeth, Southwark and Lewisham Sexual Health Strategy

3. Policy Context

3.1 From April 2013, as a result of the Health and Social Care Act 2012, the responsibility for population based health improvement through the

provision of Public Health specialist advice, strategic responsibility and the commissioning of a range of health improvement services transferred to local authorities. The duties are covered by Part 2 of the Local Authorities (Public Health Functions and Entry into Premises by local Healthwatch representatives) Regulations 2013, which sets out specific duties regarding public health advice services, weighing and measuring of children, health checks, and sexual health services and protecting the health of the local population.

1.2 These duties were transferred from Primary Care Trusts (PCTs) and the interventions and services commissioned cover all the population for universal access, as well as targeted services, and include specialist targeted areas such as sexual health and substance misuse services.

1.3 Lambeth Council is the host for a small sexual health commissioning team which operates across Lambeth, Southwark and Lewisham (as was the arrangement in the PCT). Lambeth is also host for the London-wide HIV prevention programme, which is high-level and high-profile, and led by the London Directors of Public Health.

1.4 The commissioning service, hosted by Lambeth, is governed by a three borough Board, chaired by Kerry Crichlow, Strategic Commissioning Director for Adults and Children's' Services in Southwark. Lewisham Council is represented by Ruth Hutt, Public Health Consultant. A Lewisham Children and Young Peoples' commissioner is also on the board. The Council is responsible for commissioning open access specialist GUM provision, sexual health & HIV prevention and promotion, community contraception and sexual health services, and sexual health in pharmacies and primary care (GPs). The 3-borough team also commissions termination of pregnancy services and HIV care and support on behalf of the Clinical Commissioning Groups.

1.5 Lambeth, Southwark and Lewisham have some of the poorest sexual health in the country. Lewisham was ranked 17 (out of 326 local authorities, first in the rank has highest rates) for rates of acute STIs in 2012, with 4,066 acute STIs diagnosed in residents of Lewisham (a rate of 1468.2 per 100,000 residents). Lambeth was ranked 1 in England for rates of acute STIs in 2012 with 9773 acute STIs diagnosed in residents of Lambeth (a rate of 3209.7 per 100,000 residents). Southwark was ranked 3, with 6350 acute STIs diagnosed in residents of Southwark (a rate of 2199.4 per 100,000 residents). 48% of diagnoses of acute STIs in Lewisham in 2012 were in young people aged 15-24. In Lambeth, 35% of diagnoses of acute STIs were in young people and in Southwark, 38% of diagnoses were in young people.

1.6 London local authorities account for 18 out of the 20 local authorities with the highest diagnosed prevalence rate of HIV in the country. In 2013, the diagnosed HIV prevalence in Lewisham was 8.2 per 1,000

population aged 15-59 years (compared to 2 per 1,000 in England). In Lambeth it was 14.7 per 1,000 population aged 15-59 years and in Southwark it was 12.6 per 1,000. Recently released Public Health figures show increases in serious STIs such as gonorrhoea, with treatment-resistant strains becoming an increasing problem. Gonorrhoea rates have doubled in Lewisham over the last 5 years.

4. Background

4.1 Against this background, the Commissioning Board had a priority to develop a three-borough sexual health strategy, to tackle high levels of need and set clear prevention and promotion programmes in place. The strategy builds on previous LSL strategies, achievements and work of Sexual Health Modernisation Initiative; there was an initial stakeholder engagement day in September 2013, which helped to build the local strategic priorities. Following extensive commissioning and public health engagement, a draft strategy was finalised and launched for consultation in April 2014.

