Open Agenda

Health and Wellbeing Board

Monday 16 March 2015
11.30 am
Ground Floor Meeting Room G02A - 160 Tooley Street, London
SE1 2QH

Supplemental Agenda No.1

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Contact

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Date: 11 March 2015

Agenda Item 5

Health and Wellbeing Board

MINUTES of the OPEN section of the Health and Wellbeing Board held on Thursday 29 January 2015 at 10.00 am at Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

PRESENT:	Councillor Peter John (Chair) Andrew Bland Councillor Dora Dixon-Fyle MBE Aarti Gandesha Councillor Barrie Hargrove Eleanor Kelly Gordon McCullough Professor John Moxham David Quirke-Thornton Dr Yvonneke Roe Dr Ruth Wallis
OFFICER SUPPORT:	Rachel Flagg, Principal Strategy Officer Everton Roberts, Principal Constitutional Officer

1. APOLOGIES

Apologies for absence were received from Dr Jonty Heaversedge.

2. CONFIRMATION OF VOTING MEMBERS

Those members listed as present were confirmed as the voting members for the meeting.

3. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

The chair gave notice that the following late items would be considered for the reasons of urgency to be specified in the relevant minute:

Item 14 – Safeguarding Adults Board Annual Report 2013-14

Item 15 – Cross Borough Sexual Health Strategy

4. DISCLOSURE OF INTERESTS AND DISPENSATIONS

There were no disclosures of interests or dispensations.

5. MINUTES

RESOLVED:

That the minutes of the meeting held on 2 October 2014 be approved as a correct record and signed by the Chair.

6. THE NHS FIVE YEAR FORWARD VIEW AND NHS PLANNING GUIDANCE

Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group introduced the report.

RESOLVED:

1. That the nationally determined requirements of the CCG included in the planning guidance and also the current CCG's proposed approach to meeting these requirements be noted.

2. That the CCG's locally-determined approach to delivering improved outcomes for the people of Southwark be noted.

3. That it be noted that the health and wellbeing board will receive a final draft of the CCG's Operating Plan at its meeting in March 2015.

7. PRIMARY CARE CO-COMMISSIONING

Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group introduced the report.

RESOLVED:

1. That the CCG's proposal to submit an expression of interest to NHS England on 30 January 2015 to establish the following arrangements for the co-commissioning of primary care services in Southwark be noted and supported:

   Joint commissioning of primary care services with NHS England for the Southwark population from 1 April 2015, with a commitment to a programme of work to explore and potentially apply for full delegation of these commissioning responsibilities from 1 April 2016.

2. That the local engagement process that has informed the recommendation and the future requirement to consider the final arrangements for primary care co-commissioning following this expression of interest and ahead of the establishment of any such arrangements before 1 April 2015 be noted.

8. STRATEGIC COMMISSIONING FRAMEWORK FOR PRIMARY CARE TRANSFORMATION IN LONDON

The board received a presentation from Mr Paul Roche, NHS England.

RESOLVED:

1. That the report be noted.

2. That a letter be sent in response to the consultation highlighting the issue of health inequalities. Andrew Bland to lead on the response.

9. SOUTHWARK SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2013-14

Michael O'Connor, Chair of the Southwark Safeguarding Children Board presented the report.

RESOLVED:

That the Annual Southwark Safeguarding Children Board report (Appendix 1) be noted.

10. HEALTH AND WELLBEING STRATEGY 2015 - 2020

RESOLVED:

1. That the health and wellbeing strategy be agreed and the 6 high level priorities for 2015-2020 (set out in paragraph 4 of the report) and the iterative strategy process be noted.

2. That it be noted that the focus for the board will be on ensuring added value from partners and on health inequalities and to manage by outcomes.

3. That 'air quality' be included in the strategy due to its underlying cause of health problems.

11. TOBACCO CONTROL IN SOUTHWARK

Dr Ruth Wallis, Director of Public Health introduced the report.

RESOLVED:

1. That the update of Tobacco Control In Southwark be received.

2. That the evidence based multi-pronged tobacco control approach, ensuring tobacco control is a significant element to improve health and tackle health inequalities be

endorsed.

