ISLINGTON

Chief Executive Department
Town Hall, Upper Street, London N1 2UD

Report of: The Director of Public Health

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	16th July 2014	Item	All

Delete as appropriate	~~Exempt~~	Non-exempt

SUBJECT: Update on progress against the Joint Health & Wellbeing Strategy priorities

1. **Synopsis:** This paper sets out an update on activities and progress on the three Health and Wellbeing Board (HWB) priorities, specifically in relation to the Joint Health and Wellbeing Strategy. The three priorities are: (1) ensuring every child has the best start in life; (2) preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities; and (3) improving mental health and wellbeing. The updates that follow are for the period between July 2013 (when the last update on priorities came to the Board) and July 2014.

2. Recommendations

The Health and Wellbeing Board is asked to:

- NOTE progress against the Health and Wellbeing Boars three priorities;
- CONSIDER how, as a Board, it can support and promote these activities and programmes to enhance their impact.

3. Background

3.1 This update focuses on activities and progress on the three Health and Wellbeing Board priorities, and is framed within the context of the Joint Health and Wellbeing Strategy and the specific outcomes set out in that document. It is not intended to provide a comprehensive overview of all of the work currently underway across the borough that contributes towards the delivery of these three priorities, but instead highlights some of the significant developments in the last six months. The three HWB priorities are;

- ensuring every child has the best start in life;
- preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities;
- improving mental health and wellbeing.

3.1 Priority 1: Ensuring every child has the best start in life

First 21 months:

- Four Children Centre cluster areas have been funded as learning pilots and are starting to develop the projects and pathways with midwifery and health visiting. These are Finsbury, Canonbury, Highbury and Holloway. A brief has been developed outlining the approach across all the clusters and the specific projects they are developing. Two of the four pilots focus specifically on how to identify and support vulnerable families with potentially poor outcomes, during pregnancy and in the baby's first year of life. All the pilots have some focus on user involvement to understand parents' experiences of the maternity care pathway to help shape service delivery.

- Further work streams for the programme include:

    - Children's Services ICT and data team has produced a report outlining options for enabling interconnectivity in Children's Centres for health professionals. This has been funded by Islington's CCG. These are now being consulted on with Whittington Health and UCLH as to the viability of these plans. Once agreement is reached a pilot will be undertaken within Children's Centres. The first 21 months advisory group is the project board for this project.
    - All GP practices in Islington have been approached to receive a visit and presentation from their local children's centre cluster to hear more about the wide range of services (including healthy start distribution) which are available.

Child Weight Management

- MoreLife's weight management programme has completed a full year and is established with all potential referrers in the borough. 10 week programmes are run every quarter with Holiday clubs held on a termly cycle. Over 330 children and young people participated over the last 12 months. The programmes have been very successful with 86% of 4-12s, 79% of teenagers 13-17, and 90% of those with complex needs found to have reduced weight on completing their programmes. Of those that attended holiday clubs 73% recorded a reduced weight.
- Ensuring those coming into contact with families are aware of available programmes and how to discuss healthy weight is an important part of an effective weight management pathway. Raising the issue of weight training was held for those working across Islington in July. The training was well attended and the feedback from participants very positive. Further sessions will be held later in the year.
- Public Health is working closely with MoreLife, Healthy Schools, School nursing and National Child Measurement programme supported by the communications team to implement a local obesity campaign to promote the service and increase awareness around healthy weight. The campaign will coincide with National Child Obesity week (July 13-17), which will also benefit from national media promotion from Public Health England.

- In response from feedback from service users, the eligibility criteria requiring a parent or carer to attend the weight management programme has been adapted for young people. This reflects their their need for greater autonomy and has improved the numbers engaging with services over the course of the year.
- A remaining challenge is finding suitable (affordable) premises from which to deliver the programme in the north and south of the borough.

Teenage pregnancy

The teenage pregnancy rate has continued to decline and is now 30.1 which is not significantly different to Inner London (28.5). A social marketing campaign promoting PULSE services was undertaken by peer recruiters trained by Brook and Pulse staff. A 'network model 'of sexual health services has been developed across Camden and Islington and is currently out to advert with expectation of new contracts being in place April 2015. This model will strengthen the pathway way across both boroughs and ensure consistency of service and identification/support of vulnerable young people. Young people's sexual health service will all be tier 1 and 2 in the new model so young people will be able to access the full range of tests that can only currently be accessed through GUM.