4.2 The strategy sets out the local HIV and sexual health landscape, assessing previous strategies, financial resources and sexual health services in Lambeth, Southwark and Lewisham, as follows:

- Promotion and prevention
- Sexual health services/GUM/psychosexual
- Primary Care
- HIV Care and support
- Termination of pregnancy (abortion)
- Young peoples services & teenage pregnancy

4.3 The strategy sets out the following vision and strategic priorities:

- Embedding good sexual health and wellness as part of a wider health agenda
- Actively promoting good sexual health and healthy safe relationships, not just the absence of disease
- Reducing the stigma attached to sexually transmitted infections (STIs)
- Focusing on those statistically most at risk thereby reducing health inequalities (including young people, BME groups and men who have sex with men)
- Reducing the rates of unplanned pregnancy and repeat terminations, especially for under 18 year olds
- Reducing rates of undiagnosed STIs and HIV
- Aligning strategic priorities with the intentions of our local CCGs
- Developing the workforce to deliver integrated and improved services
- Shifting the balance of care to community-based services that are accessible and responsive to the needs of service users

5. Consultation

5.1 The Strategy was developed following a stakeholder event attended by over 100 stakeholders representing a diversity of organisations and communities in September 2013. Key areas of sexual health were discussed with providers from the NHS and voluntary sectors, service users, public health colleagues and others. The draft strategy was launched at a further stakeholder event in April, and was subject to wide-ranging consultation across the three boroughs. During the consultation the Strategy was available on the Lambeth Council website and, via a link, on the Lambeth, Southwark and Lewisham CCG and Council websites, with a dedicated email and online form for responses.

5.2 The Strategy has identified three key target user groups: MSM, young people and Black minority ethnic communities. Focus groups were held in each borough with these groups to discuss the Strategy and gain feedback. The strategy was reviewed by primary care networks, by the 3 borough Local Medical Committees and Local Pharmacy Committees and presented to each relevant scrutiny committee, all of whom gave detailed feedback. Healthwatch in each borough has been engaged and responded with detailed feedback. Detailed feedback was also received from local voluntary sector organisations, local NHS (including providers of clinical sexual health services) and children and young people's services

5.3 The overall consultation response endorsed aims and vision for the Strategy, recognising the need to shift investment from treatment into prevention, and supported the move towards commissioning services that were delivered closer to home. Key concerns that were raised by the consultation are summarised below along with the response and resultant changes:

Why does the Strategy adopt a medical model and focus on services?
Response: The focus on services, and reshaping services, is key to delivering better outcomes for residents. The plan to shift to community-based services is central to the Strategy and community engagement and involvement is key to bringing about this change.

How will Community and Voluntary Sector Organisations (CVSO) be involved in delivering the Strategy
Response: CVSOs will remain central to delivery on the aims of the Strategy and future commissioning, for example, in the procurement of new prevention services. There are community forums and networks in LSL that can support delivery of the Strategy, for example, the African Health Forum. Work will be undertaken to review how to best support the work of existing networks to deliver on the aims of the Strategy. Detailed plans for community and stakeholder engagement, involvement and activation will be included in the Implementation Plan

Is there sufficient evidence to identify what works to inform commissioning, including for work with African communities and men who have sex with men (MSM)?

Response: Overall, evidence in relation to work with African communities suggests that a multi-component approach to prevention and sexual health promotion is most effective. The Strategy is informed by a service review of SRH and the epidemiology report, which also constitutes a needs assessment. The Strategy sets a direction of travel which includes a shift to self-management, online services and primary care to meet less complex needs. This is widely accepted as offering best value and as increasing patient choice, as backed up by evidence from evaluation and service-user feedback. New service models, including innovative on-line services, will be fully evaluated during development. Partnership work will support further research, looking for best value, particularly given the current financial climate.

Is there a commitment to protecting open access services and patient choice?

Response: The Strategy aims to extend patient choice by extending access to services so that people continue to access sexual health services via open access clinical services as well as an additional range of other community and online services.

Will there be a review of primary care?

Response: There is a need for a review of sexual health work within primary care as part of the work needed to drive forward the vision of the Strategy. An LSL Sexual Health Commissioning Board Primary Care sub-group will deliver this work.

Is there a commitment to supporting workforce development?

