

# Healthy Communities Scrutiny Sub-Committee

Wednesday 4 March 2015

7.00 pm

Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1  
2QH

## Supplemental Agenda

### List of Contents

Item No.	Title	Page No.
4.	<b>Minutes</b>  A summary of the decisions made at the committee meeting held on 27th January 2015 are attached.  At the last meeting follow up information was requested on the A&E performance item. The briefing attached provides supplementary information on emergency re-admission rates and on emergency department staffing. This document has been completed by Southwark Clinical Commissioning Group (CCG), King's College Hospital Foundation Trust (KCH) and Guy's and St Thomas' Foundation Trust (GSTT).	1 - 10
5.	<b>Public Health Annual Report</b>  Dr Ruth Wallis, Director of Public Health, will present the attached Public Health Annual Report.	11 - 44

### Contact

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Date: 27 February 2015

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<b>8.</b>	<b>Changes to local health services</b>	<b>45 - 54</b>
	Andrew Bland, Chief Officer, Southwark Clinical Commissioning Group (CCG) will present the following reports:	
	1. An update on extended primary care access (covering both north and south Southwark)	
	2. A paper written by Guy's and St. Thomas' (GSTT) on the impact of planned service moves in north Southwark.	
<b>10.</b>	<b>Review 2 Personalisation</b>	<b>55 - 57</b>
	Healthwatch will present the attached report on work with carer's on Personalisation.	

# Supplementary information Request: A&E Performance Review

Southwark Healthy Communities Overview and Scrutiny sub-Committee

For Information

The February 2015 meeting of the OSC Committee requested supplementary information upon Emergency re-admissions and workforce at the two local Emergency departments serving residents (Denmark Hill and St Thomas' Hospital sites)

## Emergency readmissions

Emergency readmissions rates are one of a number of performance indicators that commissioners and providers review to assess the effectiveness and quality of discharge from hospital alongside others e.g. Delayed Transfers of Care

When considering emergency readmission rates it is important to consider the rate, underlying trends and the cause of the emergency readmission (whether it was for the same or a different condition to the original admission) and whether it was avoidable. Commissioners audited avoidable readmissions in 2014 and approximately 20% of local emergency readmissions were considered to have been potentially avoidable on a whole systems basis.

Emergency readmissions rates at GSTT and KCH have been broadly static and in overall terms are not considered to be a driver of current performance challenges at either Trust.

## Workforce / Staffing

Staffing levels are one of the key metrics that providers and commissioners monitor, with vacancy rates, recruitment and retention, sickness and safe staffing levels as key areas of focus Trust wide and at individual department / service level.

A&E Departments are challenging areas in terms of recruitment and retention of staff although vacancy rates for A&E are not out of line with overall Trust vacancy rates. Both hospitals undertake regular and targeted recruitment drives to ensure posts are filled substantively wherever possible.

Where there are substantive vacancies both hospitals utilise bank and agency staff to ensure rotas are filled and that staffing levels are safe – internal monitoring of staffing levels identifies any 'red risk shifts' - shifts where staffing levels are considered to be too low so that immediate action can be taken.

**Our commissioner assessment is that substantive staffing vacancies are not a material contributory factor to the current A&E performance challenges at either St Thomas' or King's College Hospital Denmark Hill A&Es.**

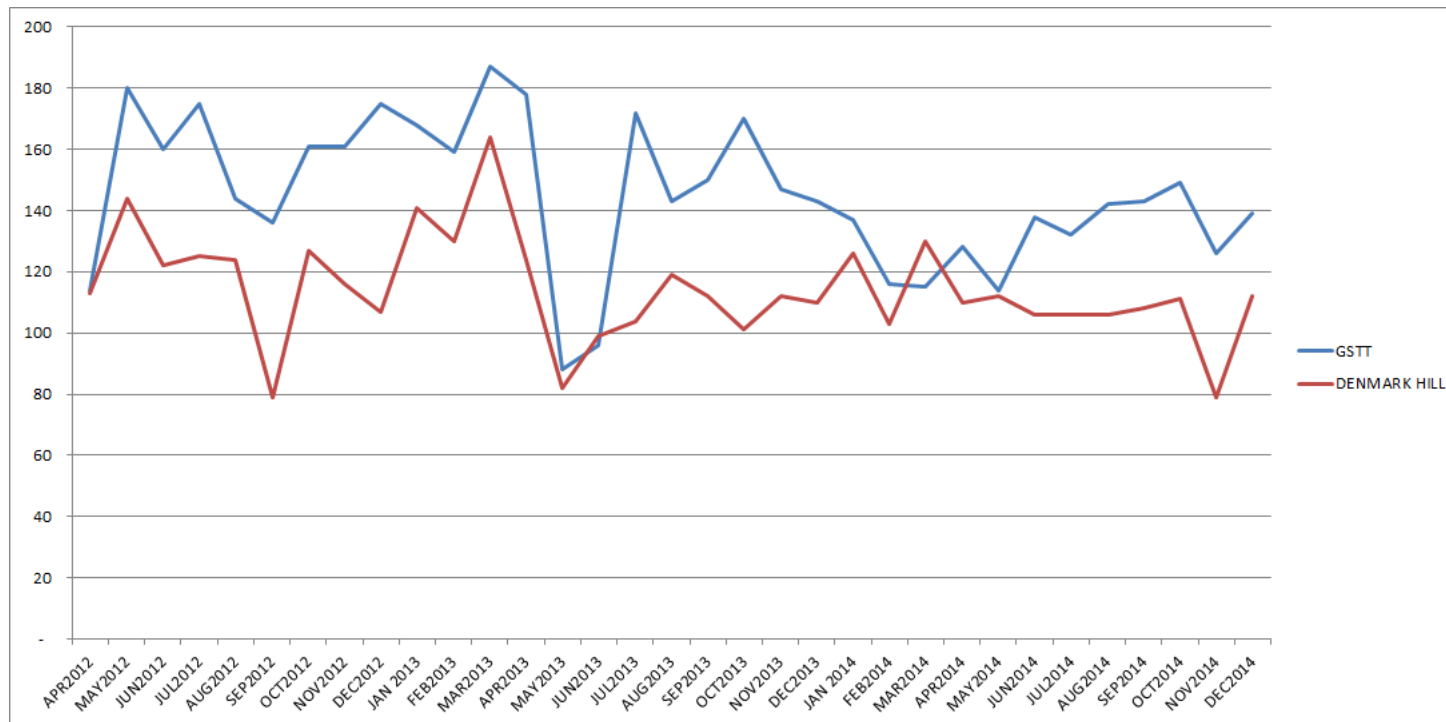
# Re-admissions within 30 days

Southwark Healthy Communities Overview and Scrutiny sub-Committee

For Information

# 30 day readmissions: Southwark patients

- A definition of 30 days readmission is set out in NHS England guidance on Payment by Results (PbR). The emergency re-admissions guidance excludes certain criteria from the data (e.g. cancer diagnoses, admissions of under 4s, renal re-admissions).
- The table and graph below shows the numbers of Southwark patients readmitted to either GSTT or KCH (Demark Hill site only) within 30 days of hospital discharge.
- The data here is the total activity count and not a readmission rate. It should not be used to compare performance between the trusts. The data sets out the number of monthly readmissions since April 2012 and is not adjusted for days in the month.



# Emergency Departments - Workforce

Southwark Healthy Communities Overview and Scrutiny sub-Committee

For Information

## A&E consultants – 0% vacancy rate.

Currently the KCH Denmark Hill site has zero consultant vacancies against this years budget. A business case by the Emergency Department (ED) is being developed to increase the current establishment by 3 whole time equivalents (WTEs) to support an increase in ED 'shop floor' presence from 8am through to midnight 7 days per week. The additional 3 consultants will provide more support for the junior staff and ensure a more timely senior decision maker to aid the flow through the department to discharge or refer patients appropriately.

## A&E junior doctors (%) – 10.4% vacancy rate

Budgeted posts (WTE)	61.95
Actual – in post (WTE)	55.73
Vacancy (WTE)	6.22

- In quarter 3 the Emergency Department at Denmark Hill received two resignations, one junior doctor is on maternity leave and one other doctor went off on long term sickness.
- The department has since advertised the vacant posts however no candidates were suitable for appointment in that process.
- The department continues to fill the vacant slots on the rota by offering vacant slots to the Trusts doctors as additional shifts and utilises locums doctors when available to cover any gaps. The department is routinely able attract junior locum doctors to cover the vacant slots on most occasions.



## Qualified A&E nursing staff – 18.5% vacancy rate

Budgeted posts (WTE)	177.93
Actual – in post (WTE)	145.01
Vacancy (WTE)	32.92

The department continues to recruit with rolling adverts for qualified nursing staff. The Trust has recruited 12 WTEs over the past month and the individuals are on track to take up the respects posts by the end of the current financial year.

Sickness for Q3 increased during month of December, 5 WTE staff members on long term sick during Q3. Sickness is reviewed monthly by HR and ED nursing management team. Maternity leave accounted for 3.45 WTE staff during Q3 and is predicated to decrease to 2 WTE in Q4.

Sickness and vacant posts are filled with a combination of in house 'bank' and external agencies. ED at Denmark Hill currently uses a regular pool of agency staff on set lines to help support stability, safety and continuity of the staffing levels

## Qualified A&E clinical support staff – 13.43% vacancy rate

Qualified A&E clinical support staff include the following groups : Health Care Assistants and Emergency Department technicians.

Budgeted posts (WTE)	21.08
Actual – in post (WTE)	18.25
Vacancy (WTE)	2.83

## A&E consultants – vacancy rate of 10.2%

GSTT are mid-way through a recruitment campaign to expand consultant numbers. The trust appointed locums at the end of Q3 and this impacted on the vacancy rate at the time.

## A&E junior doctors – vacancy rate of 5.7%

It is of note that during Q3 the trust experienced significant pressure with a reduction in CT3 and ST4+ doctors. The ED had two CT3 doctors in post, against an establishment of 4 and five ST4+ doctors against an establishment of 7.

## Qualified A&E nursing staff - vacancy rate of 17.5%

The department has recruited to all but 9 posts and these are in the recruitment pipeline, due to commence in February 2015. The trust is actively involved in a six week recruitment cycle to mitigate the risk of staff attrition rate. It is of note that there is currently a high maternity leave component, equating to 13.5 WTE which impacts bank 7 agency usage.

## Qualified A&E clinical support staff –vacancy rate of 0.0%

Apart from a Play Specialist , there are no staff members within the department that fall under this category.

## SUMMARY OF DECISIONS AND ACTION ARISING

**NAME OF MEETING:** HEALTHY COMMUNITIES SCRUTINY SUB-COMMITTEE – OPEN

**DATE OF MEETING:** TUESDAY 27 JANUARY 2015

The following is a summary of the decisions taken at the above meeting and identifies the action arising. The first named officer is the person responsible for initiating and co-ordinating the action required.

Clarification or queries on any points should be raised in the first instance with Julie Timbrell

Item No.	Title/Summary of the decisions	Action
1	<b>APOLOGIES</b>	
	There were no apologies for absence. Councillor Paul Fleming gave apologies for lateness.	
2	<b>NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT</b>	
3	<b>DISCLOSURE OF INTERESTS AND DISPENSATIONS</b>	
4	<b>MINUTES</b>	
	<b>RESOLVED</b> That the minutes of the meeting held on 8 December 2014 were agreed as a correct record.	
5	<b>ACCIDENT &amp; EMERGENCY PERFORMANCE</b>	
	<b>RESOLVED</b> The CCG will provide information on KCH and GST emergency ward :	
	<ul style="list-style-type: none"> <li>• Re-admission rates</li> <li>• Staffing levels and any issues</li> </ul>	

Item No.	Title/Summary of the decisions	Action
6	<b>ANNUAL SAFEGUARDING REPORT</b>	
	<b>RESOLVED</b>	
	Reports on the following will be provided	
	<ul style="list-style-type: none"> <li>- A response to the recommendation that there is a union representative on the Safeguarding Board to represent staff</li> <li>- Work being undertaking to encourage Safeguarding awareness amongst frontline staff, such as caretakers , housing officers and refuse workers.</li> <li>- Service user engagement with the Safeguarding Board and its work programme</li> </ul>	
7	<b>REVIEW 2: PERSONALIZATION</b>	
	<b>RESOLVED</b>	
	<p>Healthwatch will be invited to give evidence on behalf of service users</p> <p>Information given to Patient Opinion will be considered.</p>	
8	<b>UPDATE REPORT ON A &amp; E SUPPORT FOR HOMELESSNESS</b>	
9	<b>UPDATE REPORT ON CHANGES TO KING'S COLLEGE HOSPITAL ELECTIVE CARE</b>	
10	<b>WORK-PLAN</b>	



**Public Health Report  
for Southwark**









*Director of Public Health  
Annual Report 2013-14*

**NHS**

**Southwark**

**Clinical Commissioning Group**

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			Update on recommendations from last years APHR p.64

## Preface

Being well, healthy and happy is something that is affected by so many different areas, as this report so clearly shows. Where we live; who we know; where we go to school; even whether we are near green spaces or how much time we spend outside. That's why making Councils responsible for leading public health is a wonderful opportunity for us all to work together to really make a difference to the lives of our residents.

I really welcome this report from our public health team, both for the recognition it gives to areas where we are pioneering new approaches to being well, including our commitment to providing free swim and gym, and for the very useful suggestions it gives as to how we can work together to improve health.

Here at Southwark Council we passionately believe that everyone should be able to make the most of the opportunities available in this amazing, vibrant borough. The health of our population is at the heart of our commitment to deliver a fairer future for all. There is of course so much more to do, but with so much exciting work already happening in the borough and a real energy to find new ways to tackle our health problems, we are getting closer to achieving that goal.

**Clr Barrie Hargrove**  
Cabinet Member for Public Health, Parks and Leisure

# Foreword

“This has been an exciting time for public health, with councils being well placed to give strategic leadership and forge local partnerships to act on the shared goal of seeing the health of Southwark and Lambeth residents protected, sustained and improved.”

Southwark and Lambeth have quite similarly diverse populations and have seen great improvements in overall health over the last 50 years, but health inequalities still remain in both boroughs. While we can be proud of the many public health successes in Southwark, such as the improvement in life expectancy and reduction in infant mortality and in teenage pregnancy, we still have considerable work to do to reduce health inequalities. Working alongside council colleagues and other partners to do this will require new ways of working, harnessing the unique potential of directly influencing many of the external factors which result in health inequalities.

The annual public health report for this year aims to highlight the main health inequalities in Southwark and what may be driving them. A combination of the Marmot Framework and Dahlgren and Whitehead model will be used as a structure, detailing issues which public health departments are best placed to address in collaboration with other functions of local authorities and their partners. The conditions in which we live and work, lifestyle factors which affect health, and variations in healthcare will therefore be the main areas of focus in this report.

Where possible, for the topic areas covered, the report picks up on existing health inequalities, outlines the published evidence which supports action to address them, describe what is happening in Southwark at the moment and recommend what more can be done in the future. I'm grateful for the expert contributions from the PH specialist team.



**Dr Ruth Wallis**  
Director of Public Health



### Acknowledgements:

Hiten Dodhia	Veronika Thiel	Geraldine McCormick	Rosie Dalton-Lucas	Miriam McGrath
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Claudia Craig	Kate Bisset	Anna Richards	Alison Furey	
Marie Vieu	Abdu Mohiddin	Bimpe Oki	Sarah Corlett	

We welcome your comments & feedback: [PHAdmin@southwark.gov.uk](mailto:PHAdmin@southwark.gov.uk)

# Key recommendations

The key recommendations from this report reflect the widening role of public health. Implementing these recommendations will require partnership working with many agencies.

- 1 Prevent widening economic inequalities and work to sustain the financial resilience of residents through structural interventions, with the most critical being the promotion of the London Living Wage across our local employers.
- 2 All employers in the borough should be encouraged and supported to adopt good practice in relation to health and safety compliance and evidence-based workplace health programmes.
- 3 Public sector employers engaged in workplace health initiatives should be encouraged to share their knowledge and expertise with other employers as well as using their commissioning and procurement processes to encourage compliance with legislation and good employment practice.
- 4 Homeless prevention services need to reach not only those seeking statutory assistance, but also to others in critical housing situations, living in unstable or unsuitable accommodation and to those facing substantial housing need.
- 5 Work towards a co-ordinated and strategic system to identify those most likely to be at risk of food poverty and ensure that individuals and families at risk are signposted to the appropriate support services.
- 6 The universal care pathway from conception to early years in Southwark should be reviewed and strengthened using the London Maternity Standards and the Healthy Child Pathway to ensure we provide services which are fair for all and appropriate for everyone's needs
- 7 The council and Southwark CCG extend their engagement with school head teachers and governors to develop a sustainable strategy which improves young people's health and wellbeing and enables them to make healthy lifestyle choices.
- 8 Social relationships and community development should be made policy priorities.
- 9 Referral pathways for smoking cessation need to be developed for priority groups such as those with long-term conditions and mental health issues. These should be implemented along with measures to increase quit rate, prevent relapse and promote targeted community action against illegal sales, to particularly benefit those from disadvantaged groups.
- 10 Investigate whether existing interventions and services designed to prevent and reduce harm and treat substance misuse are actually reaching those most likely to be affected. We also need to ensure that the services follow the National Institute for Health and Care Excellence (NICE) guidelines shown to be effective and good value for money.
- 11 Agree and invest in a long-term approach to improve healthy weight.
- 12 The promotion of physical activity should routinely be incorporated into building, planning, social, transport, school and workplace strategies and policies. Policies should enable people to include physical activity in their everyday lives. Some population groups are less likely to be active and targeted programmes should be considered.
- 13 Comprehensive sex and relationship education should be implemented in all schools in Southwark as part of an integrated Health and Wellbeing Programme.
- 14 Improve coverage in the cancer screening programmes in Southwark, particularly in the bowel screening programme.

HEALTH IN OUR COMMUNITY

# Introduction health and health inequalities

“The social conditions in which people live powerfully influence their chances to be healthy. Indeed, factors such as poverty, food insecurity, social exclusion and discrimination, poor housing, unhealthy early childhood conditions, and low occupational status are important determinants of most diseases, deaths and health inequalities between and within countries”<sup>1</sup>.

(Commission on the Social Determinants of Health, WHO, 2004)

## Health and health inequalities

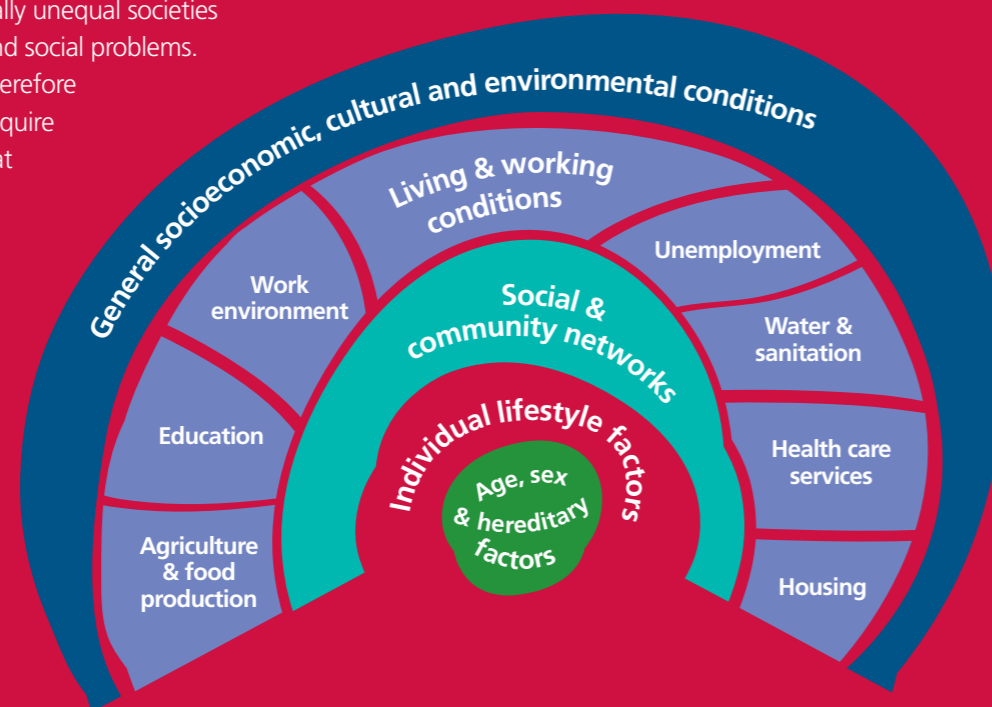
Health is not just the outcome of genetic and biological processes, but is also influenced by our social and economic conditions, the “wider determinants of health”.

**Health inequalities** are the unfair and avoidable differences in health status and outcomes between different population groups. These inequalities result from variations in the distribution of socioeconomic determinants of health, such as education, employment, and housing. The effects of these and other factors accumulate throughout the life cycle.

Health inequalities follow a socioeconomic gradient, i.e. the risk of illness and early death increases with increasing levels of deprivation. This means that more economically unequal societies have worse health and social problems. Health inequalities therefore affect all of us and require us to take actions that support a range of population groups.

## Wider determinants of health in the current socioeconomic climate

The recent welfare reforms, austerity measures and the economic downturn have affected disadvantaged communities the most. Making more affordable housing available and strengthening financial resilience are therefore priority actions to stop health inequalities from increasing further. Promotion of the London Living Wage across all public services, the provision of debt and welfare advice, referrals to appropriate agencies, and targeted hardship payments are all interventions that will lessen the mental and physical health impacts of economic deprivation.



**Figure 1:**  
The layers of influence on an individual's health<sup>1</sup>

## Health inequalities in Southwark

Important gains have been made in the overall health of the borough. However significant inequalities in health still remain.

### Not every resident lives as long as they could

Southwark residents live longer than they did 10 years ago and live almost as long as people in England overall. Healthy life expectancy for men in Southwark is 2.6 years lower than in England, and 4 years lower for women<sup>2</sup>.

However, in Southwark in 2010, women in the least deprived areas of the borough were living 7.3 years longer than women in the most deprived areas. The difference for men was 7.1 years.