National Child Measurement Programme (NCMP):

The NCMP is a joint mandatory initiative between Public Health England (PHE) and the local authority. Children in reception year (aged 4-5 years) and year 6 (10-11 years) are invited to participate in the programme. Height and weight are recorded to calculate the child's BMI for age percentile. This data enables the Public Health team to identify the number of pupils across the borough who are underweight, healthy, overweight or very overweight.
The results from last year were collated and compared to previous years and to the rates across London and England. The analysis was distributed in December 2013 by the Health and Social Care Information Centre (HSCIC).

The key findings from 2012/13 include –

- During 2012/13, 100% of invited schools participated in the programme.
- 1,742 reception and 1,370 year 6 were measured, which equates to 92% of eligible children.
- In reception 12.1% reception children were identified as overweight (210 children). There has been a reduction in the proportion of children identified as overweight in Islington, compared to previous years, but it is premature to confirm that there is any trend in the data. 10.7% of reception children were identified as very overweight. This figure has dropped from 2010/11 but shows a slight increase compared to the 2011/12 rate.
- In year 6, 13.6% of children were found to be overweight in Islington – again this demonstrates a drop, but it is too early to demonstrate a trend. 21.8% of year 6 were identified as very overweight, but again the figures are not clearly showing steady downward pattern as the prevalence fluctuates annually.

Last year, following the measurement programme, the school nurse team were able to offer contact and support to the very overweight pupils in the reception classes. This year, to build upon previous year's successes, Camden and Islington Public Health will provide extra resource to enable the School Nurse team to contact all overweight and very overweight children, identified through the measurement programme, and offer support and referral to local weight management programmes.

Healthy Start Vitamins Pilot:

Healthy Start is a national scheme aiming to improve the nutrition of families and pregnant women on low incomes. Beneficiaries of the Healthy Start scheme receive Healthy Start vouchers which can be spent on fruit, vegetables, milk and Healthy Start vitamins. Every two months the recipient receives a Healthy Start vitamin voucher, which can be exchanged for free infant drops or maternal tablets. Vitamin drops for infants and children contain vitamin A, C and D. Vitamin tablets for pregnant and breastfeeding mothers contain vitamin C, D and folic acid.

Within Islington a pilot programme was run during 2013 which provided healthy start vitamins free of charge to all breast feeding women and children aged 0 to 4 years in Islington. The programme which was jointly funded by Islington CCG and Public Health was very successful. The uptake of Healthy Start vitamins among those eligible for free vitamins increased by around 20% during the pilot and overall there has been more than a four-fold uptake in Healthy Start Vitamins. The Universal supplementation programme is therefore continuing at 16 distribution sites across the borough. The aim over the forthcoming year is to optimise distribution in these centres and then to roll out universal distribution to further children's centres. Public Health is currently developing approaches to target promotional activity and increase awareness.

Immunisation:

- There has been significant improvement over the years with childhood immunisation rates. Immunisations in 5 year olds are traditionally lower across London and England and Islington has worked hard to improve rates locally with a `12% increase observed between 2010/11 and 2013. Islington has excellent uptake of one year DTaP/IPV/Hib vaccinations for a deprived London borough. Islington is one of the few areas in London above the World Health Organisation's standard uptake of 95%.

- Work is being undertaken to increase the immunisation rates in communities where this is lower compared to the Islington average. Two projects include DVDs to raise awareness within the Somali population and also in school aged children that are eligible for the HPV vaccination.

Oral Health:

- In 2013/14, the Islington community-based fluoride varnish programme delivered a total of 13,578 fluoride varnish applications to 3-10 year olds. The provider exceeded the annual target by 13%.
- Over 10,500 fluoride toothpaste and toothbrush packs were distributed to parents of young children through the Brushing for Life scheme.
- 129 Islington dental staff received training in prevention, including child behaviour management.

Challenges and priorities over the next year:

-To increase fluoride varnish programme consent rate in those schools with lower than average consent rate.

-To encourage more parents (especially in 'harder to reach' groups) to take children to the dentist for regular check-ups.

-To procure a joint Camden and Islington OHP service.