Response: There is an on-going need for staff in mainstream services to be trained in HIV and sexual health. Also, many staff in mainstream services may already possess related skills and knowledge but should have access to training to maintain and develop them. Further detail of proposals to take forward workforce development will be included in the Implementation Plan

How can high quality SRE be delivered in all schools?

Response: There is currently extensive work across LSL aimed at ensuring high quality SRE is delivered in all schools and colleges. Work will continue with colleagues in young people's services and education to promote access to quality SRE

.

Will work related to Hepatitis prevention and Female Genital Mutilation(FGM) be commissioned?

Response: Detail on commissioning in relation to Hepatitis and FGM to be included in the Implementation Plan

5.4 In addition to the general comments above specific issues in Lewisham included concerns that funding was significantly lower than in Lambeth and Southwark. This was partially due to the fact there was some missing financial data in the consultation version of the strategy (this has now been rectified); the fact that some HIV care and support spend was transferred to local authorities rather than remaining in the CCG as was the case in Lewisham, and the fact that there is a greater level of sexual health need in Lambeth and Southwark reflecting historical spend on sexual health.

6. Financial implications

6.1 In 2014/15 the Public Health grant for Lewisham was £20.08M. Sexual Health expenditure accounts for 36% of the public health grant.

6.2 In 2013/14, Lewisham's budget for clinical services was £6.992M, with cost pressures of £300k in demand-led Genito-Uninary Medicine (GUM clinic presentations). A total of over £29m was spent on sexual health services across Lambeth, Southwark and Lewisham, mainly on clinic-based GUM services

6.3 As part of the Lewisham Futures Programme a savings proposal of up to £322k was set against sexual health. Delivering this level of saving may make the implementation of aspects of the Strategy very challenging. A final decision regarding the level of investment in sexual health by Lewisham Council will be made in February 2015.

7. Legal implications

7.1 There are no specific legal implications arising but it should be noted that, with effect from 1 April 2013, local authorities are required to ensure that comprehensive, open access, confidential sexual health services are available to all people who are present in their area whether resident in their area or not.

7.2 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

8. Crime and Disorder Implications

9.1 None

9. Equalities Implications

9.1 An Equalities Impact Assessment has been undertaken and is being further developed to incorporate the detailed response to the consultation.

10. Environmental Implications

10.1 None

11. Conclusion

11.1 The consultation on the Strategy endorsed the overall direction of travel. As a result of the response there will be additional emphasis in the Implementation Plan on: female genital mutilation; Hepatitis; workforce development; co-working with colleagues outside of sexual health; and involving the community and voluntary sector in delivery of the Strategy.

11.2 An Implementation Plan, incorporating the responses to the consultation, is being developed and will be finalised by the end of November. The Implementation Plan will show key actions over the next two years to deliver the Strategy. Key early actions are underway now.

Background Documents
Lambeth, Southwark and Lewisham Sexual Health Strategy 2014-2017
Lambeth, Southwark and Lewisham, Sexual Health Epidemiology, 2013/14

Both documents are available at:
http://www.lambeth.gov.uk/consultations/lambeth-southwark-lewisham-sexual-health-strategy-consultation

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 Elizabeth Clowes, Assistant Director, Commissioning, Social Inclusion, Lambeth Integrated Commissioning Team, EClowes@lambeth.gov.uk

Health and Wellbeing Board			
Title	Emergency Services Review: Progress Update		
Contributors	Lewisham CCG Commissioning Director, Director of Public Health, Head of Service for Strategy, Performance and Partnerships	**Item No.**	7
Class	Part 1	**Date**	25 November 2014

1. Summary

1.1 In March 2013, the Health and Wellbeing Board (HWB) considered a review of emergency services in Lewisham completed by the Council's Overview and Scrutiny Committee. The recommendation agreed by the Board was that a review of performance against the relevant recommendations in the emergency services review be included in the HWB work programme. This report updates the Board on progress relating to this area.