### Child deaths

The risk of a child dying before his/her first birthday in Southwark is similar to that in England (4.2 children per 1000 live births die in Southwark compared to 4.1 in England). We do not have data for intra-borough inequalities, but a national analysis of infant mortality showed that infant deaths tend to be higher in deprived areas, among babies of mothers born outside the UK, if the mother is under the age of 20, if the baby is born to a single mother, and for those whose parents work in routine and manual jobs<sup>3</sup>.

## A fairer future for all

In 2014 Southwark Council made ten Fairer Future promises, aimed at making Southwark a fairer place to live, where all residents have the opportunity to fulfil their potential. Southwark's approach underlines the importance of addressing the wider social economic determinants of health through improving the quality of local housing, creating jobs and supporting training, raising educational achievement, improving the physical environment and revitalising neighbourhoods.

## What can be done to address health inequalities?

In a fair society, health should not be determined by where people are born, where they live or how much they earn. Provision of services which are fair for everyone will lessen the health impacts of the socioeconomic inequalities.

Local councils and health service commissioners and providers should carry out equity and equality impact assessments to ensure that service delivery is tailored to patients' needs without inadvertently making inequalities worse. They should conduct systematic impact assessments of all strategies, policies and new contracts to ensure that those most at risk are targeted appropriately. Health equity audits can also be used to check how fair services are.

Improving housing and financial resilience are priorities that all sectors can contribute to as employers and service-providers.

The local council, together with partners, can lead on financial resilience. The NHS can contribute by ensuring early detection and effective management of long-term conditions, mental health, and infectious diseases, taking into consideration the socioeconomic background of the patients. As an employer, the NHS can contribute to the local economy and ensure that all employees, including contracted support services, are paid the London Living Wage.

Councils can also contribute to preventing some of the risks, for example, by ensuring good quality standards of housing, and preventing overcrowding. Creating equity will take time and the current drive to reduce health inequalities needs to be sustained to ensure good lives for all.

### References

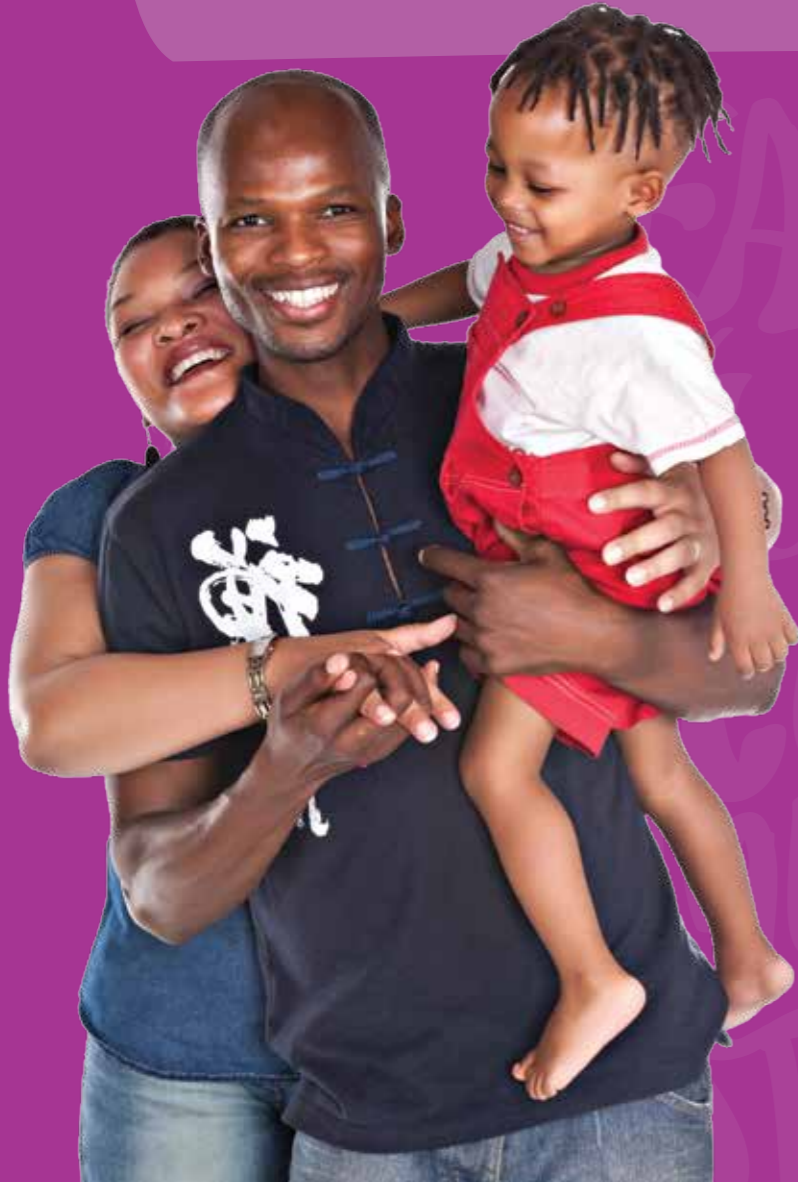
- <sup>1</sup> World Health Organisation (2004). Commission on Social Determinants of Health – Note by Secretariat; Geneva: WHO. Available at [http://apps.who.int/gb/archive/pdf\\_files/EB115/B115\\_35-en.pdf](http://apps.who.int/gb/archive/pdf_files/EB115/B115_35-en.pdf) [Accessed 26th August 2014]
- <sup>2</sup> Lambeth and Southwark Public Health Team (2013). Joint Strategic Needs Assessment (JSNA), 2013. Life Expectancy Factsheet.
- <sup>3</sup> Department of Health (2010). Tackling health inequalities in infant and maternal health outcomes. London, Department of Health. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/215869/dh\\_122844.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215869/dh_122844.pdf) [Accessed 26th August 2014]



In this section we look at ...

The conditions in which we live and work have a significant impact on our health and wellbeing. Differences in these factors and the health inequalities that result will be the focus of this chapter.

Statutory bodies, for example, the local councils and NHS services, come into contact with people throughout many of their life stages, and in some instances have a large impact on their working and living conditions. Therefore, we will also highlight where statutory bodies can work to address health inequalities resulting from differences in living and working conditions, both now and in the future.



## 1.1 Income, work and poverty

### Key messages

- 1 Low and insecure income affects health not only through material deprivation, but by generating unhealthy behaviours and stress. Most importantly, poor health in childhood can lead to poor adult health, meaning that low income can have long-lasting negative effects across generations. Thus, economic inequalities are contributing to the social gradients of illness and death.
- 2 Preventing and lessening the health impact of economic inequalities requires structural and personal interventions over the short and medium term. Promoting healthier working and fairer employment conditions as well as decent wages will contribute to reduce economic inequality. In the short-term, we need to strengthen financial resilience, while we develop interventions aimed at improving economic equity.

### Key recommendations

1. We need to bolster the financial resilience of those on low incomes, particularly among the most deprived, by providing individual targeted interventions, such as access to financial and welfare advice services and support to manage stress, depression and anxiety.
2. We need to prevent widening of economic inequalities and work to sustain the financial resilience of residents through structural interventions, with the most critical being the promotion of a healthy living wage.
3. Health professionals should strengthen their links with social and welfare services by:
  - Recording the social status of patients
  - Linking with social and welfare services
  - Using their roles as managers, employers, and commissioners or service-providers to offer good quality work, employ local people to commission or procure local services, and to pay the London Living Wage.

## What's the issue?

Overall, Southwark's population is becoming more affluent, but this masks income and employment inequalities.

### Economic activity and inactivity

The majority of residents are economically active\* (75% of working age residents), in employment† (60% of working age residents) and in a well-paid job<sup>1</sup>.

Since the economic downturn in 2008, more people in Southwark are working in relatively well-paid jobs (social classes 1-3), and fewer have manual or unskilled jobs (social classes 8 and 9). In line with the trend in London, more people in Southwark are self-employed (11% in Southwark vs. 12.2% in London)<sup>2</sup>.

The proportion of adults claiming Job Seekers Allowance (JSA) is now 3.2% of working-age residents in Southwark<sup>3</sup>. The model-based unemployment rate in Southwark has increased from 8.1% in January 2008 to 10.3% in March 2014.<sup>3</sup>

### Employment and income inequalities

Despite some of these changes, the following employment and income inequalities exist within Southwark:

- Women are less likely to be in employment than men (57.4% vs. 74.3%). This represents a bigger gap in comparison to London
- Women's wages have always been lower than men's, but the gap in earnings increased from £52.4 per week to £80.4 per week between 2002 and 2014.<sup>3</sup>
- Overall, Londoners in black and minority ethnic groups are more likely to be unemployed (black) or economically inactive (Pakistani and Bangladeshi) than their white counterparts.<sup>4</sup>
- Just over 30% of children in Southwark live in poverty<sup>5</sup>, which is higher than in London overall (26.7%). Child poverty is more common in lone-parent families.

Table 1: employment, unemployment and inactivity in London by ethnic group, 2011

Broad ethnic group	Employment rate	Unemployment rate	Economic Inactivity rate
White	73	7	21
Black	57	20	29
Indian	69	9	24
Pakistani/Bangladeshi	54	15	37
Mixed or multiple	57	16	33
Chinese & Other	61	11	32
All Ethnic Minority	60	14	30
All	68	10	25

Source: GLA Intelligence Unit, 2012/Quarter 1 – Quarter 4 2011 (4 Quarter Average) Labour Force Survey

\*Economically active refers to people who are either in employment or unemployed.

†In employment refers to people who did some paid work in the census reference week (whether as an employee or self employed); those who had a job that they were temporarily away from (e.g. on holiday); those on government-supported training and employment programmes; and those doing unpaid family work.

### Effects of the welfare reforms

The welfare reforms have added to the stress of the economic downturn, affecting the most vulnerable in the borough, with a high risk of increasing health inequalities. Currently, 13.8% (29,810 people) of the adult working population in Southwark claim at least one type of benefit, but the ongoing reforms put this income at risk and weakens households' financial resilience in the absence of work that pays enough to cover the high costs of living in the capital.<sup>6</sup>

Southwark Council conducted an in depth analysis of the top 380 households affected by the reform. While they represent 1% of the housing benefit caseload, they accounted for 41% of all discretionary support granted in 2013/14 to the Housing Benefit caseload (including DHP, Emergency Support and Hardship Funds, and section 17 payments).

The primary risk factor identified was arrears in rent and council tax payments. The majority of these households were affected by several welfare benefit changes. Key risk factors for the top 380 are single or disabled men and women aged between 36-49 and 50+, and claiming ESA or JSA. Average arrears for these groups range between £3,400 and £6,400, significantly greater than the £1,488 average for the top 380. Tax credits and self-employment appear to have limited impact against building arrears.

### Consequences of unemployment and income inequalities

The direct and indirect health impacts of unemployment and income inequalities include<sup>8, 9</sup>:

- Increased stress and anxiety, and an increase in domestic violence
- Unhealthy lifestyles, such as an increase in alcohol consumption and dependency, smoking, and unhealthy eating, all risk factors of cardiovascular disease and cancers
- Effects on physical health such as respiratory and infectious diseases resulting from fuel poverty and overcrowding. This could lead to an increased use of health services especially acute hospital admissions. Fuel poverty is likely to increase as households face competing financial priorities. Over 7,000 households in Southwark are living in fuel poverty (6.4 % of all households). However fuel poverty is unequally distributed throughout the borough<sup>9</sup>.

## Local case study

Southwark Council is tackling income inequality through its support for a London Living Wage. Only 12 Councils in London, including Southwark, have been formally accredited by the Living Wage Foundation to pay their own staff a Living Wage. Southwark Council has also taken the decision to extend the London Living Wage to contractors and agency staff. Since the Council gained Living Wage accreditation, almost 1,200 staff members, including both inhouse staff and those working for contractors, have seen a wage increase as a direct result of the council's commitment to the London Living Wage.

## What can we do about it?

The following evidence-based measures can be employed in the short and medium term to address the health inequalities that result from employment and income inequalities in Southwark:

### • Short term measures:

- Identify early financial pressure and refer people quickly and effectively to welfare and financial advice through general practices and other well-placed front line services. This approach will ensure that mitigating interventions are offered to the most vulnerable patients before their health situation deteriorates further.
- Increase financial resilience of households and families affected by the welfare reforms.
- Ensure that all staff (direct or commissioned) have access to advice if they are receiving benefits.
- Ensure that all staff in public services and services contracted are paid the London Living Wage.
- The living wage is an hourly minimum wage, optional for employers, calculated according to the basic cost of living. In 2013 the London living wage was £8.80 and the UK living wage was £7.65. Adopting the living wage has been shown to improve psychological health and wellbeing among employees and increase life expectancy.<sup>10</sup>

### • Medium term measures:

- Facilitate the availability and provision of good quality and affordable childcare for Southwark residents.
- Establish capacity for clinicians to take patients' social history<sup>11</sup>.
- Include the routine collection of patients' social status by clinical and social care staff by building on research concerning the recording of socioeconomic status previously performed in Southwark.
- Establish capacity among frontline health care professionals to identify health problems directly related to socioeconomic conditions such as domestic violence.
- Broaden public health messages to include the importance of the social determinants of health relating to income, work and poverty.

## What's happening at the moment?

There are a number of innovative initiatives being undertaken in Southwark to combat income and employment inequalities.

- **“Rightfully yours”** is providing welfare and benefit advice to people with disabilities or long-term conditions, including people with mental health support needs and children with complex support needs and all carers. They are referred by GPs, discharge teams and other agencies. Their service includes benefit checks to identify those who are entitled to benefits and are not claiming, as well as advice to people with specific benefits. The demand for this specialised service has increased since the implementation of the welfare reforms.
- Southwark Council has developed a set of measures to mitigate the impact of the welfare reforms, including:
  - Discretionary Hardship Payments to households affected by the benefit cap.
  - The housing team has provided support to households affected by the benefit cap and/or bedroom tax with the aim to avoid eviction including re-housing, moving to cheaper accommodation or obtaining employment.

As a result, the number of households affected by these benefit changes has come down. However, it is expected that the demand for support will increase with further tightening of the benefit cap and difficulty in getting employment.

- A detailed data analysis has been carried out within the Revenues and Benefits department of the council to understand the effects of the welfare reforms. This analysis informed prioritisation for additional support, including: the Council Tax Reduction Scheme; the Emergency Support Scheme (Social Fund) and Hardship Fund. Prioritisation of support to tenants most in need using Geographical Information System advice services has also been used to focus on areas of high impact.
- A financial inclusion approach has been adopted and delivered in partnership with third and voluntary sector partners. It aims to increase residents' financial capability by promoting budgeting training, opening bank accounts and discouraging payday lending. Strengthening stakeholder engagement with the annual stakeholder conference, welfare reform road-shows targeted to affected residents, Tenants & Residents Associations (TRA) meetings, estate action days and community council meetings and more than 50 local charities and voluntary groups have also had special briefings.
- Following promotion of welfare advice programmes, many people have accessed provision and received one-to-one support from agencies such as the Blackfriars Advice Centre, DWP, Council Tax officers, Discretionary Housing Payment team, House-Exchange and London Mutual Credit Union.
- The Universal Support Delivered Locally (USDL) scheme has been running since September 2014. In partnership with the Job Centre, local organisations and voluntary sector, Southwark Council triages customers in order to assess their support needs with regard to finance, digital capability, budgeting and housing. Outcomes from the project will inform how the wider vision to join up support provision across the council can be achieved, to improve customer service, quality and cost.

## What more can be done?

In line with the recommendations outlined above, better mainstreaming of equality and equity audits into work of the local council would help to build upon the excellent work already taking place in Southwark to address health inequalities resulting from income and work inequalities. These should pay particular attention not only to the geographic distribution of poverty, but also how poverty is distributed among different age groups, ethnicity, gender, and other segments of the population.

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## 1.2 Workplace health

### Key messages

- 1 Being in fairly paid and suitable employment is good for health when compared to unemployment. Worklessness is associated with poorer physical and mental health generally. However, the quality of work is also significant<sup>1</sup>.
- 2 The workplace is an effective setting for health improvement initiatives and interventions aimed at ill-health prevention. Workplace interventions can also make a significant contribution to reducing inequalities in health.
- 3 Investing in the health and wellbeing of employees makes sound economic and business sense for employers. Providing comprehensive workplace health programmes can produce significant benefits that outweigh the costs to employers<sup>2</sup>.

### Key recommendation

1. All employers in the borough should be encouraged and supported to adopt good practice in relation to health and safety compliance and evidence-based workplace health programmes.
2. Public sector employers already engaged in workplace health initiatives should be encouraged to share their knowledge and expertise with other employers as well as using their commissioning and procurement processes to encourage compliance with legislation and good employment practice.

### What's the issue?

#### Employment in Southwark

The ONS Business Register and Employment Survey 2012 shows that the largest employment sectors in Southwark are financial and other business services (76,200) and public administration, education and health (51,000). There is real potential to reach a large number of the working-age population through public sector employers, which employ large numbers of staff.

The majority of businesses in Southwark are micro-businesses (85.6 per cent, or 10,110) or small businesses (7.5 per cent, or 1335). There is a need to find cost-effective ways to address the health needs of micro and small businesses.

#### Workplace health

In terms of workplace health, nationally around 80% of new work-related conditions in 2011/12 were musculoskeletal disorders, stress, depression or anxiety<sup>3</sup>.

Additionally, employment that is more likely to damage health (for example, higher exposure to physical and chemical hazards, irregular hours, shift work, higher exposure to psychological work demands, and insecure employment) is more likely to be experienced by workers in lower socioeconomic positions<sup>4</sup>.

#### Work and long-term conditions

The working population is ageing and will face a higher burden of chronic illness in years to come<sup>5</sup>. It is essential that the health needs of these workers are not overlooked. Evidence suggests that when employees are off work for 6 months, the likelihood of a return to work is reduced to approx 50%. At 12 months this reduces to 25% and after 2 years the chances are virtually nil<sup>6</sup>. Therefore early intervention by employers in providing support and adjustments to workers who have long-term conditions can have a far-reaching impact on the health of the working-age population.

### What can we do about it?

Employers should consider implementing Marmot's recommendations on healthier workplaces<sup>7</sup>. These include initiatives aimed at ensuring employees have:

- Some control over work
- Appropriately high demands
- Fair earnings and job security
- Opportunities for training, learning and promotion

In addition, the following should be addressed:

- Preventing social isolation, discrimination and violence
- Sharing information and decision-making
- Reintegrating sick and disabled people into full employment
- Meeting basic psychological needs

Organisations should also ensure that they have reviewed and implemented NICE recommendations that relate to workplaces<sup>8, 9, 10</sup>.

Employers in Southwark should also be fully compliant with health and safety requirements. They can seek advice from Environmental Health and Trading Standards in the council or the Health and Safety Executive ([www.hse.gov.uk](http://www.hse.gov.uk)). Use of the Mayor of London's Healthy Workplace Charter by organisations in Southwark could also ensure that organisations are using an evidence-based approach to any broader health at work programmes.



## What's happening at the moment?

Twenty-seven London boroughs have signed up to use or promote the Mayor of London's Healthy Workplace Charter. One of its main aims is to increase the number of employers using best practice and proven interventions to reduce work related ill health and the flow of employees out of work. It can also support reduction in health inequalities because of the potential to reach population groups that are difficult to access through primary care, such as migrant workers, shift workers and, more broadly, men.

Southwark was one of the pilot boroughs working with the Charter, and Guys and St Thomas' Foundation Trust, Greater London Authority and Forster Communications have achieved accreditation against the Charter's standards. A further 6 are actively working towards accreditation, including Southwark Council.

In 2013, small grants were made available for voluntary sector organisations to address aspects of workplace health relevant to their staff and volunteers. Six organisations were funded to develop projects around health and safety, mental health and wellbeing, and healthy eating.

## What more can be done?

More needs to be done to support smaller employers. Public Sector and larger employers should be urged to act as role models to other sectors and employers so that they can share resources and expertise. Larger private sector should be encouraged to use CSR programmes to support smaller organisations. The London Healthy Workplace Charter should also be adopted and promoted by all London councils.

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## Local case study

In 2013 / 14 Southwark Council, Southwark Clinical Commissioning Group (CCG) and Community Action Southwark (CAS) worked in partnership to help improve the health and wellbeing of staff and volunteers in a number of Southwark-based charities.

6 grants were awarded to encourage voluntary sector organisations to use the Mayor of London's Healthy Workplace Charter to make improvements in a range of areas. These include health and safety, sickness absence, mental health and wellbeing, healthy eating, and physical activity.

The "Health in Your Workplace" small grants scheme awarded funding to:

- Daughters of Divine Love Training and Assessment Centre
- Southwark Law Centre
- Surrey Docks Farm
- Family Action Southwark
- Volunteer Centre Southwark
- HomeStart Southwark

Some of the outcomes of the funded projects included staff taking more regular breaks to promote their well-being; use of relaxation (yoga) techniques at work; going for walks at lunchtime; and improvements in staff confidence in reporting health and safety concerns, first aid and fire safety.

Further opportunities for voluntary sector organisations to access workplace health resources and initiatives will be offered in 2014 / 15.

## 1.3 Housing and homelessness

### Key messages

- 1 Poor housing harms mental and physical health, impairs children's development, and undermines neighbourhood cohesion and wellbeing.
- 2 Good quality housing, housing management, and housing advisory services make a substantial contribution to preventing and reducing health inequalities at all stages of the life course.
- 3 Public Health is a partner in developing a thirty year Housing Strategy which gives significant weight to health and well-being in Principle 4: **We will help vulnerable individuals and families to meet their housing needs and live as independently as possible.**

### Key recommendation

Increases in rent and cost of living and extensive welfare reforms mean that more people may be at risk of becoming homeless.

The prevention of homelessness needs to be a key task due to the harms it brings, leading to two overarching recommendations:

1. Homeless prevention services need to reach out not only to those seeking statutory assistance, but also others whose situation is critical because they are living in unstable or unsuitable accommodation and are in substantial housing need.
2. A multi-agency approach should be encouraged to help residents sustain their tenancies. It should also support vulnerable residents in the transition from homelessness to permanent accommodation via temporary accommodation.