3. That the tobacco control priorities be aligned across the Partnership. Partnership priorities for Tobacco Control should Include:

   - Prevention: Incorporating preventing tobacco use (including shisha) within a whole school health and wellbeing approach
   - Promoting access to evidence based commissioned stop smoking services, that have a more targeted approach to supporting priority groups (pregnant women, unemployed, LTC including mental health)
   - More systematic approach and better resourcing to effectively tackle illicit tobacco sales

4. That partners be encouraged to be exemplars through more "explicit" workforce / workplace polices.

5. That the signing of the NHS Statement of Support for Tobacco Control by the Southwark CCG and local acute trusts be encouraged.

12. SOUTHWARK PHARMACEUTICAL NEEDS ASSESSMENT (PNA) CONSULTATION

Dr Ruth Wallis, Director of Public Health introduced the report.

RESOLVED:

That it be noted that:

a) the draft Southwark PNA is available for consultation to the public and key stakeholders from 19 December 2014 until midnight on 28 February 2015.
b) the draft PNA for consultation and associated appendices can be found on the Southwark website via the following link: www.southwark.gov.uk/pna.
c) all feedback received by midnight on the 28 February 2015 will be collated for consideration by the HWB in the March board meeting – including the final PNA report.

13. DIRECTOR OF PUBLIC HEALTH REPORT - LAMBETH & SOUTHWARK

Dr Ruth Wallis, Director of Public Health introduced the report.

RESOLVED:

That the Director of Public Health report covering the period October to December 2014 attached as Appendix 1 to the report be noted.

14. SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2013-14

This item had not been circulated 5 clear working days in advance of the meeting. The Chair agreed to accept the item as urgent to enable the annual report to be presented to the health and wellbeing board at the earliest opportunity.

Deborah Klee, Chair of the Safeguarding Adults Board presented the report.

RESOLVED:

That the annual Southwark Safeguarding Adults Board report 2013/14 (Appendix 1) be noted.

15. CROSS BOROUGH SEXUAL HEALTH STRATEGY

This item had not been circulated 5 clear days in advance of the meeting. The chair agreed to accept the item as urgent as sexual health was a national and local public health priority and Lambeth, Southwark and Lewisham were working together to commission services in a tri-borough agreement. It was imperative that the board considered the strategy as soon as possible to enable it to endorse the strategy in line with the other boroughs.

RESOLVED:

1. That the responses to the public consultation on the Lambeth, Southwark and Lewisham Sexual Health Strategy (Appendix 1 of the report be noted).

2. That the Lambeth, Southwark and Lewisham Sexual Health Strategy (Appendix 2 of the report) be agreed.

16. LONDON HEALTH COMMISSION REPORT

This item was not considered at the meeting.

Meeting ended at 12.12pm

CHAIR:

DATED:

Agenda Item 6

Item No. 6.	Classification: Open	Date: 16 March 2015	Meeting Name: Health and Wellbeing Board
Report title:		Annual Report from the Director of Public Health	
Wards or groups affected:		All	
From:		Ruth Wallis, Director of Public Health	

RECOMMENDATIONS

1. The board is requested to:

   a) Note that this year's Annual Report from the Director of Public Health (Appendix 1) focuses on health inequalities and their causes.

   b) Note that the recommendations in the report reflect the widening role of public health and the importance of partnership work to achieve the necessary system wide changes.

BACKGROUND INFORMATION

2. Southwark has a diverse population and has seen substantial improvements in overall health over the last 50 years. However, health inequalities still remain in the borough. While there have been many public health successes in Southwark, such as the improvement in life expectancy and reduction in infant mortality and in teenage pregnancy, there is still considerable work to do to reduce health inequalities. Working alongside council colleagues and other partners to do this will require new ways of working, so as to harness the unique potential of directly influencing many of the external factors which result in health inequalities.

3. The annual public health report highlights the main health inequalities in Southwark and what may be driving them. The Marmot Framework and Dahlgren and Whitehead model provide the structure, detailing issues which public health is 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 are the main areas of focus in the report.

KEY ISSUES FOR CONSIDERATION

4. Key recommendations in the report include

   - 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.

   - 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.

- 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.

- 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.

- 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.

- 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.

- 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.

- Social relationships and community development should be made policy priorities.

Policy implications

5. The annual report and the recommendations will help to inform on the development of policy frameworks to address health inequalities.

Legal implications

6. The Director of Public Health is responsible for the public health functions of the local authority and has a statutory requirement to produce an annual report on the health of the local population. The publication of this report fulfills this requirement.