2. Recommendation

2.1 The Health and Wellbeing Board is recommended to:

- Note the progress in relation to relevant recommendations of the Emergency Services Review.
- Note that where possible, relevant recommendations have been incorporated in the Health and Wellbeing performance dashboard and agree that future updates will be presented as part of the performance dashboard.
- Note that where relevant recommendations fall outside of the Health and Wellbeing performance dashboard, appropriate assurance processes are in place for the performance to be managed by the CCG and consider how these recommendations should be reviewed in future.

3. Policy Context

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

3.2 The work of the Board directly contributes to Shaping our Future's priority outcome that communities in Lewisham should be Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing.

3.3 The Health and Social Care Act 2012 requires the Health and Wellbeing Board to encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area.

4. Background

4.1 At Council on 23 January 2013, members resolved that the Overview and Scrutiny Committee be asked to undertake an urgent investigation into emergency service provision across the borough. The review was scoped and agreed in February 2013 and evidence sessions were held at Housing, Sustainable Development, Children and Young People, Healthier Communities and Safer Stronger Communities Select Committees between May and September 2013.

5. The Emergency Review Recommendations - Overview

5.1 The report, attached as a background paper, presents the written and verbal evidence received by Select Committees and includes the 35 recommendations agreed by Overview and Scrutiny.

5.2 Recommendation 34 states that:

"The Mayor and Cabinet, the Safer Lewisham Partnership, the Health and Wellbeing Board should regularly review performance against the recommendations made within this report, in their role as local strategic leadership bodies."

5.3 A number of the recommendations, specifically those relating to prevention and partnership, are already aligned to priorities within the Health and Wellbeing Strategy and the Adult Integrated Care Programme.

5.4 The relevant Emergency Review recommendations are as follows:

Recommendation 13 states that:
"Capacity and activity at neighbouring A&E departments, as well as Lewisham, should be closely monitored by Lewisham CCG before any changes to accident and emergency provision are proposed or implemented at Lewisham hospital."

Recommendation 14 states that:
"More public information on the Norovirus is needed to support people to self-manage the illness where appropriate and to help prevent the spread of the disease and the closure of hospital wards."

Recommendation 27 states that:
"National campaigns, such as the recent "Choose well" campaign, need to be supported and reinforced locally. Clear, appropriate guidance should be given to people locally, about the most appropriate local service to access if they have an urgent medical need outside of GP hours, when they are making routine contact with health services."

Recommendation 28 states that:
"Out of Hours care and urgent care both need to be comprehensive, easily accessible and well publicised to enable the public to choose the most appropriate care setting for their needs."

Recommendation 30 states that:

"The CCG has a key role in ensuring that appropriate urgent care and out of hours services are available. The Council and CCG need to work closely together to ensure that all the necessary care pathways are in place, and appropriately utilised, to ensure undue and inappropriate pressure is not placed on Accident and Emergency units."

Recommendation 31 states that:
"The Council should continue to work closely with Lewisham Healthcare NHS Trust to ensure appropriate and timely discharge from hospital takes place where patients have social care needs."

Recommendation 32 states that:
"The CCG should work with the Lewisham and Greenwich NHS Trust to understand the high number of patients attending A&E who require specialist referral to the mental health team. The CCG should then review the appropriate care pathways, particularly the out of hours availability of services, to ensure that there is an appropriate level of service provided."

Recommendation 33 states that:
"Projected future population growth should be factored into service planning."

6. Updates in Relation to Relevant Recommendations

6.1 System Resilience:

The System Resilience Group (SRG) for Bexley, Greenwich and Lewisham Clinical Commissioning Groups (as outlined to the Health and Wellbeing Board on 23 September 2014) provides the vehicle, governance, management and monitoring by which capacity and demand for emergency services are addressed across the system. Consequently, Lewisham CCG is appropriately addressing the recommendations made by the Healthier Communities Select Committee's Emergency Services Review in September 2013, which are being delivered and managed through the SRG.