### What's the issue?

Poor housing is strongly associated with poor health and psychological distress. Secure and good quality homes will lead to improved health. The relationship between housing and health is complex and researched widely. A recent review of literature highlighted that improved health is most likely when the housing improvements are targeted at those with poor health and inadequate housing conditions, in particular inadequate warmth.<sup>2</sup> Improved health may also lead to reduced absences from school or work.

Improvements in energy efficiency and provision of affordable warmth may allow householders to heat more rooms in the house and increase the amount of usable space in the home. Greater usable living space may lead to more use of the home, allow increased levels of privacy, and help with relationships within the home.

#### Homelessness

In the last few years, a shortage of affordable homes and rising rents in the private rented sector have made it difficult for the councils to find sustainable solutions for rough sleepers and households threatened with homelessness, leading to longer stays in temporary accommodation which is undesirable for many reasons.

In 2013/14 in Southwark, 555 households were accepted as statutorily homeless.

A study commissioned by Shelter<sup>4</sup> found that interviewees identified several factors contributing to their homelessness, rather than a single cause. Family conflict/relationship breakdown was the most common factor (68%), however drug (31%) and alcohol (28%) problems and mental health problems (19%) played a significant role.

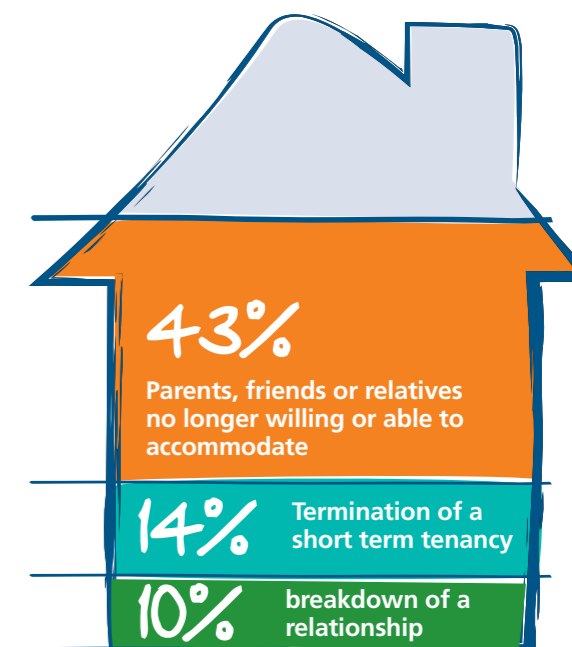
In Southwark, 63% of the households accepted as homeless were families led by single females, underlining the social and economic vulnerability of this group and the potential ill effects on children and young people.

The number of rough sleepers in London has risen by 64% since 2010, and one third of these have slept rough in previous years.<sup>5</sup> Over this same period, beds in homeless accommodation dropped by one quarter.

#### Overcrowding

Overcrowding is also a risk factor for homelessness. The 2011 Census found that 18,475 households in Southwark were overcrowded. Out of all households, 12.4% lacked one bedroom, 2.9% lacked two<sup>6</sup>. There is also the issue of "hidden homelessness", 'sofa surfing', or multi-family occupancy of one-family households, for which we do not have official data.

#### The three most common reasons for homelessness in Southwark:



## What can we do about it?

Nationally, there is a wide array of evidence-based interventions which contribute to homelessness prevention. The approaches currently used in the council and nationally can serve for public health to inform health and social care agencies about options available to help prevent homelessness, and to investigate other councils' approaches and new ways of cross-organisational working.

## What's happening at the moment?

In 2013/14, the borough prevented 3088 households becoming homeless; 342 (10.1%) households were helped to find alternative accommodation and 2746 (88.9%) households were helped to stay in their own home by the following means:

- Financial payments from a homeless prevention fund - 1662 (60.5%)
- Resolving Housing Benefit problems – 386 (14.1%)
- Debt Advice – 308 (11.2%)
- Negotiation or legal advocacy to ensure that someone can remain in accommodation in the private rented sector - 152 (5.5%)
- Sanctuary scheme measures for domestic violence – 114 (4.2%)
- Conciliation including home visits for family or friend threatened exclusions - 84 (3.1%)
- Resolving rent or service charge arrears in the social or private rented sector – 40 (1.5%)

Whilst Southwark had a good rate of success in helping people stay in their own home, this relied on making payments from a homeless prevention fund, which may not be sustainable in the long run, making it important to explore and develop other interventions.

Southwark Council has also committed £326 million over five years to March 2016, to ensure that all Southwark Council homes are Warm, Dry and Safe. This is one of the council's major works programmes for housing and more information about the programme can be found at the following link: [http://www.southwark.gov.uk/info/200510/major\\_works/3407/1\\_what\\_is\\_warm\\_dry\\_and\\_safe](http://www.southwark.gov.uk/info/200510/major_works/3407/1_what_is_warm_dry_and_safe)

Currently, the following services help residents to stay in their current accommodation:

- START Team – offers assessment and support to people with mental health problems who are homeless/ at risk of homelessness.<sup>7</sup>
- Southwark Homelessness and Housing Options service and the Tenancy Sustainment Team – a council service that helps vulnerable social housing tenants to keep their home when at risk of losing it.
- Southwark Legal Advice Network (SLAN)<sup>8</sup> – the council is also working with the voluntary sector to establish a multiagency homelessness forum to work towards minimising the number of residents needing statutory services.
- The council and Registered Social Landlords (RSLs) have co-developed a Preventing Homelessness & Eviction Protocol.
- Since 1st April 2014, a hospital discharge protocol has been in force with the key aim of reducing homelessness and providing a seamless service delivery between Housing, Health and Social Care organisations. All three acute trusts serving Southwark are required to identify the address that the patient will be discharged to as early as possible. If the patient is homeless or does not have appropriate accommodation to return to, a referral form must be made to Homelessness and Housing Options.
- The council commissions an independent support and advocacy service for victims of domestic abuse from Solace and is working with them to provide improved support to prevent homelessness.
- A private sector licensing scheme based on the Southwark rental standard is being rolled out to smaller HMOs (Houses in Multiple Occupation) and selected properties.
- Shelter carried out an evaluation of council homelessness services and presented the results in July 2014. The Homelessness Advice Service was rated at 56%. A number of recommendations were made around training; standards of casework and monitoring for improved quality and performance. There will be a further audit in December 2014.

## What more can be done?

Southwark Council plans to build 11,000 new affordable homes in the borough. There is also a long-term strategy aimed at improving the standard of the private rented sector through licensing and accreditation.

The strategy is currently in consultation phase and consultation documents can be found at the following link: [http://www.southwark.gov.uk/info/200529/lets\\_talk\\_rent/3604/consultation\\_documents](http://www.southwark.gov.uk/info/200529/lets_talk_rent/3604/consultation_documents)

In addition, there is a need to:

- Ensure that all council, NHS, partner and voluntary sector services designing, commissioning or re-commissioning services for vulnerable individuals and families prioritise homelessness prevention opportunities within these services.
- Develop a cross-departmental programme of work involving the council, NHS, voluntary sector and other partners in the borough which will identify people at risk of homelessness at an early stage and increase the numbers of households prevented from becoming homeless using a wider range of interventions.
- Ensure that there are effective and well-publicised processes of signposting and referral to support this aspiration.
- Raise awareness in local agencies (including the Private Rental Sector (PRS)) as to how housing

and other advisory services can assist people at risk of homelessness before a crisis develops.

- Find practical ways of addressing any gaps in co-ordination/information-sharing between housing, health and social care services/drug and alcohol treatment services/mental health services/domestic abuse service relevant to identifying those needing intervention/support to prevent them losing their home.
- Ensure that households in temporary accommodation are linked into relevant health and social care services and other support networks to help them maintain their tenancy.
- Support Partnership working/liaison around recognising risk factors for homelessness by including it in induction training for relevant council and NHS staff and ensuring that homeless protocols are well known and properly deployed.
- Consider joint commissioning of schemes for young people at risk of homelessness/on the edge of care and a positive accommodation and support pathway.
- There have been over 100 referrals to Housing and Homelessness options in the 6 months since the inception of the Hospital Discharge scheme. Awareness and use of this protocol needs to be further embedded in the work of all relevant agencies and its impact needs to be monitored with the aim of improving its effectiveness and coverage.

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- <sup>8</sup> Southwark CABx and Blackfriars Advice Centre provide debt and money support for local residents. Southwark Law Centre and Cambridge House Law Centre provide legal advice for people facing eviction.

## 1.4 Food poverty

### Key messages

Food Poverty is defined as 'the inability to afford or have access to healthy food'<sup>†</sup>.

- 1 The people most likely to be in food poverty are older people, people with disabilities, households with dependent children or someone who is unemployed, and members of black and minority ethnic groups.
- 2 Food poverty causes poor physical and mental health and contributes to heart disease, diabetes and strokes. For children, food poverty can lead to malnutrition, and is linked to obesity, low levels of vitamin D, and stunted growth.
- 3 Inequalities in diet caused by food poverty can also lead to inequalities in health and life chances.
- 4 Food poverty generates very significant cost to public services, especially health services. For example, it has been estimated that malnutrition costs the UK's health services up to £7.4 billion a year.

### Key recommendation

We need to work towards a co-ordinated and strategic system to identify those most likely to be at risk of food poverty and to ensure that individuals and families at risk are signposted to the appropriate support services.



<sup>†</sup>Taken from Choosing a better diet: a food and health action plan, Department of Health, 2005

### What's the issue?

Food poverty is on the increase locally and nationally. One of the manifestations of food poverty can be seen in the increased use of food banks. In Southwark for the period of April 2013 to March 2014 a total of 2073 food bank vouchers were issued. The total number of those benefitting from the vouchers included 2427 adults and 2081 children. There are multiple drivers to this problem, including low income, the effects of the welfare reform, rising food prices, rising energy costs and food deserts.

People on low incomes eat more processed foods that are much higher in saturated fats and salt. They also have a less varied diet as they buy and cook in bulk to achieve economies of scale and to avoid potential food waste.

### What can we do about it?

Food poverty is a complex economic and social phenomenon. Addressing it will require a co-ordinated and strategic public, private and voluntary sector response. For example, interventions to tackle child hunger could include using early years, school, community and street settings to provide universal access to breakfast clubs, cook and eat sessions for families and children, workshops on shopping on a budget, or tasting and learning about different cultures and foods, and to socialise generally.

The statutory, voluntary and the private sectors should join efforts and increase access to nutritious foods, both in and out of school term-time, through food growing projects, local food businesses, and voluntary organisations that offer food to vulnerable families. School settings can also play an important role and innovative activities. For example, the art and enterprise sessions can also be used to encourage young people to eat a nutritious diet.

### What's happening at the moment?

#### Cooking on a budget

Food workers collaborate with Children Centres, providing practical sessions on shopping, preparing and cooking healthy recipes for parents and children. Participants can taste and eat as well as share learning and experiences around healthy eating.

#### Free healthy school meals

In Southwark, every child in Reception to Year 6 is entitled to a Free Healthy School Meal (FHSM) funded by Southwark Council. Feedback and a recent review of the FHSMs, suggest that the FHSMs help families financially, save time and encourage children to eat a variety of food.

The introduction of FHSM – in terms of alleviating hunger, improving educational attainment and wellbeing, and in removing the stigma behind free school meals that frequently discourages children from low income households accepting their free school meal – are clearly demonstrated by the evidence presented by those boroughs that have introduced the policy and through the pilot projects initiated in 2009.

#### Southwark food bank

The Peckham Foodbank was opened in December 2009 and collects food from the public, supermarkets, local churches, local groups and schools. A referral system has been established with church pastoral workers, Social Services, health visitors, probation officers, schools and others working in the front line to address food poverty.



## What more can be done?

### Welfare catering

Welfare Catering is based on offering meals in the community to people facing significant difficulties in preparing food in the home. In London boroughs, these will predominantly be older people and people with disabilities. Community meals can help older people to remain in their own homes and therefore prevent escalation of needs.

Southwark Council is halving the price of community meals. This step aims to ensure that older people are supported to remain independent and avoid going into residential or nursing care. The council expects that community meals will remain a key component of future support for older people, in particular those over 85.

Agencies across all sectors could develop pilot programmes around vulnerable children and families focusing on early years, schools, and the wider community. The learning from the evaluation of these interventions could help to build local evidence and services.

### Local case study

Melissa had bailiffs knocking at her door and couldn't afford to buy food or clothes, or to go out. She and her two-year-old daughter came to Foodbank for help.

Foodbank manager Lurliene, was on hand to help, providing her with food and introducing her to Christians Against Poverty, a charity that helps people who are in serious debt.

*'Within a week my world had turned around,'* explains Melissa.

*'Me and my daughter were eating three meals a day and I was able to get a debt relief order.'*

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<sup>6</sup> Free Healthy School Meals News Story. Available at: <http://ampp3d.mirror.co.uk/wp-content/uploads/2014/02/208307042-Free-School-Meals-London-Cost-of-Living-Report-FINAL.pdf> [Accessed 6th October 2014]



## 2.1 Maternity and early years

In this section we look at ...

### Key messages

- 1 Illness prevention and early intervention services are particularly important for pregnant women, babies and young children, contributing to better health in adulthood and helping to break the cycle of health inequalities.
- 2 This approach requires a strong universal care pathway from every baby's conception through to early childhood, identifying a wide range of risks and needs and offering timely provision of effective local services.

### Key recommendation

Southwark's universal pathway for children from conception to early years should be reviewed and strengthened, using the London Maternity Standards and the Healthy Child Pathway, to ensure our service provision is fair for all and appropriate for everyone's needs.

### What's the issue?

There are inequalities in health between Southwark's pregnant women. They include obesity, higher infant mortality rates, domestic violence, and mental health needs among certain population groups.

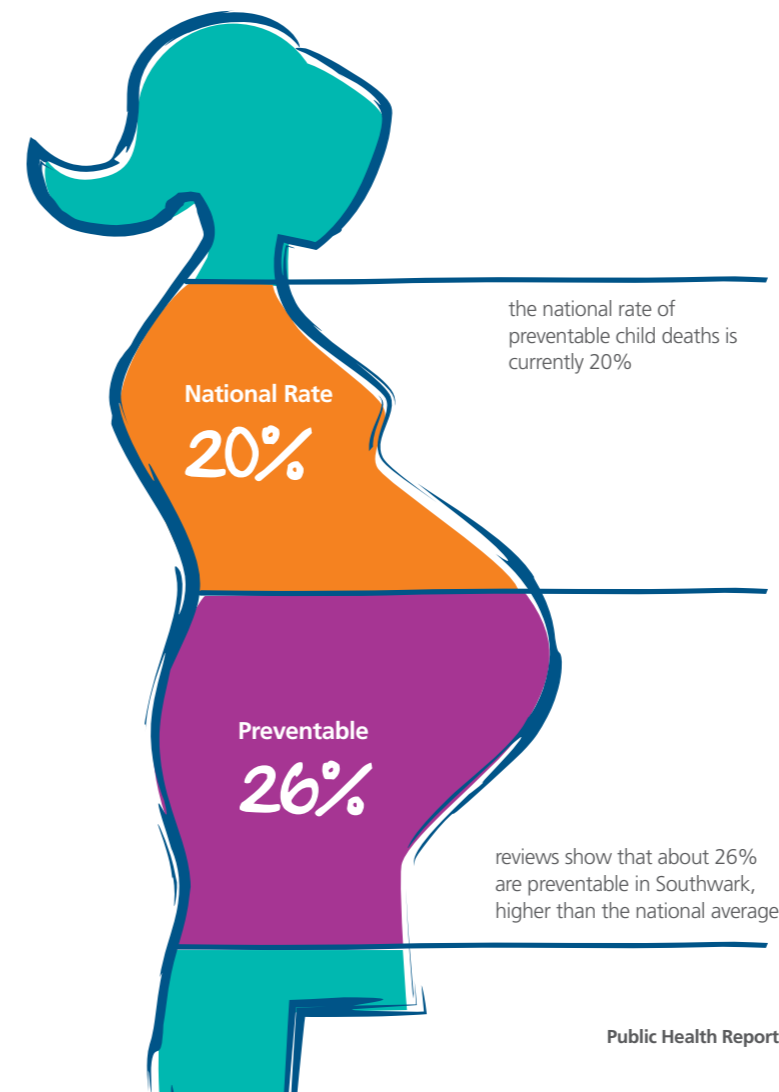
For example, local data suggests that obesity in pregnancy varies considerably in different ethnic groups (around three-fold), and reviews of all child deaths show that about 26% are preventable, higher than the national rate (20%)<sup>1,2</sup>.

Vitamin D deficiency is another important area where there is inequality. It is more common in children from low-income families and Black and Minority Ethnic (BME) families, which make up a large proportion of Southwark's population. The Chief Medical Officer estimates Vitamin D deficiency at 20-40% of young children. The deficiency is not always spotted, resulting in poorer health outcomes in pregnancy and early childhood.

### What can we do about it?

The Marmot Report, 'Fair Society, Healthy Lives',<sup>3</sup> makes recommendations which are shown to address health inequalities in early childhood, summarised below<sup>4</sup>:

1. Allocate more of the budget to the developmental needs of young children and make sure spending is highest in population groups where the need is greatest.
2. Support families to achieve ongoing improvements in their young children's development by:
  - Giving priority to women before and immediately after the baby's birth including intensive home visiting
  - Providing paid leave for parents in the first year of every baby's life, with a minimum income to enable healthy living
  - Giving routine support to families through parenting programmes, children's centres and key workers
  - Supporting children and families through the transition to school.
3. Provide good quality early years education and childcare fairly across the whole population, using evaluated models and must meet quality standards. This should be combined with outreach to increase the take-up by children from disadvantaged families.



## What's happening at the moment?

Southwark Council and the NHS are currently working in the following areas to address the health inequalities outlined on the previous page:

1. A review of maternity services in Southwark using the London standards<sup>5</sup>. This also forms part of the South East London Maternity Commissioning Strategy.
2. A Southwark-wide Vitamin D supplement programme for pregnant women and children aged under 4 years old. Midwives and health visitors issue cards to parents to exchange for supplements, freely available from participating pharmacies.

## What more can be done?

The following initiatives could be introduced to strengthen and build on existing work in Southwark, designed to tackle health inequalities:

1. Improvement of the detection and treatment of mental health disorders in new mothers.
2. Provision of evidence-based parenting support to families at a level which meets their needs.



### References

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<sup>2</sup> Royal College of Paediatrics and Child Health and National Children's Bureau 2014 (2014). Why children die: death in infants, children and young people in the UK. Available at: <http://www.thehealthwell.info/node/763356> [Accessed 30th July 2014].

<sup>3</sup> Department of Health (2013). Annual Report of the Chief Medical Officer 2012: Our children deserve better-prevention pays. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/255237/2901304\\_CMO\\_complete\\_low\\_res\\_accessible.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255237/2901304_CMO_complete_low_res_accessible.pdf) [Accessed 29th September 2014].

<sup>4</sup> Marmot, MG; Allen, J; Goldblatt, P; Boyce, T; McNeish, D; Grady, M; Geddes, I; on behalf of the Marmot Review. (2010). Fair society, healthy lives: Strategic review of health inequalities in England post-2010. The Marmot Review: London UK.

<sup>5</sup> London Health Programmes. (2013). Quality and Safety Standards Programme: Maternity Services. London Quality Standards. Available at: [http://www.londonhp.nhs.uk/wp-content/uploads/2013/03/Maternity-Standards\\_FINAL-Feb2013.pdf](http://www.londonhp.nhs.uk/wp-content/uploads/2013/03/Maternity-Standards_FINAL-Feb2013.pdf) [Accessed 30th July 2014].

## 2.2 Improving the health and wellbeing of young people in schools

### Key messages

- 1 Schools are a key setting for forming and changing the health behaviours of young people, resulting in improved long-term health and wellbeing.
- 2 As a council, we need to continue to engage and challenge schools to champion young people's health and wellbeing.

### Key recommendation

Further engagement with head teachers and school governors to develop a sustainable strategy which encourages young people to make healthy lifestyle choices to improve their overall health and wellbeing.



## What's the issue?

Education is an important influence on the health of people and communities. Improving the educational outcomes of the most disadvantaged has the potential to make a positive impact on health inequalities.

Southwark has a young and diverse population. A larger proportion of children under 16 live in poverty compared to England as is the rate of family homelessness and the number of first time entrants into the youth justice system. Southwark children and young people have higher rates of obesity than the English average (see figure below):

There is also:

- unmet need around mental health and wellbeing
- poor sexual health
- an increase in levels of long term conditions

We know that these inequalities are linked to deprivation and ethnicity, so our interventions should target the specific needs of these groups.

Many health behaviours and problems are initiated in adolescence and track into adulthood. Half of lifetime mental illness starts by age 14, eight out of ten adult smokers started as teenagers, and eight out of ten obese teenagers become obese adults.

For this reason, it is crucial that the council supports 'Whole School' approaches. Current Government policy encourages schools to focus on pupils' academic attainment. Personal, social, health and economic education (PSHE) is not a statutory subject and could therefore be regarded as less important in the curriculum. Despite this, many schools do value the health and well being of pupils, but may lack the expert knowledge to deliver a diverse programme, for example, around sex and relationships or drugs and alcohol.

## What can we do about it?

Research highlights that young children with higher levels of emotional, behavioural, social and educational wellbeing tend to achieve better academic results in school, and are more engaged, both concurrently and in later years (DFE, 2012).

Southwark Council should support schools to develop a 'Whole School' approach to health and wellbeing. Research has indicated that this will be cost effective in the longer term.

The offer should include an integrated education programme which covers:

- sex and relationships
- drugs, alcohol and tobacco
- emotional health and wellbeing including anti-bullying work
- tackling violence and development of non-violent relationships
- food, nutrition and weight management.