Financial implications

7. There are no direct immediate financial implications contained within this report. Any specific financial implications will need to be considered as part of the Council budget setting and other partnership commissioning processes.

BACKGROUND PAPERS

Background papers	Held at	Contact
Previous reports of the director of public health	See link	PHAdmin@southwark.gov.uk
Link: http://www.southwark.gov.uk/downloads/download/3408/previous_annual_public_health_reports		

APPENDICES

No.	Title
Appendix 1	Director of Public Health Annual Report 2013/14

AUDIT TRAIL

Lead officer	Ruth Wallis, Director of Public Health	
Report author	Ruth Wallis, Director of Public Health	
Version	Final	
Dated	10 March 2015	
Key decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer title	Comments sought	Comments included
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Date final report sent to Constitutional Team		10 March 2015

APPENDIX 1

Southwark Council

Public Health Report for Southwark

Director of Public Health Annual Report 2013-14

NHS Southwark Clinical Commissioning Group

Contents

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.

Cllr 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, Jin Lim, Ruth Sheridan, Catherine Mbema, Claudia Craig, Marie Vieu, Veronika Thiel, Alex Trouton, Ginette Hogan, Vida Cunningham, Kate Bisset, Abdu Mohiddin, Geraldine McCormick, Kate Harvey, Lucy Smith, Susan Unger, Anna Richards, Bimpe Oki, Rosie Dalton-Lucas, Emma Robinson, Sarah Robinson, Gillian Holdsworth, Alison Furey, Sarah Corlett, Miriam McGrath, James Crompton

We welcome your comments & feedback: **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.

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"[1].

(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[1]

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[2].

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[3].

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 acheivement, 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

[1] 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 [Accessed 26th August 2014]

[2] Lambeth and Southwark Public Health Team (2013). Joint Strategic Needs Assessment (JSNA), 2013. Life Expectancy Factsheet.

[3] 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 [Accessed 26th August 2014]

1.0 Income, work, housing and environment

INCOME, WORK, HOUSING AND ENVIRONMENT

Income, Work and Poverty
Workplace Health
Housing
Food Poverty

OUR CHILDREN, OUR FAMILIES, OUR COMMUNITY

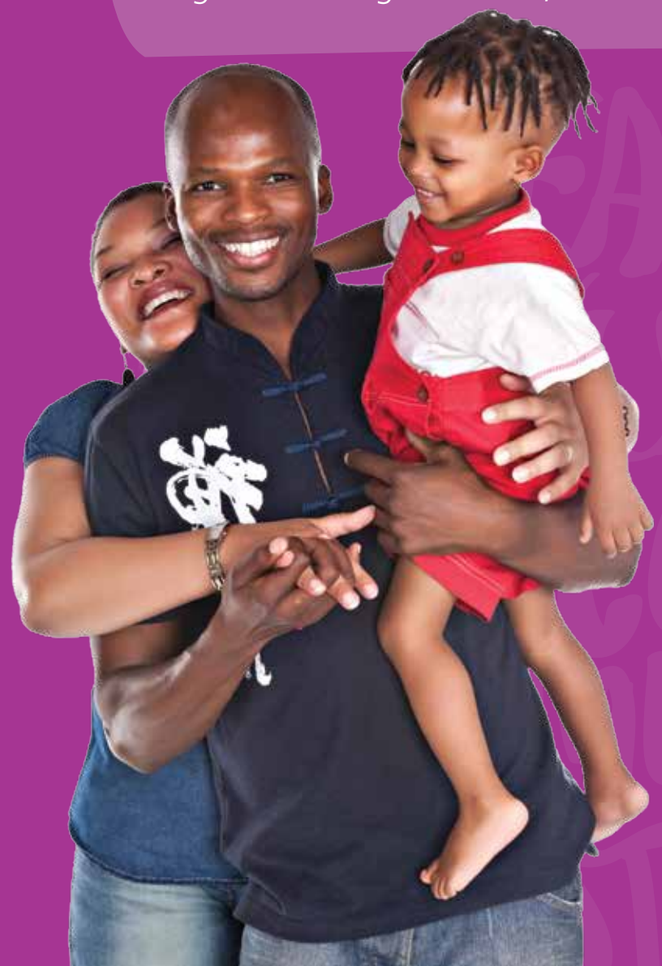
STAYING HEALTHY

PRIMARY CARE

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[1].