It is important to note that the recommendations made by the Healthier Communities Select Committee in September 2013 were prior to the formation of the new trust Lewisham and Greenwich Trust in October 2013 – more so that the 3 Clinical Commissioning Groups have adopted a collaborative approach underpinned by the System Resilience Group. However, the messages taken from the recommendations remain pertinent.

The recommendations in summary centred on; managing demand and capacity across the system and ensuring effective service planning; providing access to appropriate out of hours and urgent care services; enabling timely discharging planning recognising the interfaces with adult social care; and developing effective messages to the public in accessing A&E and emergency services.

The 2014/15 System Resilience Plans and Winter Schemes will address and support the recommendations made by the committee. System Resilience by its very nature and as outlined earlier adopts a 'system-wide approach' to planning, managing demand and public engagement.

Clinical Commissioning Groups received confirmation from the NHS England that the first tranche of funding for Winter Schemes will be released. Details of the schemes and expected benefits that relate specifically to the University Hospital Lewisham site can be found at Appendix 1.

For example the scheme submitted by the South London and Maudsley NHS FT (SLaM) in partnership with the joint (Lewisham Council and Lewisham CCG) commissioning mental health team for an *'Enhanced Mental Health Liaison Team & Specialist Registrar cover at weekends'* supports recommendation 32. There is a 24 hour psychiatric liaison service at the University Hospital Lewisham site A&E providing assessment for referred mental health patients that are in crisis. Their function is to assess and where necessary admit patients to mental health inpatient services.

Lewisham CCG, SLaM and Lewisham & Greenwich Trust meet on a monthly basis to review performance and patient outcomes. Additional capacity during out of office hours has been identified as an issue for the effective management of the pathway. As result Lewisham CCG and SLaM successfully bid for winter pressure funding to increase the capacity of the team to provide additional twilight and weekend cover. A second tranche of funding has been agreed and will provide additional nursing cover and dual diagnosis support for patient with co-morbid mental health and drug and alcohol issues.

6.2 Capacity and Demand:

South East London CCGs (Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark) have undertaken demand and capacity modelling for all acute trusts, which focused on electives and emergency capacity. Where deficits in capacity were identified all SRGs are actively taking steps to bridge these gaps. This programme is being supported by a newly appointed Head of System Resilience for SEL. This role will support with ensuring that plans across South East London are complementary and not contradictory.

6.3 Local Campaigns:

The *Not Always A&E* campaign was first launched across south east London at the end of October 2013. The campaign was developed in partnership with all the south east London Clinical Commissioning Groups and aimed to;

- Reduce the number of people attending A&E
- Better public understanding of A&E use and other primary and urgent care facilities available
- Encouraging self-management
- Targeting specific groups to help reduce health inequalities.

The *Not Always A&E* campaign used the Yellow Men: a family of sculptures, painted bright yellow and measuring seven feet tall, with each figure suffering from a different ailment – from an upset stomach to unstoppable bleeding. These figures were installed in busy public spaces across south London with an accompanying launch event in each borough, creative advertising campaign and supporting multimedia (E.g. placement advertising on Buses and shelters, LBL JCD billboards) content. The independent evaluation of the SEL campaign found that; 40% of responders 'unprompted' recalled the campaign; 57% recalled the message that A&E is for emergencies only; and 58% of responders stated that they would change their behaviour because of the campaign.

The 2014/15 campaign commissioned by Lewisham CCG will be launched in November 2014. The overall campaign message will continue to be *'Not always A&E'* and will promote key messages to the public on the appropriate use of A&E, the Urgent Care Centre, utilising GP Surgeries, Pharmacies and better self-

care/management. However, the campaign will specifically emphasise the availability of and access to GP out of hour's services. This was as a direct response to public engagement events undertaken by the CCG over the past year, where members of the public demonstrated a lack of awareness and understanding of GP out of hours services. The multimedia campaign will be similar to 2013/14 but will include a double-page in *Lewisham Life* (distributed to all households) in addition to leaflets in school bags and distribution to voluntary partners/organisations, public buildings, Pharmacies and GP surgeries.

