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Healthier Communities Select Committee Agenda

Thursday, 12 November 2015
7.00 pm,
Committee Room 1
Civic Suite
Lewisham Town Hall
London SE6 4RU

For more information contact: Simone van Elk (Tel: 0208 314 2336)

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

Part 1

Healthier Communities Select Committee Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Thursday, 12 November 2015.

Barry Quirk, Chief Executive
Thursday, 5 November 2015

Councillor John Muldoon (Chair) Councillor Stella Jeffrey (Vice-Chair) Councillor Paul Bell Councillor Colin Elliott Councillor Ami Ibitson Councillor Jacq Paschoud Councillor Pat Raven Councillor Joan Reid Councillor Alan Till Councillor Susan Wise Councillor Alan Hall (ex-Officio) Councillor Gareth Siddorn (ex-Officio)	

MINUTES OF THE HEALTHIER COMMUNITIES SELECT COMMITTEE

Wednesday, 14 October 2015 at 7.00 pm

PRESENT: Councillors John Muldoon (Chair), Stella Jeffrey (Vice-Chair), Paul Bell, Colin Elliott, Ami Ibitson, Jacq Paschoud, Pat Raven, Alan Till and Susan Wise.

ALSO PRESENT: Aileen Buckton (Executive Director for Community Services), Dee Carlin (Head of Joint Commissioning) (LCCG/LBL), Tim Higginson (Chief Executive) (Lewisham Healthcare NHS Trust), Joan Hutton (Interim Head of Adult Assessment & Care Management), Corinne Moocarme (Joint Commissioning Lead, Community Support and Care, Community Services, LBL) (Community Services, LBL), Sarah Wainer (Head of Strategy, Partnerships and Improvement), Martin Wilkinson (Chief Officer) (Lewisham Clinical Commissioning Group), Fiona Jolly (Direct Payments Manager), Simone van Elk (Scrutiny Manager) and Georgina Nunney (Principal Lawyer).

1. Minutes of the meeting held on 9 September 2015

1.1 **RESOLVED**: that the minutes of the meeting held on 9 September 2015 be agreed as an accurate record.

2. Declarations of interest

2.1 The following non-prejudicial interests were declared:

Councillor Muldoon: Lead Governor of South London and Maudsley NHS Foundation Trust.
Councillor Jacq Paschoud: Chair of the Parent Carers Forum; and a family member in receipt of a package of social care.
Councillor Pat Raven: a family member in receipt of a package of social care.
Councillor Paul Bell: member of the King's College Hospital NHS Foundation Trust.
Councillor Susan Wise: member of the King's College Hospital NHS Foundation Trust

2.2 Councillor Paul Bell also declared a prejudicial interest in agenda item 4 as he is employed by Unison.

3. Briefing on Health and Adult Social Care Integration

3.1 Martin Wilkinson (Chief Officer Lewisham CCG) gave a presentation to the Committee. The following key points were noted:

- Lewisham Health & Care Partners work together on the integration of health and adult social care. The relevant partners are Lewisham Clinical Commissioning Group, Lewisham Council, Primary Care and local GPs, Lewisham and Greenwich NHS Trust, and South London and Maudsley NHS Foundation Trust.
- Lewisham Health & Care Partners have the following shared vision: To achieve a viable and sustainable 'One Lewisham Health and Social Care System' that will enable the local population to maintain and improve their physical and mental wellbeing,

enable independent living, and have access to person-centred, evidence-informed, high quality, yet cost-effective pro-active care, when it is needed.

- The partners have been engaging with service users on their views of the services provided to ensure the right services are offered at the right place.
- Neighbourhood care networks are being created to provide care and support for residents closer to home. The networks will bring together individuals from different services and agencies to coordinate care for adults. There is separate work going on for care provided to children and young people.
- There will be four networks across Lewisham, which will map onto the existing four GP neighbourhoods in the borough. The networks will also be aligned with the existing adult mental health teams.
- Sites are being identified to place the network team. The Waldron Health Centre has been identified as the first site for one of the network teams to operate from.
- The work on neighbourhood care networks is the same work as the Local Care Networks/ Community Based Care, being promoted through the Our Healthier South East London (OHSEL) programme.

3.2 Martin Wilkinson, Tim Higginson (Chief Executive, Lewisham and Greenwich NHS Trust) and Aileen Buckton (Executive Director for Community Services) responded to questions from the Committee. The following key points were noted:

- There is engagement with community pharmacies in Lewisham around the programme of health and adult social care integration. There is a trial on-going to see if pharmacists could work in GP practices. In addition, the CCG promotes “walk-in-my-shoes” days where GP’s and pharmacists get the opportunity to shadow each other’s roles for a day.
- Recently the Lewisham Integrated Medicines Optimisation Service (LIMOS) was recognised in the Value in Healthcare Awards 2015. Under LIMOS, pharmacies work together with GP’s and social services to support patients with long-term conditions to manage their medicines.
- Any patient treated by a neighbourhood care network will have to sign up to a protocol before any of their data can be shared amongst the participating agencies. Patients always have the right to opt of this agreement. The sharing of data about patients between agencies will make it easier for health and care professionals to provide appropriate care and creates better outcomes for patients. Work is currently underway through Connect Care to enable data sharing.
- A map of the GP neighbourhoods would be provided to the Committee and the partners are working towards producing a map which shows where all the relevant services are located in the borough.
- Patients who are being discharged from hospital with serious conditions will often get a more flexible and personalised care package from social services for the immediate future. After the rehabilitation period, care workers will assess their long-term care needs and identify a care package to support residents in the long-term.
- The Community connections work is modelled on the same areas as the neighbourhood care networks. Support workers will take referrals from GP’s and social workers. They will then, based on an individual’s needs and preferences, advise about relevant voluntary sector organisations that can offer support and provide activities.
- It is a requirement of the Care Act that the Council provides a website which lists information on what providers of care exist in the community. The Council’s website will be developed to be fully interactive. It currently contains information uploaded by the voluntary sector and gives links to relevant websites hosted by the voluntary sector. The website is intended to become the first port of call for people for self-referral to services and self-assessment for care needs. The next phase of the website is due to go live in April 2016. The Council is working with relevant advice agencies to provide the best possible content.

RESOLVED: to note the presentation, and to receive a map of Neighbourhood Care Networks based on GP populations.

4. Development of the local market for Adult Social Care Services

4.1 Dee Carlin (Head of Joint Commissioning), Corinne Moocarme (Joint Commissioner) and Fiona Jolly (Direct Payments Manager) introduced the report to the Committee. The following key points were noted:

- The provision of adult social care is changing so the need for residential care is avoided where possible. As care for residents who live at home has changed and improved, people tend to stay at home longer and are much frailer once they require a residential or nursing bed.
- The process of personalisation is part of the Care Act. The Council is offering information and advice about the care and support services available for people with a personal budget. This advice is offered to people who are able to select their appropriate care themselves.
- The Council has a website with information and advice on adult social care services. Members of the Healthier Communities Select Committee will receive the link to the website. Officers are actively seeking feedback on the website.
- A new role within the Council's adult social care has been created for support planning. Support Planners advise people on available care services and activities that could suit their needs and preferences. They also have a vital role in shaping the market by identifying gaps, as they will be aware of what people want and need in terms of care services. The work done by the Council in creating community connections is important to this role.
- The Council is in the process of re-procuring its domiciliary care contracts. The tenders for the domiciliary care contract are being evaluated. The Council's procurement has been based on an outcome focused approach where the success of a service is measured by results that matter to residents as opposed to time spent on activities.

4.2 Dee Carlin, Corinne Moocarme and Fiona Jolly answered questions from the Committee. The following key points were noted:

- Performance indicator LP1254 1C (2) captured in the Council's management report indicates that the Council is not meeting its aim of increasing the percentage of people using social care who receive direct payments. There has previously been a problem with the IT, but this has now been resolved. There have been reviews of people using direct payments, who are subsequently no longer using direct payments. The percentage of people using direct payments has been increasing week on week, but this data wasn't available in time for the Council's latest management report. One of the difficulties in encouraging people to use direct payments, is many people require a small number of hours of care for specific times. There isn't an excess of supply of care workers for whom such working conditions are favourable.
- The award of the contracts for domiciliary care provides options to Mayor and Cabinet (Contracts). They can decide to include a requirement in the contracts for providers to pay the London Living Wage (LLW) to their staff and increase the cost of the contract for the Council. They can also decide to require providers to pay care workers for travel time and therefore also increase the cost of the contract for the Council. If the Council's requires its providers to pay the LLW and travel time, it could then decide to sign up to Unison's Ethical Care Charter.
- Direct payments mean that residents pay people directly to provide them with care. Any arrangements about the pay and working conditions including paying LLW or paying for

travel time are part of the employment contract between the resident and the care worker. The Council cannot impose any conditions for care workers paid via direct payments. The direct payments the Council provides to people using social care who receive a direct payment cover the full cost of employment, including provision for maternity leave and sick pay. If residents require specialist care, the Council has a process in place to review whether increased payment for travel time under that specific direct payment is appropriate.

- Any new provider awarded a contract by the Council for domiciliary work would be expected to reduce any zero hour contracts with their staff. Providers would also be required to provide training and development for their staff.
- Support planners review on an individual basis whether it is appropriate to refer residents to existing support networks, either family and friends or community based. The aim is to not take people's independence away. The other role of support officers is to identify what services are missing from the current supply and feed this back to commissioners.
- The Council also employs care planners or brokers, who plan and arrange placements for people with long term care needs. Their work is different from that of support planners. Support brokers are not required to have a specific qualification. The employees come from a range of backgrounds with a range of skills. The majority have worked for the Council for many years.
- The support planners receive extensive training to reach a specific Qualification Credit Framework (QCF) Level. It was clarified after the meeting this was QCF 3. This method of working by the Council has been published as a model of good practice at the Association of Directors of Adult Social Services (ADASS) conference.
- People can use their direct payments to access services that anyone else would be able to. They can for instance use their payment to enable them to access a specific restaurant. The Council does review whether direct payments are used to pay for appropriate support services, but isn't able to review and monitor every single provider of such support. Support planners maintain a registered list of activities and providers that they use to advise people of suitable support available.
- The Council is developing a function on its website that allows residents to exchange information on services they've used and advise each other on the quality of service they've experienced. Residents would also be able to use this online service to plan group activities together.
- Ensuring the payment of LLW in care homes is complicated. Most placements of residents in nursing or residential homes is done by spot-purchasing beds. A local authority may only pay for a small number of the beds provided in one home and one home may provide beds to more than 10 different local authorities at once. Requiring the payment of LLW for the staff employed on just the beds for one Council, could mean unfair treatment of staff across one care home or significantly increased prices for the beds used by that one authority to cover the costs of paying LLW to all staff employed by a home. Unfortunately not all local authorities are committed to LLW or to ensuring their contractors pay LLW.
- A number of nursing and residential care providers have exited the market due to a number of factors: the costs of staff, the difficulties in recruiting and maintaining staff, the difficulties in providing appropriate training for staff and the requirements of the CQC's inspection regime.

RESOLVED: to note the report.

5. Our Healthier South East London Strategy Update

5.1 This agenda item was moved forward on the agenda to be heard immediately after agenda item 3.

5.2 Martin Wilkinson introduced the report on Our Healthier South East London Strategy Update to the Committee. The following points were noted:

- The OHSEL programme is led by the six south east London CCGs – Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark – and NHS England. The programme aims to develop a commissioning strategy to ensure improved, safe and sustainable services across the six boroughs.
- Following agreement on the general direction of travel, the next phase has been to scope out further options for care models before an options appraisal takes place. Following the options appraisal and the specific changes being suggested, this could be followed by a formal consultation process at a later stage. Although many aspects of the strategy will not require this level of public consultation going forward.
- Four areas have been identified where further works needs to be done: urgent and emergency care, maternity services, children and young people's services, and planned care.
- The aim of the work in urgent and emergency care is to reduce further growth in the demand for emergency services, not to reduce the demand for emergency care that currently exists. The OHSEL programme has this week sent a letter to its stakeholders to affirm that there are no plans to close any A&E departments in South East London, including the A&E in Lewisham. Nor are there any plans to reduce the provision of 24-hour care by Lewisham's A&E. Further works needs to be done in urgent and emergency care to ensure it adheres to the London Quality Standards across in South East London.

5.3 Councillor Muldoon advised the Committee that a Joint Health Overview and Scrutiny Committee (JHOSC) was being established between the 6 boroughs. A report on the JHOSC was due to go the Council meeting on 25 November.

5.4 Georgina Nunney advised the Committee that if a JHOSC was formed, this would not preclude the Committee from also looking at the OHSEL programme.

5.5 Martin Wilkinson responded to questions from the Committee. The following points were noted:

- The OHSEL programme has reviewed the demand for NHS services and has concluded that all hospital sites across South East London will be needed to meet current demand although what each hospital does may change over time. To avoid the need to build an entire new hospital, community based services are being developed as well as a range of different hospital models of care.
- Each borough's Health and Wellbeing Board (HWB) receives the same briefings from the OHSEL programme, but the focus of any presentation is likely to differ depending on the priorities set by each HWB. In some ways the populations in each of the boroughs is similar, but in other ways it can differ significantly. The same principles and planned outcomes are agreed in the OHSEL programme, but the methods of delivery can change from borough to borough and provider to provider.
- Providers have separate strategies to prevent people from not attending appointments. These can range from sending reminders via letters and texts to providing access over the phone instead in person. This is done to avoid waste and duplication.
- NHS England is involved in the OHSEL programme as a co-commissioner of primary care, while some specialised, tertiary care services are commissioned directly by NHS England from hospital trusts. NHS England also serves as the assurance body for the

CCG. The CCG is accountable to its membership, the population it serves and to NHS England.

RESOLVED: to note the report.

6. Select Committee work programme

6.1 Simone van Elk (Scrutiny Manager) introduced the report. The Committee discussed its programme of work and agreed the work programme for the next Committee meeting.

RESOLVED: that the work programme be noted

7. Referrals to Mayor and Cabinet

None

The meeting ended at 9.05 pm

Chair:

Date:

Healthier Communities Select Committee			
Title	Declaration of interests		
Contributor	Chief Executive	Item	2
Class	Part 1 (open)	12 November 2015	

Declaration of interests

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

1. Personal interests

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

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

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

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

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

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

(d) Beneficial interests in land in the borough.

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

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

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

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

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

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

3. Other registerable interests

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

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

4. Non registerable interests

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

5. Declaration and Impact of interest on members' participation

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

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

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

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

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

6. Sensitive information

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

7. Exempt categories

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

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

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Healthier Communities Select Committee			
Report Title	Response from Cabinet to matters referred by the Healthier Communities Select Committee - Referral on transition from Children's to Adult Services.		
Key Decision	No		Item No 3
Ward	All		
Contributors	Executive Director for Resources (Head of Business & Committee)		
Class	Part 1	Date: 12 November 2015	

1. Summary

This report informs members of the response given at Mayor and Cabinet to a referral which the Committee considered in June 2015.