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) [2].

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

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.[3]
- Overall, Londoners in black and minority ethnic groups are more likely to be unemployed (black) or economically inactive (Pakistanis and Bangladeshis) than their white counterparts.[4]
- Just over 30% of children in Southwark live in poverty[5], 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.[6]

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[8, 9]:

- 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[9].

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.[10]

- **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[11].
  - 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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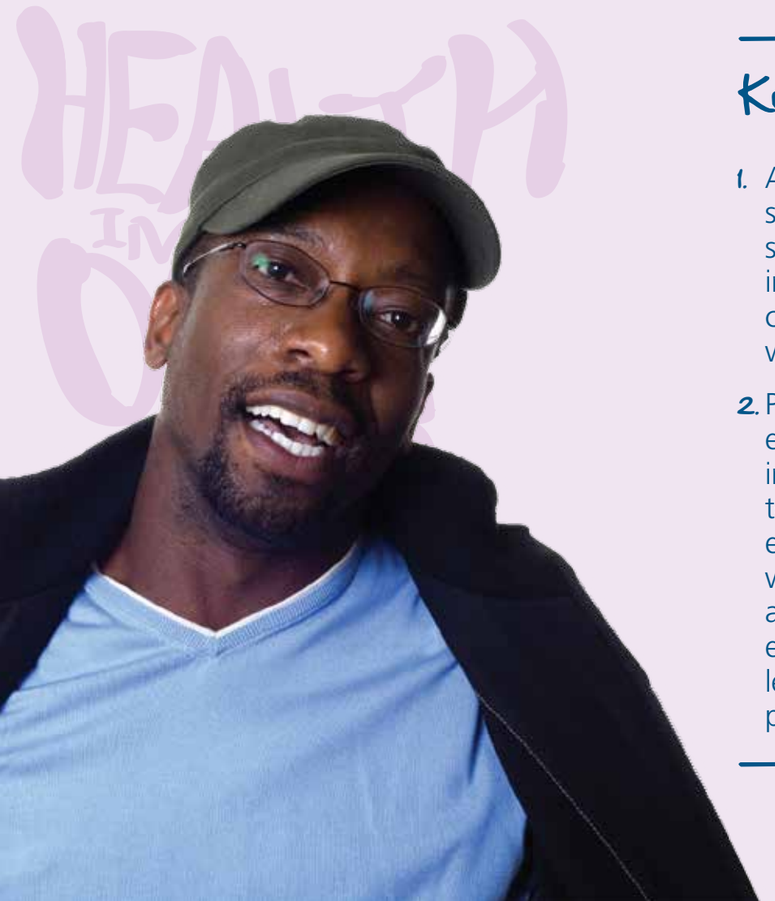
1.2 Workplace health

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[1].
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[2].



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[3].

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[4].

Work and long-term conditions

The working population is ageing and will face a higher burden of chronic illness in years to come[5]. 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[6]. 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[7]. 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[8, 9, 10].

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). 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.[2] 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[4] 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.

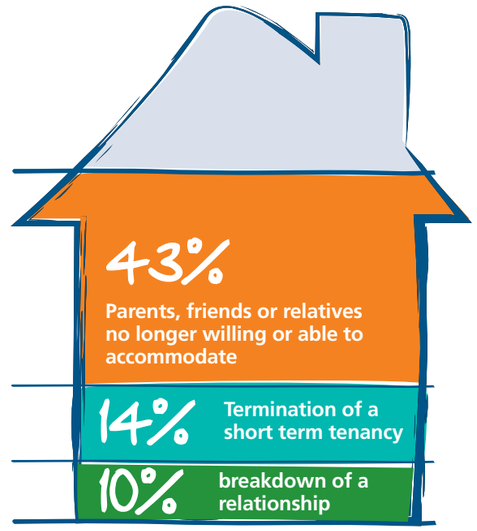
In Southwark, 63% of the households accepted as homeless were families led by single females, underlining the social and economic vulnerability of this group and the potential ill effects on children and young people.

The number of rough sleepers in London has risen by 64% since 2010, and one third of these have slept rough in previous years.5 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[6]. 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 has 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 councils 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**

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.[7]
- 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)[8] – 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**

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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1.4 Food poverty

Key messages

Food Poverty is defined as 'the inability to afford or have access to healthy food'[†].