Breastfeeding:

- Islington's breastfeeding prevalence (the percentage of infants being breastfed at the 6-8 week check either totally or partially) rates have remained at a consistent and steady increase since 2011 by 1% annually from 73% in 2010/11 to 75% in 2012/13, which is higher than the England average 47.2%.

- The breastfeeding support service in Islington made 7076 contacts to 3180 mothers in 2013. The type of contacts included telephone support, visits to mothers on the postnatal ward (UCLH and Whittington) and drops-ins at Children Centres, baby clinics and home visits. The service uses a range of peer supporters from within the local community who represent the diversity of Islington's population. The breastfeeding support service for Islington was re-procured to The Breastfeeding Network (BFN) in April 2014 for three years.

- The UNICEF UK Baby Friendly Initiative provides a recognised and accredited framework to support women to initiate and continue to breastfeed and to promote practices that will maximise early child development. Assessment is carried out in three main stages and Islington achieved Stage 2 accreditation in December 2013 and stage 3 assessment is planned for January 2015.

Priority 2: Preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities

Integrated care

- Islington CCG and Islington Council were awarded Pioneer Status as part of the Department of Health's Integrated Care Programme in November 2013. During the past few months, both organisations have been working together on developing a more integrated approach to health and social care within the borough with the aim of improving people's experience of care and their health and wellbeing outcomes. Some key areas where there has been progress as part of the Integrated Care Pioneer Programme Plan are:

- **MDT working**
  A multi-disciplinary team (MDT) teleconference service has been in place for over a year across the four Islington localities and during this time over 250 highly complex patients have been reviewed. The teleconference provides the opportunity for different professionals to come together to discuss individual patients. In addition to this we have invested in the new role of "Local Service Navigator", recruited through the voluntary sector, who support patients with their goals.

- **Self-management**
  One of the key outcome measures for integrated care, and key strategies to improve the management of Long Term conditions in Islington, is to promote self-care by supporting people to become more confident in their own abilities to manage their conditions.

  The LTC6 survey, a tool developed by the Department of Health, is used to measure this for people with long term conditions. Our target in 2013/14 was for 75% of people feeling supported to manage their long term condition. Of the 47,476 questionnaires sent out we had a response rate of c25% with 11,721 patients responding. We were delighted with this and also the fact that we exceeded our target with 84% feeling supported.

- A **Patient Activation Measure**, a validated tool used to help understand and link patient activation, subsequent behaviour and graded need for support is being implemented in Islington for all patients registered with a long term condition. This will enable the commissioning of tailored self-management support informed by a co-produced implementation plan**.**

- **Care Planning**
  Islington is committed to the implementation of care planning for all patients with long term conditions. This is a radical shift in the way that consultations are delivered in primary care, by providing the patient with greater information about their condition in advance of their consultation and empowering them to develop a care plan and set goals jointly with their GP at an extended appointment. The goals are then followed up several weeks later to provide extra support. The aim is to empower patients allowing them to take charge of their condition rather than relying on a previously paternalistic approach to disease management.

  The new diabetes locally commissioned service was used as the mechanism to embed care planning through the Year of Care consultation. This is already reaping rewards with positive feedback from patients who feel more confident about managing their diabetes.

Long-term conditions pathways

A number of long-term condition pathways have been developed and implemented with local patients, primary and secondary care, and public health to standardise and implement best practice.

- **COPD pathway**

New developments include:

- o A COPD acute exacerbation pathway was launched last year providing rapid domiciliary multidisciplinary support for COPD patients who have had an acute exacerbation and who are vulnerable to further deterioration and admission to hospital.

- o A COPD rehabilitation and self-management programme for newly diagnosed COPD patients who have MRC 1& 2 and not eligible for Pulmonary Rehabilitation has just been commissioned as a two year pilot and was launched in June 2014.

- o Specialised Stop Smoking support for COPD housebound patients has been commissioned for a further two years following a successful one year pilot.

- o A one year pilot of the COPD Nurse Champions Network was completed in December 2013. The Network was led by the Integrated Respiratory Consultant and Community Respiratory team and aimed to improve COPD care by sharing existing knowledge, developing relationships between primary and secondary care, and providing a mechanism for support from the Islington Specialist COPD team. Planning is underway to develop a Long Term Conditions Nurse Champions Network to continue up skilling of practice and community nurses in the management of LTCs.