2. Purpose of the Report

To report to members the response given at Mayor and Cabinet to recommendations made by the Committee on 25 June 2015 on the transition from Children's to Adult Services.

3. Recommendation

The Committee is recommended to receive the Cabinet's response to their consideration of the transition from Children's to Adult Services.

4. Background

4.1 The Cabinet , in the absence of the Mayor, considered the attached report entitled 'Response to Healthier Communities Select Committee: Referral on transition from Children's to Adult Services' at the Mayor & Cabinet meeting held on October 21 2015.

5. Mayoral Response

5.1 The Cabinet received an officer report and presentations from the Cabinet Member for Health, Well-Being & Older People, Councillor Chris Best and the Executive Director for Community Services.

5.2 The Cabinet resolved that the attached response be submitted to the Committee.

BACKGROUND PAPERS

Mayor & Cabinet minutes October 21 2015

If you have any queries on this report, please contact Kevin Flaherty, Head of Business & Committee, 0208 314 9327

Mayor and Cabinet			
Report Title	Response to Healthier Communities Select Committee: Referral on transition from Children's to Adult Services		
Key decisions	Yes		**Item:**
Wards	All		
Contributors	Executive Director for Community Services, Executive Director for Children and Young People		
Class	Part 1	Date: 21 October 2015	

1. Summary

This report responds to the comments and views of the Healthier Communities Select Committee arising from discussions held on the officer report entitled, *'Preparing for Adulthood: Transition from Children's to Adult Services'* considered at its meeting on 25 June 2015.

2. Recommendations

The Mayor is recommended to:

2.1 Note the response of the Executive Director for Community Services and Executive Director for Children and Young People in relation to the issues raised by the Healthier Communities Select Committee and in particular their request that the provision of education and care services for young adults with disabilities is further developed within Lewisham.

2.2 Agree for the response to be forwarded to the Healthier Communities Select Committee.

3. Policy Context

3.1 Both the Children and Families Act 2014 and the Care Act 2014 acknowledge the importance of providing timely information, guidance and appropriate support to young people with special educational needs and disabilities and their families in preparation for adulthood.

3.2 These two pieces of legislation provide a context in which Children and Adult multi-agency services can work collaboratively to ensure that young people and their families are supported to exercise greater individual choice and control in planning and preparing for their future into adult life.

3.3 The Children and Families Act 2014 requires and promotes the importance of early intervention and integrated planning across Adults and Children's services. The Special Educational Needs and Disabilities (SEND) Reform introduces a new approach which seeks to join up support across education, health and care from birth to 25 years. The implementation of Education, Health and Care plan (EHC) replaces both the Statement of Special Educational Needs for children and young people and the Learning Difficulty Assessment.

3.4 The principles which underpin the Children Families Act 2014 and the SEND code of Practice 0-25 years gives recognition to the importance of planning with young people and their families rather than planning for them at both an individual and strategic level. The new system requires a joined up approach including co-production, holistic planning and multi-agency working.

3.5 The Care Act 2014 places a duty on local authorities to conduct transition assessments for children, children's carers and young carers where there is a likely need for care and support after the child in question turns 18. As in all assessments, local authorities need to consider the needs of the person, what needs they are likely to have when they (or the child they care for) turn 18, and the outcomes they want to achieve in life. Consideration should also be given to what types of adult care and support might be of benefit at that point, and whether other options beyond formal services might help the individual achieve their desired outcomes.

3.6 This report assists the Council in meeting the following priority outcomes as defined in the Sustainable Community Strategy 2008-2020:

- *Ambitious and achieving* – celebrate local achievements so people feel proud of their area and eager to be a part of its success.
- *Empowered and responsible* – champion diversity and the contribution everyone makes to the borough's quality of life.
- *Healthy, active and enjoyable* – Support people with long term conditions to live in their communities and maintain their independence.

3.7 In addition, this paper contributes to the following corporate priorities:

- *Community leadership and empowerment* – developing opportunities for the active participation and engagement of people in the life of the community.
- *Protection of children* – better safeguarding and joined up services for children at risk.
- *Young people's achievement and involvement* – raising educational attainment and improving facilities for young people through partnership working.
- *Caring for adults and older people* – working with health services to support older people and adults in need of care.

4. Response to the views of the Healthier Communities Select Committee

4.1 On 25 June 2015, the Healthier Communities Select Committee considered a report *'Preparing for Adulthood: Transition from Children's to Adult Services'*.

4.2 Healthier Communities Select Committee Views

4.2.1 *The Committee recommends that further work be carried out to improve the opportunities for children and young people to access education and care*

provision in Lewisham that meets their needs. The Committee is concerned about the number of young vulnerable people placed outside of the borough.

4.2.2 *The Council should consider working with neighbouring boroughs to ensure that a range of provision is in place for children and young people in receipt of social care.*

4.2.3 *The Committee also recommends that the Council take into account the need for transitional support for families in cases where children are not eligible for adult social care upon reaching adulthood.*

4.3 Response

4.3.1 We welcome the recommendations from the Healthier Communities Select Committee. New legislation – the Children and Families Act 2014 and the Care Act 2014 – has introduced wider responsibilities for all young people with special education needs. Our aim for all children and young people with special educational needs is that there needs are met within universal school and community settings wherever possible.

4.3.2 In August 2015, 380 children attend out of borough education provisions. Of the total number of children and young people who attend out of borough education provisions, 12 % (47) are in residential placements. The largest age cohort placed out of borough are those young people age 14 years to 18 years, accounting for 164 young people. Approximately 13% (22) of these 14-18 years old are in residential placements. Approximately 20% (75) of young people placed out of borough are aged 19 and over, approximately 21% (16) of these young people are in residential placements.

4.3.3 Outlined below are key areas of development that both children and adults services are working together on in order to develop the preparing for adulthood agenda, these include:

- the establishment of clear pathways and service structures across the partnership which allows for transition arrangements to begin at 14yrs.
- development of multi-agency programme which supports practitioners to gain the knowledge and skills required to fully embed the principles of the all aspects of the preparing for adulthood agenda.
- ongoing co-production with parents and young people to ensure that they play an active role in developing this agenda.
- development of advice, information and signposting for young people, parents and professional, through the Local Offer. This includes those young people who do not meet the eligibility criteria for Adult Services.
- development of the market place to ensure that there is suitable provision in place to support young people aspiration and life choice through to adulthood
- Lewisham is part of the south east London commissioning consortium for SEND, and will continue to explore opportunities with neighbouring boroughs to develop the local market.

5. Financial Implications

5.1 Funding of these programmes in the future, as described in this report, will not be adversely affected by any proposed savings identified in the Children's Social Care or Adult Social Care budgets for 2016/17.

6. Legal Implications

6.1 There are no specific legal implications arising from this response, save for noting that the Council's Constitution provides that the Executive may respond to reports and recommendations by the Overview and Scrutiny Committee.

7. Crime and Disorder Implications

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

8. Equality Implications

8.1 The arrangements the Council puts in place to support children with educational needs and/or complex disabilities are designed to maximise the opportunities and life chances for our more vulnerable adults.

9. Environmental Implications

9.1 There are no specific environmental implications arising from this report.

Background Documents

Report to the Healthier Communities Select Committee on Preparing for Adulthood: Transition from Children's to Adult Services – item 4 in the attached link:

http://councilmeetings.lewisham.gov.uk/ieListDocuments.aspx?CId=133&MId=3770&Ver=4

Comment of the Healthier Communities Select Committee on transition from Children's to Adult Services – item 226 in the attached link:

http://councilmeetings.lewisham.gov.uk/ieListDocuments.aspx?CId=139&MId=3856&Ver=4

If there are any queries on this report please contact Joan Hutton – Head of Adult Social Care on 020 8314 8634 or Warwick Tomsett – Head of Commissioning, Strategy and Performance on 020 8314 8362.

HEALTHIER COMMUNITIES SELECT COMMITTEE				
Report Title	Draft Partnership Commissioning Intentions for Adults 2016/17			
Contributors	Executive Director for Community Services and Chief Officer, Lewisham Clinical Commissioning Group		Item No.	4
Class	Part 1	Date:	12 November 2015	

1 Purpose

1.1 The draft Partnership Commissioning Intentions for Adults provides Members of the Committee with an opportunity to comment on the key areas for Lewisham's commissioning work for 2016/17.

2. Recommendations

2.1 Members of the Healthier Communities Select Committee are asked to:

Provide comment on the proposed key areas for Lewisham's commissioning work programme for 2016/17, which have been informed by the Adult Integrated Care Programme. (Appendix A Section 8)

3. Policy Context

3.1 The Health and Social Care Act 2012 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.

3.2 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.

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.

3.4 The activity of the Health and Wellbeing Board is focused on delivering the strategic vision for Lewisham as established in 'Shaping our

Future', Lewisham's Sustainable Community Strategy and in the refreshed Lewisham's Health and Wellbeing Strategy.

3.5 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.

4. Background

4.1 Clinical Commissioning Groups (CCGs) are required to produce their Commissioning Intentions annually. It is a public document and should provide a formal statement about the CCG's intentions to improve the commissioning of local health services.

4.2 In Lewisham, the Adult Joint Strategic Commissioning Group is responsible to oversee the development of the Commissioning Intentions for Adults, working closely with the Adult Integrated Care Programme Board (AICPB), Adult Social Care (ASC), Public Health and Lewisham CCG.

4.3 Last year was the first time that a joint Commissioning Intentions was produced covering all local health and care services for Lewisham people. It was a single plan for the two year period 2015/16 and 2016/17, with one set of priorities for all commissioned services across the CCG and Adult Social Care in Lewisham.

4.4 The joint Commissioning Intentions were developed within the framework set out by the Health and Wellbeing Strategy. The refreshed Health and Wellbeing Strategy was approved by the Health and Wellbeing Board in September 2015, which highlighted three interdependent broader priorities for 2015-18:

- To accelerate the integration of care
- To shift the focus of action and resources to preventing ill health and wellbeing and promoting independence
- Supporting our communities and families to become healthy and resilient

4.5 This year's Partnership Commissioning Intentions are a continuation of the journey to deliver the above strategic priorities and take forward the work started in 2011, to develop and deliver an integrated health and social care model.

4.6 Our Partnership Commissioning Intentions for 2016/17, builds on last year's Joint Commissioning Intentions, and has been informed greatly by the feedback received from the public during 2015, the work of the Adult Integrated Care Programme Board and the South East London - Our Healthier South East London consolidated strategy.

4.7 We have titled this year's Commissioning Intentions as 'Partnership Commissioning Intentions' to emphasise that our intent is to strengthen our partnership work with the public and our local partners. In 2016/17 the focus will be on **how we will work differently** and more effectively with the public and our providers to implement a stepped change in the way health and care is delivered in Lewisham.

4.8 This year the Commissioning Intentions is a refresh of the second year of the last year's Joint Commissioning Intentions, thus it covers only one year - 2016/17. The Commissioning Intentions is in two parts - for Adults and for Children and Young People.

4.9 It should be noted that the NHS national planning guidance for 2016/17 has not been received yet, which may change the financial context and assumptions for Lewisham CCG and local health providers.

4.10 These Partnership Commissioning Intentions are still work in progress, to be finalised in November 2015 and which will be informed by comments of the committee. Also further work is required to identify the measures which will be used to assess our success and the level of ambition in both the short and medium term.

5. Public Engagement

5.1 There has been ongoing public engagement and involvement in developing this year's Partnership Commissioning Intentions. Last year's three months public engagement exercise on the Joint Commissioning Intentions [1] was an opportunity for people to give us their views. Generally people supported the joint Commissioning Intentions, while highlighting some of the challenges and/or opportunities ahead in delivering these commissioning priorities.

5.2 Below is a summary of what local people told us:

Prevention and early intervention

- Overall people supported the priorities around prevention and early intervention.

[1] http://www.lewishamccg.nhs.uk/get-involved/Pages/Have-your-say

- More self-care was supported, so long as the right services are still in place to support people to manage their conditions, when they need them.

- There are a number of ways the NHS and the Council could be more proactive about sharing health and wellbeing information with local people, and this should include a focus on providing more information on related health issues like benefits, social isolation.

- There is a need to provide more health and wellbeing services and support for carers as an important resource for keeping people well.

- The need to recognise mental health as the starting point to keeping people physically well.

GP Practices and Primary Care

- GP accessibility was a recurring theme in the responses to the priorities around GP practice and primary care.

- There is a need to provide more information on accessing mental health services.

- It was felt that ongoing training (i.e. continuing professional development) for GPs and practice staff was an important factor in improving the patient experience of primary care services.

Neighbourhood care networks for adults

The importance of providing an ongoing programme of training for staff in these neighbourhood roles was highlighted, to assure delivery of safe, person-centred services, which also meet the needs of groups that do not easily engage with local services.

Enhanced care and support for adults

- Improve access to mental health services and resources, with better signposting to the full range of services available.

- Poor experiences of existing re-ablement services should be taken into account when planning new services.

- Services should consider the health needs of newly arrived asylum seekers and refugees.

5.3 Also there have been ongoing public engagement events including recently the Phoenix Festival (May 2015), 'Your Voice Counts (July 2015), Lewisham Peoples Day (July 2015) and Lark in the Park (July 2015).

5.4 This continuous public involvement in planning has strengthened the depth of the public's understanding of the challenges in Lewisham and the recognition that the health and care system needs to change.

6. Commissioners' proposals for Adults health and care

6.1 Lewisham health and care face some major, complex challenges which include:

- too many people die early from deaths that could have been prevented by healthier lifestyles
- too many people live with preventable ill health
- there are significant health inequalities in Lewisham
- demand for care is increasing, both in volume and complexity
- high quality care is not consistently available all the time
- there is a CCG and ASC commissioning funding gap of £15.6 million between the projected spending requirements and resources expected to be available in 2016/17

For further details about these challenges see Appendix A sections 3 and 4

6.2 The Partnership Commissioning Intentions summarises what we, the commissioners working with Lewisham people and providers, are doing to respond to these challenges. For each of the following six priorities the Partnership Commissioning Intentions sets out the proposed key areas for our partnership commissioning work now and in 2016/17:

- Prevention and Early Intervention
- GP practices and Primary Care
- Neighbourhood Community Teams
- Enhanced Care and Support
- Urgent and Emergency Care
- Planned Care

6.3 There is an additional section on the supporting strategies – Workforce Information Technology and Estates – which are key to enabling successful delivery of change across the health and care system

For further details see Appendix A section 8

7. Financial implications

7.1 There are no direct financial implications arising from this report. Any proposed activity or commitments arising from the Partnership Commissioning Intentions for 2016/17 will be agreed by the delivery organisation concerned and will be subject to confirmation of resources. The funding available will take account of any required

savings or any other reduction in overall budgets and national NHS planning guidance, not yet received.

8. Legal implications

8.1 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 the area to work closely with the Health and Wellbeing Board.