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.

[†]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.

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.

What more can be done?

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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2.0 Our children, our families, our community

INCOME, WORK, HOUSING AND ENVIRONMENT

OUR CHILDREN, OUR FAMILIES, OUR COMMUNITY

Maternity and Early Years
Improving the Health and Wellbeing of Young People in Schools
Relationships and Community

STAYING HEALTHY

PRIMARY CARE

2.1 Maternity and early years

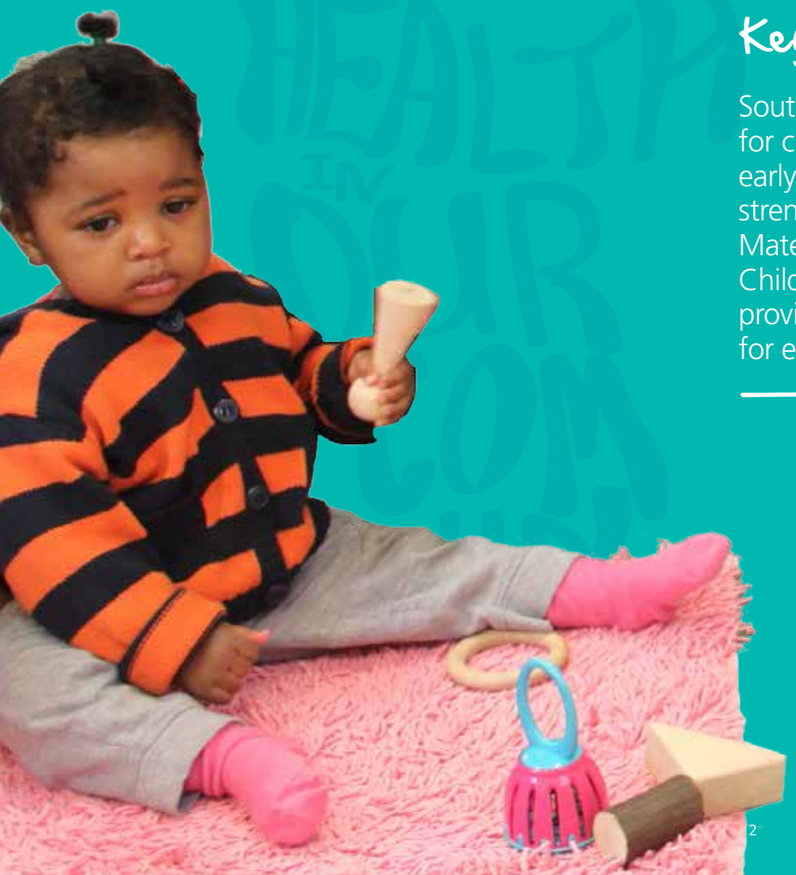
In this section we look at ...

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.

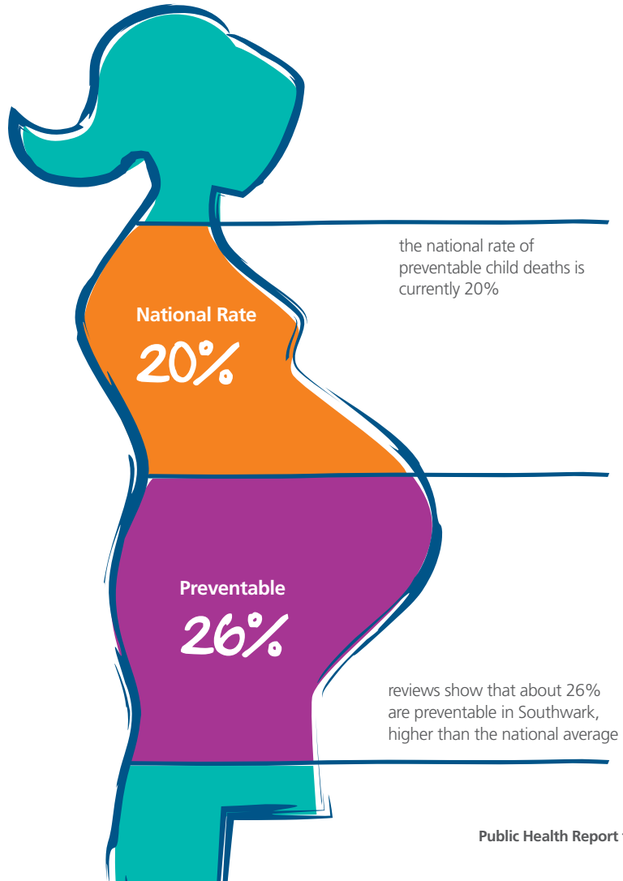


What's the issue?