- **Diabetes pathway**

A new primary care locally commissioned service for diabetes commenced in February 2013 with the aim of implementing “Year of Care” care planning within patient consultations. This approach provides patients with a longer consultation with their GP and early access to test results, thereby facilitating a more informed discussion with their clinician.

The Diabetes steering group has overseen a number of other initiatives for diabetic patients in Islington, including access to a new web based self-management programme (HeLP-DIABETES), another self-management resource in Turkish, Somali and Bengali, as well as a local pharmacy service designed to ensure optimisation of diabetes medication.

- **Kidney Disease**

A particularly innovative pathway, based on one of the Health Foundation's SHINE projects, commenced in February 2014. It is uses software to identify the early signs of kidney deterioration in patients with diabetes and hypertension and ultimately it should reduce the number of patients on kidney dialysis.

Diabetes Value Based Commissioning

- Islington CCG is working in collaboration with Haringey CCG on a pilot project to implement a Value Based Commissioning (VBC) approach to diabetes service provision. This approach seeks to ensure that the patient's own outcomes are treated as the main driving force for the overall service pathway (known as an Integrated Practice Unit – IPU).

- Value Based Commissioning aims to achieve an overall benefit to the patient rather than concentrating on a number of separate medical and process indicators to measure success. The outcomes are built around agreed patient goals e.g. I want to be able to do the things I want to do & I want to feel in control of my condition.

- Work has progressed over the last few months on developing the IPU with engagement from all stakeholders who have interest in diabetes services in Haringey and Islington. A final draft version of the design is currently being reviewed by the VBC steering group.

- A business case will be drafted by the end of August and financial modelling is currently being undertaken which will help support this document. If the business case is then accepted by the NCL Chief Officers' group, the IPU will go out to procurement for service commencement in April 2015.

Long-Term Conditions Locally Commissioned Services

- Three new locally commissioned services (LCS) supporting case finding, secondary prevention and management of long term conditions including diabetes, chronic kidney disease, hypertension, and depression were developed and launched in 2013. These services complement the successful COPD locally commissioned service that has now been running for three years. Uptake of these services has been promising and delivery will continue until November 2014.

- Patient at high risk of diabetes are now also being identified and provided with on-going review and monitoring to prevent the development of diabetes.

- A holistic health check for people aged 75 and over, designed to improve case finding and improve signposting to social care, seasonal health support and other functional services, was also implemented across primary care in Islington.

- Islington CCG are now working to develop a Long Term Conditions Locally Commissioned Service (LCS) which will combine the most effective elements of each of the current LCSs, and will be launched in December 2014. The aim is to provide a more integrated and person-centred experience, particularly for those people with multiple long term conditions.

NHS Health Checks Programme

The NHS Health Checks programme has continued to perform well in Islington, with 11,828 health checks offered (exceeding target by 32%) and 6,945 checks delivered in 2013/14.

- Islington is the 4th best performing London borough and ranks 9th out of 152 Local Authorities in England. Health checks are key to lowering people's risk of developing four common but often preventable diseases: heart disease, stroke, diabetes and kidney disease.

- In addition to GP surgeries, checks have been delivered in a range of settings to increase uptake amongst population groups at greater risk e.g. people living in social housing or areas of high deprivation, unemployed people and carers.

- Islington has seen a 32% reduction in deaths from cardiovascular disease (CVD) over the past 5 years, and the NHS Health Checks programme, which aims to identify people at high risk of CVD early and to provide appropriate intervention to manage and their risk, could have made a contribution to this decline by targeting those at the highest risk first. Now in the 5th year of programme implementation, we are focussing on ensuring that Islington residents identified as being at high-risk of developing CVD receive appropriate support to reduce their risk.

Cancer

- Public Health are running a cancer awareness campaign within community pharmacies in Islington. 60 pharmacy staff across 23 Pharmacies attended the Cancer Research UK training session and are taking part in the campaign. In the first three months of the campaign 1300 conversations were had with customers and 140 people were advised to see their GP because of their symptoms.

- A dedicated primary care facilitator is continuing to support Islington GP practices on the early diagnosis of cancer. To date, 70% of practices in Islington have been visited by the facilitator.

- "Get to know cancer" pop-up stalls were held in the summer of 2013. Nurse consultations were had with over 2,600 people and 98% of people asked said they found the stall useful.