8.2 Where there is an integration of services and/or joint funding, then this is dealt with under an agreement under Section 75 NHS Act 2006 which sets out the governance arrangements for the delivery of service 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.

8.3 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 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 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.

9. Crime and Disorder Implications

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

10. Equalities Implications

10.1 An Equality Impact Assessment (EQiA) has been undertaken of last year's Joint Commissioning Intentions for 2015/16 and 2016/17.

10.2 The Adult Joint Strategic Commissioning has considered the summary recommendations of the Equality Impact Assessment and will be ensuring that these recommendations inform the more detailed Equality Impact Assessment programme to be undertaken by the Adult Integrated Care Programme.

11. Environmental Implications

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

12. Conclusion

12.1 This report provides an update on the development of the Partnership Commissioning Intentions for Adults and invites members to comment on the draft commissioning priorities for 2016/17

Background Documents

Refreshed Health and Wellbeing Board Strategy
http://councilmeetings.lewisham.gov.uk/documents/s38499/Item%203%20Health%20and%20Wellbeing%20Strategy%20Draft%20Refresh%2022%2009%2015.pdf

Joint Commissioning Intentions 2015/16 and 2016/17 -
www.lewishamccg.nhs.uk/get-involved/Commissioning%20intentions%20documents/Summary%20commissioning%20Intentions%20summary.pdf

Draft Children and Young People Plan 2015-2018
http://councilmeetings.lewisham.gov.uk/documents/s38511/Item%207B%20Draft%20Children%20and%20Young%20People%20Plan%202015-18%2022%2009%2015.pdf

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Draft Lewisham's Partnership Commissioning Intentions for Adults 2016 - 2017

Contents

1. Foreword

NHS Lewisham Clinical Commissioning Group (CCG) and Lewisham Council are responsible for commissioning (planning, buying and monitoring) the majority of health and care services in Lewisham.

This document sets out our plans to commission health and care for Lewisham adults in 2016/17. There are separate Commissioning Intentions for children and young people's services.

This year's Partnership Commissioning Intentions are a continuation of the journey to deliver our strategic vision for 'Health and Wellbeing for all Lewisham residents by 2023', which started in 2011, when the Council, the Lewisham Primary Care Trust and the former Lewisham Healthcare Trust agreed to develop and deliver an integrated health and social care model.

Our Partnership Commissioning Intentions for 2016/17, builds on last year's Joint Commissioning Intentions, and has been informed greatly by the feedback received from the public during 2015, the recently refreshed Lewisham Health and Wellbeing Strategy and the work of the Adult Integrated Care Programme Board on developing and implementing Neighbourhood Care Networks (section 7).

In 2016/17, our focus will be on how we can strengthen partnership working with the public (section 5) and with local providers (section 6). We believe that by working together, as equal partners, real solutions can be found to the complex challenges we face, to make sure our health and care systems are delivering the right care in the right place and at the right time to meet local needs.

We would welcome your views on this year's Partnership Commissioning Intentions - please see further information on how to be more involved in our commissioning work at www.lewisham.gov.uk/myservices/socialcare/our-approach or at www.lewishamccg.nhs.uk/get-involved

Aileen Buckton - Executive Director for Community Services, Lewisham Council
Dr Marc Rowland - Chair, NHS Lewisham CCG
Dr Danny Ruta - Director of Public Health, Lewisham Council

2. Current Position

Lewisham has a growing population, projected to increase from 292,000 to 318,000 by 2021, and is the 15th most ethnically diverse local authority in England - 46% of the population are from black and ethnic minority groups. Around 27,400 residents are above 65 years of age and over 3,650 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 2015 ranks Lewisham 48th of 326 districts in England and 10th out of 33 London boroughs. People living in the most deprived areas 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. There are nearly 40,000 one person households in Lewisham.

Lewisham has over 800 active voluntary and community sector organisations and more than 200 individual faith groups. All these groups and many others help to strengthen our communities by galvanising our citizens, addressing local concerns and advocating on behalf of some of the most vulnerable in society.

There have been some improvements in people's health and care in Lewisham. People in Lewisham are living longer because of the success in managing particular conditions such as stroke, heart disease and respiratory disease.

Overall more people who use Adult Social Care (ASC) services in Lewisham say they are extremely or very satisfied with their services compared to other London Boroughs. More people in contact with mental health services in Lewisham are living independently with or without support in comparison to the national average

More information is available about Lewisham's population at www.lewishamjsna.org.uk

3. Local Challenges

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.
- 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 2011-13 it had increased to 83.0 years and 78.7 years respectively, however, for both men and women life expectancy remains lower than the England average.
- 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.

There are significant health inequalities in Lewisham:

- People living in the most deprived wards, in Lewisham, have poorer health outcomes and lower life expectancy compared to England's average. For example premature death rates are significantly higher in Lewisham Central, Bellingham and New Cross wards compared to the Lewisham average.
- Health inequalities should also be considered by ethnic group. Lewisham is one of the most ethnically diverse areas of the country. The Department of Health has highlighted ethnicity as the major inequality in Severe Mental Illness. Black residents are disproportionately over-represented in mental health admissions.

Too many people live with preventable ill health:

- More people have one or more long term conditions - 29% of Lewisham's population have 1 LTC; about 86,570 people.
- 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

Demand for care is increasing, both in numbers and complexity:

- 14% of people in Lewisham identify themselves as having limitations in carrying out day-to-day activities. That is equivalent to around 38,000 people.
- Lewisham's over 60 population is projected to increase by around 15,000 by 2040 which will increase demand for the health and care services

High quality care is not consistently available all the time - too often, the quality of care that patients receive and the outcome of their treatment depends on when and where they access health and care services.

More information is available about trends in health and care at:

Lewisham's Health and Wellbeing Strategy

Add link

London Borough of Lewisham - Local Account 2014 - 2015
www.lewisham.gov.uk/myservices/socialcare

CCG's Strategic Plan 2013 – 18

www.lewishamccg.nhs.uk/about-us/our-plans

Our Healthier South East London's Strategy - www.ourhealthiersel.nhs.uk

4. The Financial Challenge

In England, a major challenge is that the amount of money we have to commission services is not keeping pace with demand and the rising costs of providing care. The costs of care are rising much faster because we are now caring for more people with more complex conditions and people are living longer.

Collectively the CCG, Adult Social Care (ASC) and Public Health have nearly £472.9 million to commission advice support and care on behalf of Lewisham people.

We are facing a funding gap of £15.6 million between the projected spending requirements and expected resources available in 2016/17 and a further £16.6m in2017/18 – see summary table opposite.

In addition local providers will be required to make efficiency savings. This financial gap, however, cannot be addressed by efficiency and productivity improvements only.

With the limited resources available to us, and demand increasing, the way we deliver health and social care will have to change.

	2016/17*	2017/18*
Estimated revenue budget**		
• **CCG**	£399.4m	£404.2
• **ASC and Public Health**	£ 73.5m	£ 69.3m
Total		
Total estimated health and care revenue budget	£472.9m	£473.5m
Net savings requirements		
• **CCG**	£11.4m	£10.9m
• **ASC and Public Health**	£ 4.2m	£ 5.7m
Total health and care savings requirements	£ 15.6m	£16.6m

*split between years to be confirmed
**This excludes additional external funding and NHS revenue budgets for 2016/17 remain estimates ahead of NHSE planning guidance expected in December 2015.

Better Care Fund – a pooled Better Care Fund has been established to provide resources to support a stepped change in the way that health and care is delivered and to reduce the demand for hospital based care.

5. Partnership approach with the Public

To address the above major challenges, the voice of the public and users is vital; effective public communication and engagement is essential.

We, the commissioners, are committed to developing stronger relationships with local people, community groups and voluntary organisations to connect with them in a more meaningful way.

Lewisham people have said 'prevention is better than cure' - we plan to have a much greater focus on prevention (see section 8.1 on Prevention and Early Intervention) to make choosing healthy living easier for the individual. We intend to commission greater support for people to look after their physical and mental health and wellbeing, by reducing the levels of smoking, obesity, alcohol intake and inactivity, which would reduce many deaths each year that could have been avoided.

Lewisham people have said 'we want more control of our condition' - we plan to improve the support provided to increase people's knowledge, skills and confidence to manage their own care and involve them in all decisions about their care and treatment, particularly those people with long term conditions (see section 8.3 on Neighbourhood Community Teams) and people with complex needs (see section 8.4 on Enhanced Care and Support).

Lewisham people want to build strong communities to give support to their neighbours. Specifically people have said that the role of the voluntary and community sector needs to be considered in supporting delivery of services, but also in reaching out to more people.

We want to work with local communities to harness the energy, skills and knowledge of local communities to reach out to all people, including marginalised groups, to co-design and co-deliver local neighbourhood care networks (see section 7 on Neighbourhood Care Networks).

Only by working in partnership with individual, local communities, voluntary organisation and Healthwatch will commissioners be able to ensure that the advice, support and care meets the diverse needs of individuals and communities.

More Information is available on the feedback from Lewisham People at:

Your Voice Counts – add link

'Have your say' a summary of public feedback on the Joint Commissioning Intentions for 2015/16 and 2016/17 – add link

London Borough of Lewisham - Local Account 2014 - 2015 www.lewisham.gov.uk/myservices/socialcare

CCG's AGM www.lewishamccg.nhs.uk/news-publications/Pages/Lewisham-CCG-AGM---slides.aspx

6. Partnership approach with Providers

In parallel to partnership working with the public, we wish to work in partnership with a broad range of statutory, voluntary and independent sector providers to tackle the way historically heath and care has been provided in a fragmented and disjointed way.

Many people have told us that their care is not joined up between different services. Service users and carers find it frustrating to have to continually provide the same information to different people. People with complex conditions are often passed from one service to another while the services do not always communicate with each other.

We plan to support providers to work in greater collaboration with other providers, to reduce the traditional barriers between organisations to develop 'One Lewisham Health and Social Care System' which is sustainable across the health and care services.

This will require:

- Joining up services between primary care, community services and hospital care, between physical and mental health and between health and social care, supported by different commissioning approaches .
- Well led organisations with strong leadership to support their staff to change the way in which care is delivered across the health and care system to provide person centred care (see section 8.7)
- Commissioning more care in the community, as part of developing our four Neighbourhood Care Networks. We are planning that more personalised, co-ordinated care will be provided by our primary care and neighbourhood community care teams, with extra enhanced care and support to help people to live independently in the community.
- Improving accessibility to advice, support and care so that a greater proportion of care is proactive and planned, thereby reducing the levels of unplanned and emergency hospital admissions which often result in poorer health outcomes.
- Commissioning less emergency inpatient care in acute and mental health hospitals as we plan that there will be a reduction in demand for emergency admissions due to there being earlier intervention and greater support based in the community.
- Some investment to develop community based care delivered by Neighbourhood Care Networks while in parallel hospital care is transformed.

7. Our Partnership Approach – Neighbourhood Care Networks

What are we doing	What the benefits
Improving quality and maintaining safety of today's services – we will continue to focus on greater consistency in the quality of care	You will have a more positive experience and services will be more reliable and of higher quality
Helping people to find the right information and to make decisions about their own health and care	You will be more able to help yourself to stay healthy and do more self-care
Places users at the heart - providing personalised advice , support and care	You will be able to direct your own care
Shifting the focus of services to prevention - there will be greater accessibility to preventative and early intervention support	Your problems will be dealt with at an early stage to stop them from getting worse
Developing the range of local primary and community based services in the Borough with a shift to out of hospital care	You will have a greater choice of high quality services closer to your home
Joining up health and social care services - there will be greater alignment of physical and mental health and social care, with the development of neighbourhood care networks	You will find your way between services and support more easily, with a quicker response to your needs
Targeting support to vulnerable people, their families and carers – there will be more effective coordination of care for people with complex conditions	It will be easier for everyone to remain independent for longer
Improving accessibility to planned care and making it easier to access urgent emergency care.	Services will be accessible and quick to respond to you when you need them

During the last year we have been putting in in place the foundations for Neighbourhood Care Networks based in the four local neighbourhood, across prevention and early intervention, neighbourhood community teams, general practice and enhanced care and support, on which we can build – see map on the next page

Each Neighbourhood has different populations with different requirements, so there is no single blueprint for the Neighbourhood Care Networks.

We believe by fully involving and engaging with service users, carers and other voluntary and community organisations in the co-design and co delivery that each Neighbourhood Care Network may be different.

We intend to ensure the following benefits to the population will be delivered, over time, by each Neighbourhood Care Network – see summary table opposite

Lewisham's Neighbourhood Care Networks

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

8.1 Prevention and Early Intervention

Why this is a priority

In Lewisham we have higher rates of the key risk factors for the major diseases. Reducing levels of smoking, obesity, alcohol intake and inactivity would contribute to improving health outcomes for Lewisham residents:

- Nearly 21% of adults in Lewisham smoke (about 59,800 people) which is above both the London (17.3%) and national (18.4%) averages. Smoking levels are even higher among people with mental health problems and routine, manual workers and lesbian, gay, bisexual, and transgender communities.
- The alcohol profile for Lewisham suggests that around 7% of the population who drink alcohol in Lewisham engage in high risk drinking. This equates to around 12,300 people.
- 61% of the adult population are overweight or obese -approximately 137,000 people in Lewisham.
- Over a quarter of adult residents are physically inactive - approximately 56,000 people in Lewisham.
- The number of people with high blood pressure (hypertension) in Lewisham is 11.3% (33,700 people) which is lower than the national average of 13.7% (2013/14). However, the growth has been 9% in Lewisham since 2009/10 compared with just 2% nationally and there are high levels of undiagnosed people with hypertension.

The rate of emergency hospital admissions for accidental falls also is significantly higher in Lewisham than the England average.

A key message from the 'Your Voice Counts' engagement event in July 2015 was 'prevention is better than cure'. Local people want a greater focus on prevention through, for example, proactive care and strong communities

Lewisham people also said that they do not always understand where to get help or how the health and care system works.

8.1 Prevention and Early Intervention

Priority Aim

- To encourage people to live well, stay healthy and independent longer
- To connect people to services and communities across the borough to promote physical and mental wellbeing; where people recognise their personal strength and abilities as well as those of their families, friends and communities.

What we are doing

Supporting people to look after and improve their own health and wellbeing by:

- providing clear information and advice about local health and social care services and information on benefits, debt and financial management through the redesign and promotion of the Social Care and Health website and directory of services
- making it simpler to access the right services by developing a 'Single Point of Access' which will provide the initial point of access for all district nursing and social work services
- making it easier to live a healthier lifestyle through increased access to advice and support to stop smoking, reduce alcohol misuse, promote mental and emotional well being, healthier eating, increase physical activity and improved sexual health. This will be through a range of interventions including face to face support, mobile applications and the internet
- ensuring that carers' advice, assessment and support meets their needs. Working with Carers Lewisham to enable carers to continue caring, but also to lead independent lives

Supporting people to live in their own homes safely and independently by :

- piloting a new contact and referral approach which will provide a quick and simple way for vulnerable older people, and those supporting them, to access a wide range of services to support safe and independent living
- redesigning fall's prevention and management services by establishing a community based falls team and improving interventions for those at risk of falling

8.1 Prevention and Early Intervention

What we are doing (continue)

Enhancing capacity in the community and voluntary sector to support a greater focus on prevention and early intervention by working with a range of voluntary and community sector organisations including Voluntary Action Lewisham (VAL) and Healthwatch Lewisham, building on work at a neighbourhood level through the Community Connections Team, health trainers and area based initiatives such as Well Bellingham and the North Lewisham Health improvement programme.