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%)[1, 2].

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,'[3] makes recommendations which are shown to address health inequalities in early childhood, summarised below[4]:

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[5]. 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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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):

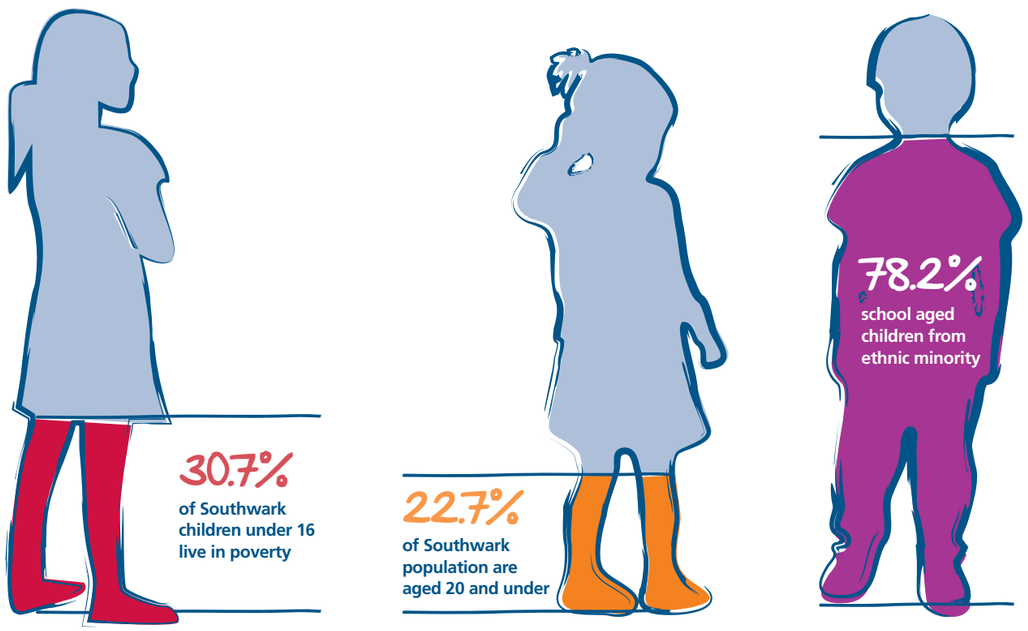
There is also:

- 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.

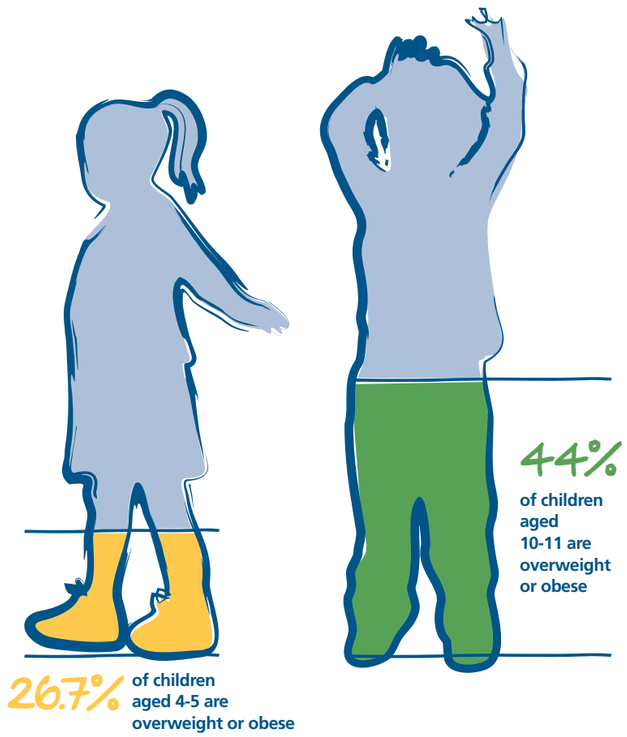
What's happening at the moment?

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.