6.4 LBL Public health is working with key partners such as the Clinical Commissioning Group, Lewisham and Greenwich NHS Trust and NHS England to ensure that information is provided to the public on norovirus to support people to self manage where appropriate and to help prevent the spread of disease and closure of hospital wards.

6.5 From an Adult Social Care perspective, the relevant recommendations from the Emergency Review have been incorporated in the Health and Wellbeing performance dashboard. Projected future population growth continues to be considered routinely as part of service planning undertaken at the Council. Progress is included on the Council's management report.

7. Financial Implications

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

8. Legal Implications

8.1 The overview and scrutiny committee is responsible for the overview and scrutiny of functions in accordance with the Local Government Act 2000.

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 There are no specific equalities implications arising from this report.

11. Environmental Implications

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

12. Conclusion

12.1 The HWB has established arrangements for reviewing performance against the Health and Wellbeing Strategy and Adult Integrated Care Programme that include some of the recommendations of the Emergency Services Review. The CCG has

ensured that appropriate arrangements for the review of recommendations not included in the dashboard are in place.

Background papers

Emergency Services Review:
http://councilmeetings.lewisham.gov.uk/documents/s25522/Emergency%20services%20review.pdf

If you have any queries on this report, please contact Diana Braithwaite, Commissioning Director, Lewisham CCG (0203 049 3214) or Carmel Langstaff, Strategy and Policy Service Manager (0208 314 9579).

Appendix 1 – Summary of BGL System Resilience Tranche 1: 2014/15 Winter Schemes (relating specifically to University Hospital Lewisham Site)

Scheme	Expected Benefits
Lewisham & Greenwich NHS Trust	
Weekend Discharge Consultant (Both sites)	This project increases the levels of discharges on weekends and in particular for those admissions from Thursday/Friday who may not otherwise get a consultant review over the weekend. Senior support also provided to the medical on take teams reduces avoidable delays and supports early decision making.
Dedicated Nurse and HCA for LAS arrivals (QEH)	LAS waits are a regular issue for ED at QEH and a dedicated resources to support offloading and triaging this patient group.
Dedicated Flow nurse (Both sites)	A senior nurse on a 12 hour shift during peak activity working to manage patient flow, challenge delays and ensure all members of the team are working to expedite a patients journey through ED.
Additional SPR on night shift (Both sites)	Increasing the levels of senior decision makers on shift has had a significant positive impact on performance and on reducing out of hours breaches, particularly amongst the patient group who are discharged home.
Additional porter out of hours to speed up patient flows (Both sites)	This was highly successful in winter 2013/14 in reducing the numbers of avoidable delays for ward transfer and to diagnostic services.
4 hour co-ordinator (Both sites)	This post will work alongside the flow nurse in ED to manage patient flow and ensure that referrals to specialist teams are made in a timely manner reducing the numbers of 4 hour breaches.
Additional nurse on night duty in UCC (UHL)	UCC increasingly busy overnight additional nurse on shift to support SPR and manage surges in activity.
Provision of winter escalation areas as required (Both sites)	One escalation ward per site (Foxbury/Sapphire ward UHL).
Weekend Therapy Intervention (Both sites)	Increase levels of assessment at weekends and reduce avoidable delays. Home Access visits at weekends to ensure discharges are not delayed.
Additional Vehicle to support discharges (Both sites)	On both sites late transport leads to cancelled discharges. This will provide an additional vehicle to concentrate solely on discharges at the time of peak departures from the ward reducing cancelled discharges.
Extended day working in Radiology (Both sites)	The provision of weekend MRI and CT as well as an EPAU service will ensure that vital diagnostics to support decision making and discharges are not delayed over the weekend period.
Additional Senior	Activity in paediatric ED increased in the late afternoon and