Developing low level proactive services and support, to enable people to continue to live in their own homes:

- providing the appropriate equipment at the right time
- undertaking minor housing improvements and adaptations

Implementing a new service model for sexual health. The London Sexual Health Transformation Programme has set out a Case for Change based on a needs assessment and review of current services. It is recognised that significant change is required to the historic models and patterns of service delivery. It is anticipated that by working together at both a London and SE London level the services for residents can be improved to be more responsive and easier to navigate whilst also being more cost effective.

8.2 General Practices and Primary Care

Why this is a priority

Public satisfaction with general practice remains high, but satisfaction with access is poor. People find it hard to get GP appointment when they need it and sometimes the length of appointment time is considered to be too short for complex issues. Accessing GP services has been a recurring theme at public engagement events in Lewisham.

In Lewisham some GP practices achieve excellent clinical outcomes and patient satisfaction, but there is significant variation in performance and quality. GPs have an important role in the earlier diagnosis for people with long term conditions to help them get better sooner and prevent their illness becoming more serious. The number of people with long term conditions is increasing in Lewisham.

Nationally GPs' workloads are increasing, with rising number of patients and growing complexity of their health needs

The public feedback on the service provided by pharmacists has been positive.

Transforming Primary Care in London: A Strategic Commissioning Framework outlines a new vision for general practice, sets out a new specification ('patient offer') around three aspects of care that matters most to patients:

- Proactive care
- Accessible care
- Coordinated care

Lewisham has higher rates for emergency admissions which usually would not be admitted to hospital (for example, conditions like influenza and pneumonia which can be preventable by vaccine, kidney and urinary tract infections, ulcers and Ear, Nose and Throat Infections, dental conditions). Lewisham's rate for these types of emergency admissions is 1005.9 per 100,000 population in comparison to the London rate of 717.5 per 100,000 and the England rate is 808.5 per 100,000 (2014-15) .

8.2 General Practices and Primary Care

Priority aim

- To provide strong GP practices and primary care 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 we are doing

Proactive care – primary care supporting and improving the health and wellbeing of its population and keeping people healthy by:

- increasing the earlier identification and diagnosis for people with Long Term Conditions - e.g. diabetes, Cardiovascular-disease (CVD), chronic-obstructive pulmonary-disease (COPD), dementia and cancer
- promoting immunisations to protect people from serious illness and preventing the need for admission to hospital
- Consolidating the current service offer for psychological support for individuals with long term condition through the expanded remit of Psychological Therapy services
- Promoting health through community pharmacies – healthy pharmacy champions and enhanced public services such as sexual health, smoking, health checks, drug misuse, as well as referring all heavily addicted smokers to stop smoking services

Accessible Care – primary care providing a personalised responsive, timely and accessible service by:

- reviewing and simplifying arrangements for the provision of extended primary care access as part of developing a new integrated urgent and emergency care offer to patients locally – (see Urgent Care section)
- increasing the utilisation of online services, specifically for booking an appointment, requesting a repeat prescription and accessing medical records
- improving the co-ordination with the wider primary care team – with community pharmacists (e.g. Pharmacy First for minor illnesses), general dental practitioners and optometrists

8.2 General Practices and Primary Care

What we are doing (Continue)

Coordinated Care – primary care providing patient centred, coordinated care and GP/patient continuity by:

- improving the management and consistency of care for people with Long Term Conditions - e.g. diabetes, cardiovascular-disease (CVD), chronic-obstructive pulmonary-disease (COPD), dementia, cancer and those at the end of life – and the behaviour changes towards healthier lifestyles
- promoting a proactive and holistic care approach working with the person, their carers and their families using risk profiling and collaborative care planning methodologies as part of the Neighbourhood Community Teams
- providing greater support to patients to self-manage their long term conditions by the re-procurement of structured education for COPD and type 2 diabetes

8.3 Neighbourhood Community Teams

Why this is a priority

In Lewisham people are living longer - there are around 27,400 residents are above 65 years of age and over 3,650 are aged over 85 years. An ageing population will increase the number of people with multiple chronic conditions and a growing number of functional and cognitive impairments. People over 85 years often have complex needs and have high use of health and care services.

The high premature mortality rates in Lewisham suggest that the proportion of people with LTCs who have poorly controlled disease is higher than elsewhere.

An increasing number of individuals need support to effectively managing their long term conditions. Current data suggests that:

- 8.6% of the population have 3 or more LTCs (about 25,700 people).
- 11.9% of the population have 2 LTCs (about 35,520 people).
- 29% of the population have 1 LTC (about 86,570 people).
- Rates are rising fastest for Type 2 Diabetes and Chronic Obstructive Pulmonary Disease (COPD).
- Lewisham's Black and Minority Ethnic communities have a greater risk from health conditions such as diabetes, hypertension and stroke.
- Level of mental health needs for both common and severe mental illness are significantly higher for adults in Lewisham compared to London and England.

Many people have fedback that they would like to have greater involvement and control of their own care and be supported to do more to care for themselves.

People want more joined up services between health and care with better information and advice to enable them to navigate to the right service at the right time; a common theme at public engagement events.

People have said also that there needs to be more support for people with mental health issues in Lewisham.

8.3 Neighbourhood Community Teams

Priority Aim

- To provide 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

What we are doing

Improving the effectiveness of Neighbourhood Community Teams by working towards the implementation of joint processes, underpinned by sharing of information across professional groups and organisations by:

- piloting the co-location of a Neighbourhood Community Team in one of the neighbourhoods in Lewisham
- having a common approach to identifying and targeting those people who will most benefit from the support of multidisciplinary meetings
- developing case management and key workers for those people with complex needs to support them to be more in control of their own care
- working towards a single assessment process with shared health and social care records and reviews, which streamlines the care planning processes across health and care
- ensuring that the Neighbourhood Community Teams have appropriate quality assurance processes across health and social care including for safeguarding
- maximising the effectiveness of medication reviews to optimise the use of medication with the expansion of the Lewisham Integrated Medicines Optimisation Service (LIMOS)

Increase the scope of Neighbourhood Community Teams currently comprising district nursing, therapy staff and social worker staff, working with general practices, by aligning them more closely with community mental health teams.

8.3 Neighbourhood Community Teams

What we are doing (continue)

Improving the consistency in the quality of care and patient experience provided by District Nursing based on the key audit findings undertaken in January 2016 and by:

- implementing the outcomes of the audit reviewing the wound care (tissue viability) service;
- re-procuring Lymphedema services
- implementing the recommendations of the January 2016 audit of District Nursing

Streamlining care pathways to ensure the right people at the right time receive the right support and care to manage their care better in the community, with an appropriate interface with the neighbourhood community teams, including for:

- people with dementia by ensuring timely access to assessment, diagnosis and community based support.
- people with diabetes by further developing the integration of specialist community and primary diabetic care and support across Lewisham, with the intention to commission the service differently in 2017/18
- Supporting individuals with common mental health disorders by Improving Access to Psychological Therapies (IAPT)
- Progressing the accepted recommendations from the Psychological therapies review (2015) to establish an integrated model of service
- 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 providing support to reduce relapse and need for hospital re-admission and the reliance on adult mental health inpatient beds

8.4 Enhanced Care and Support

Why this is a priority

The Lewisham population is projected to grow across all age groups over the next five years. Over the next fifteen years the greatest percentage increase will be in the 65+ age group.

The prevalence of having a long term condition increases with age and over fifty percent of those aged 75+ will have two or more long term conditions. The prevalence of dementia increases markedly with age, at about 1% of 65 to 69 year olds and almost one in four people aged over 90.

It is estimated that a third of patients admitted to hospital and care homes are already malnourished or at risk of malnutrition.

Lewisham has higher rates of emergency admissions rates for people over 65years in comparison to both London and England. In 2012/13 almost 8,000 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.

This suggests that in Lewisham a higher number of people are being admitted to an acute bed who could have been seen and cared for at home and in a way that optimised their independence.

Patients sometimes stay longer in hospital because joined up arrangements for their care in the community on and after discharge have not been put in place. This may be due to a number of reasons including co-ordination between different agencies, complexity of cases, patient and family wishes and provider capacity issues. Early supported discharge and a stronger focus on rehabilitation could help patients return home more quickly and safely, preventing unnecessary delays.

People in Lewisham strongly supported joined up health and social care (including the voluntary sector).

8.4 Enhanced Care and Support

Priority Aim

- To develop a coherent and co-ordinated set of services which avoid unnecessary admissions into a hospital or care home and facilitate early discharge into the community /home.
- To develop integrated physical/ mental health & social care pathways above and beyond "core" services, delivered in the most appropriate setting for the service user which optimises levels of independence.

What we are doing

Commissioning a range of joined up community based health and care services to improve the hospital discharge planning process and the effective follow up care for individuals with complex needs by:

- improving discharge planning and the utilisation of community beds (e.g. Brymore House, Sapphire ward), based on the findings of the 2015/16 discharge service audit
- streamlining the NHS funded continuing care process by the development of single assessment and review pathway, offering Personal Health Budgets to eligible clients
- increasing 7 day working arrangement to increase discharges at weekends
- implementing a new service model for domiciliary care with a focus on outcome based commissioning and neighbourhood lead providers
- reviewing the Early Supported Discharge pathway for COPD - with the intention to commission the service differently in 2017/18

8.4 Enhanced Care and Support

What we are doing (continue)

Commissioning a wider range of joined up community based health and care services which avoid unnecessary admissions into a hospital (acute or community) or a care home and support frail older people to be cared for in their own homes, informed by the audits and the evaluations of the winter scheme pilots undertaken in 2015/16. This is likely to include:

- strengthening the capacity and capability of a set of co-ordinated community based services which are able to respond quickly when a patient's conditions deteriorates and there is a need for rapid assessment and support. This may include a short hospital visit
- developing the Ambulatory Care model, to provide assessment and same day discharges, on the Lewisham hospital site, working with Lewisham and Greenwich NHS Trust
- piloting a community based 'home ward' providing enhanced health and care support for a short time to enable a person to stay at home with the necessary additional support
- providing additional support to care homes from GPs, community nursing, pharmacists, community dieticians and palliative care teams
- developing Extra Care services and Older Adults Housing to support people to stay in their own homes and out of residential and nursing care for longer. This will increase the availability of adapted and single level accommodation and the commissioning of 'care on demand' services to support a higher range of needs than those traditionally associated with Extra Care.
- expanding the scope of the Mental Health Crisis service to more effectively support people at times of crisis in line with the local Crisis Care Concordat plan.
- improving patient experience by enhancing the local service offer for mental health crisis care by establishing a whole system approach comprised of A&E Psychiatric Liaison, Peer Support & 24/7 Crisis Telephone Line
- implementing a community malnutrition care pathway

Improving the quality of community based specialist care services within the Borough:

- reviewing the community specialist palliative care services to ensure all people have equal access to high quality, responsive, 24/7 services, with the intention to commission the service differently in 2017/18
- reviewing the care provided for people with long term neurological conditions and acquired brain injury, specifically the balance of highly specialised rehabilitation bed provision, locally available specialist rehabilitation beds (2B) and community based neuro-therapy, as currently there is very limited provision capacity for people to receive specialist neuro rehabilitation within south east London

8.5 Urgent and Emergency Care

Why this is a priority

Many people are going to A&E unnecessarily when other more suitable care is available. Nationally nearly 40% of patients seen in A&E are discharged with no further input, indicating that potentially patients could have been seen away from A&E. Further analysis by the Royal College of Emergency Medicine estimates that 15% of patients attending A&E could have been seen elsewhere in the community.

Many A&E departments in London are having difficulty in meeting the target that 95% of people attending A&E should be seen within 4 hours.

No hospital in south east London fully meets the quality standards for emergency care as set out by the London Quality Standards. These include the requirement that senior doctors (consultants) are present on emergency wards a minimum of 16 hours a day, 7 days a week.

Patients with mental ill health often have longer waits to see a psychiatric liaison nurse.

People in Lewisham want greater information on how to access services out of hours and at weekends.

8.5 Urgent and Emergency Care

Priority aim

- Emergency care is for people who have a condition that is life-threatening or presents an immediate risk to long term health.
- Urgent care services are for people who have a problem that needs attention the same day, but is not life-threatening or life-changing

What we are doing

Developing an integrated Urgent and Emergency Care model and new offer to patients with primary care for Lewisham – this will operate 7 days a week over extended hours to offer a consistent Urgent Care service in the community. This will provide an alternative to A&E, accessible by both patients and clinicians for non-acute urgent cases. The potential for co-locating these services with the Emergency Department will be explored further.

Support the development of Ambulatory Care models across the integrated Urgent and Emergency Care Model in order to treat patients more quickly in the most appropriate setting. This should see an increase in the numbers of patients assessed, treated and discharged without the need for admission.

Improving quality standards in Lewisham's A&E department, working with Lewisham and Greenwich NHS Trust to achieve the London Quality Standards for emergency care and with the London Ambulance Service to improve 999 response times.

Undertaking the re-procurement of the south east London 111 service and the GP element of the Urgent Care Centre in line with the Urgent Care Model for Lewisham.

Exploring the opportunities for supporting people who have both physical and mental health problems and who need a hospital admission by testing out the concept of an all age Mental Health hospital liaison service building on the Core 24 Psychiatric Liaison Nursing service model.

8.6 Planned Care

Why this is a priority

There are differences in patient outcomes and experiences, depending on where and when they access care, for example screening for breast and bowel cancer.

Time from first appointment, to diagnostic test, to getting results could be quicker and more efficient leading to earlier diagnosis and better outcomes for patients.

Patients could be better prepared for their operation/ procedure which would help patients to recover more quickly.

8.6 Planned Care

Priority aim

- to ensure all people who need planned care the same quality of care and outcomes. Planned care is treatment that is planned in advance, such as an operation that is booked on a certain date

What are we doing

Improving the quality of hospital referrals and also patient experience of the appointment booking process (including proactive offer of choice) through the two year Referral Support Service pilot which will be fully evaluated to inform long term commissioning intentions.

Improving the patients' experience and delivering value for money by re-specifying the service requirements and evaluating the different models of commissioning and contracting for Musculoskeletal and Physiotherapy services.