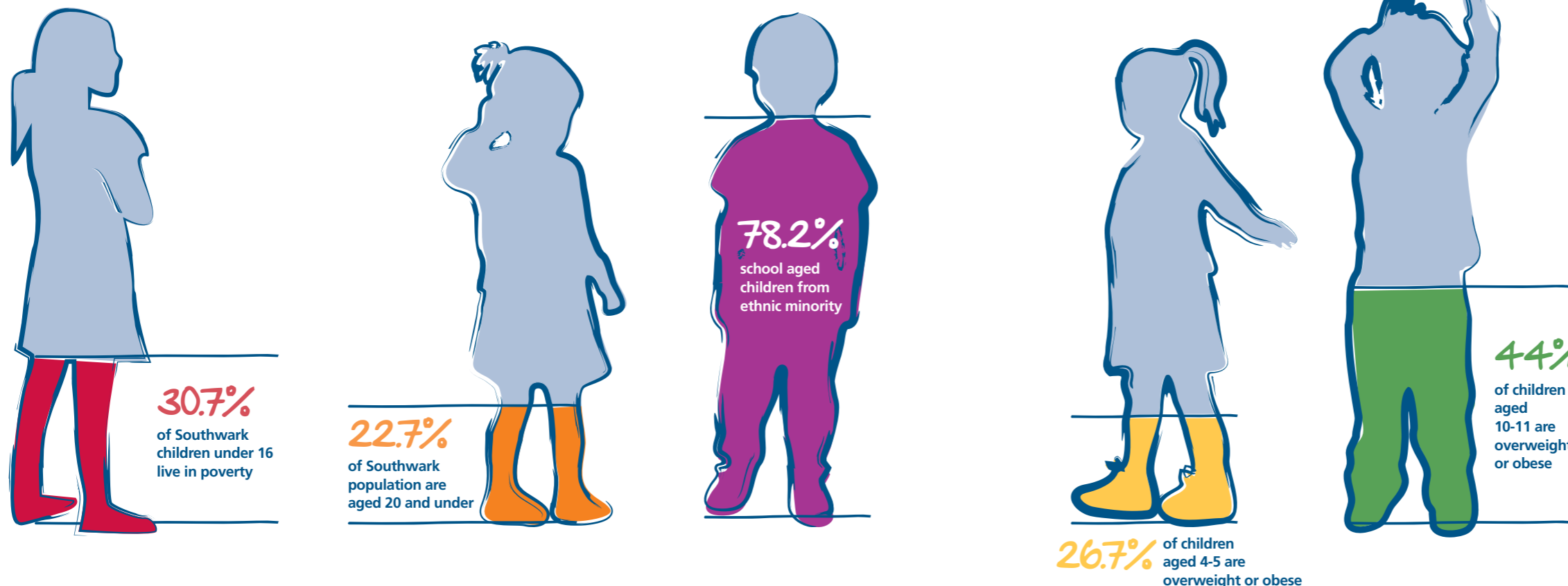
## What's happening at the moment?

There is a range of work underway to support schools in Southwark. A strategic group under the Director of Education with representation from head teachers and commissioners is meeting to co-ordinate the current work which is offered to schools to support Personal Social and Health and Economic Education (PSHE) and also to identify where additional support is needed. A PSHE co-ordinator has been recruited to undertake this work.

Southwark secondary and primary schools are being encouraged and supported to register and be accredited to the Healthy Schools London Awards. Currently 40 schools are registered and one school has achieved the Bronze award and is now working towards the silver award. Universal free healthy school meals are also provided in all primary schools. The London Physical Education (PE) network is commissioned to provide a tailored programme of high quality PE in 71 primary schools.

## What more can be done?

A more co-ordinated approach needs to be taken to address the emotional and mental health needs of young people in schools, particularly targeted at those most at risk.



### References

<sup>1</sup> Lambeth and Southwark Public Health Team. (2013). Lambeth and Southwark JSNA: Children and Young People's Health and Wellbeing. Available at: <http://www.lambeth.gov.uk/sites/default/files/sc-jsna-children-and-young-people-2013-2.pdf> [Accessed 30th July 2014].

## 2.3 Relationships and community

### Key messages

- 1 The quality and quantity of social relationships are linked to mental wellbeing, ill health and deaths in a population with resulting health inequalities.<sup>1,2</sup>
- 2 Good social relationships are as beneficial to health as quitting smoking. Resilient communities with a core of strong social relationships do better in the face of adversity and austerity<sup>1</sup>.
- 3 People on lower incomes are more likely to be affected by low levels of social participation.
- 4 The public sector has a role to play in strengthening people's social networks through one-to-one work, community development and planning new public spaces<sup>3</sup>.

### Key recommendation

Reducing social isolation and improving social relationships and community development should be made policy priorities.



### What's the issue?

Social relationships have been damaged by cultural and economic trends in the UK. Population mobility, long working hours, distance from immediate family, perception of safety, culture of self-reliance, fast paced city living, 'gentrification,' inequalities between different social groups and tensions between others all play their part.<sup>4</sup>

There are certain groups which are less likely to have good relationships and have poor social networks resulting in inequalities which impact on their health and wellbeing:

- Retired and older people are particularly at risk
- Unemployed people are twice as likely not to know anyone in a position of influence<sup>3,5</sup>
- People living in poverty<sup>5</sup>
- Men compared to women
- People with mental health problems, learning disabilities, ex offenders, new migrants, BME communities, people with disabilities and high users of social care.

A poor network of relationships has been shown to result in the onset and persistence of conduct problems in children<sup>6</sup>.

The current austerity measures are likely to make the situation worse.

### The five ways to wellbeing

are evidence based ways to improve mental wellbeing that is to help individuals and communities to feel good and do well. The 5 ways are

1. Connect; keep in touch with friends, family and community. Make friends throughout life.
2. Be active; keep fit and active every day with whatever you enjoy
3. Take notice; take time to appreciate the world around you. Be mindful.
4. Keep learning; keep your mind active, maintain and learn new skills. Pursue your interests throughout life
5. Give; be kind, say thank you, give back, volunteer

For more information see [www.neweconomics.org/issues/entry/well-being](http://www.neweconomics.org/issues/entry/well-being)

## What can we do about it?

The evidence base for interventions which foster good social relationships is growing.<sup>7</sup>

The following have proved effective:

- Encouraging the use of 'Five Ways to Wellbeing' – particularly 'Connect' and 'Give'
- Parenting support
- Whole school approach to emotional health and wellbeing
- Health and wellbeing strategies and interventions at work, for example, team social events, sports activities, reading groups
- Fostering support and exchange through informal neighbourhood connections, for example, befriending, Men's Sheds, timebanking, reading groups, free community festivals<sup>8</sup>
- Building neutral social space into regeneration projects
- Promoting use of technology to encourage social connections.

## What's happening at the moment?

There is currently a whole host of activities taking place in Southwark which contribute towards improving social relationships.

These include:

- Community festivals, for example, Southwark Splash, The Elephant and Nun, Black History Month
- Consortium of Older People's Services in Southwark (COPSINS)
- Peer support and self-management programmes
- Unwin & Friary Estate (Well London)
- Targeted campaign on 'Five Ways to Wellbeing' for older people, using posters, direct mail and an article in Southwark Life magazine
- Community arts projects, for example, Cooltan arts, Dragon café
- Peckham Pocket Places (<http://pocketplacespeckham.wordpress.com/about/>)

## What more can be done?

Despite the wide range of activity taking place in Southwark, the effects of these initiatives can be further promoted, particularly when it comes to addressing health inequalities.

Firstly, there needs to be greater awareness among policy makers and commissioners about the benefits of good social relationships for overall health and wellbeing, and the role of the public sector in influencing this. This may prompt improvements in data collection by public services to discover who is isolated and which geographical areas have weaker social networks.

It is also important to recognise the contribution of community activities which enhance social networks and cohesion. For example, community arts projects, local community festivals and free activities in libraries.

Public servants should strive to build and sustain relationships with clients' families and friends and help them to make new connections.

Regeneration programmes should give people opportunities to socialise and play, empty shop spaces could become 'pop up' services.

Social prescribing models – local, non-clinical services, often provided by the voluntary and community sector – can all also play an important part in increased efforts to reduce health inequalities caused by social isolation. 'Five Ways to Wellbeing,' good neighbours' schemes and community navigators are seen to work well alongside personalisation of services and mentoring.

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- <sup>2</sup> Chanfreau J, Lloyd C, Byron C, et al (2013). Natcen Social Research: Predicting Wellbeing. Available at: <http://www.natcen.ac.uk/media/205352/predictors-of-wellbeing.pdf> [Accessed 23rd September 2014]

- <sup>3</sup> Marcus G, Neumark T, and Broome S (2011). *Power Lines*. London: RSA. Available at: [http://www.thersa.org/\\_data/assets/pdf\\_file/0005/402755/RSA\\_Power\\_lines\\_FINAL-110511.pdf](http://www.thersa.org/_data/assets/pdf_file/0005/402755/RSA_Power_lines_FINAL-110511.pdf) [Accessed 23rd September 2014]

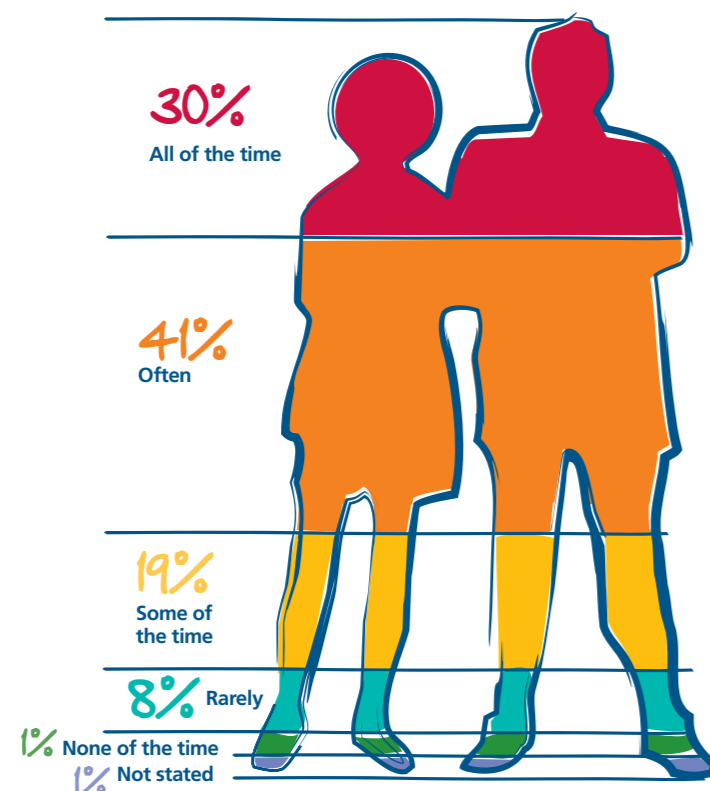
- <sup>4</sup> Griffin J, The Mental Health Foundation (2010). *The Lonely Society?* Available at: [http://www.mentalhealth.org.uk/content/assets/PDF/publications/the\\_lonely\\_society\\_report.pdf](http://www.mentalhealth.org.uk/content/assets/PDF/publications/the_lonely_society_report.pdf) [Accessed 8th October 2014]

- <sup>5</sup> Dominguez, S and Arford, T (2010). It is all about who you know: Social capital and health in low-income communities. *Health Sociology Review*, 19(1): 114-129.

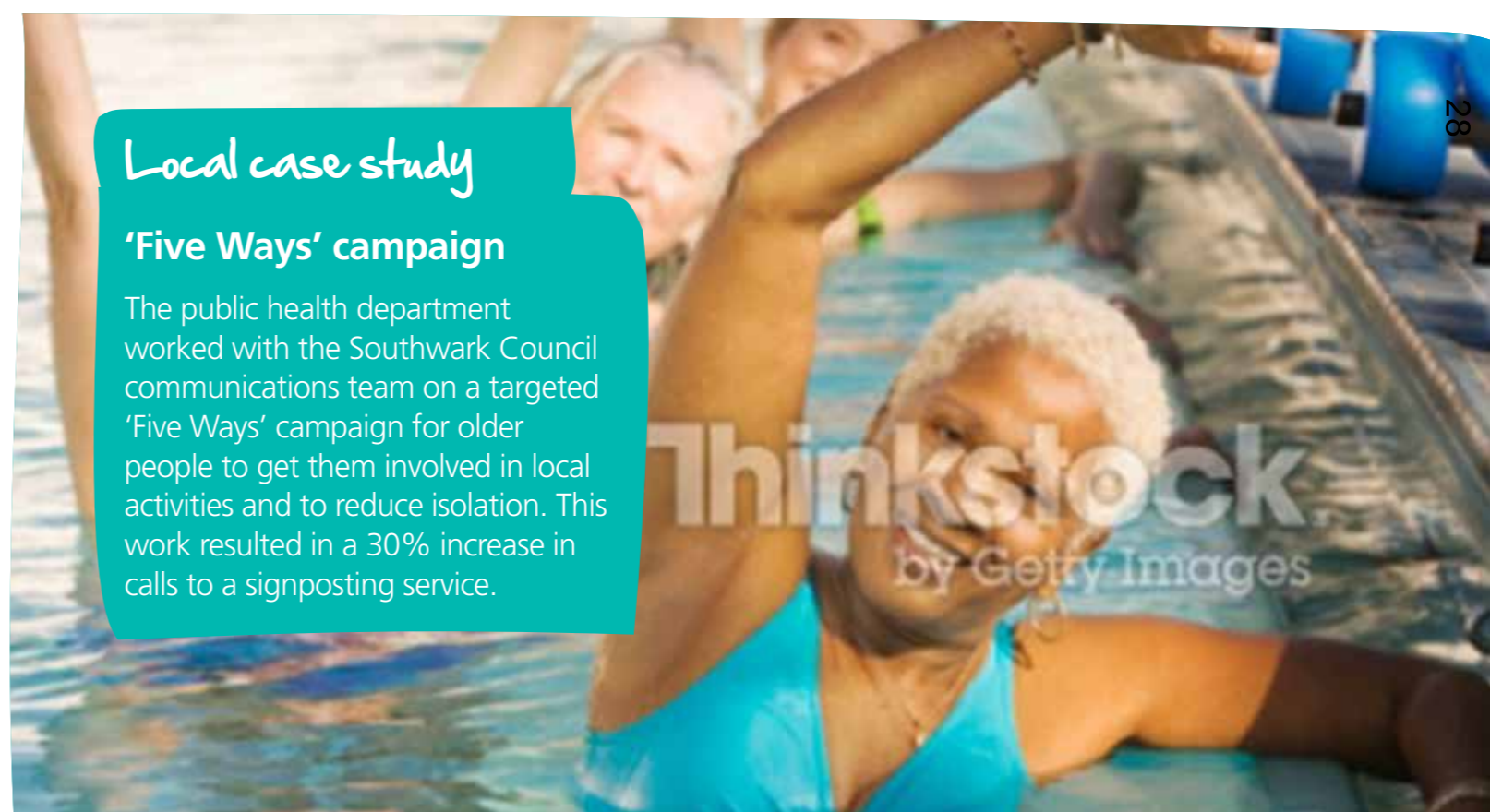
- <sup>6</sup> Clements A, et al (2008). Three years on: Survey of the emotional development and wellbeing of children and young people, London: ONS. Available at: [www.ons.gov.uk/.../people...children.../follow-up-report-on-mental-health-of-children.pdf](http://www.ons.gov.uk/.../people...children.../follow-up-report-on-mental-health-of-children.pdf) [Accessed 8th October 2014]

- <sup>7</sup> Windle, K et al. SCIE Research briefing 39: Preventing loneliness and social isolation: interventions and outcomes. Available at: <http://www.scie.org.uk/publications/briefings/files/briefing39.pdf> [Accessed 8th October 2014]

- <sup>8</sup> Mulgan G, Hothi, M et al (2008). Neighbourliness + empowerment = wellbeing. Is there a formula for happy communities? The Young Foundation.



Result from Southwark resident's survey when asked if they had felt close to other people in the last two weeks.



### Local case study

#### 'Five Ways' campaign

The public health department worked with the Southwark Council communications team on a targeted 'Five Ways' campaign for older people to get them involved in local activities and to reduce isolation. This work resulted in a 30% increase in calls to a signposting service.

In this section we look at some of the most important lifestyle factors which impact on health and some of the ways in which our work can mitigate against resulting health inequalities.

### 3.1 Tobacco control and smoking

## Key messages

- 1 Smoking is the single largest preventable cause of poor health and health inequalities in Southwark, so to address this must be a priority.
- 2 A comprehensive evidence-based tobacco control approach is necessary to reduce the high levels of smoking. This includes tackling illegal sales, and measures to prevent people from taking up smoking, helping them to stop and protecting others from second hand smoke.
- 3 Shisha use, particularly among children and young adults, is a growing public health concern.
- 4 A recent Health Equity Audit revealed that although those from BME communities and deprived areas made use of the stop smoking service, they were less likely to quit within 4 weeks. This needs to be addressed with tailored interventions.

## Key recommendation

Referral pathways for smoking cessation need to be developed for priority groups, such as those with long term conditions and mental health issues. These should be implemented alongside measures to increase quit rate, prevent relapse and promote targeted community action against illegal sales, to benefit those from disadvantaged groups in particular.

## What's the issue?

In Southwark, 19.7% of people smoke, similar to the national and London averages<sup>1</sup>. Tobacco use is associated with a number of demographic factors and well-recognised negative health effects. Health inequalities result from exposure to tobacco smoke. The use of evidence-based approaches is required in order to tackle these effectively.

There is a strong link between tobacco use and those from lower socio-economic groups. 29.7% of people with routine or manual occupations smoke, compared to the national average of 20%. When looking at the differential effects on mortality, death rates from tobacco are two to three times higher among disadvantaged social groups than among the better off.<sup>1</sup>

Aside from the associations with deprivation, several other population groups are affected differentially by tobacco use.

Smoking during pregnancy significantly increases the risk of miscarriage, stillbirth, and cot death.

- Approximately 4.8% of pregnant women are recorded as smokers<sup>1</sup>
- Women in low-paid jobs are three times more likely to smoke during pregnancy as professional women.
- Children born to mothers who smoke are much more likely to smoke themselves.

The disease registers show that:

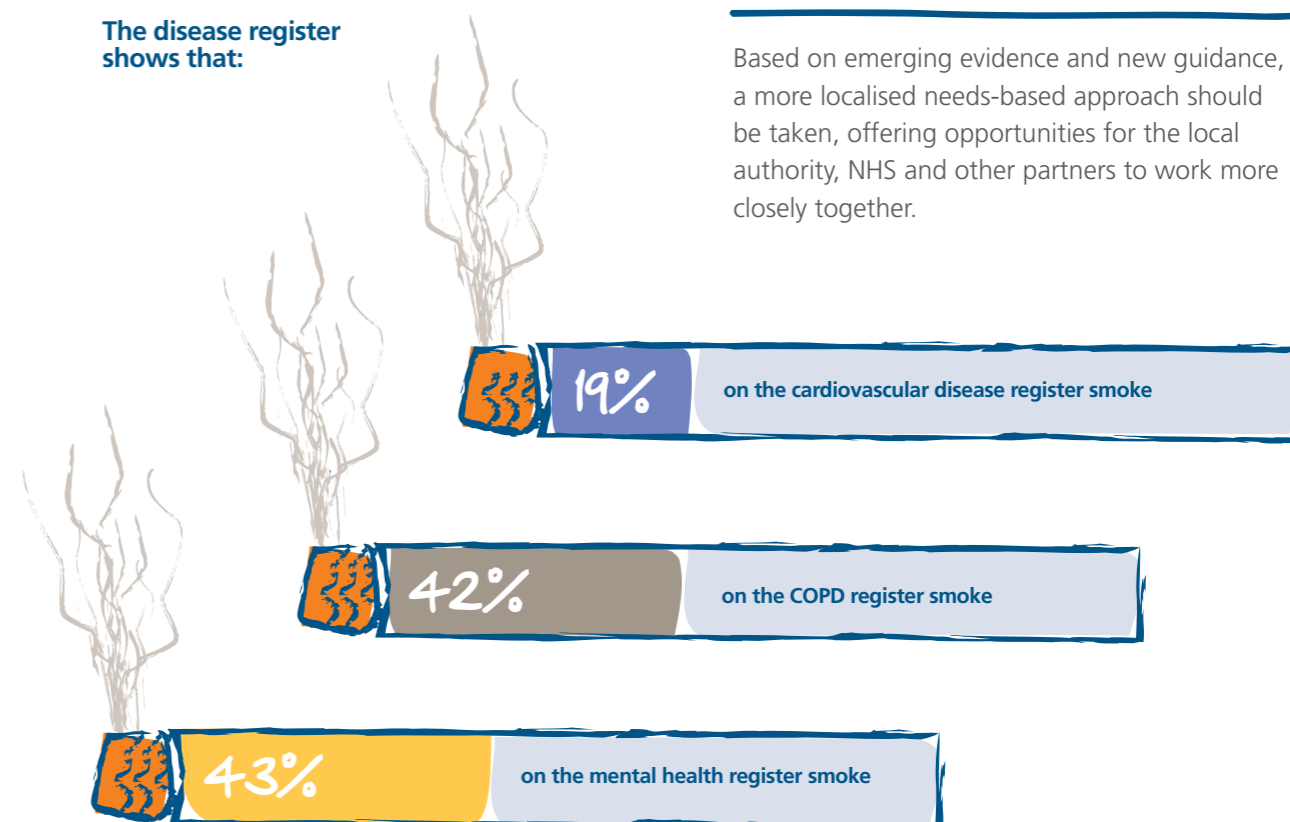
- 43% on the mental health register smoke
- 19% on the cardiovascular disease register smoke
- 42% on the COPD register smoke.

In Southwark, there are additional concerns associated with tobacco use, such as the use of illegal cigarettes: 1 out of every 5 cigarettes smoked in Southwark is illegal compared to 1 in 10 in London<sup>2</sup>, and therefore may contain contaminated tobacco or additional toxic substances.

## What can we do about it?

Based on emerging evidence and new guidance, a more localised needs-based approach should be taken, offering opportunities for the local authority, NHS and other partners to work more closely together.