Medical staff in evenings (Both sites)	evening during winter 2013/14 – the provision of senior support at this time reduced breaches.
Additional nurse in ED (UHL)	This will support patient flows from ED onto the wards and ensure patient safety at all times.
Additional ED nursing (QEH)	This will provide an additional nurse in paediatric ED to manage patient flow and liaise with HPAU.
Pharmacy Runner (Both sites)	This was a success in 2013/14 and ensured that urgent TTOs for discharges were not delayed waiting for the main pharmacy rounds.
Rapid Response HCA team (UHL)	A team of HCA who are trained to take blood and ECG and provide care wherever needed, able to respond to surges in activity under the direction of the lead nurse and reduce avoidable delays.
London Borough of Lewisham/Lewisham CCG	
Enablement Care Services and Equipment	To support the increase in Supported Discharge and Admission Avoidance provision we need to increase the amount of Reablement/Rehabilitation care (Enablement) provided in the community to help people reach their optimum level of independence. This will increase the capacity to allow discharges to take place during weekends and increase support to admission avoidance teams in keeping people in their own homes. A mixture of hands on care, equipment and aids to daily living will be provided to people in their own homes for up to a period of 6 weeks, closely monitored and evaluated by senior staff.
Enhanced Community Admission Avoidance Services	As part of winter 2013/14 Lewisham increased capacity of social workers, nurses and therapies working across the whole service and streamlined the hours of provision to cover weekend working. This scheme dovetailed with the additional capacity funded by LBL so going forward the service will be flexed across the system. The aim of this is reducing admission and supporting discharge, reducing length of stay by providing support and an appropriate care package. The service dovetails with the development of the Appropriate Care Pathways (ACP) for Falls and the planned future development of COPD and Diabetes ACPs and the development of the 7/7 clinical specialist nurses in ED for Long-term conditions, providing a whole system approach to urgent care and the reduction of emergency admissions.
Continuing Care Assessments	We continue to see an increase in the needs of older adults particularly with dementia issues that need Continuing Care assessments completed. These assessments are complex and the quality of them needs to reflect the presenting needs. Due to the large increase in numbers in both Hospitals and Community we are seeing lengthy delays in decision making, thus people are often delayed in beds whilst the process is undertaken. In the community the process has not always been completed early enough which has led to patients not receiving appropriate Health and Social Care services that would prevent admissions to hospital. This could be prevented by completing the process faster and having the

	resources to deal with the demand.
South London and Maudsley NHS FT	
Enhanced Mental Health Liaison Team & Specialist Registrar cover at weekends	The proposed scheme involves the employment of an additional psychiatric liaison nurse working a twilight shift from 5pm - 2am, covering the busiest time in the ED for mental health presentations. This nurse would work differently from a normal PLN insofar as they would be based in the ED working alongside the ED Triage nurse, carrying out an initial assessment of the patient at the point of presentation. They would assess the patient using a specific assessment tool and decide whether the patient required to be referred on to the team for a full mental health assessment or if they could be re-directed from the ED in order to achieve help and support through an alternative service, such as referral back to GP, referral to a CMHT, Home Treatment Support, third sector agency etc.

HEALTH AND WELLBEING BOARD				
Report Title	Health and Wellbeing Board Work Programme			
Contributors	Service Manager, Strategy and Policy (Community Services, London Borough of Lewisham).		Item No.	8
Class	Part 1	Date:	25 November 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 (HWB) 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 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.

4.3 The HWB has agreed that the work programme would include the following standing items:

- progress in relation to the Health and Wellbeing Strategy
- progress in relation to the Integrated Adult Care Programme
- the work programme

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.

5.2 As agreed by the HWB at its meeting on 3 July 2014, the work programme has been amended to include an update on the Autism Strategy and an update on progress in relation to a Food Summit. The items have been scheduled for January and March 2015 respectively.

5.3 The item on Lewisham CCG's 5 year Strategy has been deferred from the November meeting to the January meeting due to the new approach to the despatch of papers and revised deadlines.