Improving cancer care, working in partnership with the London Cancer Alliance by:

- earlier detection of cancer and increasing access to diagnostics
- reducing the variation in cancer care in hospitals
- supporting people with and beyond cancer

Reviewing the following clinical planned care pathways with the intention to commission these services differently in 2017/18:

- Dermatology
- Gynaecology
- Ophthalmology

Reviewing the feasibility of fast tracking surgery for uncomplicated procedures in surgically fit patients e.g. cholecystectomy, hernia repairs, working with Lewisham and Greenwich NHS Trust.

8.7 Supporting Strategies

Workforce Development

A modern workforce will be crucial to the delivery of person centred care, which is joined up across primary, secondary, community and social care. 'One Lewisham health and care system' will not become a reality without a workforce with the right numbers, skills, values and behaviours to deliver it.

This will require commissioners and providers to develop and implement a system wide workforce development plan. The first steps have been taken already to:

- bring groups of multidisciplinary staff together to develop local approaches on how they can better work as a team underpinned shared values and behaviours
- undertake a stocktake of current provider development activity to identify areas of overlap between different partner organisations, to achieve synergies and potential economies, and to identify shared or common priorities for further joint working

Our ambition is to:

- ensure that all staff are caring, compassionate and understand the importance of language and cultural differences
- develop new, effective ways of working using a different skill mix, introducing new roles and new competencies,
- change the relationship between the workforce and the people who use our services and carers, supporting greater empowerment and independence
- Staff are supported to lead healthy lives themselves
- support an open culture of evaluation, learning and continuous professional development

8.7 Supporting Strategies

Information Technology

Our ambition is to maximise the potential of technological advances to support:

- people who use our services to have access their health care record electronically
- people to look after themselves and self-manage their long term conditions by providing more appropriate information and greater use of technology
- people to navigate the right care at the right time with up to date information and advice about available support and services
- sharing information between care providers including GPs, pharmacists, secondary care clinicians, A&E, community care and social care. Lewisham heath and care providers have collaborated to begin to roll out a virtual patient record (Connect Care)
- mobile/remote working in the community by a greater number of staff

However we will need to take steps to ensure that we build the capacity of all citizens to use Information Technology, like the internet and smartphones, and train our staff so that they are able to support those who are unable or unwilling to use new technologies

Estates

Our plan is to ensure that estates planning is embedded within the wider service planning.

Representatives from the CCG, LGT, Council and SlaM are in discussions on how better use could be made of the estates across the system to deliver new models of care.

Estate audit work is being undertaken across the whole borough to support this work.

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Healthier Communities Select Committee			
Title:	Lewisham Health and Wellbeing Strategy Refresh 2015-18		
From:	Director of Public Health	Item:	5
Class:	Part 1 (Open)	12 November 2015	

1. Purpose

1.1 This report provides Members with an updated refresh of the Health and Wellbeing Strategy for 2015-18.

1.2 The Lewisham Health and Wellbeing Strategy Refresh 2015-18 was considered by the Health and Wellbeing Board on 22 September. The Board approved the refreshed strategy subject to minor revisions which have been included in the final draft.

2. Recommendations

2.1 Members of the Healthier Communities Select Committee are asked to note the information provided in the report and the appendix.

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 2012 also required health and wellbeing boards to encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area.

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. Financial implications

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

5. Legal implications

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

6. Crime and disorder implications

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

7. Equalities implications

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

8. Environmental implications

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

If there are any queries on this report please contact Dr Danny Ruta, Director of Public Health on 020 8314 8637 or by email at danny.ruta@lewisham.gov.uk

Appendix 1

LEWISHAM HEALTH AND WELLBEING STRATEGY DRAFT REFRESH 2015-18

1. SUMMARY

1.1 Refreshing Our Strategy

1.1.1 This is a refresh of Lewisham's ten year health and wellbeing strategy produced. It encompasses the original nine long term **priority outcomes** for Lewisham, identified in 2013, which were:

1 Achieving a healthy weight
2 Increasing the number of people who survive colorectal, breast and lung cancer at 1 and 5 years
3 Improving immunisation uptake
4 Reducing alcohol harm
5 Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking
6 Improving mental health and wellbeing
7 Improving sexual health
8 Delaying and reducing the need for long term care and support
9 Reducing the number of emergency admissions for people with long term conditions

1.1.2 This refresh provides a greater strategic focus on a smaller number of short term **priorities for action** over the next three years**:**

1. to accelerate the integration of adult, children's and young people's care;

2. to shift the focus of action and resources to preventing ill health and promoting independence;

3. supporting our communities and families to become healthier and more resilient, which will include addressing the wider determinants of health.

Collective and concerted action on these three priorities, working with our local communities, could bring about significant population level improvements over the next three years across all nine priority outcome areas. At the same time these priorities align with, and support delivery of, key national and local policies and programmes. These include the NHS five year Forward View, the Care Act, the Our Healthier South East London Consolidated Strategy, Lewisham's Adult Integrated Care Programme, and Lewisham's new Children & Young People's Plan. All these policies and programmes prioritise integration, prevention, collective action and stronger communities.

1.2 Our vision remains the same: "Health and Wellbeing for all Lewisham residents by 2023"

1.2.1 Our strategy is an ambitious one – it sets out a strategic commitment to 2023 focused on achieving our vision of:

1.2.2 *"Health and Wellbeing for all Lewisham residents by 2023"*

1.2.3 We acknowledged in our original strategy that good health and wellbeing mean different things to different people, so we used the World Health Organisation's (WHO) definition of health as 'a state of complete physical, mental and social wellbeing' and we defined wellbeing as having 'the capability to do and be what you want in your life'.

1.2.4 Health inequalities can also be interpreted differently, so we have used the National Institute for Health and Care Excellence (NICE) definition of health inequalities as 'differences between people or groups due to social, geographical, biological or other factors that result in people who are worst off experiencing poorer health and shorter lives'.

1.3 Tackling the root causes of health inequalities

1.3.1 We knew that achieving our goal of Health and Wellbeing for All by 2023 would require us to think differently about the root causes of health inequalities. We recognised that health and wellbeing is affected by social and environmental factors as well by the choices and actions taken by individuals.

1.3.2 Reducing inequalities is certainly a significant challenge but this should not stop us pursuing further action. In order to tackle health inequalities in Lewisham, we recognised:

- the importance of empowering individuals to take action by themselves, and also within their families and communities;
- the need to create physical and social environments that encourage healthy habits, choices and actions;
- that every aspect of people's lives, their work, their housing, their finances and their relationships can have an impact on their health and wellbeing.
- the roles that organisations across all sectors must play in order to achieve improvements in the borough.
- That while the underlying causes of health inequalities are common, the priority actions for reducing inequalities will vary between communities, in response to specific local circumstances.
- that there are opportunities to reduce inequalities across a range of settings – in schools, workplaces and community centres and at all stages of the life course.

1.4 Taking action at three levels – population, community and individual/family

1.4.1 We propose to take action at three levels: at population, community and individual/family level. Approaches directed at the whole population will include healthy public policies, using legislation, and regulatory powers to support making 'healthy choices easy choices' for individuals and communities. Individuals and families will only choose certain behaviour and actions if those behaviours fit with the cultural and belief system of their own community. A powerful way to facilitate communities' awareness of and capability to alter the factors affecting health and wellbeing is through community development approaches that have been pioneered in Lewisham. At the individual and family level, developing the personal skills amongst staff and service users to allow those service users to manage their own care is critical to achieving population level changes.

1.4 Summary statement of intent

1.1.3 Our refreshed strategy can be summarized in the following statement:

We will ACT at the level of: populations, communities, individuals and families

THROUGH: healthy public policy, community development, new neighbourhood care networks, making every contact count, self care and self management

TO: accelerate the integration of care, to prevent ill health and promote independence, and to support healthy and resilient communities

IN ORDER TO: improve and maintain health and wellbeing, reduce health inequalities and deliver our nine priority outcomes.

2. LEWISHAM HEALTH AND WELLBEING BOARD AND ACHIEVEMENTS TO DATE

2.1 Role of the Health and Wellbeing Board

2.1.1 Lewisham's Health and Wellbeing Board brings together individuals from the key organisations that deliver health and care services, as well as representation from the borough's voluntary and community sector. The perspective of citizens and patients is provided by Healthwatch. Key roles of the board include the promotion of integrated health and care services and the development of a Health and Wellbeing Strategy, based on a clear understanding of the needs of the population (through the Joint Strategic Needs Assessment process).

2.2 Delivery of the Health and Wellbeing Strategy 2013-15

2.2.1 In the period from 2013 to April 2015, significant progress was achieved for each of the nine ten year prioritiy outcomes of the health and wellbeing strategy. Key achievements have included:

2.2.2 Priority 1: Achieving a Healthy Weight: Community and maternity services achieved the UNICEF Baby Friendly Initiative stage 2 award in 2014; implementation of a universal free vitamin D scheme reached 30% of eligible women and 50% of infants under 1 year; and the introduction of an exclusion zone (400m) for new fast food takeaways around schools and maximum percentages outside exclusion zones.

2.2.3 Priority 2: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years: Reducing variation in early detection has been incorporated into the work of the CCG Primary Care Development Strategy Board; and Public Health England's National Be Clear on Cancer Campaigns have been promoted to Primary care and communities.

2.2.4 Priority 3: Improving Immunisation Uptake**:** Overall, uptake of immunisation in Lewisham's children continues to improve so that, with the exception of one vaccine, local uptake is now at or above the mean uptake in London. Local performance continues to improve whilst uptake in other boroughs has begun to decline. In the 2014/2015 Flu season, Lewisham saw its best performance yet and its greatest levels of improvement on uptake of flu vaccine.

2.2.5 Priority 4: Reducing Alcohol Harm: training was delivered to at least 750 front line workers to skill them in Identification and Brief Advice on Alcohol; and there was a focus on enforcing the sensible supply of alcohol, including a Responsible Retailers Scheme the introduction of the Director of Public Health as a 'Responsible Authority' and the re-commissioning of some specialist services.

2.2.6 Priority 5: Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking: Lewisham had the biggest seizure of any local authority of illegal tobacco in the UK and has been cited as a model of success regionally; training was delivered to at least 1200 front line workers in very brief advice on smoking ie skills and confidence to raise the issue of smoking and refer for support; and training was delivered to more than 300 pupils aged 12 to 13 years to persuade more than 3000 of their peers not to start smoking.

2.2.7 Priority 6: Improving mental health and wellbeing; mental health first aid training was successfully delivered to all front line public and voluntary sector workers to support them to respond to the needs of people with mental health needs; and over 400 families have benefited from targeted family support in the year ending March 2015.

2.2.8 Priority 7: Improving sexual health: A total of 19 pharmacies are now offering emergency contraception & Chlamydia and gonorrhea screening; the number of online screening for sexually transmitted diseases requests in 2014/15 increased on the previous year; all secondary schools were offered access to free Sex & Relationships Education (SRE) in the 2013/14 school year, and 9 schools took up this offer.

2.2.9 Priority 8: Delaying and reducing the need for long term care and support: Partners across the health and care system reviewed the support and help that is available to enable people to maintain their independence and wellbeing, and to reduce their reliance on statutory health and care services. This has resulted in the bringing together of those health and care staff involved in an individual's care and improved co-ordination of services across the whole system.

2.2.10 Priority 9: Reducing the number of emergency admissions for people with long term conditions: The CCG has supported GP practices to deliver the National Unplanned Admissions Enhanced Services (ES) and 40 of the 41 GP practices have used the Risk Stratification Tool to identify patients who are at most risk; a structured programme was successfully delivered to support practices to increase the numbers of NHS health checks, increase stop smoking and improving immunisations 2013/14; and DESMOND (Diabetes Education and Self-Management for On-going and Newly Diagnosed) has been commissioned by the CCG and is enabling patients to self-refer for support.

3. OUR REFRESHED STRATEGIC PRIORITIES FOR 2015-18

3.1.1 While the Board will continue to monitor progress using our H&WB Outcomes Dashboard and ensure that existing delivery groups and plans work effectively to deliver the original 9 priority outcomes within the resources available, the board now wants to provide a greater strategic focus on a smaller number of actions where collective and concerted effort by the Health and Wellbeing Board member organisations in partnership with other stakeholders, and working with our local communities, could bring about significant population level improvements in Health and Wellbeing.

3.1.2 Over the last six months a series of Board workshops and stakeholder engagement events have taken place. They confirmed that our ten year strategy has not changed: our vision remains to achieve health and wellbeing for all residents by 2023. They also generated a strong consensus that the best way to make progress over the next three years towards realising this vision is by preventing ill-health, maintaining good health and keeping more people well and independent throughout their life course. This will require a much greater focus on creating the conditions that make healthier lifestyle choices easier for individuals and families, and providing the support for older people and those with disabilities to live well and independently for as long as they can.

3.1.3 In order to prevent ill health and promote wellbeing and independence the board and its partners identified a clear need for an integrated health and social care system and stronger communities. What also emerged from discussions is the need for simultaneous joined up action across the following 'fronts:

- integration of physical and mental health services;
- Integration of health and social care;
- Integration of care and prevention;
- Integration of primary and second health services (including community services);
- building on the strong and active communities that already exist in Lewisham, to mobilise their efforts and support them to help each other to make changes in their daily lives, and empower them to take control over their health and wellbeing.

3.1.4 Following the engagement activity with stakeholders and the discussions by the Board, the three interdependent broader priorities have been identified for 2015-18:

1) <u>To accelerate the integration of care</u>

2) <u>To shift the focus of action and resources to preventing ill health and promoting independence</u>

3) <u>Supporting our communities and families to become healthy and resilient</u>

3.1.5 These broad priorities align with, and support delivery of, key national and local policies and programmes. These include the NHS five year Forward View, the Care Act, the Our Healthier South East London Consolidated Strategy, Lewisham's adult integrated care programme, and Lewisham's new Children & Young People's Plan.

4. THE APPROACH WE WILL TAKE

4.1.1 We propose to take action on these three priorities for action at three levels: at a population, community and individual/family level.

4.2 Population level approaches

4.2.1 Approaches directed at the whole population will include healthy public policies, using legislation, and regulatory powers to support making 'healthy choices easy choices' for individuals and communities. Social marketing, communication and education strategies, service support and even enforcement actions will be required to achieve the biggest impact.

4.3 Community level approaches

4.3.1 Individuals and families will only choose certain behaviour and actions if those behaviours fit with the cultural and belief system of their own community. These communities can be based on place (neighbourhood, school, workplace), culture (ethnicity, faith), and others (disability, sexual orientation). A powerful way to facilitate communities' awareness of and capability to alter the factors affecting health and wellbeing is through community development approaches that have been pioneered in Lewisham. Lewisham's voluntary, community and faith sector acts as a bridge between services and communities, and the new neighbourhood care networks emerging from the integration of health and social care can provide an additional vehicle for engaging and empowering communities to improve their own health and wellbeing. Working with businesses is also part of a community approach.

4.4 Individual and family level approaches

4.4.1 Many interventions taken up at the individual and family level can only be implemented effectively to scale in an integrated health and care system where every contact presents a health improvement opportunity. Brief Interventions for behaviour change will be delivered to scale by front line staff, developing the personal skills amongst staff and service users to allow those service users to manage their own care is also critical to achieving population level changes.