The disease register shows that:



## What's happening at the moment?

The Lambeth and Southwark Tobacco Control Alliance, with representatives from statutory and non-statutory sectors, continues to promote an evidence-based tobacco control approach.

In 2013-14, 3208 people made use of the stop smoking service, and of these, 1369 still didn't smoke after four weeks.<sup>3</sup> Stop smoking support is being offered through 45 GP practices, 42 pharmacies, specialist services and SLAM.

An action plan is being developed as a response to the intelligence-gathering exercise around shisha and illegal tobacco sales.<sup>6</sup> Priority areas of work include joined-up enforcement across councils and improved local intelligence-gathering, making use of the crime stoppers number, training and communication.

## What more can be done?

More targeted support for those from disadvantaged groups is required in order to tackle smoking. Priority groups would include black and ethnic minority groups, the unemployed, those with long-term conditions and mental health problems.

### Local case study

Water pipe tobacco smoking is commonly known as shisha and has grown in popularity across the UK. UK-based shisha research is currently limited. However, evidence reveals that twice as many young people use shisha as those who smoke cigarettes.<sup>7</sup> The Department of Health has recognised that shisha is a health risk warranting attention.<sup>8</sup>

The South East London Illegal Tobacco group commissioned work to find out the local use and awareness of shisha. In Southwark, 196 people were interviewed:

- 60% were aware of shisha
- 22% stated they had smoked shisha
- 7% stated they had smoked shisha in the last year.

This is evidence that shisha is a growing concern. The South East London Illegal Tobacco group seeks to collaborate with Public Health England and other partners to create an effective strategy to reduce the uptake.<sup>9</sup>

#### References

<sup>1</sup> Public Health England (2014). Local Tobacco Control Profiles for England. Available at: <http://www.tobaccoprofiles.info/profile/tobacco-control/data> [Accessed 13th October 2014]

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<sup>5</sup> Jawad M. Public Health Implications of Shisha Smoking in London. Department of Primary

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<sup>6</sup> Department of Health (2011). Healthy Lives, Healthy People. A Tobacco Control Plan for England.

<sup>7</sup> Power G. Shisha Smoking in South East London: A Cross Population Survey of Shisha Use and Awareness in South East London, 2014.

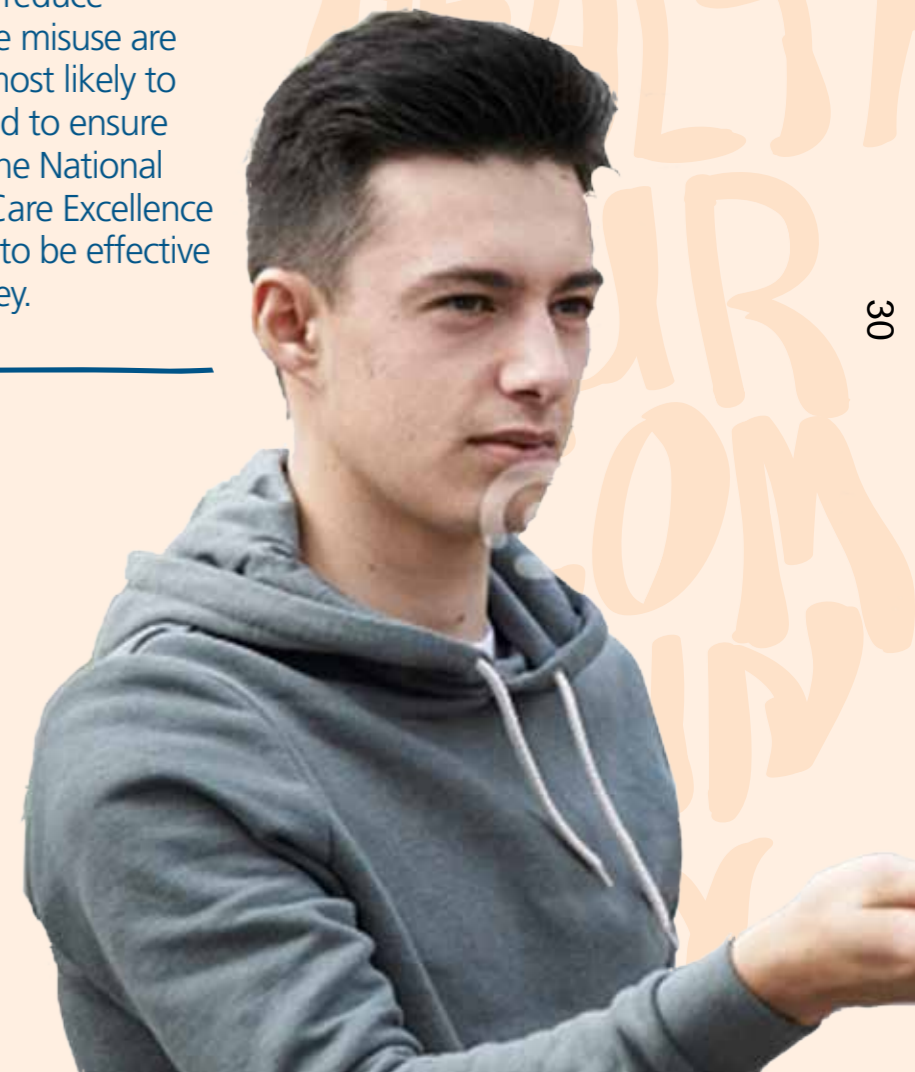
## 3.2 Alcohol and substance misuse

### Key message

- 1 People who misuse drugs and alcohol come from a variety of backgrounds, but those who live in deprived communities are more likely to experience the harms associated with substance misuse than those from more affluent areas.

### Key recommendation

We need to investigate whether existing interventions and services designed to prevent and reduce harm and treat substance misuse are actually reaching those most likely to be affected. We also need to ensure that the services follow the National Institute for Health and Care Excellence (NICE) guidelines shown to be effective and good value for money.





## What's the issue?

### Alcohol

After smoking, alcohol is the second biggest preventable killer. Alcohol misuse has been linked with a range of health and social harms. If you drink too much in one session you are more likely to suffer from bad moods and to end up in A&E or a police cell, while regular alcohol consumption can lead to heart disease, stroke, liver disease and certain types of cancer.

Alcohol consumption is highest in the most affluent groups who drink more often but in smaller amounts. However, alcohol-related harm is greatest in the least affluent groups.

Figure 1 shows the strong relationship between deprivation and alcohol-related harm. Those local authorities, with relatively high levels of deprivation, such as Southwark have higher rates of alcohol attributable hospital admissions.

### Drugs

There is a well-recognised link between poverty and drug misuse. Vulnerable individuals who live in deprived communities or are part of disadvantaged families are more likely to be affected by problem drug use.

Figure 2 shows that those areas with relatively high levels of deprivation, such as Southwark, have higher rates of problematic drug users – users of opiates and/or crack cocaine.

Figure 1

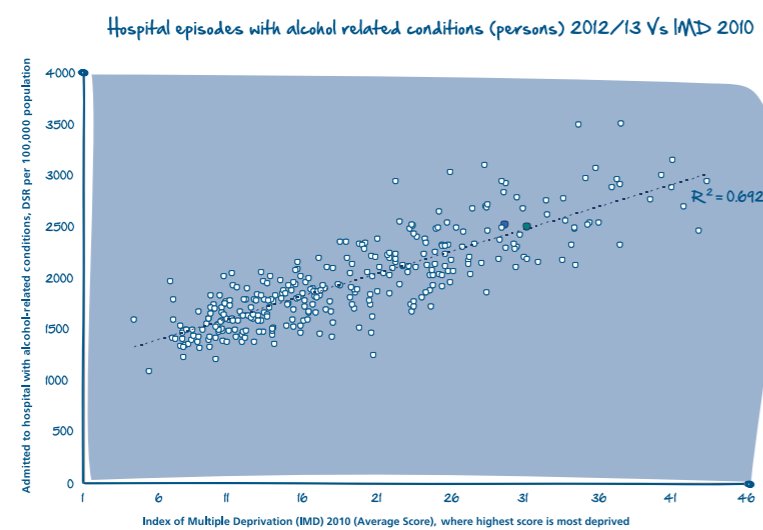
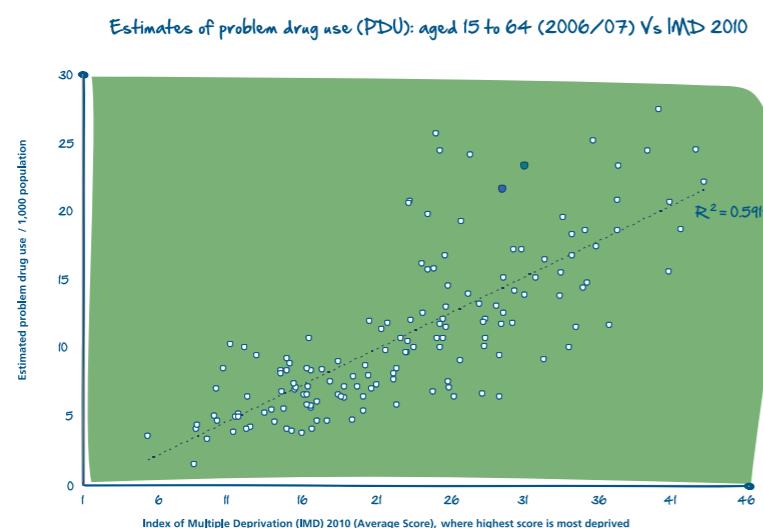


Figure 2



## What can we do about it?

There is a wealth of evidence about what works well. NICE has collated this information to provide national guidance on how we can effectively reduce and prevent harm and provide treatment for people with substance misuse problems. These guidelines can be roughly divided into 'preventing harm', 'reducing harm' and 'treatment.'

## What is happening at the moment?

There is a large amount of work taking place across Southwark to prevent and reduce harm, and provide high quality treatment to those experiencing alcohol and drug-related problems.

### Preventing harm

Southwark has a specialist service (Insight) working with young people who either use substances or are at risk of using substances. Insight delivers training to relevant agencies, prevention-focused workshops in schools and works one-to-one to divert young people from using substances. Insight also works with family members and young people whose parents use substances problematically.

### Reducing harm

Southwark has excellent provision of needle exchange facilities. Specialist packs are made up specifically for steroid users and crystal meth users as the needs of these groups were not adequately met by generic needle exchanges. This helps prevent the spread of blood borne viruses.

### Treatment

Access to sexual health treatment for substance-using clients has been particularly poor. Southwark treatment services now work in partnership with sexual health clinics delivering sexual health advice alongside substance use treatment. This is preventing unwanted pregnancies and transmission of sexually transmitted diseases.

## What more can be done?

Over the next two years, drug and alcohol treatment services for adults in Southwark will be reorganised. The plan is to develop a flexible service which can support both drug and alcohol needs, rather than treat them individually. This will include support for individuals engaged with the criminal justice system. One of the main ambitions of the new model is a focus on reducing health inequalities linked to substance misuse. Under the new arrangements, and for the first time in Southwark, alcohol treatment will stand on an equal footing with drug treatment. The opportunities for reducing health inequalities will be considered throughout the service development process and will be central to the way the service is monitored.

We also need to make sure that we invest in preventing children and young people and adults from drug and alcohol misuse. To support this approach, we need a better understanding of the financial as well as health gains that could be made from local investment in prevention.

### Any prevention work needs to:

1. Look at drug and alcohol programmes and services to make sure they include all the actions recommended by NICE guidelines.
2. Ensure equal access to information and alcohol misuse services for population groups at higher risk of alcohol-related harm

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<sup>1</sup> Gilchrist G, Radcliffe P, Keen J et al. Physical Health Audit of Substance Misusers in Lambeth, July 2014)

### 3.3 Healthy weight

## Key messages

- 1 The causes of obesity are complex, with many factors involved. Effective actions to address unhealthy weight will therefore require a strategic and whole system approach, delivered in multiple settings and with the involvement of a range of stakeholders.

## Key recommendation

Southwark Council needs to agree and invest in a long-term approach to improve healthy weight.



## What's the issue?

Childhood obesity is a growing concern locally and nationally. Childhood obesity can cause social, psychological and health problems. Overweight and obese children are more likely to:

- be ill
- be absent from school due to illness
- experience health-related limitations
- require more medical care than healthy weight children
- experience bullying and stigma, which can affect their self-esteem and may, in turn, affect their performance at school.
- become obese adults and have a higher risk of ill health, disability and premature mortality in adulthood.

The data from National Childhood Measurement Programme (NCMP) show that obesity levels in Southwark children have been consistently higher than the London average, and significantly higher than the England average. Nationally, the NCMP shows a strong relationship between deprivation and obesity among children in each age group. However, in Southwark, where deprivation is fairly widespread, significant differences between the most and least deprived are not as stark. Inequalities are more evident between certain ethnic groups, with children in Black ethnic groups having a significantly higher risk of obesity than those in Mixed, Asian, Other and White ethnic groups.

## What can we do about it?

- Healthy weight requires a life course approach starting with obesity prevention from birth through the promotion of breastfeeding, healthy weaning and eating practices and physical activity in line with a child's development. Once children reach school age, the whole school environment should support healthy eating and activity behaviours for all. Reinforcing small positive changes into daily life can help maintain and achieve a healthy weight.
- Families who struggle to achieve a healthy weight should be supported with information and support from trained, multi-agency, front line staff and should be able to access appropriate, evidence based supportive services.
- In addition to targeted obesity prevention and treatment activities, the wider environment should be a place which promotes healthy eating and physical activity behaviours. For example, working in partnership with different communities and agencies to address the Food System\* and enabling families, children and communities to have access to healthy, safe and affordable food. Also by working with Local Authority colleagues to make an active lifestyle easier for the local population through policies and planning to encourage active travel and planned physical activity sessions accessible to all.

\* The Food System is defined as all the structures, activities and connections relating to how food is produced, processed, procured, distributed and consumed and the impact this has on individuals and the community.

## Local case study

A mother accessing a local Cook and Eat programme commented that:

*'This course is helping all poor parents to help and safeguard ourselves and our children. I used to believe that children need as much sugar as they can take for growth, and that my cooking will never taste nice without salt and saturated oils. But now I know much more all down to the course. Also, reading food labels has never caught my interest all these years. But when I learnt how to check food labels, it made possible for me to shop for healthier foods, which helped me a lot and even my sons. Now I feel lighter after each meal. She (food worker) has been so helpful; she took her time to come down to our level and to re-explain every bit we don't get. All thanks to this course.'*

## What's happening at the moment?

Public Health has reviewed the local and national evidence on childhood obesity and recommendations were made for the commissioning of evidence-based services as part of a local care pathway to address healthy weight across a multi-agency, whole systems approach in Southwark. This approach will help to ensure that services are made available and are accessible for all children, which will contribute to improving health and reducing health inequalities. There has since been agreement to fund a local care care pathway and a programme is being commissioned.

Public Health and partners are currently working to develop a multi-agency healthy weight care pathway for children between the ages of 0-12. The care pathway aims to promote healthy weight from targeted prevention work through to treatment of children who are overweight or obese.

Prevention will begin from birth, with the implementation of the UNICEF Baby Friendly Initiative to ensure early years settings are environments which support breastfeeding and healthy feeding practices. There will also be a service to ensure that early years settings and children's centres promote policies and practices that support children to achieve and maintain a healthy weight. Primary schools in Southwark will also be supported to promote healthy weight through a whole school approach.

The Southwark Care Pathway will include weight management services which support children and families to reach a healthier weight, either through a multi-component, lifestyle or specialist weight management service delivered by a multi-disciplinary team, depending on the needs of the family.

Underpinning the pathway will be a programme of capacity building activities for multi-agency staff to understand the care pathway, issues around healthy weight and how they can signpost to relevant services.

While the new services are being developed as part of a comprehensive pathway, there are currently stand-alone services in place, which target and promote healthy weight in Southwark children and their families.

The care pathway implementation will support families to achieve and maintain a healthy weight, while there is ongoing work within Southwark Council to support healthy eating and physical activity. For example, the Healthy Catering Commitment initiative in Southwark works with local food businesses to make changes to reduce saturated fat, sugar, salt in food served, encourages businesses to offer smaller portion sizes and adopt healthier cooking practices. In Southwark, six new businesses have signed up in the last 12 months.

The provision of free healthy school meals and fruit as a mid-morning snack ensures that all primary aged children in Southwark have access to healthy food during the school day.

## What more can be done?

There are gaps within the current provision, however the development of the Southwark Multi-agency Healthy Weight care pathway will help to support children and families to reach and maintain a healthy weight.

## 3.4 Physical activity

### Key message

- 1 Physical inactivity is a risk factor for at least 20 chronic diseases. Many of the leading causes of ill health and early death in Southwark such as coronary heart disease, cancer and Type 2 diabetes could be prevented if more inactive people were to become active.

### Key recommendations

1. The promotion of physical activity should be routinely incorporated into building, planning, social, transport, school and workplace strategies and policies. Policies should support people in being able to include physical activity in their everyday lives.
2. In adopting a whole population approach to increase physical activity, it is important to take targeted action moving those that are non-active to becoming active. This would include people with disabilities, younger women, older people and those living in deprived communities.



## What's the issue?

Physical inactivity currently accounts for nearly one-fifth of premature deaths in the UK and is due to increase by a further 15% by 2030. Physical inactivity leads to an estimated 236 premature deaths per year in Southwark. The annual health costs of physical inactivity are estimated as £1.7 million per 100,000 population in Southwark.

To optimise the health benefits of exercise, it is recommended that:

- adults do 150 minutes of moderate physical activity a week in bursts of 10 minutes or more
- children and young people spend 60 minutes a day
- under fives spend 180 minutes

Approximately 56.5% of adults in Southwark are active – achieving recommended levels of physical activity – which is similar to the regional and national average. However 27% are deemed to be inactive, doing less than 30 minutes a week.

The Active People Survey shows that 38% of adults in Southwark participate in at least 30 minutes of moderate intensity sport once a week, which is higher than the regional and national average, and second most improved borough in London over 2005-2014 period. However, this masks some significant inequalities: men and those from the highest socio-economic status participate almost twice as much as women and those from the lowest socio-economic status.

National data shows that girls, people with disabilities, the unemployed and those from black and minority ethnic groups are less active. Physical activity also decreases with age.

Physical activity benefits extend well beyond physical health and into areas such as psychological and social wellbeing, community cohesion and employment with the benefits of physical activity being felt in all areas of life.

### Free swimming and gym in Southwark

Southwark Council is taking a bold new approach in Spring 2015 to launch a free swimming and gym offer to reduce the barrier of cost for all residents. The pilot will target children and young people (setting good habits early); disabled and older people (supporting independence and inclusion); and patients on key health referral schemes (helping manage and prevent further ill-health).



#### References

- <sup>1</sup> All Party Commission on Physical Activity (2014). Tackling Physical Inactivity-A Coordinated Approach. Available at: <http://activitycommission.com/report-tackling-physical-inactivity-a-coordinated-approach> [Accessed 20th October 2014]
- <sup>2</sup> Transport for London (TfL) (2014). Improving the health of Londoners: Transport Action Plan. Available at: <http://tfl.gov.uk/cdn/static/cms/documents/improving-the-health-of-londoners-transport-action-plan.pdf> [Accessed 20th October 2014]
- <sup>3</sup> HM Government (2014). Moving More, Living More. The Physical Activity Olympic and Paralympic Legacy for the Nation. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/279657/moving\\_living\\_more\\_inspired\\_2012.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279657/moving_living_more_inspired_2012.pdf) [Accessed 20th October 2014]
- <sup>4</sup> National Institute for Health and Clinical Excellence (NICE). Guidance on physical activity webpage. Available at: <https://www.nice.org.uk/GuidanceMenu/Lifestyle-and-wellbeing#/Guidance/Lifestyle-and-wellbeing/Physical-activity> [Accessed 20th October 2014]
- <sup>5</sup> UK Active (2014). Turning the tide of inactivity report. Available at: [http://ukactive.com/downloads/managed/Turning\\_the\\_tide\\_of\\_inactivity.pdf](http://ukactive.com/downloads/managed/Turning_the_tide_of_inactivity.pdf) [Accessed 20th October 2014]
- <sup>6</sup> Public Health England (2013). Public Health Outcomes Framework. Available at: <http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/101/page/0/par/E12000007/are/E09000028> [Accessed 20th October 2014]

## What can we do about it?

Tackling population inactivity requires a whole system approach as there is no single intervention that will solve this problem on its own.

Evidence supports encouraging physical activity amongst children and young people. Good habits established when young can last a lifetime. Taking a whole school approach to promoting physical activity has been shown to be more effective than stand-alone interventions.

Increases in activity can be supported by designing environments which promote physical activity, including buildings, streets, and open spaces. For example, provision for cyclists, walking routes between residential areas, essential public services and retail areas, and accessible leisure amenities.

Behaviour change interventions such as motivational interviewing and brief advice from primary care are proven to work and have been shown to be especially cost effective.

Walking has been shown to be a particularly good activity to promote as it is very accessible, and is an effective gateway into other physical activities.



## What's happening at the moment?

Council leisure facilities and parks in Southwark have seen significant capital investment in recent years, supporting the improved access to good quality leisure options, including green open spaces and playgrounds.

Implementation of the Southwark's Physical Activity and Sport Strategy is underway with support from a wide variety of partners supporting development of active opportunities, skills and information for schools, workplaces and communities. Community led initiatives, such as Parkrun, led walks and community gardening initiatives are a key strand of the offer. Get Active Southwark now lists over 800 active opportunities in a searchable directory.

Southwark is also improving active travel infrastructure within comprehensive transport plans recently becoming a 20mph borough, and developing an ambitious new cycling strategy.

GP Exercise referral services programmes are in place in Southwark, offering 12-week supported exercise programmes, as well as other health-focused schemes such as Walking Away From Diabetes.

CoolWalks are public walks to enhance physical and mental wellbeing. Developed with community organisation CoolTan Arts, libraries and public health, the programme has trained and supported over 20 volunteers to map, research and lead public walks from the 12 libraries in Southwark. "Really good to walk and learn more about the area ... things I'd see everyday and not consider".