- The Islington Cancer Survivorship Exercise Programme, which is offered free to Islington residents who have been diagnosed with cancer, has been re-commissioned for another 3 years. In 2013, the programme won a Quality in Care (QiC) Excellence in Oncology Award in the category 'Improving the quality of life and experience of care for people living with cancer'.

Lifestyles and behaviour change

Physical activity and weight management

- Public Health re-commissioned exercise on referral in 2013. The 3 year contract for Exercise on Referral, awarded to Aquaterrra Leisure, commenced in January 2014. To date referrals are higher than achieved in the same period last year and the service is on target to achieve 1200 starters in the first year.
- The recommendations from research to explore the decline in physical activity among residents aged 40+ were shared with ProActive Islington in June. Among the findings was a reported lack of confidence to exercise due to limited knowledge of the types of exercise which could be undertaken safely. Proactive will consider how to fill this gap and address the other findings at its meeting in September. The insight research can be found on Islington's Evidence Hub
- The Adult Weight management programme is now well established with over 430 overweight and obese adults accessing the service in the first year, achieving a 64% completion rate. Of

those completing, more than one in four successfully sustained a 5-10% weight loss 3 months after programme completion

Tobacco Control

- The NHS Stop Smoking Services commissioned from Whittington Health achieved 95% of the quit target for 2013-14 recording 2123 successful 4-week quitters. This can be partly explained by fewer people accessing services and the impact of e-cigarettes. London and England data is not yet available, but anecdotal feedback from the region suggests that few boroughs hit their 13/14 targets.

- Work has begun with the community service, Clinical Commissioning Group and Local Pharmacy Committee to identify the measures that can be put in place to improve performance during 2014/15

- The first joint meeting between Camden and Islington on tobacco control was held in February, led by the lead members for Health and Wellbeing in each borough. Camden and Islington stakeholders from Community Safety, Regulatory Services, Whittington Health, Solutions4Health, and pan London agencies including the Fire Service and Public Health England worked together to identify areas for collaborative action. There was also agreement that Camden & Islington would combine to form a joint Smokefree Alliance, with its inaugural meeting taking place in July to consolidate a new action plan for the next two years

- The ASCOT service (for people with severe mental illness) has recently completed its first year of operation offering a quit service to some of the heaviest tobacco consumers in the borough. They have engaged 113 service users, 65 of whom either stopped smoking or reduced their smoking by at least 50%. 83% of the first cohort of quitters remained smoke-free at 12 months

Alcohol

- Alcohol awareness training for non-specialists has been re-commissioned with the current provider HAGA. Between April and June 2014, more than 70 resident-facing professionals were trained, including professionals from the psychological therapies service; victim support; the stop smoking service; and job centres. They gave positive feedback on the training and will use the skills they learned raising awareness of alcohol harm with their clients and signposting to the alcohol service.

- Community awareness raising events took place throughout 2013/14. Dry January was advertised and promoted throughout the council and the borough and Alcohol Awareness Week was marked with stalls at Town Hall and in Nag's Head / Angel shopping areas.

- www.dontbottleitup.org.uk continues to be available for all Islington residents. In 2013/14 over, 500 Islington residents received personalised advice on their drinking. The website has been redesigned for 2014 and now features enhanced content including motivational videos. This work is supported by alcohol 'pop-ups' in the borough which will be taking place at Community events throughout the year.

- Joint work between licensing and public health remains a priority with projects including: an evaluation of Reducing the Strength; tracking and responding to licensing applications and reviews from a public health viewpoint; and an evaluation of the Cumulative Impact Areas. The

joint work between licensing and Public Health to ensure health data is assessed as part of the licensing review process was identified as an example of good practice across London.