5. PUTTING IT ALL TOGETHER: LEWISHAM HEALTH & WELLBEING STRATEGY REFRESH 2015-18

5.1 Our refreshed strategy can be summarised in the following narrative:

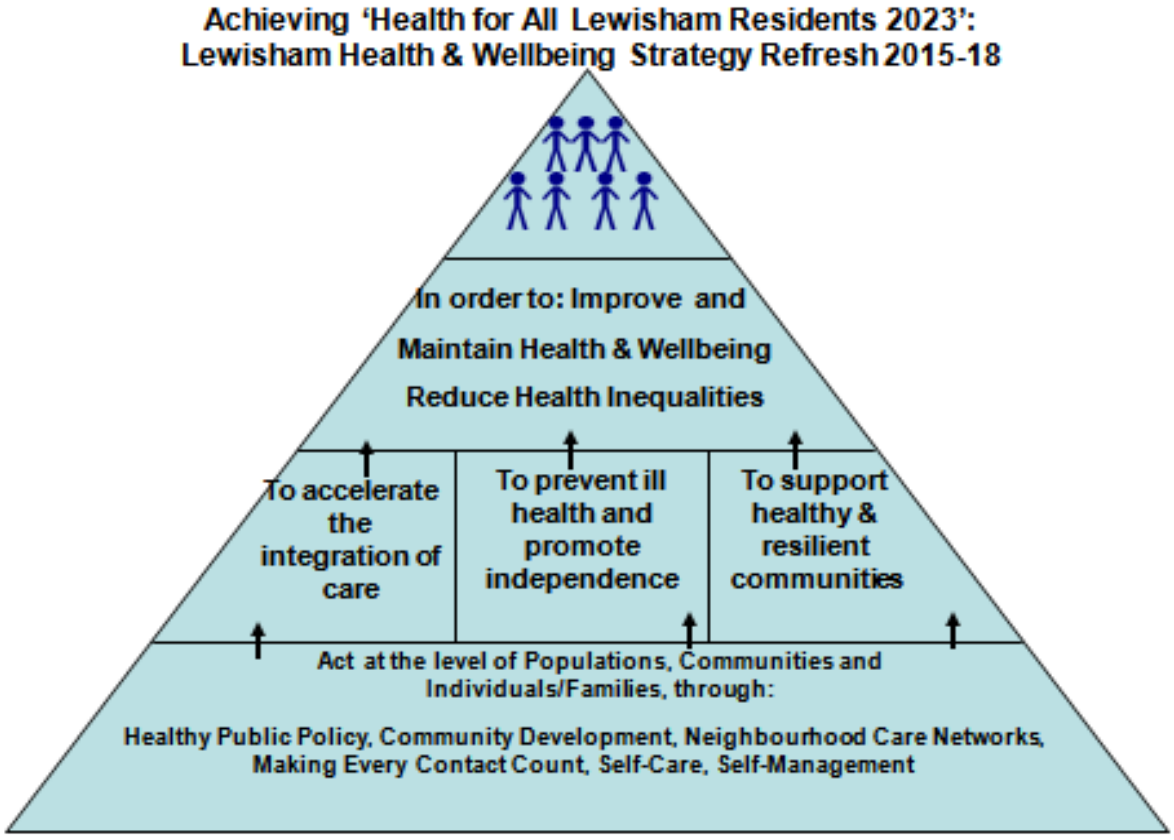
We will ACT at the level of: populations, communities, individuals and families

THROUGH: healthy public policy, community development, new neighbourhood care networks, making every contact count, self care and self management

TO: accelerate he integration of care, to prevent ill health and promote independence, and to support healthy and resilient communities

IN ORDER TO: improve and maintain health and wellbeing and reduce health inequalities.

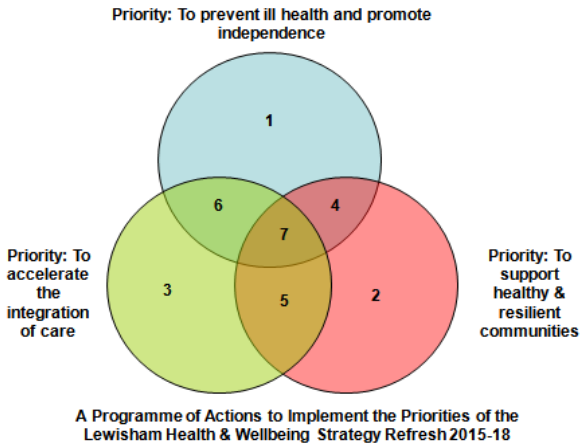
5.2 The diagram below illustrates this narrative, bringing together our original vision and overall aim, our new strategic focus and priorities for the next three years, and the approaches we will take to addressing these priorities, in a Lewisham Health & Wellbeing Strategy Refresh 2015-18:



6. ACTIONS WE WILL TAKE TO DELIVER OUR STRATEGY

6.1.1 The series of board workshops and stakeholder engagement events held during 2015 culminated in a large stakeholder event in which partners across agencies met to identify the key actions required to deliver a refreshed strategy over the next three years.

6.1.2 In order to achieve population level change in outcomes, we recognised the need to identify a programme of actions that addresses all three priorities, and wherever possible to identify actions that operate on two or three priorities at the same time. The Venn diagram below illustrates how identified actions operate together:



A Programme of Actions to Implement the Priorities of the Lewisham Health & Wellbeing Strategy Refresh 2015-18

Examples of how actions will operate together to address H&WB Strategy Refresh Priorities

- 1 – Promote smoke free environments, including homes & playgrounds
- 2 – Identify community assets & gaps, and how public services can better support communities to support themselves
- 3 – Co-locate health & care staff (inc primary care) in each of the four neighbourhoods
- 4 – Work with local retailers / off licenses to reduce the supply of super strength lager/beer
- 5 – Promote cancer screening programmes in the community & work with GP practices so that they are more proactive in following up cancer screening non-attenders
- 6 – Support children at risk of deteriorating mental health or those exposed to risk factors for mental ill health
- 7 – Achieve and maintain baby friendly accreditation across maternity and community health

6.1.3 In order to achieve population level change in outcomes with maximum impact, it will not be sufficient to identifying actions that operate across priorities. We will also need to ensure a balanced programme of actions that operates simultaneously at a population, community and individual level.

6.1.4 The Health & Wellbeing Board will review all the actions identified through the engagement events in 2015, and use the approach described above to develop a new three year action plan that will deliver our refreshed strategic priorities.

7. HOW WE WILL MONITOR AND MEASURE SUCCESS

7.1.1 Over the last three years, existing governance and performance monitoring arrangements have delivered significant progress in implementing Lewisham's Health and Wellbeing strategy. A Health and Wellbeing Strategy Implementation Group, with representation from local authority and health commissioners, and the voluntary sector, will take responsibility for developing a Health and Wellbeing delivery plan and monitoring its implementation. The Implementation Group will report on progress in delivery of actions to the Health and Wellbeing Board every six months, but will exception report performance issues when necessary. It will also use the the Health and Wellbeing Board's outcomes dashboard to monitor progress in delivery of outcomes.

7.1.2 The JSNA process and the public health annual report will also be used to assess the success of implementation of the strategy in addressing health and social care needs.

Healthier Communities Select Committee			
Title:	Additional Information on Savings Proposals A14 and A16		
From:	Executive Director for Community Services	Item:	6
Class:	Part 1 (Open)	12 November 2015	

1. Summary

1.1 On 9 September 2015, the Healthier Communities Select Committee considered a report entitled Lewisham Future Programme: 2016/17 Draft Revenue Budget Savings Proposals. The Committee requested further information in relation to the following savings proposal:

- A14 – Managing the demand for formal social care and achieving best value in the provision of care packages

1.2 In addition, the Committee discussed its concerns about the following savings proposal in relation to free swimming for 0-16 year olds and those over 60 and felt it would be helpful to have further information:

- A16 – Public Health (not including sexual health, drugs and alcohol)

1.3 Additional information to support these savings proposal is attached to this report at Appendix 1 and 2.

1.4 Any further comments from the Committee in relation to the additional information provided will be considered by Mayor and Cabinet.

2. Recommendation

2.1 The Committee is recommended to note the additional information provided with this report as Appendix 1 and 2.

For further information about this report please contact Joan Hutton, Head of Adult Social Care on 020 8314 8364 or Danny Ruta, Director of Public Health on 020 8314 9094.

Appendix 1

Additional information on Savings Proposal A14 – Managing the demand for formal social care and achieving best value in the provision of care packages

1. Background

1.1 The Care Act 2014 requires local authorities to *'consider the person's own strengths and capabilities, and what support might be available from their wider support network or within the community to help'* in considering *'what else other or alongside the provision of care and support might assist the person in meeting the outcomes they want to achieve'.* In order to do this the assessor *'should look at the person's life holistically, considering their needs and agreed outcomes in the context of their skills, ambitions and priorities'.*

1.2 The Care Act also states that *'Any suggestion that support could be available from family and friends should be considered in the light of their appropriateness, willingness and ability to provide any additional support and the impact on them of doing so'.*

1.3 Taking a person's own strengths and capabilities, alongside their wider support, into account is referred to as using "asset-based approach".

1.4 The objective of using an asset-based approach is to protect the individual's independence and resilience and their ability to make choices and maintain their wellbeing. Supporting the person's strength can help address needs (whether or not they are eligible) for support in way that allows the person to lead, and be in control of, an ordinary and independent day-to-day life as much as possible. It may also help delay the development of further needs.

2. How we are approaching the savings

2.1 For 15/16, the identified savings are being achieved primarily through ensuring that an "asset-based approach" is being taken in relation to packages of care, including residential and nursing home placements. These assessments are being undertaken within a clear framework and resource allocation system that enables the service to manage demands within a reduced budget.

2.2 Multi-disciplinary teams – which bring together social workers, district nurses and other therapies – have been formed and now work more closely together to problem solve and reduce duplication in any care package being delivered. Newly trained support planners now work with the service user and their families/carers to create support plans that maximize resources available within their family network and in the community before calling upon resources available through Adult Social Care. The support planners also assist in market development.

2.3 Specialist Occupational Therapy (OT) resources are working with services users who have high cost double handed packages of care. These service users are often

discharged from hospitals with complex health conditions. Within 6 weeks of discharge OT's work with the service user, families and care workers to reduce double handed visits by using specialist equipment and by providing training to care workers on moving and handling techniques. This more personalized support plan puts the service user back in control of their daily living and effectively reduces the care cost.

2.4 By working closer with specialist health services we are also delivering care in a different way. For example, the Medicine Management Service reviews medication requirements and where possible prescribes medication that only needs to be administered once a day, and therefore reduces the number of care calls a person received during the day.

2.5 We are re-tendering our Domiciliary Care Framework so that providers will deliver assessed needs and agreed outcomes within the service user's personal budget in line with co-produced support plan.

3. Identifying and mitigating risk

3.1 Adult Social Care takes a structure approach to the identification, assessment and management of risk. In addition regular reviews of incidents take place as the total elimination of risk is unrealistic.

3.2 To ensure we identify and mitigate risk associated with providing the right levels of care, the following has been put in place:

- All staff continuously receive training in identifying and mitigating risk.
- Assessments and Support Planning tools identifying risks and mitigating actions are agreed and signed off with service users, families and carers.
- Neighbourhood co-ordinators work with GP's and multi-disciplinary staff to deal with urgent cases where care packages are no longer meeting needs due to declining health and wellbeing.
- All services users have a named key worker to contact should an emergency arise or care is no longer sufficient.
- Dedicated duty desk take calls from service users, their families/friends or care providers and undertake emergency re-assessments should a need or risk be identified.
- Regular monitoring of pre-paid card accounts for those service users managing their personal budgets via direct payments. This ensures expenditure within the accounts is aligned with the service user's identified care needs.
- The Vulnerable Adults (VA) panel considers all applications for care packages to ensure the package meets clients' needs, delivers agreed outcomes and deals with associated risks.
- Specialised risk assessments are carried out on manual handling and enablement care.
- Ault safeguarding process and procedure have been put in place.
- Quality monitoring of care providers is carried out in line with safeguarding and risk management procedures.

4. Work underway in 2015/16

4.1 We are currently undertaking a programme of service user reviews:

- Re-assessment of all care packages using the Resource Allocation System (RAS).
- Reviewing Independent Living Fund (ILF) cases as a result of its discontinuation.
- Reviewing all double-handed care packages
- Reviewing high cost residential packages
- Reviewing high cost nursing packages
- Review of CAT 1 funded care packages
- Review of Laundry service
- Review of Meals on Wheels service

4.2 In any one year there are approximately 4600 Lewisham adults receiving Adult Social Care. From the reviewing programme above, in the first 4 months of 2015/16 (April – July) we have completed 728 reviews achieving a £722k reduction in packages of care. The amount of savings relating to review that have taken place in August and that first half of September will be available shortly.

4.3 By 31 March 2016 we will have completed approximately 3000 reviews and anticipate achieving total full year savings of £2m.

4.4 In 2016/17 and 2017/18 e will continue with the current reviewing regime ensuring that any current service user and all new service users receive an “asset-based” assessment approach as detailed above. We therefore forecast that a further £600k saving can be achieved in 2016/17 and a further £500k in 2017/18.

5. Case Studies

5.1 <u>Case Study 1 – Re-assessment of Independent Living Fund (ILF)</u>

5.1.1 Mr J is a 61 year old Black African-Caribbean man who resides with his father in a two storey maisonette which is on the 3rd floor of a council building.

5.1.2 Mr J has been left with brain injury as a result of having meningitis followed by several strokes in 2001. He presents with difficulty in speech, understanding and communication. His mobility is affected with inability to balance, high risk of falls and difficulty negotiating stairs and needs assistance at all times for personal care.

5.1.3 Mr J currently receives a care package of £495 weekly from the Independent Living Fund to meet his night time care needs, and £235.71 weekly from the Local Authority to meet his daytime care needs.

5.1.4 Analysis of the care package demonstrated that the Local Authority and ILF had been double funding part of the previous package for this service user. Discussions with Mt J’s sister resulted in her offering to order food on line for both Mr J and his father; she also agreed to provide some support with some domestic tasks. Mr J’s church

through their volunteering scheme will now provide 2 weekly visits to church meetings and social events.

5.1.5 Mr J's package of care was re-assessed using the newly introduced assessment tool which resulted in a reduced care by £213.78 weekly. This represented an accurate reflection of his care needs.

5.2 Case Study 2 – Continuing Health Care

5.2.1 Mr G was born in Scotland in 1966. He was involved in a Road Traffic Accident aged 27 when he was a passenger in a car hit by a drunk driver. The accident left him paralysed from the neck down.

5.2.2 Mr G has been known to Lewisham Adult Social Care for nearly 20 years. He has complex health needs relating to the spinal injury which took place in the 90's.