## What more can be done?

Ensuring that people with the greatest needs can access a range of opportunities to be more active, including targeted support. Designers of services and the built environment can also help incorporate more physical activity into our everyday lives.

### 3.5 Sexual health and HIV prevention

#### Key message

- 1 The focus of all sexual health work and investment should be shifted into evidence-based prevention, which is embedded in all clinical services.

#### Key recommendation

Comprehensive sex and relationship education should be implemented in all schools in Southwark as part of an integrated Health and Well-Being Programme.

#### Local case study

Launching in January 2015, SH:24 is a free, online sexual health service for people living in Lambeth and Southwark. SH:24 will provide a quick, discrete and completely confidential service 24 hours a day. This innovative service will provide clear and simple home sampling kits (testing) for sexually transmitted infections, information about symptoms, advice on prevention and signposting to our local sexual health services. The development of SH:24 is funded by Guy's and St Thomas' charity. Established as a Community Interest Company it is developed in partnership with the NHS, led by public health and delivered by a dedicated team of individuals including public health, specialist sexual health services and the Design Council. During 2015 the team will be extending the service to provide access to and advice about contraception – follow its progress on: <http://sh24.squarespace.com>. By embracing design led innovation and working collaboratively with NHS services and users, SH:24 believes that it can improve the sexual health of the local population, reduce the number of unplanned pregnancies and improve the user experience. Evaluation of SH:24 is led by Kings College London and will provide important learning both for sexual health services as well as transferability to other sectors of health care delivery within the NHS.



#### What's the issue?

Sexual health in young people seems to be steadily improving in Southwark. Teenage pregnancy rates continue to fall. Amongst all age groups however, Southwark continues to have the highest sexually transmitted infection (STI) rates in the country.

Inequalities in sexual health also persist among particular population groups in Southwark. Men who have Sex with Men (MSM) continue to have very high rates of HIV and STIs. Some MSM in Southwark are taking very high risks as highlighted in the Chemsex study commissioned by Lambeth and Southwark 2013/14 (<http://lambeth.gov.uk/social-support-and-health/public-health/thechemsex-study>). Black African and Caribbean communities have high STI rates and a high prevalence of HIV.

Rates of infection continue to rise, partly due to additional cases being identified as more people are coming forward to be tested and treated.

#### What can we do about it?

The following measures can work to improve sexual health in Southwark:

- Continue to increase access to testing and treatment services, and partner notification, whilst ensuring affordable models of sexual health service delivery
- Provide distribution of condoms which is comprehensive and joined up, supported by training to enable people to use condoms correctly
- Deliver sex education in schools, within a wider healthy schools framework, which includes self-esteem, tackling stigma and attitudes towards sex, sexuality and relationships
- Develop a clear plan for increasing the coverage of HIV testing in community settings, including general practice, and review the evidence base for other testing venues, for example pharmacies.

#### What's happening at the moment?

Southwark is ranked number 5 for Chlamydia screening and diagnosis rates (2013). However, these rates show a reduction on the previous year's coverage of 15 to 24 year olds, the main age group at risk.

Despite Southwark having one of the highest rates of HIV (11.7 per 1000 15-59 year olds), late diagnosis rates are lower than elsewhere in London due to high levels of HIV testing.

#### What more can be done?

- Continue to increase access to all services, shifting non-complex activity out of hospital-based specialist GUM clinics into community settings, including GPs, pharmacies and SH:24, employing new online technology
- Implement the new MSM national framework which includes mental health, substance misuse and sexually transmitted infection (STI).

In this section we look at ...

#### 4.1 Primary care

### Key messages

- 1 Primary care is an effective means of improving the health of the Southwark population. **Brief advice from GPs on alcohol, smoking and activity is effective in increasing healthy behaviours.**
- 2 Fair access to primary care services can work to decrease the health disadvantages of socioeconomic inequalities. Conversely, variation in the coverage and quality of primary care services in Southwark may actually contribute to health inequalities. It is therefore important for GPs to be made aware of the link between the socioeconomic status of their patients and the variations in practice outcomes.

### Key recommendation

To promote the fair provision of primary care services throughout Southwark.



### What's the issue?

Primary care is an important part of the local healthcare delivery system. Effective preventive services delivered in primary care include the NHS Health Checks programme; and brief advice for stopping smoking, reducing alcohol harm and increasing physical activity. The Inverse Care Law operates so that those most in need of healthcare services are least likely to access them. For example, respiratory disease is more prevalent in lower income groups, who are more likely to smoke.

Variation in the delivery of primary care services in Southwark can be illustrated on a practice basis, with some GP surgeries achieving better patient outcomes than GP surgeries in others. Two examples of patient outcomes which may differ are the detection of those with long term conditions and those prescribed statins as part of the primary prevention of heart disease following an NHS Health Check.

Differences in these outcomes may be the result of several factors associated with the practices, in addition to the provision of appropriate primary care, for example, the level of deprivation in the area within which the practice is based. Nevertheless, efforts to reduce these inequalities should be employed irrespective of the underlying cause.

#### Doubling the numbers of Health Checks

Southwark is committed to increasing the numbers of people aged 40 - 74 having a Health Check. Everyone is at risk of developing heart disease, stroke, diabetes, kidney disease and some forms of dementia.

The aim is to detect potential problems before they do real damage and to provide personalised advice and support on how to reduce it, and where necessary clinical care.

[www.southwark.gov.uk/info/200504/nhs\\_health\\_checks](http://www.southwark.gov.uk/info/200504/nhs_health_checks)

### What can we do about it?

In 2011, the King's Fund carried out an independent inquiry into the quality of general practice in England. It revealed that whilst the quality of care in most practices is good, there were 'wide variations in performance and gaps in the quality of care both within and between practices'<sup>1</sup>. The following areas were highlighted as having particular scope for improvement<sup>1</sup>:

- Long-term conditions
- Continuity of care
- Co-ordination of care
- Patient involvement and engagement
- Prescribing

Informed by the inquiry, the following suggestions were among those recommended to improve quality and reduce variation in primary care<sup>1</sup>:

- Raising awareness amongst those working in general practice about variations in quality and to understand how much of this is avoidable
- Strengthening links between general practice and other services in areas where patients with complex problems receive care from multiple providers
- Ensuring that all patients receive all their recommended care as defined in clinical best-practice guidance, for example, in the prescription of low-cost statins and in delivering recommended care to people with long-term chronic illness.

Although these suggestions have been outlined for action at the national level, local application of some of the most relevant recommended actions could be considered.

## What's happening at the moment?

The Southwark Primary and Community Strategy Plan aims to improve equity of access to primary care on a population basis using Local Care Networks – a neighbourhood service delivery model including pharmacies.

To address inequalities in the management of long-term conditions in primary care, the Southwark and Lambeth integrated care (SLIC) project has been introduced to support integrated care in both boroughs

## What more can be done?

It is clear that there is a need to close the gap between the expected and detected prevalence of long-term conditions in primary care and to reduce variation. Further interrogation of the research evidence will be required to identify the most effective approaches to do this. At present the use of co-production and systems change approaches in Southwark may lead to optimal treatment of this patient group.

Commissioners and GPs should also look more to wider determinants of health in their practice area to adapt service delivery to the needs of their patients and to ensure that variations do not exacerbate health inequalities.

## Local case study

Public Health has undertaken some modelling of the health impact of statins in preventing cardiovascular events in people identified as at risk following a health check in community settings (GPs, pharmacies and outreach services).

In Southwark, in those people who are identified as at risk following a health check and who are prescribed a statin, currently around 40 emergency hospital admissions and six deaths are avoided every year. However, if 60 % of these people at risk were prescribed a statin, 117 emergency hospital admissions and 16 deaths could be prevented, with a net saving of £373,000 per annum.

This modeling work has been circulated to relevant stakeholders to highlight the importance of prevention in primary care and community services.

### References

The King's Fund (2011). Improving the Quality of Care in General Practice: Report of an independent inquiry commissioned by the King's Fund.

## Immunisations

### 4.2.1 Childhood Immunisations

## Key message

There have been consistent year-on-year improvements in childhood immunisation uptake rates in Southwark.

## Key recommendations

1. To maintain the existing local immunisation team.
2. To further incentivise GPs to enable health visitors to target harder to reach children.

## What's the issue?

Complex NHS changes have left several organisations with a remit for immunisation – NHS England, CCGs, local councils, GPs and community services.

## What can we do about it?

The excellent work of the GSTT immunisation team has produced considerable improvements in uptake locally. For the first time ever, uptake of the three doses of Diphtheria vaccination at two years old has now reached 95% in Southwark.

Timely gathering of local data with appropriate cleaning and validation, and extensive follow up of unimmunised children has resulted in achieving this in all population groups.

Robust call and recall can also ensure good uptake. Locally this involves consolidating the existing GP birthday card scheme for inviting children for their immunisations.

## What's happening at the moment?

Childhood immunisation uptake rates in Southwark are above the London average. Focused work to improve uptake of the 1st dose of MMR and pre-school booster is also being undertaken to ensure high uptake in all population groups.

## What more can be done?

Consider making GP payments, graduated for under 5s and conditional upon GPs achieving certain targets within 4 months of the due dates.

Continue with the practice nurse training established to support local health professionals.



## 4.2.2 Adult Immunisations

### Key message

1. Flu vaccination levels for at-risk groups in Southwark vary widely across GP practices.
2. Local health and social care staff vaccination remains below the national target

### Key recommendations

Vaccination of health and social care staff should be increased to help protect patients, family, and colleagues as well as themselves<sup>1</sup>

### What can we do about it?

A good level of seasonal flu vaccination is key to reducing harm from flu, and pressures on health and social care in winter<sup>2</sup>. Eligible for free flu vaccination are those aged 65 and over, pregnant women, people in clinical risk groups (e.g. diabetes, chronic respiratory disease, chronic heart disease etc), residential care home residents, children aged 2-4, and carers.

GP practice vaccination of 65s and over during winter 13/14 stood at 70% in Southwark. The coverage was lower in other risk groups, with wide variation across practices. In 2012/13 the vaccine uptake by those aged 6 months to 65 years in an at-risk category was just below 50%<sup>3</sup>.

Data from Kings and Guys & St Thomas' showed 43% of flu related emergency hospital admissions were in patients in one of the higher risk groups<sup>4</sup>.

Local health staff vaccination rates over 2012/13 showed low GP vaccination at around 50%, with practice nurses showing better uptake as a staff group (53% in Southwark)<sup>5</sup>.

### What works to address this?

- Tackle myths around flu vaccination to encourage uptake particularly in eligible groups
- Ensure social care leads are aware of the need for, evidence about and availability of flu vaccination
- Encourage and support general practice staff and other key staff leads to act as role model 'flu champions' in being immunised
- Immunise 2-4 year olds to reduce the spread of flu.

### What's happening at the moment?

- Local public and staff-facing communication campaign
- Improved links with NHS England who are responsible for improving general practice flu immunisation
- Flu training updates planned by public health with CCG nurse leads for practice nurses and health care assistants.

### Local case study

In 2013/14, a local council social care lead identified key front line staff for vaccination. He purchased a supply of pharmacy vaccination vouchers and staff could then get vaccinated at a time and place convenient to them.

### What more can be done?

Social care employers need to be made more aware that their duty of care responsibility includes ensuring flu vaccination availability to front line staff.

National plans to introduce the delivery of flu vaccine to all children will protect the children and further reduce the spread of flu in the community. Analysis of the current pilot shows that this works best through the school nursing service with additional staff who can be redeployed when not in the flu season.

#### References

<sup>1</sup> NHS Employers. (2011). Clinical Evidence: Flu vaccination. Available at: [http://www.nhsemployers.org/~media/Employers/Documents/Campaigns/Flu%20fighter/Flu\\_clinicalevidence2013.pdf](http://www.nhsemployers.org/~media/Employers/Documents/Campaigns/Flu%20fighter/Flu_clinicalevidence2013.pdf) [Accessed on 31st July 2014]

<sup>2</sup> Department of Health. (2014). National Flu Programme 2014 and 2015. Available at: <https://www.gov.uk/government/publications/flu-immunisation-programme-2014-to-2015> [Accessed on 31st July 2014]

<sup>3</sup> South East London Health Protection Unit (SELHPU). (2013). SELHPU report: South East London Seasonal Influenza Vaccination Review.

<sup>4</sup> Lambeth & Southwark Public Health Team. (2013). Local Public Health Dataset (unpublished).

<sup>5</sup> Public Health England (PHE). (2013). IMMFORM data. Available at: <https://www.gov.uk/government/collections/immform> [Accessed on 31st July 2014].





## 4.3 Cancer screening

### Key message

- 1 Early diagnosis of cancer through screening results in better outcomes and increased survival rate.
- 2 There are currently three national cancer screening programmes: breast, cervical and bowel. The effectiveness of these depends on their coverage (the percentage of the eligible population group who have been screened).

### Key recommendation

We need to improve coverage in the cancer screening programmes in Southwark, particularly in the bowel screening programme.

### What's the issue?

The incidence and severity of some cancers varies between different communities and the general population. This is thought to be linked to a combination of factors, including lifestyle, ethnicity, socioeconomic circumstances, age, gender, genetic pre-disposition and knowledge of and access to services. All these factors also impact on screening uptake.

#### Breast cancer

- Breast cancer is the most common cancer in the UK and the second most common cause of cancer death in women<sup>1</sup>. Studies have shown that black women are more likely to present at an early age with more aggressive disease and have a significantly worse survival rate than other ethnic groups<sup>2</sup>. Black women on average, present 21 years younger than white women<sup>3</sup>.
- Breast screening is offered every three years to all women aged 50-70 registered with a GP. This programme is being extended to include women aged 47 to 73 years
- For the breast screening programme, coverage is defined as the percentage of 50-70 year old women that have had a breast screen result in the last three years. The national coverage target is 70%. Breast screening coverage in November 2013 in Southwark was 60.5%, which is lower than the London average.

#### Cervical cancer

- Cervical cancer is the most common cancer in women aged under 35<sup>4</sup>. Local incidence and mortality from cervical cancer is higher than national and London rates<sup>5</sup>
- The cervical screening programme offers screening to women between the ages of 25 to 64, with women aged between 25-49 being offered screening every three years, and those aged 50-64 every five years
- For the cervical cancer screening programme, coverage is defined as the percentage of eligible women between the ages of 25 and 64 years who have had an adequate test result in the last five years. The national target is 80%. Cervical screening coverage in November 2013 in Southwark was 72.3%
- Human papilloma virus (HPV) is a common virus that can be transmitted during intimate sexual contact, and is linked to the development of abnormal cervical cells. If left untreated, these abnormal cells may go on to develop into cervical cancer. HPV triage and test of cure have been introduced into the cervical screening programme across England
- All girls aged 12 or 13 are offered the HPV vaccine as part of the childhood vaccination programme. The vaccine protects against the two types of HPV responsible for more than 70% of cervical cancers in the UK. Current research suggests the HPV vaccine is protective for at least 20 years.



## What can we do about it?

### Bowel cancer

- Bowel cancer is the second most common cause of death from cancer in the UK and the third most common cancer<sup>6</sup>. Southwark and Lambeth both have a high incidence of bowel cancer, a high mortality from bowel cancer and two thirds of people who are sent a bowel screening kit as part of the bowel cancer screening programme do not return it
- As the bowel screening programme is relatively new, the number of 60 to 69 year olds who return their test kit (uptake) is used as a measure instead of coverage. The uptake of the programme in Southwark is 35%, which is the lowest in London and well below the national target of 60%
- A study has shown a low uptake of bowel screening in the Asian community that cannot be explained by differences in other factors such as age, gender, date of screening invitation, or deprivation index. The likelihood of participating in screening remains two and a half times lower among Muslims and Sikhs, and about twice lower among Hindus even if these other factors are taken into consideration<sup>7</sup>. As Southwark has a large Asian population, this may explain in part the low uptake rate in the borough.

Population based screening programmes help in the early detection of disease. For example, people engaged with the breast cancer screening programme have a lower mortality. An independent review of breast screening found that breast screening saves around 1,300 lives from breast cancer in the UK each year.

Following the introduction of the NHS cervical screening programme in the late 1980s, cervical cancer rates have decreased considerably, reaching a plateau in the early 2000s.

Reported incidence of bowel cancer is increasing, while mortality is decreasing. The main reason incidence appears to be increasing is that more cancers are identified due to the screening programme. The reduction in mortality is due in part to earlier diagnosis as a result of the screening programme as well as improved treatments.

## What's happening at the moment?

Challenges to the cancer screening programmes in Southwark include a high population mobility, which makes keeping records up to date difficult. The multi-ethnic and socioeconomic make up of the population may also contribute to low coverage due to incorrect patient details on GP records.

In addition, for bowel and breast screening, the programmes are not embedded within primary care, so there is little incentive for GPs to promote the service.

### Current work includes:

- An audit to determine the training history and needs of cervical smear takers in primary care, to ensure that all smear takers are trained and up to date with programme developments
- Developing health promotion materials and information to raise awareness among GPs and to keep them updated of changes to the programmes
- Following on from the success of a telephone intervention pilot conducted recently to improve bowel screening uptake, we are working with local GP practices to improve uptake among their practice population through patient engagement. There is evidence to suggest that people are more likely to return the test if they have a conversation with their GP about it.

## What more can be done?

Further work will be undertaken on awareness-raising and piloting interventions in primary care to establish whether this improves uptake in bowel cancer screening.

We will continue to work closely with the commissioners and providers of the screening programmes to ensure coverage improves and inequalities are reduced.

### References

- <sup>1</sup> Cancer Research UK Website (2014). Breast cancer statistics webpage. Available at: <http://www.cancerresearchuk.org/cancer-info/cancerstats/keyfacts/breast-cancer/> [Accessed 7th November 2014]
- <sup>2</sup> Jack RH et al (2009): Breast cancer incidence, stage, treatment and survival in ethnic groups in South East England. Br J of Cancer, 100, 545-550
- <sup>3</sup> Bowen RL et al (2008): Early onset of breast cancer in a group of British black women. Br J of Cancer, 98, 277-281
- <sup>4</sup> Cancer Research UK Website (2014). Cervical Cancer statistics webpage. Available at: <http://www.cancerresearchuk.org/cancer-info/cancerstats/keyfacts/cervical-cancer/> [Accessed 7th November 2014]
- <sup>5</sup> Health and Social Care Information Centre (2014). Available at: <https://indicators.ic.nhs.uk/webview/> [Accessed 7th November 2014]
- <sup>6</sup> Cancer Research UK Website (2014). Bowel cancer statistics webpage. Available at: <http://www.cancerresearchuk.org/cancer-info/cancerstats/keyfacts/bowel-cancer/> [Accessed 7th November 2014]
- <sup>7</sup> The UK CRC Screening Pilot Evaluation (Ethnicity) Team (2003). Ethnicity: UK Colorectal Cancer Screening Pilot Final Report. Available at: <http://www.cancerscreening.nhs.uk/bowel/ethnicity-finalreport.pdf> [Accessed 7th November 2014]



## Local case study

### A pilot to improve uptake in bowel cancer screening

Recently, a pilot project was run with some GP practices. The intervention was to identify and then telephone those men and women who were due to be invited to complete the bowel screening kit and to check whether:

- they had received the kit
- they understood how to use the kit
- they had the intention to use and return the kit.

If they had not received a kit then we were able to send a replacement and if they did not understand how to use it we were able to talk them through the process if they wished.

As a result of the intervention, a significant number of additional people participated in the screening programme who may not otherwise have done so. Further work around following up those who do not return their kit is now being considered.

## Key messages

- 1 The risk of poor mental health is not equal across the population. Early life experiences, socioeconomic circumstances, and physical health all influence risk.
- 2 People with mental health problems are disadvantaged in society in terms of discrimination, unemployment, poverty, social isolation, physical ill health and premature death. As a result of their social and economic situation the benefit cuts are having a disproportionate impact.
- 3 The social and economic cost to society of mental ill health and poor mental wellbeing is huge. In 2011, mental ill health was the largest single source of disability in the UK, accounting for 22.8 per cent of the 'burden of disease'.
- 4 Solutions are societal, attitudinal and economic as well as medical. A focus on health behaviour change approaches is likely to blame the most disadvantaged rather than 'creating the better social and financial environments that enable individuals and communities to have more control over their health and wellbeing'<sup>1</sup>.
- 5 Reducing inequality doesn't just happen. 'Unless consciously designed not to, policies and actions that work for populations as a whole can often inadvertently entrench inequalities'<sup>2</sup>.

## Key recommendations

1. All future commissioning strategies and plans should start with what needs to be done to ensure the most disadvantaged and excluded groups will benefit.
2. People with mental health problems frequently have a mix of issues for which they need support. Organisations should come together to offer a holistic problem-solving approach without the need for lots of referrals and multiple assessments, and be supported to do so.

## What's the issue?

At any one time, 16.2% of the adult population (age 16 & over) may have a common mental disorder (CMD), such as depression, anxiety, panic disorder, phobias, obsessive compulsive disorders and eating disorders<sup>3</sup>. In Southwark, this rate translates into about 43,000 people (using the GP registered population).

Nationally about 1% of the population are expected to have a severe mental illness (SMI), mainly schizophrenia and bipolar disorder. One in ten children and young people (10%) aged 5-16 have a clinically diagnosed mental disorder. One in five children diagnosed with a mental health problem may have more than one disorder, and children with an emotional disorder are more likely to have poor physical health (23% compared to 5% of children with no disorder).<sup>4</sup>

However not everyone is at the same risk. Risk of a mental health problem increases as household income decreases. In Southwark, a borough with high levels of deprivation, 1.4% of the population known to their GP are severely mentally ill. This is 40% higher than expected from national surveys.

Having a mental health problem is at least as bad for health as smoking 20 cigarettes a day<sup>5</sup>. People with severe and enduring mental ill health:

- Die much earlier than the general population in South East London (between 8 to 17.5 years earlier).<sup>6</sup>
- Are more likely to have one or more physical illnesses.
- Are more likely to be at risk of poor physical ill health, because they are more likely to smoke, be overweight, and to lack the opportunities and support to live a healthy life.