Priority 3: Improving Mental Health & Wellbeing

- There has been a continued annual increase in the number of people accessing psychological services with 4288 patients entering treatment in 2013/14. The service is on track to reach a national target of 15% of those with common mental health problems by March 2015. Health Equity Audits of the services show that historically under-represented groups, such as men, people living in deprived communities and people from Black Caribbean groups, are now well represented amongst service users. This is achieved through targeted initiatives to promote awareness and to tackle stigma and discrimination associated with mental health.
- Programmes designed to improve understanding and awareness of mental illness and encourage early identification continue to operate locally through the provision of mental health awareness training, the mental health champions' project and the direct action project. These specifically target hard-to-reach communities and young people. Further flexibility has been added the mental health awareness training programme by offering both Mental Health First Aid training and other shorter and bespoke courses to front line staff such as housing workers and teachers.
- The development of a new suicide prevention steering group has progressed, and this group will oversee a pathway review which will in turn inform a new suicide prevention action plan. An eight-year suicide audit has been completed of 151 suicides in Islington during this period which will inform the review. The opportunity to develop a shared approach to suicide prevention with Camden is likely to be realised. Islington Mental Health and Poverty Networking Forum led a workshop on suicide prevention in February to raise awareness of current issues and share good practice. The workshop was attended by over 100 people representing a wide range of statutory and voluntary organisations.
- Public health has led a review of the quality, content and scope of mental health awareness training within schools. This has resulted in the development of a co-ordinated approach to mental health awareness in secondary schools including teacher training, a new scheme of work for pupils in year 9 and a new information booklet for young people. The steering group for this work are now developing with schools a new approach to increasing pupils' and staff emotional resilience through whole school systems. The model will be piloted in a small number of schools with the help of UCL Partners, with the aim of all schools then learning from the development of good practice. The work has involved a close partnership between Public health, school improvement and CAMHS as well as the voluntary sector, school nursing and educational psychology.
- Islington Mental Health and Poverty Networking Forum and Islington Faiths Forum, with the support of the local authority and public health, hosted a conference in March to examine the impact of poverty and welfare reforms on mental health. The conference made a strong case for the dis-proportionate impact of welfare reform on people suffering from mental ill-health, and also between mental ill health and poverty (low income, troubled life and poor outcomes). The conference brought together voluntary and community groups (mainly service providers), service users and statutory agencies with an interest in addressing mental health and poverty related issues.
- Public Health has worked closely with colleagues in joint commissioning to provide knowledge and intelligence in a number of areas including a major review of crisis care and of dual diagnosis in 2013-14. Public health will be collaborating further this year in CCG reviews of talking therapies and of day opportunities for people with mental health problems. Public health has also been providing health intelligence support to a new local programme of value-based commissioning. The Value Agenda moves the focus towards achieving patient outcomes, and away from volume and activity, which is how most healthcare services are currently commissioned. Public health will be helping to define appropriate outcomes.

- Islington Clinical Commissioning Group has made a number of new investments in 2013/14. Many of these support the public health agenda including:
    - Procurement of a new community development worker service from Hillside clubhouse. This service will identify and address inequalities in mental health and address some of the barriers faced by people from excluded communities.
    - A new contract for Dementia Navigators which has been awarded to Camden & Islington Foundation Trust
    - New long-term conditions matrons working with people with serious mental illness to address poor outcomes from physical illness.
    - Implementation of a smoke free site at Highgate mental health centre
    - A new parental mental health service to support the families in need agenda

4. Implications

4.1. **Financial implications**

None Identified.

This paper provides an update across a wide range of programmes and services being delivered by various organisations including the Council and the CCG in support of the Health and Wellbeing Board's priorities

4.2. **Legal Implications**

Section 193 of the Health and Social Care Act 2012 inserted new section 116A into the Local Government and Public Involvement in Health Act 2007, which imposes a duty on the Council and the CCG to produce a joint health and wellbeing strategy for meeting the needs identified in the joint strategic needs assessment.

4.3. **Equalities Impact Assessment**

This paper provides an update across a wide range of programmes and services being delivered in support of the Health and Wellbeing Board's priorities. Consequently there is no separate EIA relating to this report. Reducing health inequalities is an underpinning principle across the Board's three priority areas, and the report identifies the ways in which the interventions, services and programmes described are being tailored and targeted to reduce health inequalities.

4.4. **Environmental Implications**

None identified.

5. Conclusion and reasons for recommendations

The Health and Wellbeing Board is asked to:

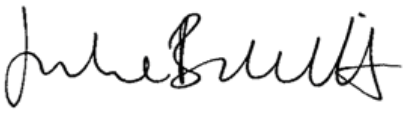
- NOTE progress against the Health and Wellbeing Boars three priorities;
- CONSIDER how, as a Board, it can support and promote these activities and programmes to enhance their impact.

Background papers:

Attachments:

Final Report Clearance

Signed by



8th July 2014

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