5.2.3 He currently receives a care package of £507.59 weekly from the Independent Living Fund to meet his night time care needs, and £923.59 weekly from the Local Authority to meet his daytime care needs.

5.2.4 A thorough examination and review of his existing care package clearly indicated that the service user may be eligible for Continuing Health Care funding as he would likely score in high Mobility, Continence and Breathing domains. A joint re-assessment took place with a District Nurse and it was determined that Mr G has met the eligibility criteria for CAT 1 funding due to the complex nature of his health needs. Funding responsibility has now moved from Adult Social Care budgets to NHS funding.

5.3 Case Study 3 – Occupational Therapist Re-assessment of care package

5.3.1 Mr X is a 107 year old gentleman that had been experiencing some decline in his abilities to mobilise and carry out activities independently. He requires a lot of prompting and encouragement to carry out his personal care and support with transfers and mobility.

5.3.2 He was admitted to hospital in July 2015 following a fall due to left leg weakness and confusion.

5.3.3 His previous care package before being admitted into hospital as a result of his fall was 1.5 hours care calls daily.

5.3.4 On discharge from hospital his care package was increased to two hours daily (double-handed) – one hour in the morning, half an hour in the afternoon and half an hour late evening to support the service user on discharge.

5.3.5 A re-assessment of his care package was carried out three weeks after discharge by an occupational therapist.

5.3.6 Despite his advanced age, Mr X showed a significant improvement and his care package was reduced to one hour daily.

5.4 Case Study 4 – Re-assessment Adult with Learning Disability

5.4.1 Mr Y is an adult with learning disability who currently lives in a registered residential care home in Kent. Mr Y has no health problem although he is found to have borderline level of cholesterol. He has been advised by his GP to manage his cholesterol with healthy diet and exercise and to quit smoking.

5.4.2 Mr Y can independently manage his personal care needs including shaving. He also independently manages his dressing and undressing needs.

5.4.3 Mr Y reported that his is able to manage some aspects of day to day living activities such as preparing his choice of cold breakfast, sandwich and hot drinks. He also reported that he is able to managed shopping for basic everyday items but needs support to manage large household shopping. He has no mobility issues and travels independently on local buses.

5.4.4 Mr Y participates in many community based activities and spends alternate weekends away from his residential home with his parents in their home.

5.4.5 Mr Y currently receives a residential care package at a cost of £1,309 weekly. A re-assessment of his care needs was undertaken recently and it was identified that his care needs are best met within a supported accommodation environment rather than a residential placement. This was discussed and embraced by Mr Y and his care team to enable him to live more independently.

5.4.6 We are now working to find Mr Y a suitable support living tenancy. His new car costs will be in the region of £470 per week.

5.5 Case Study 5 – Re-assessment due to MDT request

5.5.1 The Community Nurse (CN) telephoned the Neighbourhood Co-ordinator (NC) as she had visited the service user and reported that the service user had a blocked catheter and was being conveyed to hospital. Concerns were also raised that the service user was unable to cope at home, home was in disrepair and the service user was eating takeaway food which was not good for his diabetes. The service user attended A&E and was discharged home.

5.5.2 The service user is housebound due to mobility issues, has a long term catheter and heart condition and is also a diabetic. He also has a visual impairment but this has been undiagnosed as yet. His also has low mood and is socially isolated.

5.5.3 The service user had Enablement input after a lengthy hospital admission UHL and Enablement has recently ended their involvement. The service user seemed very upbeat and well when he was receiving input and support from the Enablement team and therefore deemed to be able to cope without support but when the support was withdrawn the service user was unable to cope.

5.5.4 The Community Nurse noticed on another visit that the service users had a necrotic toe. The Nurse was concerned as it was so bad that she thought that the toe may

need amputating. An ambulance was called and he was conveyed to St Thomas' Hospital.

5.5.5 Whilst the service user was in hospital the Neighbourhood Co-ordinator discussed the case with the Senior Social Worker and also with the Visual Impairment Team Lead to discuss the best way forward for this service user. As the case hadn't come over to the Community team at this stage the Senior Social Worker discussed the case with the Enablement Support Planner and they put in an ongoing package of care consisting of 1 x call a week to assist the service user with light shopping and housework.

5.5.6 The Neighbourhood Co-ordinator also discussed with the Support Planner some of the difficulties the Community Nurses were facing and their concerns about the welfare of the service user which were as follows:

- The service user was having difficulty in reading letters a=due to his visual impairment and some hospital appointments had been missed. There were issues in regards to booking of transport to take him to medical appointments. This was highlighted by the Community Nurse who managed to book the transport for some of his appointments when the service users asked her to read his letters but there were other times when it was too late to book transport and so appointments were not attended, thus being detrimental to the health of the service user. The Neighbourhood Co-ordinator contacted the GP to see if there was a way that the surgery could notify the Community Nurse of any hospital appointments for the service user so that the Neighbourhood Co-ordinator could convey the information to the relevant people but the GP stated that they were only informed of non-attendance of appointment or information after the appointments.

- The Neighbourhood Co-ordinator contacted various departments within the hospital that the service user had appointments with as it was deemed that the service user can read but can only read large, bold font. He requested that any appointment letters be sent out to the service user in the appropriate font to allow him to read the letters and also requested that transport be booked at the time of sending the appointment where possible as the service users was not able to book his own transport unaided.

- Concerns were raised by the Community Nurse in regards to the bedding and clothing of the service user was dirty ad he seemed to be wearing the same clothes for most of the time. It came to light that the service user was unable to operate his washer/drying machine. The Support Planner set up temporary additional support via the Enablement team to work with the Service user to enable him to complete his own washing tasks.

- The service user was unable to complete any shopping tasks due to his poor mobility. The service user had been given Wiltshire Farm Foods information but was unable to complete orders unaided. A regular order was placed on his behalf so that he could access nutritional food and heat the food himself.

- Staff referred the service user to the Podiatrist who visited the service user at home and suggested some more suitable shoes/slippers be purchased to aid the healing process of the service user's toe. The Support Planner liaised with the service user around the purchase of the items required and has arranged to purchase the items for him on his behalf.

- One Support have been assisting the service user with his housing and benefits, completing benefits check to ensure the service user is claiming all that they are entitled to. It came to light that the service user was in rent arrears as he has mislaid his rent card. The Service user was supported to the post office via taxi to withdraw money and paid his rent and clear his rent arrears and also to put money on his gas and electric key and to have some money for shopping which was required. Due to his mobility issues the service user is reluctant to venture out on his own at this current time. One Support has also been supporting the service user to open a bank account and join a credit union to enable the service user to pay his bills via direct debit.

- The Service user also raised concerns in regards to his sash windows and felt that the window would fall on him and the windows do not stay open independently. The Support Planner contacted his housing association and arranged for a site visit. It came to light that the decent homes initiatives but they also found a substantial leak underneath the property which has occurred over a period of time which has a contributed to the damp and overall condition of the property.

- The service user has now been registered on the housing register and a possible property has been identified for him which is in an elderly block on the ground floor, also nearer to the shops. We are awaiting the outcome from Phoenix Housing.

- The Visual Impairment Worker has been to visit the service user. The Service user has been referred to the hospital for a diabetes eye check and we are awaiting the outcome of his appointment.

5.5.7 This case study has not be concluded as yet but to date the service user has benefited from multi-disciplinary team working as the service user was socially isolated and has no family in this country or friends. With input from the Community Nursing Team, Enablement Team, his regular Agency Worker, One Support, Visual Impairment Team, Phoenix Housing, GP and the Neighbourhood Co-ordinator we have worked together to achieve the following outcomes for the service user:

- The service user is now able to read his letters independently due to the larger and bold font.

- We have put in mechanisms for the hospital to arrange transport to permit him to attend appointments therefore saving the NHS money in missed appointments and unnecessary hospital admissions due to appointments being missed.

- The Service user was ordering takeaways and pizzas to be delivered which was having an impact on his health as he is a diabetic. He is now having a volunteer

buy his shopping and is also being supported to order Wiltshire Farm Foods therefore eating a proper balanced diet. The service user can also prepare light snacks and hot drinks independently.

- The service user is able to complete the following household chores independently after Enablement input: operate his washing machine; complete washing of clothes and bedding.

- The service user is more in control of his finances and having bills paid via direct debit.

- Brought to the attention of the Housing Association the problems with his accommodation which highlighted the main leak under the property and that the house had been missed on the Decent Homes Initiative.

- Supported the service user in a possible house move to more suitable accommodation so that the service user is not socially isolated.

- The service user is no longer in receipt of a care package from Adult Social Care but is receiving support from other agencies.

Appendix 2

Additional information on Savings Proposal A16 – Public Health (not including sexual health, drugs and alcohol)

The following information relates to the free swimming element of the above savings proposal.

1. Free Swimming Data

1.1 Free swimming is available in Lewisham for over 60s and children up to 16 years old.

1.2 The number of people accessing it is recorded through the user of library/leisure card. There are concerns about the quality of the data because in some instances reception staff do not always scan the cards or there are issues with the IT systems which record the information.

1.3 In the last financial year 2014/15 just under 14,000 individuals accessed free swims. The total number of free swims in the same period is 66,500. Data from April 2014 to July 2015 showed that the majority of people accessing free swimming go infrequently on average 4.8 times over the 15 month period.

1.4 Over 60s swim more frequently. Males use free swims more than females.

- 8% of the population over 60 accessed at least 1 free swim. 2.3% of the total over 60s population swim at least once a month.
- 23% of the 0-16 population accessed at least 1 free swim over the period. 8.7% of the 0-16 population swims at least once a month.

1.5 The number of people swimming more frequently, at a level which would sustain physical activity levels, is much lower. A more detailed analysis over the most recent period from April 2015 to the end of August 2015 showed that:

- Less than 1% (20 individuals) of 0-16 year olds accessing free swims swam more than 3 times per months under the free swims programme.
- 8.3% of over 60s (133 individuals) accessing free swims went at least 3 times per month.

1.6 Of those swimming frequently (more than 3 times per month) most are from the White ethnic group, although there is a large amount of uncoded ethnicity so this data should be interpreted with caution.

1.7 The numbers of individuals accessing different centres varies. Wavelengths has the highest number of people accessing free swimming, closely followed by Downham. Around 12% of users access more than one site.

2. Children's Swimming Ability

2.1 Children's ability to swim is poor in Lewisham. Most Lewisham primary schools offer at least half a term of swimming during the juniors, usually in years 4 and 5. Children are assessed for swimming ability at this point. From this data it is clear that around half (48%) of children are non-swimmers. This varies by school and centre the children attend and is summarised below. By the end of their KS2 swimming assessment 32% can swim the equivalent of a length of the pool.

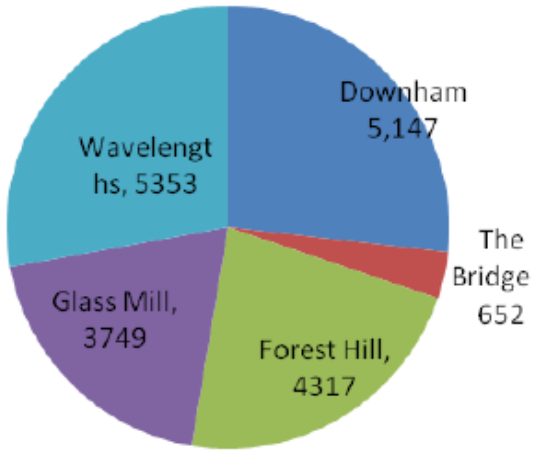
2.2 This poor swimming ability does vary from school to school and is possibly a reflection of the socio economic and cultural status of the pupils and their families but also on the degree of important that the school places upon swimming.

3. Data Tables

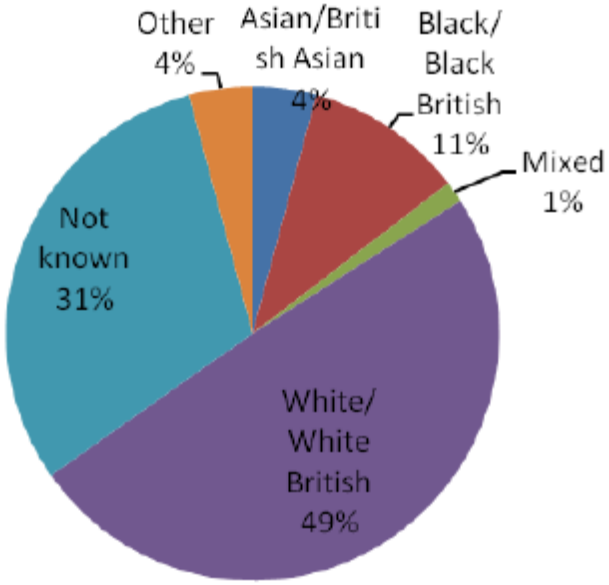
3.1 Table 1: Access to free swimming – April 2014 – July 2015

Persons	No. of people swimming at least once a month	Total no. accessing free swims	% swimming at least once a month	Average no. of swims
0-4	94	1267	7%	2.6
5-16	1316	13250	10%	3.5
Over 60	848	2929	29%	11.5
Totals	**2258**	**17446**	**13%**	**4.8**

3.2 Chart 1: Number of individuals accessing free swims by center April 2014 – July 2015



3.3 Chart 2: Ethnicity of those accessing free swims more than 3 times per month



3.4 Table 2: Swimming ability KS2 school class swimming 2014/15 school year

Centre	Non-swimmers	Able to swim 25m (KS2)	Total number
The Bridge	53%	32%	1653
Forest Hill Pool	25%	48%	1046
Glass Mill	47%	43%	2367
Wavelengths	64%	15%	1808
Downham	50%	23%	1319
Overall	**48%**	**32%**	**8193**

Healthier Communities Select Committee			
Title	Select Committee work programme		
Contributor	Scrutiny Manager	Item	7
Class	Part 1 (open)	14 October 2015	

1. Purpose

To advise Members of the proposed work programme for the municipal year 2015/16, and to decide on the agenda items for the next meeting.

2. Summary

2.1 At the beginning of the municipal year, each select committee drew up a draft work programme for submission to the Business Panel for consideration.

2.2 The Business Panel considered the proposed work programmes of each of the select committees on 28 April 2015 and agreed a co-ordinated overview and scrutiny work programme. However, the work programme can be reviewed at each Select Committee meeting so that Members are able to include urgent, high priority items and remove items that are no longer a priority.

3. Recommendations

3.1 The Committee is asked to:

- note the work plan attached at **Appendix B** and discuss any issues arising from the programme;
- specify the information and analysis required in the report for each item on the agenda for the next meeting, based on desired outcomes, so that officers are clear on what they need to provide;
- review all forthcoming key decisions, attached at **Appendix C**, and consider any items for further scrutiny.