People with mental illness lose out across society for the following reasons:

- They are more likely to be unemployed. In 2012, the Mental Health Foundation reported that nationally, only 27% of working age adults with mental illness were in work (compared with about 70% of the general working age adult population)<sup>7</sup>. Nearly 50% of long term sickness absence is thought to be due to mental health problems<sup>8</sup>.
- They are more likely to live in poor quality or otherwise unsuitable accommodation. Of working age adults (18-69 years) on the Care Programme Approach (CPA) in Southwark (about 1200 people) only 4.2% respectively are working<sup>9</sup>.
- They are more likely to be excluded from opportunities to make friends, volunteer and contribute to their communities.
- They are more likely to be living on their own, socially isolated, and vulnerable to financial or sexual exploitation, as well as being subject to verbal abuse and negative stereotyping in the media and elsewhere. Frequently they do not have a voice or control of their own care<sup>10</sup>.

Despite increased risk of physical ill health people with mental ill health may be denied access to health and health promotion services because of their mental health<sup>11</sup>.

## What can we do about it?

- All commissioning strategies and plans should address how people with or at risk of poor mental health will be included. Services should not be designed or commissioned with just an average person in mind.
- Health and local government should foster the conditions which enable people and communities to take control over their health and wellbeing and pay attention to the role of social relationships, physical health, housing and employment in recovery of people with mental health problems. The mental and emotional health of people with physical conditions also needs to be addressed.
- As a matter of urgency, local partners should agree how they will act to change the overall social and economic circumstances in which people are born, grow, live, work and age so as to reduce risk of mental and physical ill health for future generations. Shift investment 'upstream' especially to preventive action with new parents, families and young people in school.
- Take all possible action to avoid the worst impact of benefit cuts on the poorest, including people with or at risk of mental health problems. As a minimum, institute appropriate surveillance so the extent of the impact on the local population can be measured.
- Ensure front line health and council professionals have access to relevant and appropriate learning and development on mental health and wellbeing and are supported to do so, so that they are aware of the mental health component of many issues that people present with and have basic skills and confidence to identify and deal with these appropriately, for example, support, advice, signposting.

## What's happening at the moment?

A re-ablement service was set up in 2012 to offer more integrated and solution-focused health and social care support to people with mental health problems as part of their recovery. The aim was to offer a 13-week intensive and flexible programme including:

- recovery and support planning to help people take more control over their life and their symptoms by action planning for their future, for example, to expand their social connections or volunteer
- developing new approaches to combat obstacles and negative thoughts which block progress
- support to daily living including personal safety, household routines and eating healthily.

An early evaluation suggested the service was well received by patients who valued the more intensive input and personal approach. Levels of need reduced considerably in some domains, for instance isolation, decision-making, personal care and hygiene, work and learning, and in domestic routines. Although most people's mental health status was unchanged, this level of improvement in ability to cope was thought valuable. Clients who were male and of black ethnic background engaged less well with the service despite having similar levels of need, suggesting the service needs to develop strategies to engage this group more effectively if inequalities are not to widen.

The Southwark talking therapies services are being re-commissioned and will include specialist support for people at risk of losing their job or looking for work.

A small amount of Mental Health First Aid and mental health awareness training is available mainly for voluntary and community organisations. This is an evidence-based two day introduction to mental health and wellbeing, common myths and taboos, when to consider someone maybe experiencing mental distress and what non-experts can say and do to help.

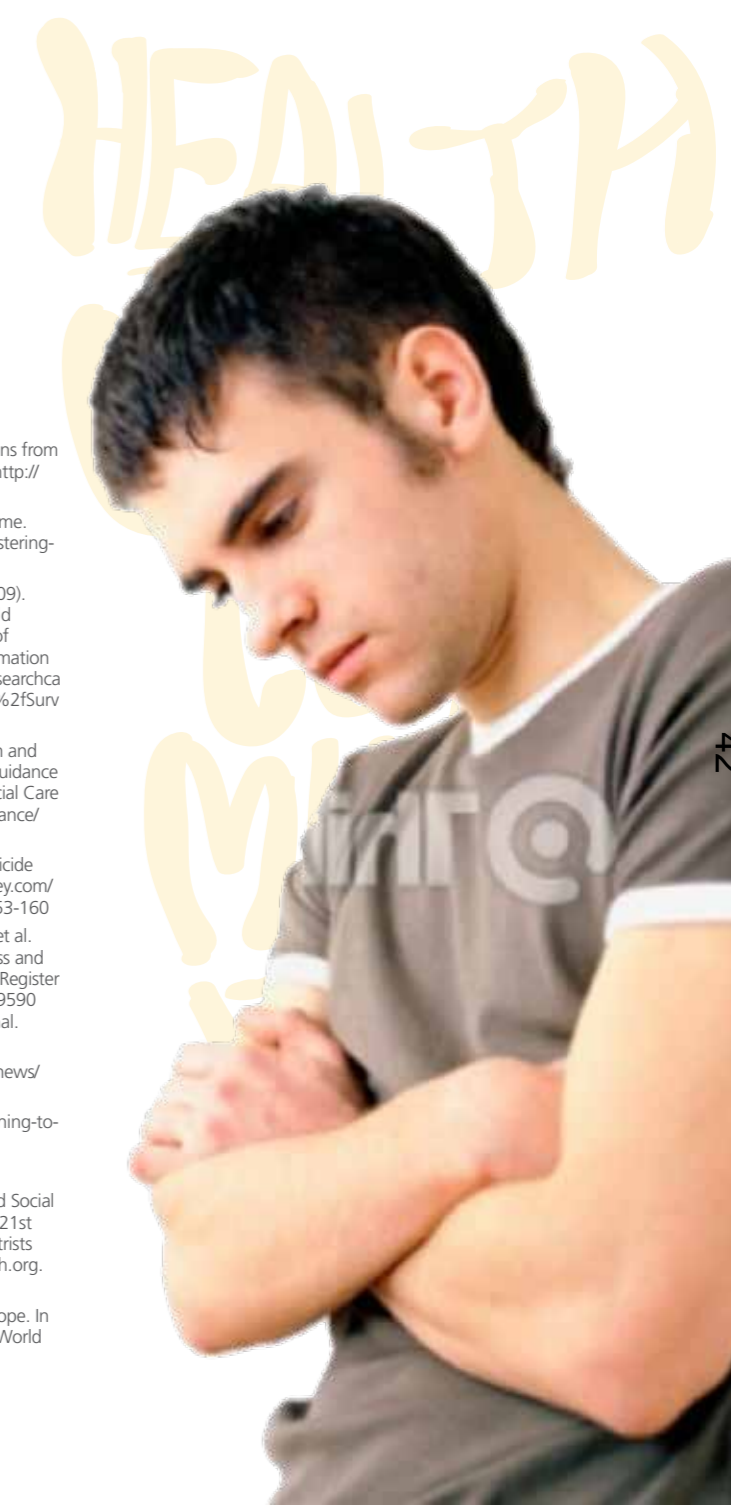
As part of their commitment to integrated care, Southwark CCG wish to incorporate mental health support to the care of people with long term physical health conditions. This is starting with the care of older people with dementia. The next stage is to make this work for adults of working age and older people with common mental disorders like anxiety and depression.

## Local case study

In King's Health Partners, the IMPARTS programme aims to integrate mental and physical healthcare in research, training and clinical services. This includes training on core mental health skills for physical healthcare teams. <http://www.kcl.ac.uk/ioppn/depts/pm/research/imparts/index.aspx>

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- <sup>8</sup> NHS Choices <http://www.nhs.uk/Livewell/mentalhealth/Pages/returning-to-work-mental-health.aspx>.
- <sup>9</sup> Mental Health Minimum Dataset, April 2014
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# Update on recommendations from last years Annual Public Health Report

## Recommendations APHR 2012/13

## Progress so far

- 1 All agencies to work together to ensure reducing the impact of child poverty is embedded in strategies, practice and investment choices. Child poverty reduction has been embedded into many strategies and work in Southwark including work on neglect, economic development and wellbeing, and housing.
- 2 The specialist public health team should support all partners to recognise the impact of the wider determinants of health and work to improve health and reduce health inequalities. Mental wellbeing impact assessment has been used across many council departments e.g. Thames Tidal Tunnel, Camberwell Green regeneration plans and Volunteering Strategy. This is now a focus of the Southwark CCG Primary & Community Care Strategy.
- 3 The NHS, council and voluntary agencies should develop a needs based multi-agency approach to reducing levels of overweight and obesity in children. A review to identify evidence based interventions has been conducted to address childhood obesity. The interventions have been prioritised and these are being commissioned to meet local needs. Partnership working across the different agencies continues to support the promotion of healthy eating and physical activity.
- 4 It is important to maintain the focus and funding to improve outcomes in adolescents and recognise the interplay of risk factors which impact adversely on health and life chances. Key stakeholders have contributed to a Guys and St. Thomas's Charity funded Young Person's Health Initiative. Additionally, a healthy lives in schools programme has been working to promote healthy lifestyles in young people.
- 5 The NHS, council and voluntary agencies should develop a multi-agency strategy for improving the mental wellbeing of children and adults in Southwark, particularly in areas of deprivation. There is now one Lambeth and Southwark Wellbeing Programme, a new Healthy Schools group for Southwark and a PSHE lead is being recruited.
- 6 Implement the Southwark Alcohol Strategy 2013-2016. The Southwark Alcohol Strategy 2013-2016 has been launched and is currently being implemented in Southwark.

## Recommendations APHR 2012/13

## Progress so far

- 7 The NHS, Council and voluntary sector continue to prioritise prevention and early intervention services such as tobacco control. Smoking is the single most preventable cause of ill health and health inequalities. Tobacco control which includes smoking cessation continues to be a local priority. Southwark CCG has prioritized Prevention as one of its main work programmes for 14/15.
- 8 The public health department should ensure a smooth transition of the cancer screening function to the NHS Commissioning Board and work with local commissioners and providers to identify further actions to increase uptake. The cancer screening function is commissioned and managed by NHS England and Public Health England. The Public Health Team works closely with these organisations as well as the Clinical Commissioning Groups to identify interventions that will improve screening uptake and quality.
- 9 The NHS commissioning board should continue to work with GPs to encourage the identification of patients with undiagnosed chronic conditions. NHS England published a Call to Action for primary care in November 2014. This sets the vision for Primary care Transformation and aspires to Accessible, Coordinated, Proactive care for all. See <http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/12/london-call-to-action.pdf> for further information.
- 10 The 2010 Annual Public Health Report identified marked variations between some practices for quality of care indicators. Work should continue to improve the quality of care across primary care. This is now a focus of the Southwark CCG Primary & Community Care Strategy and the Lambeth Primary Care Development Plan.
- 11 There are many opportunities for further integrating health and council services. Opportunities for innovative partnerships that can improve public health should be explored. The Southwark and Lambeth Integrated Care Programme (SLIC) has been initiated with GSTT Charity funding and represents a partnership based approach to improving integrated care.



## Extended Primary Care Services in Southwark: progress report Overview and Scrutiny Committee

### 1. Background

NHS Southwark Clinical Commissioning Group (CCG) undertook a review of urgent care services across Southwark during 2013 including our local Walk-in Centre. Local analysis and engagement with residents showed the current model for accessing primary care was neither consistent nor optimal with:

- variation in service provision and quality
- system is complicated and difficult for patients to navigate leading to use of A&E and other urgent care services as default
- different ways in which these services are funded and commissioned leads to fragmentation, duplication and inefficient use of resources.

Following the review of the Walk-in Centre, Southwark CCG agreed to commission an alternative service across Southwark delivering extended primary care access. The CCG made an investment of £2.1 million to fund recurrent service costs and was successful in securing Challenge Fund resources (£975K) to support infrastructure, GP engagement and set up.

The key elements of the new service model are:

- Access point in two locations across Southwark, 8am – 8pm, 7 days a week – accessible via booked appointments in primary care (local general practice and GPOOH) and referral from King's A&E/ other agreed urgent care access points.
- Access to patient primary care record
- Rapid telephone management by senior clinician to support robust demand management and balance the needs for same day demands with the needs of patients who require continuity of care for planned care needs.
- Alignment and consistent application of access policies across general practice

The new service, providing additional levels of access to Southwark patients, will operate seven days a week, 8am to 8pm. The CCG has commissioned this new model of care from the two neighbourhood GP federations - Improving Health Ltd (IHL) and Quay Health Solutions (QHS). The CCG has kept the Oversight and Scrutiny Committee (OSC) apprised of progress since the review of urgent care services first began in late 2013 and this paper provides an update on progress.

### 2. Progress to date

This service will be delivered from two sites across the borough – Lister Health Centre in the south and Bermondsey Spa in the north. The first site went live at the Lister Health Centre on 11 November 2014 and an overview of progress to date is provided below. The second site in the north is due to go live on 1 April 2015.

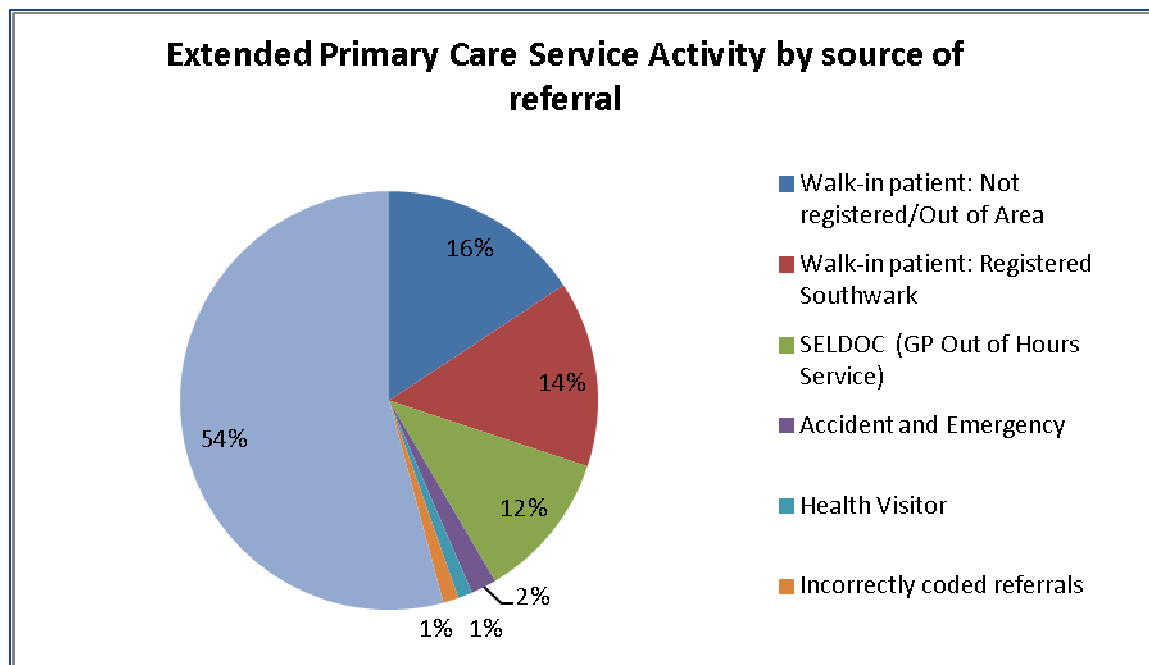
#### a) South service: Lister Health Centre

##### i) Service activity

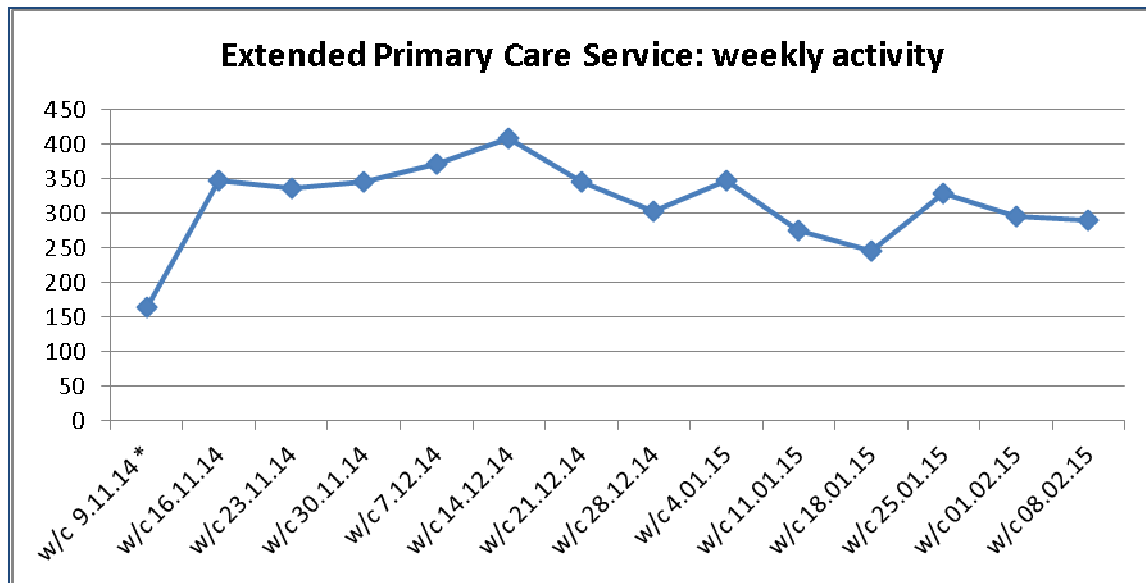
- Overall activity: Over the first 14 weeks over 4500 patients have been seen in the Extended Primary Care Service (EPCS), over half of which were booked via general

practice. All practices have now used the service, although utilisation varies. After a steady increase, activity dipped during the holiday period which was mainly driven by a reduction in practice referrals to the service.

Source of referral	Activity
Walk-in patient: Not registered/Out of Area	707
Walk-in patient: Registered Southwark	649
SELDOC (GP Out of Hours Service)	516
Accident and Emergency	89
Health Visitor	50
Incorrectly coded referrals	54
Practice booked appointments	2440
<b>TOTAL</b>	<b>4505</b>

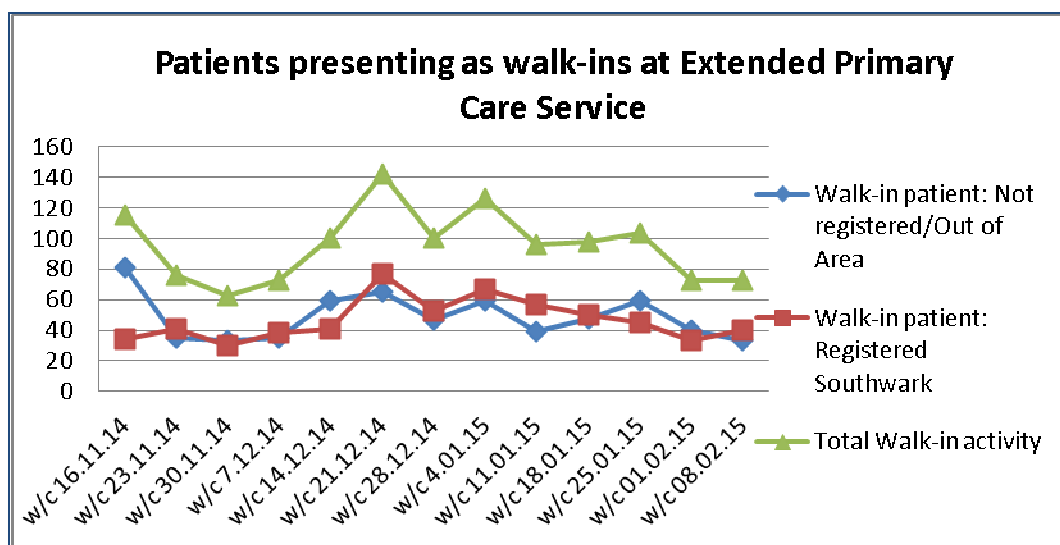




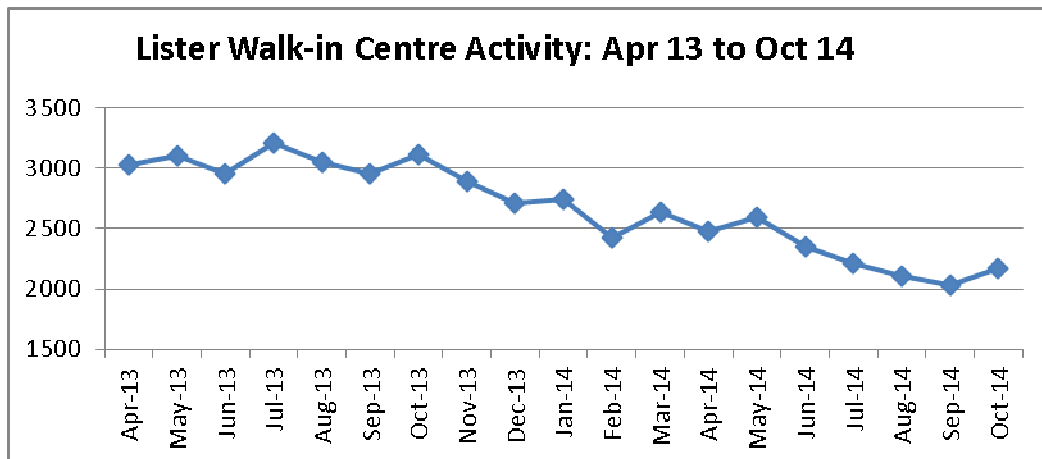


- Walk-in presentations:** As the Committee will be aware, the EPCS replaces the Walk-in Centre previously based at the Lister Health Centre, which was decommissioned in November. Whilst there was work undertaken during October and November to communicate the service changes to the public through a number of mechanisms it was recognised that some patients may continue to present at the centre. Therefore the CCG has agreed a transitional arrangement will be in place to manage this cohort of patients and ensure they receive appropriate clinical treatment. This arrangement will be reviewed after six months and take into account patient activity and activity. In addition, there are PALS officers on site to provide information and support registration.

The graph below shows that whilst walk-in presentations to the new service reduced over the first three weeks, an increase was seen leading into the holiday period as may be expected. However the number of walk-in presentations has continued to decrease over January and February. There is ongoing work to understand the types of patients presenting and this information will be shared with practices as part of regular reporting.