5.4 The following items have been proposed for the January meeting:

- Lewisham Future Programme: Revenue Savings Proposals 2015/16 (Public Health)
- Findings from the Second Voluntary Sector Mental Health Conference
- Primary Care Development Strategy
- Development of the new Children and Young People's Plan

5.5 The following items have been proposed for the March meeting:

- Transfer of 0-5 children's public health commissioning to local authorities
- Integrated inspections of services for children in need of help and protection, children looked after and care leavers and joint inspections of the Local Safeguarding Children Board

5.6 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.

5.7 Upon agreement of the work programme, the Health and Wellbeing Agenda Planning group will request the necessary reports and activities.

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 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

Item 8 - Appendix 1

Health and Wellbeing Board – Work Programme

Meeting date	Agenda Planning	Report Deadline	Agenda Publication
20 Jan 2015	1 December 2014	15 December 2014	12 January 2015
Agenda item	**Report Title**	**Deferred**	**Lead Organisation(s)**
1	Adult Integrated Care Programme Update		LBL/CCG
2	CCG 5 Year Strategy	Deferred from November 14	CCG
3	Children and Young People's Plan 2015 - 18		LBL
4	The Local Account		LBL
5	Public Health Budget		LBL
6	Lewisham Future Programme: Revenue Savings Proposals 2015/16 (Public Health)		LBL
7	HWB Strategy Delivery Group: progress update (a) Mental Health (b) CVD		LBL
8	Developing an Integrated Approach to Public Health in SE London: Establishing an Urban Public Health Collaborative - Update		LBL
9	Healthwatch Performance Review		LBL
10	Findings from the Second Voluntary Sector Mental Health Conference		VAL
11	Autism Strategy: Update		LBL
12	Health and Wellbeing Board Work Programme		LBL

Meeting date	Agenda Planning	Report Deadline	Agenda Publication
24 March 2015	W/C 2 February 2015	19 February 2015	16 March 2015
Agenda item	**Report Title**	**Deferred**	**Lead Organisation(s)**
1	Adult Integrated Care Programme Update		LBL/CCG
2	Integrated Inspections (services for children in need of help and protection, children looked after and care leavers) and Joint Inspections of the Local Safeguarding Children Board		LBL
3	Transfer of 0-5 Children's Public Health Commissioning to Local Authorities		LBL
4	Early Intervention and Targeted Support – Progress Update		LBL
5	Food Summit: progress update		VAL /LBL
6	Health and Wellbeing Board Work Programme		LBL

Meeting date	Agenda Planning	Report Deadline	Agenda Publication
19 May 2015	**W/C 7 April 2015**	**16 April 2015**	**11 May 2015**
Agenda item	**Report Title**	**Deferred**	**Lead Organisation(s)**
1	**Adult Integrated Care Programme Update**		LBL/CCG
2	**Health and Wellbeing Board Work Programme**		LBL
3	**Performance Dashboard Update**		LBL

Meeting date	Agenda Planning	Report Deadline	Agenda Publication
7 Jul 2015	**W/C 1 June 2015**	**4 June 2015**	**29 June 2015**
Agenda item	**Report Title**	**Deferred**	**Lead Organisation(s)**
1	**Adult Integrated Care Programme Update**		LBL/CCG
2	**Health and Wellbeing Board Work Programme**		LBL

Meeting date	Agenda Planning	Report Deadline	Agenda Publication
22 Sept 2015	W/C 20 July 2015	20 August 2015	14 September 2015
Agenda item	**Report Title**	**Deferred**	**Lead Organisation(s)**
1	Adult Integrated Care Programme Update		LBL/CCG
2	Health and Wellbeing Board Work Programme		LBL

Meeting date	Agenda Planning	Report Deadline	Agenda Publication
24 Nov 2015	W/C 5 October 2015	22 October 2015	16 Nov 2015
Agenda item	**Report Title**	**Deferred**	**Lead Organisation(s)**
1	Adult Integrated Care Programme Update		LBL/CCG
2	Health and Wellbeing Board Work Programme		LBL
3	Performance Dashboard Update		LBL