4. The work programme

4.1 The work programme for 2015/16 was agreed at the Committee's meeting on 21 April 2015.

4.2 The Committee is asked to consider if any urgent issues have arisen that require scrutiny and if any existing items are no longer a priority and can be removed from the work programme. Before adding additional items, each item should be considered against agreed criteria. The flow chart attached at **Appendix A** may help Members decide if proposed additional items should be added to the work programme. The Committee's work programme needs to be achievable in terms of the amount of meeting time available. If the Committee agrees to add additional item(s) because they are urgent and high priority, Members will need to consider

which medium/low priority item(s) should be removed in order to create sufficient capacity for the new item(s).

5. The next meeting

5.1 The following reports are scheduled for the meeting on 8 December 2015:

Agenda item	Review type	Link to Corporate Priority	Priority
The state of the local health economy	Standard item	Active, healthy citizens	Medium

5.2 The Committee is asked to specify the information and analysis it would like to see in the reports for these items, based on the outcomes the committee would like to achieve, so that officers are clear on what they need to provide for the next meeting.

6. Financial Implications

There are no financial implications arising from this report.

7. Legal Implications

In accordance with the Council's Constitution, all scrutiny select committees must devise and submit a work programme to the Business Panel at the start of each municipal year.

8. Equalities Implications

8.1 The Equality Act 2010 brought together all previous equality legislation in England, Scotland and Wales. The Act included a new public sector equality duty, replacing the separate duties relating to race, disability and gender equality. The duty came into force on 6 April 2011. It covers the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

8.2 The Council must, in the exercise of its functions, have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not.
- foster good relations between people who share a protected characteristic and those who do not.

8.3 There may be equalities implications arising from items on the work programme and all activities undertaken by the Select Committee will need to give due consideration to this.

9. Date of next meeting

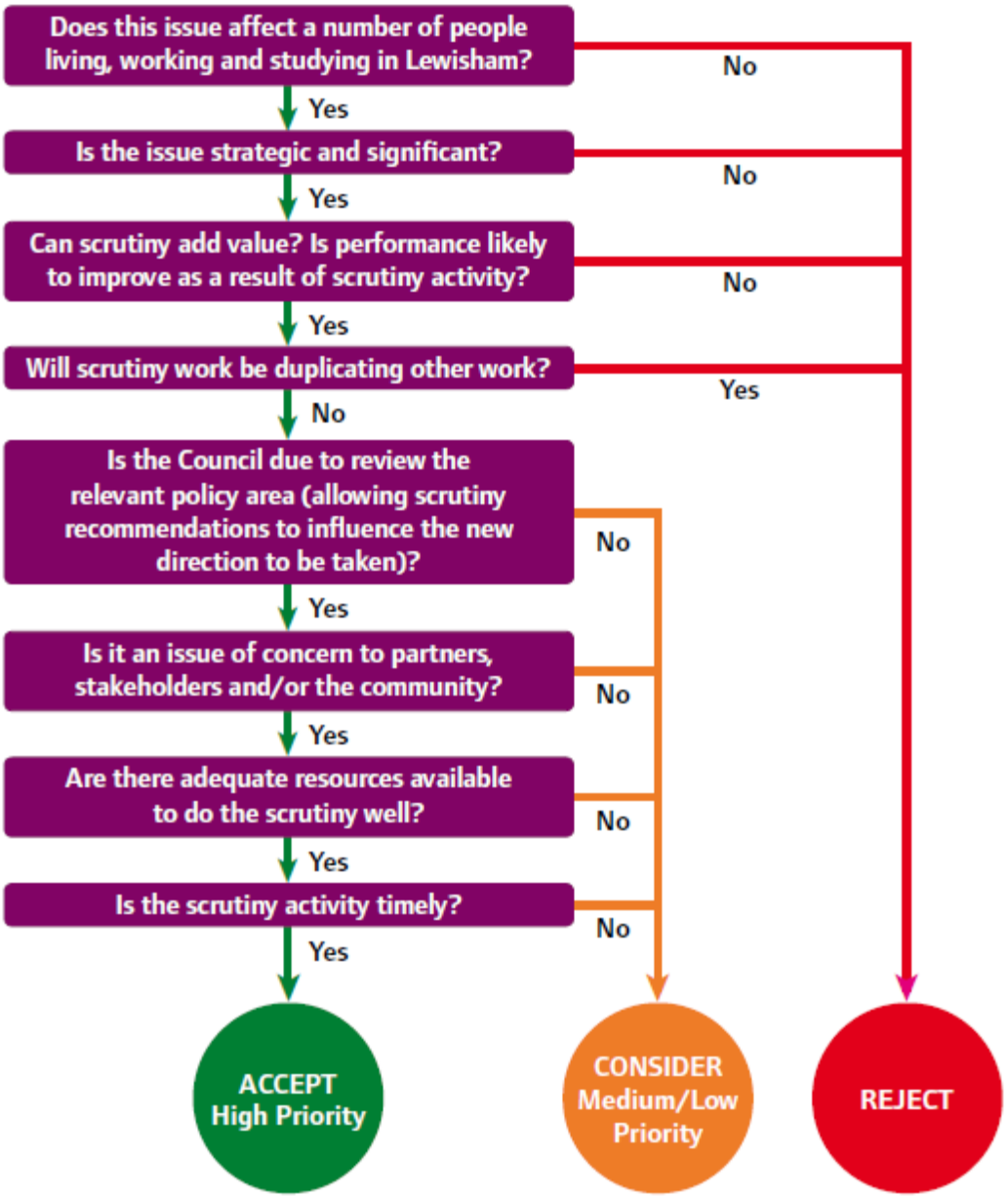
The date of the next meeting is Tuesday 8 December 2015

Background Documents

Lewisham Council's Constitution

Centre for Public Scrutiny: the Good Scrutiny Guide

Scrutiny work programme – prioritisation process



FORWARD PLAN OF KEY DECISIONS

Forward Plan November 2015 - February 2016

This Forward Plan sets out the key decisions the Council expects to take during the next four months.

Anyone wishing to make representations on a decision should submit them in writing as soon as possible to the relevant contact officer (shown as number (7) in the key overleaf). Any representations made less than 3 days before the meeting should be sent to Kevin Flaherty, the Local Democracy Officer, at the Council Offices or kevin.flaherty@lewisham.gov.uk. However the deadline will be 4pm on the working day prior to the meeting.

A "key decision"* means an executive decision which is likely to:

(a) result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates;

(b) be significant in terms of its effects on communities living or working in an area comprising two or more wards.

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
August 2015	**Community Budget: Establishment of a joint committee between Lambeth, Lewisham and Southwark**	21/10/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
September 2015	**Making of instrument of Government The Governing Body of te Leathersellers Federation of Schools**	21/10/15 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
August 2015	**New Homes Better Places Programme Update**	21/10/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
February 2015	**Review of Licensing Policy**	21/10/15 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Rachel Onikosi, Cabinet Member Public Realm		
August 2015	**Lewisham River Corridor Improvement Plan Supplementary Planning Document**	21/10/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
June 2015	**Homecare Contracts Extension**	21/10/15 Mayor and Cabinet	Aileen Buckton, Executive Director for		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
		(Contracts)	Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
September 2015	**Beckenham Place Park Golf Course Contract Extension**	21/10/15 Mayor and Cabinet (Contracts)	Kevin Sheehan, Executive Director for Customer Services and Councillor Rachel Onikosi, Cabinet Member Public Realm		
August 2015	**Re-procurement of Sexual Health Services (GUM)**	21/10/15 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
November 2014	**Award of Highways Public Realm Contract Coulgate Street**	21/10/15 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
September 2015	**Interim arrangements for Project Management Support to the School Places programme**	21/10/15 Mayor and Cabinet (Contracts)	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
June 2015	**Woodvale Contract award**	21/10/15	Kevin Sheehan,		

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		Mayor and Cabinet (Contracts)	Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
August 2015	**Annual Complaints Report 2014/15**	11/11/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Joe Dromey, Cabinet Member Policy & Performance		
August 2015	**Annual Parking Report**	11/11/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Rachel Onikosi, Cabinet Member Public Realm		
	Beckenham Place Park Consultation	11/11/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Rachel Onikosi, Cabinet Member Public Realm		
June 2015	**Capital and Revenue Budget Monitorig**	11/11/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2015	**Children and Young People Plan**	11/11/15 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and		

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			Councillor Paul Maslin, Cabinet Member for Children and Young People		
August 2015	**Discharge into the Private Rented Sector**	11/11/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
September 2015	**Disposal of Land at corner of Deptford Church Street and Creekside**	11/11/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2015	**Heathside & Lethbridge Housing Regeneration Scheme update Parts 1 & 2**	11/11/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
August 2015	**Homelessness out of Borough Locational Priority Policy**	11/11/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
	Horniman Museum Heritage Lottery Fund Proposal	11/11/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		

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August 2015	**Housing-Led Regeneration Opportunities Parts 1 and 2**	11/11/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
September 2015	**National Non Domestic Rates - Discretionary Discount Scheme for Businesses Accredited to Living Wage**	11/11/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		
	The 2020 Programme	11/11/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
	School Minor Capital Works Programme 2016	11/11/15 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
September 2015	**Sheltered Housing Investment and Improvement Update**	11/11/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
September 2015	**Voluntary Sector Accomodation Implementation**	11/11/15 Mayor and Cabinet	Aileen Buckton, Executive Director for		

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	Plan Consultation Parts 1 and 2		Community Services and Councillor Joan Millbank, Cabinet Member Third Sector & Community		
	Working Skills strategy	11/11/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
	Annual Report on Energy Prices	11/11/15 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2015	**ICT Shared Service Update**	11/11/15 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
	Award of Homecare Contracts	11/11/15 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
	Public Health Contracts for Health Checks and Sexual Health Promotion	11/11/15 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and		

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			Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
August 2015	**Children and Young People Plan**	25/11/15 Council	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
August 2015	**Lewisham River Corridor Improvement Plan Supplementary Planning Document**	25/11/15 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
February 2015	**Review of Licensing Policy**	25/11/15 Council	Aileen Buckton, Executive Director for Community Services and Councillor Rachel Onikosi, Cabinet Member Public Realm		
August 2015	**Copperas Street Depot - Disposal**	09/12/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
June 2015	**Council Tax Reduction Scheme 2016-17**	09/12/15 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia,		

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			Cabinet Member Resources		
August 2015	**Parks Events Policy 2016- 2020**	09/12/15 Mayor and Cabinet	Councillor Alan Smith, Deputy Mayor and Councillor Rachel Onikosi, Cabinet Member Public Realm		
	Planning Service Annual Monitoring Report 2014-15	09/12/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
June 2015	**Revenue Budget Savings**	09/12/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2015	**Section 75 arrangements for Children and Young People**	09/12/15 Mayor and Cabinet	Kath Nicholson, Head of Law and Councillor Paul Maslin, Cabinet Member for Children and Young People		
June 2014	**Surrey Canal Triangle (New Bermondsey) - Compulsory Purchase Order Resolution**	09/12/15 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
	Youth Service Mutual	09/12/15 Mayor and Cabinet	Sara Williams, Executive Director, Children and		

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			Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
September 2015	**FM Contract Structure and Procurement approach**	09/12/15 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
September 2015	**FM Compliance Contracts Structure and Procurement approach**	09/12/15 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
September 2015	**Extension of Security (CIS Security Limited) & PPM (Interserve Facilities Management) Contracts**	09/12/15 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
	Prevention and Inclusion Contract	09/12/15 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Janet Daby, Cabinet Member Community Safety		
	Resouce Link Contract Extension	15/12/15 Overview and	Janet Senior, Executive Director for Resources &		

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		Scrutiny Business Panel	Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
	Setting the Council Tax Base, the NNDR Base and Discounts for Second Homes and Empty Homes	13/01/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2015	**Determination of the applications to establish a neighbourhood forum and to designate a neighbourhood area for Lee Green**	13/01/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2015	**Determination of the applications to establish a neighbourhood forum and to designate a neighbourhood area for Deptford**	13/01/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
May 2015	**Formal Designation of Crystal Palace & Upper Norwood Neighbourhood Forum and Area**	13/01/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
September 2015	**Determined School Admissions Arrangements for 2017/18**	13/01/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young		

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			People		
	Award of Contracts Tier 4 Services and Day Programmes People with Substance Misuse Services	13/01/16 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Janet Daby, Cabinet Member Community Safety		
	Setting the Council Tax Base, the NNDR Base and Discounts for Second Homes and Empty Homes	20/01/16 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
June 2015	**Council Tax Reduction Scheme 2016-17**	20/01/16 Council	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		
June 2015	**Capital and Revenue Budget Monitoring**	10/02/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2015	**Housing Allocations Policy**	02/03/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		

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Healthier Communities Select Committee work programme 2015/16 — **Programme of work**

Work item	Type of item	Priority	Strategic priority	Delivery deadline	21-Apr	25-Jun	09-Sep	14-Oct	12-Nov	08-Dec	13-Jan	02-Mar
Lewisham future programme	Standard item	High	CP9	On-going			Savings		A14 and A16			
Confirmation of Chair and Vice Chair	Constitutional req	High	CP9	Apr								
Select Committee work programme	Constitutional req	High	CP9	Apr								
SLaM specialist care changes	Consultation	High	CP9	Apr								
Health and social care integration	Standard item	Medium	CP9	Apr								
Healthwatch annual report	Standard item	Medium	CP9	Jun								
Development of the local market for adult social care services	Standard item	Medium	CP9	Oct								
CQC update	Standard review	Medium	CP9	Jun								
Day centres consultation	Standard review	High	CP9	Jun								
Reinvesting Public Health savings	Standard item	Medium	CP9	Sep								
Public health annual report	Performance monitoring	Medium	CP9	Sep								
LCCG commissioning intentions	Standard review	Medium	CP9	Oct								
Transition from children's to adult social care	Standard review	Medium	CP9	Jun								
Delivery of the Lewisham Health & Wellbeing priorities	Performance monitoring	Medium	CP9	Nov								
Lewisham hospital update	Standard item	Medium	CP9	n/a					removed			
Leisure centre contract	Performance monitoring	Medium	CP9	Jan								
Implementation of the Care Act	Standard review	Medium	CP9	Jan								
Community education Lewisham annual report	Performance monitoring	Medium	CP9	Mar								
Adult safeguarding annual report	Standard item	Medium	CP9	Mar								
Campaign in Lewisham for Autism Spectrum Housing	Information item	Medium	CP9	Mar								
Lewisham and Greenwich NHS Trust Quality Account	Standard item	Medium	CP9	Jun								
South East London Strategy	Standard review	High	CP9	Ongoing								
Adult Social Care Integration - All Member briefing	Information item	Medium	CP9	Oct								
SLaM CQC Inspection report	Performance monitoring	Medium	CP9	Mar								
State of the local health economy	Information item	High	CP8	Dec								
DNAs review	In-depth review	High	CP9	Mar								

	Item completed
	Item on-going
	Item outstanding
	Proposed timeframe
	Item added

Meetings					
1)	Tue	21 April	5)	Thu	12 November
2)	Thur	25 June	6)	Wed	13 January
3)	Wed	9 September	7)	Wed	2 March
4)	Wed	14 October			

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