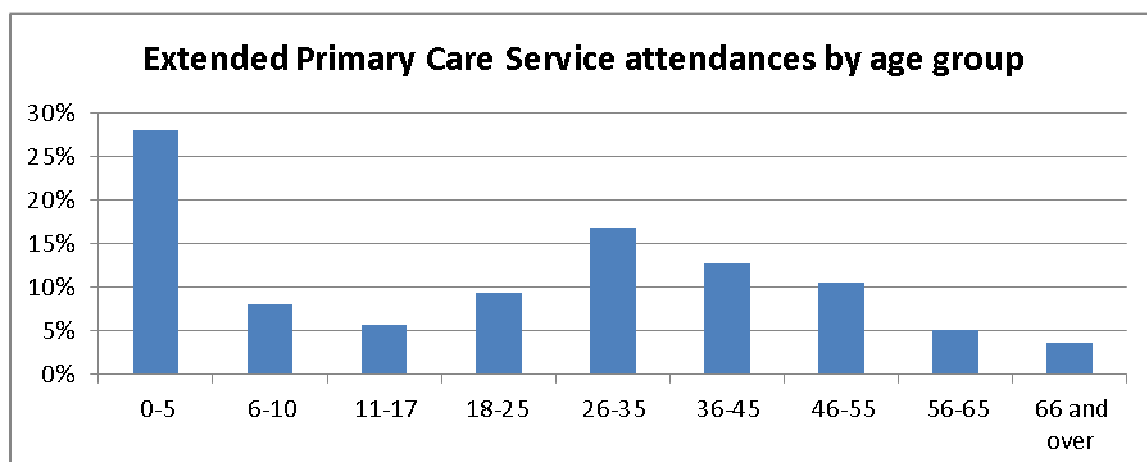
It should be noted that the number of patients self-presenting to the EPCS remains low relative to activity levels at the previous Walk-in Centre. During December, there were 418 walk in presentations to the Extended Primary Care Service which compares with a monthly average of approximately 2200 patients attending the Walk-in Centre during 2013/14. It should also be noted that the activity at the Lister Walk-in Centre had decreased year on year as shown below.



Further information on activity at surrounding Walk-in Centre's has been requested; however anecdotally, no increases in Southwark presentations have been reported. Work to improve coding will provide clarity on the distribution of out of area patients as opposed to unregistered local patient.

- Distribution of activity

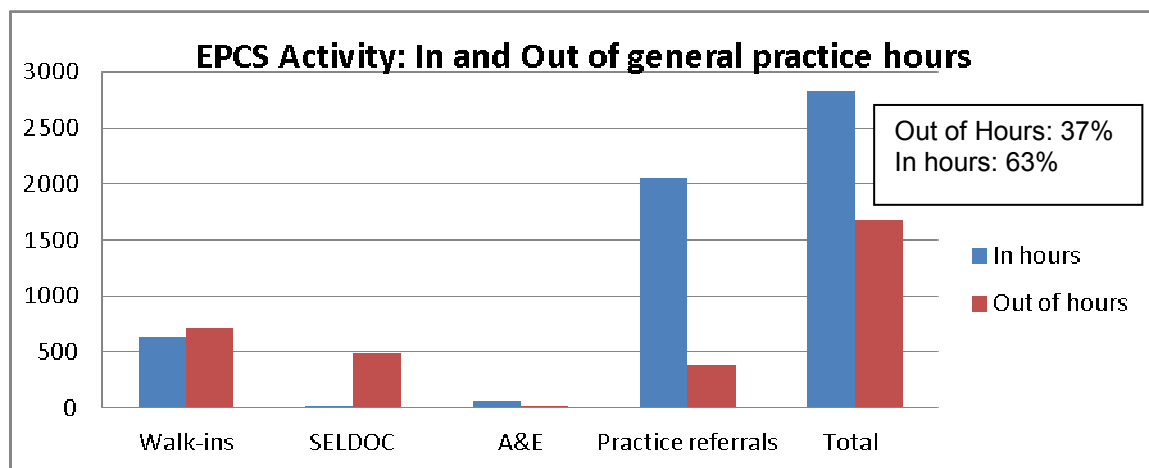
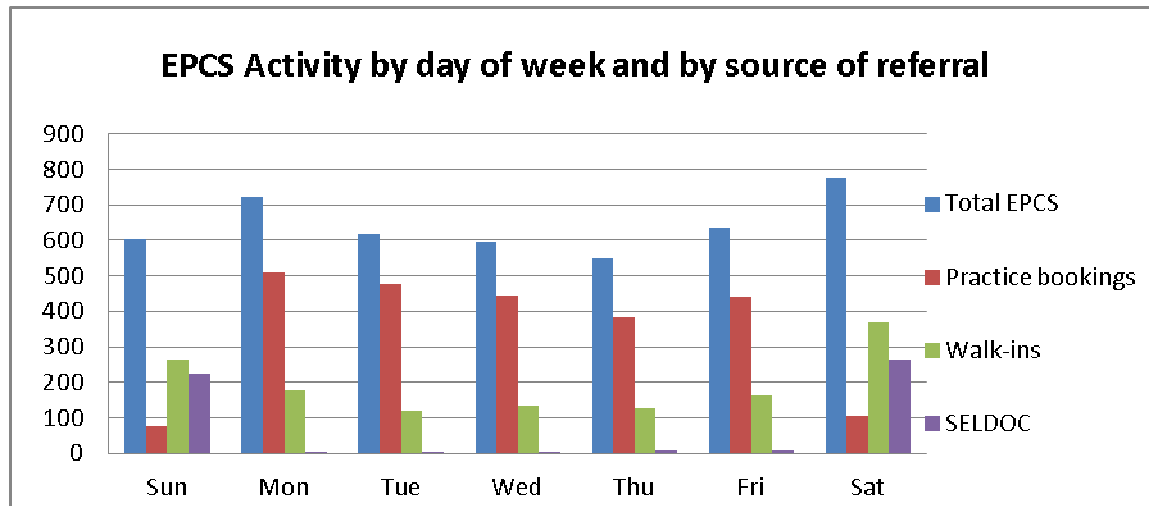
Age: Young children accounted for the majority of attendances over the first three months, with just over a third of patients aged 0 to 10 years, whilst younger working age adults (18-45) made up 39% of presentations. The planned communication and engagement campaign aims to target these particular groups.



Day and time: This service aims to improve access to primary care services and to date over a third of appointments have been delivered outside of core GP hours. The distribution over

the week is relatively even although the busiest days are Monday and Saturday. Areas for development include

- Practice referrals for Sunday appointments and early morning slots: this would be considered as part of the borough wide work to review and align practice access policies.
- SELDOC: The local GP out of hours provider has continued to refer to the service and whilst activity has increased since go-live, absolute numbers remain relatively low. Whilst the majority of referrals would be expected take place over the weekend, SELDOC are able to book morning appointments during the week and this is an area that will be explored.



- **Impact upon A&E**

The Lister Health Centre is located near King's Emergency Department and there is a re-direction pathway in place. A comparison of activity at the King's Urgent Care Service, which is staffed by GPs and manages minors, in the periods before and after the service went live in 2013 and 2014 was undertaken to consider any changes in minor attendances at King's ED. This showed no significant changes following the launch of the service.

At this point in time it is not possible to assess the impact of the service on urgent and emergency care services in a meaningful way. This is due to a number of factors including the short period of time the service has been running for, the holiday period not being representative of usual service utilisation and the wider

issues impacting upon A&E performance. The CCG is working with relevant parties to more clearly understand the impact upon patient flows and the wider system.

The service provider met with King's Emergency Department leads in February to review the re-direction protocol and identify opportunities for improvement which includes providing access to the electronic shared appointment system.

- Health Visitor Service: a new service, funded through NHS England winter monies, operating at weekends and accepting referrals from the Extended Primary Care Service began in December and there are discussions in progress to increase activity
- Coding: Please note there is ongoing work to improve coding and reporting and some caveats on the data provided here.

#### ii) Practice and patient feedback including complaints

- Since go-live in the south site, all twenty member practices have used the service, although utilisation has varied. The Improving Health Ltd (IHL) team has completed a programme of 'check-in' calls and practice visits which has informed ongoing service improvements. Feedback to date has been positive.
- Patient feedback has been positive, with 97% of survey respondents indicating they were 'Extremely likely' or 'Likely' to recommend the service to friends and family. The service is in the process of collating this information and summary reports will be considered as part of contractual discussions. Patient experience and views of the changes to the overall primary care pathway including consistent telephone management, will be considered as part of the local evaluation. This is being overseen by the Challenge Fund Steering Group.
- Complaints and incidents  
The CCG funded two Patient & Liaison Services (PALS) officers to support patient navigation and signposting during the transition period. The PALS log of issues and complaints has highlighted themes and issues. This is reviewed at weekly provider management team meetings and reported to Commissioners. In some instances, this has highlighted a lack of clarity regarding the scope of the service. For example, there have been some inappropriate referrals to the service from practices which has reinforced the need for timely senior clinical review. The provider clinical lead has reviewed cases and followed up with the practices in question. The service provides both GP and Nurse Practitioner appointments and feedback has highlighted the need to clearly communicate this to patients at the point of referral. Subsequently this has been reiterated in practice communications.

Any incidents will be raised at provider senior management team level and reported as part of standard contractual monitoring process.

#### b) North service: Bermondsey Spa

- Scope of service: The north service will be delivered from Bermondsey Spa and provide appointments for same day and urgent care needs, in line with the model operating in the south of the borough. However it will also offer some routine appointments, namely some routine tests, dressings and contraception delivered by a practice nurse.
- Service start date: The service is now due to go live on 1 April 2015. Whilst it was originally due to mobilise on 24 February 2015, following internal review and discussion

with the service provider a new mobilisation start date was agreed. This has been agreed with NHS England, as co-Commissioners.

- **Premises:** The CCG commissioned a utilisation review in September to identify a well located space in the north of the borough, following confirmation that no single GP practice could accommodate the Extended Primary Care Service. The preferred option was Bermondsey Spa Medical Centre, however the freeing up of appropriate space required the consolidation of some GSTT services from Bermondsey Spa to Artesian. The CCG has worked closely with GSTT to
  - appraise the Overview & Scrutiny Committee of the changes and plans in place to manage this
  - support communication to patients affected by the changes through development of appropriate materials and
  - review progress and ensure the service moves were completed within the required timescales. The service moves were completed on 6 February 2015.

Harprit Lally  
Challenge Fund Programme Manager  
Southwark CCG  
February 2015

## GSTT Service Moves - update Overview and Scrutiny Committee March 2015

### 1. Background

NHS Southwark CCG has commissioned Extended Primary Care Services, 8am – 8pm, seven days a week across the borough, representing an annual investment of £2.1million. This will improve access to general practice services through the provision of approximately 100,000 additional primary care contacts per year. The service will be delivered from two locations across the borough. The first site in the south went live at the Lister Health Centre on 11 November 2014.

The CCG commissioned a utilisation review to identify a well located space in the north of the borough for the second site, following confirmation that no single GP practice could accommodate the Extended Primary Care Service. The preferred option highlighted by this review was to locate the new service at Bermondsey Spa Medical centre, with appropriate space being freed up through the consolidation of some services from Bermondsey Spa to the Artesian health centre (with no reduction in service).

In December 2014, the CCG & GSTT completed an OSC trigger template outlining plans to move three services from Bermondsey Spa to Artesian to accommodate the Extended Primary Care Service, and describing how the changes would be managed to ensure minimal disruption for patients. Following review with the Overview and Scrutiny Chair, Councillor Lury, it was agreed that a minor change pertaining to the location of services only was planned and should, as a result, proceed but with further updates to the committee as to its progress and impact. This paper provides an update on the GSTT Service moves in line with that commitment.

### 2. Progress

#### a) Service moves and number of patients affected

The OSC trigger template completed in December outlined the proposal to move three community services from Bermondsey Spa to the nearby Artesian Health Centre which is a 7-10 minute walk away (700 yards away) with bus routes offering equivalent access.

- Borough-wide heart failure clinics
- North Southwark diabetes service
- Local midwifery services

These services are accessed via booked appointment and for a known caseload. As noted above, there will be no change to the type, means of accessing or level of service provided.

During the detailed work planning the implementation of these moves it became clear that three additional services would also need to be moved. In order to maintain complete transparency about these changes, further discussions were held with the OSC Chair about the additional service moves. These service moves also involved a minor relocation and no reduction or change in the actual service delivered. The table provides a summary of the patient numbers affected by all the service moves.

	Patient numbers affected		
	Original (Dec 14)	Updated (Jan 15)	
Midwifery	220	220	Moving to Artesian
Heart Failure	56	56	Moving to Artesian
Diabetes-	150	150	Moving to Artesian
Medical Gynaecology clinic caseload	0	102	Moving to Walworth Clinic to be located alongside other sexual health services
Psychosexual health clinic caseload	0	45	Moving to Lloyd Clinic at Guy's Hospital to be located alongside other sexual health services
Abdominal Aortic Aneurysm Screening Service	0	200	Borough wide service that is moving back to Aylesbury area where it was located two years ago – rationale for previous move purely lack of regular space at practice now resolved through use of alternative clinical space at the Aylesbury Health Centre.

GSTT analysis showed a very limited number of patients would be impacted upon per year and the numbers are reflected in the table above. An internal GSTT steering group, comprising of service leads affected by the proposals, was established to oversee implementation. The GSTT project manager met with CCG leads on a weekly basis to review progress and facilitate resolution of issues as appropriate.

The movement of all the services listed above from the Bermondsey Spa Health Centre was completed on 6<sup>th</sup> February 2015.

#### b) Communication of changes to patients and key stakeholders

GSTT has worked with CCG leads to develop a communication and engagement plan to support the service moves. Activities undertaken during January included:

- The Trust and CCG wrote to all patients and service users explaining the changes in location and this was followed up with telephone calls.
- Simple communication materials (e.g. posters / leaflets) were developed and displayed in Bermondsey Spa
- GSTT mapped patient footfall through the health centre based on clinic schedules and arranged for an information stall to be in place on Friday 23<sup>rd</sup> and Monday 26<sup>th</sup> January. This was staffed by GSTT and CCG leads who were able to discuss the changes with patients and answer any questions or concerns. In addition, it allowed identification of any additional actions to mitigate any concerns raised by service users.
- Clinic staff communicated the changes to patients during appointments and were provided with a briefing to ensure consistency of messages.

#### c) Patient feedback

The changes have been successfully implemented with no reported impact upon patient experience. Very few comments were made about the move at the

information stall, all of which were positive or neutral. Patients already knew where the Artesian Health Centre was, while others recognised that it was not far by foot from Bermondsey Spa and was served by local buses. In some cases, patients were registered with the GP at Artesian or attended another service there, so said they would find the relocation more convenient for them.

Patient letters included the contact details of the service leads and invited patients to contact them directly with any queries. No other comments or feedback have been received from patients by phone.

**d) Equality Impact Assessment**

An Equality Impact Assessment (EIA) was completed in December 2014. The EIA is included in the appendix, alongside the EIA patient demographics used to review the impact of the change in location of the services.

The action to review the moves with the services was completed in February and all services reported that the moves went smoothly with no disruption to the patient pathway and patient experience.

Amanda Williams, General Manager Adult Community Services  
Richard Gurney, Project manager Adult Community Services

20<sup>th</sup> February 2015



## Healthy Communities Scrutiny Sub-Committee

### Personalisation: Carer's Focus Group

Feb 2015

#### What is Southwark Carers?

[Southwark Carer's](#) provides support, information and advice to carers across the Borough. Southwark Carers undertake the majority of Carers Assessments in the borough; these are used to create **support plans** for carers, which can include a **personal budget** towards a holiday or break, **flexi respite hours** to allow the carer up to 30 hours of time per year away from their care role. Other services include advocacy, benefits maximisation, housing support, therapies, counselling, peer support groups and mentoring.

#### What is Healthwatch Southwark?

[Healthwatch Southwark](#) is the independent consumer champion for patients and the public. We advocate and support local people to get involved in their local health and care services. A key part of our role is the different ways we engage with groups and individuals, and how we use this to influence those responsible to improve services.

One key activity is our community focus group (FG) programme, we hold focus groups every quarter focusing on a particularly topic. We have previously presented our FG findings to this committee from the Latin American Women's Rights Services (LAWRS) and the Southwark Deaf Forum.

In late January 2015, we worked with Southwark Carers to bring together a small group of mainly adult carers to share their experiences, particularly the process of a Carer's assessment and to lesser extent their view of the Cared-For-Person's assessment for a personal budget. Due to the short timescale, this brief will highlight some key issues/findings in relation to personalisation. Detailed FG findings will be available after the March meeting.

#### Carer's assessment

The whole pathway experience to obtain a carer's assessment from: initial awareness, the process, to its outcome on the carer highlighted a number of key issues, particularly in the context of how 'personalised' services are for carers.

- **The lack of awareness and information surrounding a carer's assessment.** Many said it took years for them to be made aware of a carer's assessment. For some people, this also meant that the role they were currently doing could be part of the personal budget for the cared-for person.
- **The process itself**, i.e. the application, could be very long, confusing and it was **not clear on the eligibility criteria**. Carers mentioned that in the form they did not always know how their responses would be marked against the criteria and would have liked some help in completing the forms.
- **Continuity and relationship building** with local authority officers. Carer's would speak to a 'different person each time' and sometimes did not even know who to contact or where to go.

#### Carers' assessment outcomes – respite care

Carer's assessments, which had to be reflected in a support plan, related to a 'pot of respite care hours' ('flexi-respite') they could use, and/or a personal budget towards a break or holiday.

When accessing their respite care, many carers stated that it was mainly used to ease their caring duties, and not on their own health and wellbeing, which is the intended use of respite care. They were uncertain on how they could use or access their respite care with many stating they usually '*saved them for emergencies*' or used to carry out household chores or 'carer's admin'. In other situations, upon receiving receipt of respite care, the process dictated that they had to use the respite quickly, and within a certain time period.

Where home carers were brought in to relieve carers, some highlighted this itself was an '*additional stress*', as it would be a 'stranger' coming in and with no preparation time for the home care, they were not familiar with the individual or his or her needs. In some cases, this left the cared-for person bewildered, especially those with cognitive issues, but also create anxiety for carers when they were away.

For example 1 hour respite was not enough because these again were taken up by 'carer's duties, from queuing up at the pharmacy to get medication, food shopping or household chores and not the intended use of respite care. Furthermore, where more hours were provided, travel time was not always considered.

### Other issues

- Carer's continuously hear that the **health of a carer** needs to be looked after, however many felt this was 'easier said than done' and that various factors stopped them from being able to concentrate on themselves. This included not being aware they were entitled to an annual health check, or the view that only they knew how to appropriately care for the individual.
- **Emergency care** – Some carers understood the need to plan for emergency care, but sometime these were not carried out by the local authority even after advance notice. Other times, it was not always possible to conform to council processes and timelines to put emergency plans in place, even if they knew about the process which some did not.
- **Hospital discharge** could be a positive trigger for social care to become involved, some experienced very positive experiences of the carers and cared-for-person assessment and the care package put in place. Others experienced extremely negative experiences with little communication between different departments resulting in a repetitive and emotional stressful period.
- Information and how to **access various other services**, around the health and wellbeing of carers and this include the encouragement of **social workers and GPs to signpost** more.
- **Peer support for carers** but also consideration on how they could arrange care for the cared-for-person.
- **Joint respite care breaks** for both carers and cared-for-person, to avoid the anxiety and guilt carers sometimes felt when they were away from the cared-for-person
- **Understanding that being a carer requires precise management skills and 'carer's administration'** and that this is considered by services and staff when arranging appointments (for example not keeping to time or moving times around) but also when in relation to respite care as some carers used the respite care for these reasons.
- Some suggested **training** to be provided on their own health, social care process, legal entitlement etc. to empower them and understand their role.

### In summary:

The above issues seem to indicate there is still a long way to go in order to really develop and embed personalised services to carers. This involves a lot of understanding of the role of carers and the daily challenges their face, which others (services, professionals) may not always realise. In the context of a personalised climate, these are some of the key shortcomings raised:

- **Information should be accessible form a variety of sources.** Carer's sighted the GP as a source, but other external bodies. Over the years, we have heard of the growing need of some sort of directory

of support services that is accessible to both GPs, professionals and to the public, instead of reliance on professionals 'historical know-how of services available'

- **Clearer information on the assessment process and accessing respite care and emergency care.** This should be more easily and readily available. Underlying this is the foundation of knowledge that all professionals should have, and being able to potentially provide this at each encounter with carers.
- **More transparency around the eligibility criteria.** Carer's filling in the forms may not know what the 'assessor' is looking for or how to accurately reflect their needs. [*note: this is a different criteria from the FACs and incoming national criteria*]
- **The impact of and how respite care is used means something different** to the Local Authority and to the Carer. Many attendees used this to carry out caring-related duties.
- **Exploration on how respite care can be provided/administered in a more flexible** way to meet the carer's needs. This also includes the process of respite care which can be process-driven.
- **Where home carers are used in respite care, how can we make this personalised** to address carer's concerns, as highlighted above.

### Going forward

- Fuller analysis of our questionnaire and focus group findings, to feed into our social care priority: looking at assessment process and what happens to those not eligible, and our sharing of our findings through relevant representative boards.
- Hoping to organise a complementary session focused on children and parent carers social care
- At our next Public Forum on [Thursday 19<sup>th</sup> March, 4pm – 7pm](#), we will be presenting our Carer's Focus Group findings and discussing these and wider social care issues further.

**For further information, please contact us on [info@healthwatchsouthwark.co.uk](mailto:info@healthwatchsouthwark.co.uk) or call 020 7358 7005.**

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**HEALTHY COMMUNITIES SCRUTINY SUB-COMMITTEE  
MUNICIPAL YEAR 2014-15**

**AGENDA DISTRIBUTION LIST (OPEN)**

**NOTE:** Original held by Scrutiny Team; all amendments/queries to Julie Timbrell Tel: 020 7525 0514

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