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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.[1,2]
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[1].
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[3].

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.[4]

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[3,5]
- People living in poverty[5]
- 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[6].

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

What can we do about it?

The evidence base for interventions which foster good social relationships is growing.[7]

The following have proved effective:

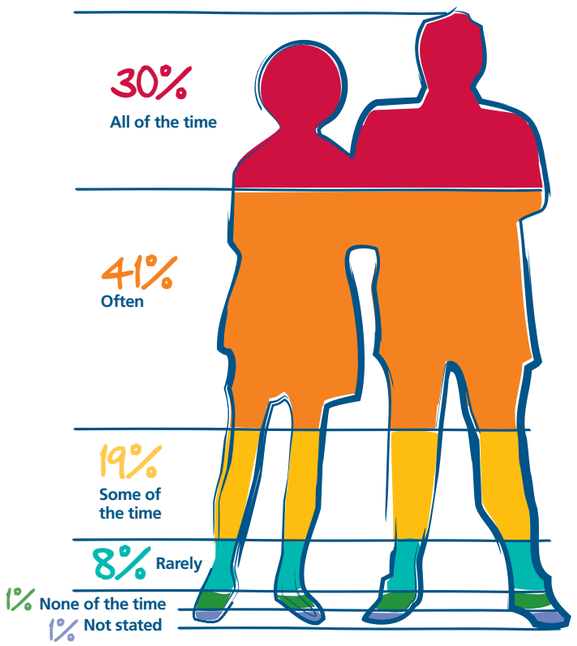
- Encouraging the use of 'Five Ways to Wellbeing' – particularly 'Connect' and 'Give'
- Parenting support
- Whole school approach to emotional health and wellbeing
- Health and wellbeing strategies and interventions at work, for example, team social events, sports activities, reading groups
- Fostering support and exchange through informal neighbourhood connections, for example, befriending, Men's Sheds, timebanking, reading groups, free community festivals[8]
- 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/)



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

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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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.

3.0 Staying healthy

INCOME, WORK, HOUSING AND ENVIRONMENT

OUR CHILDREN, OUR FAMILIES, OUR COMMUNITY

STAYING HEALTHY

Tobacco Control
Alcohol and Substance Misuse
Healthy Weight
Physical Activity
Sexual Health and HIV Prevention

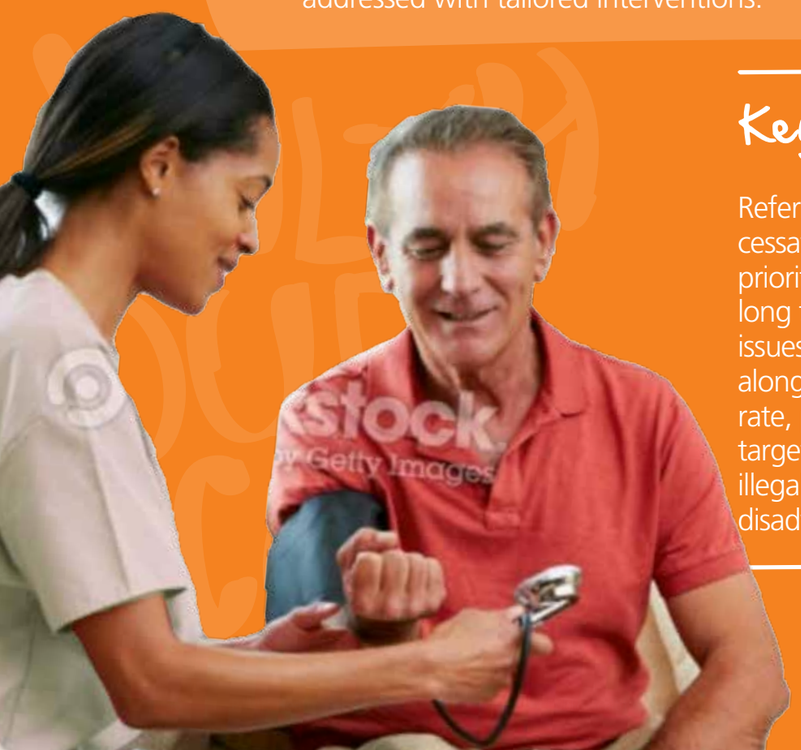
PRIMARY CARE

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[1] 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.[1]

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[1]
- 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:

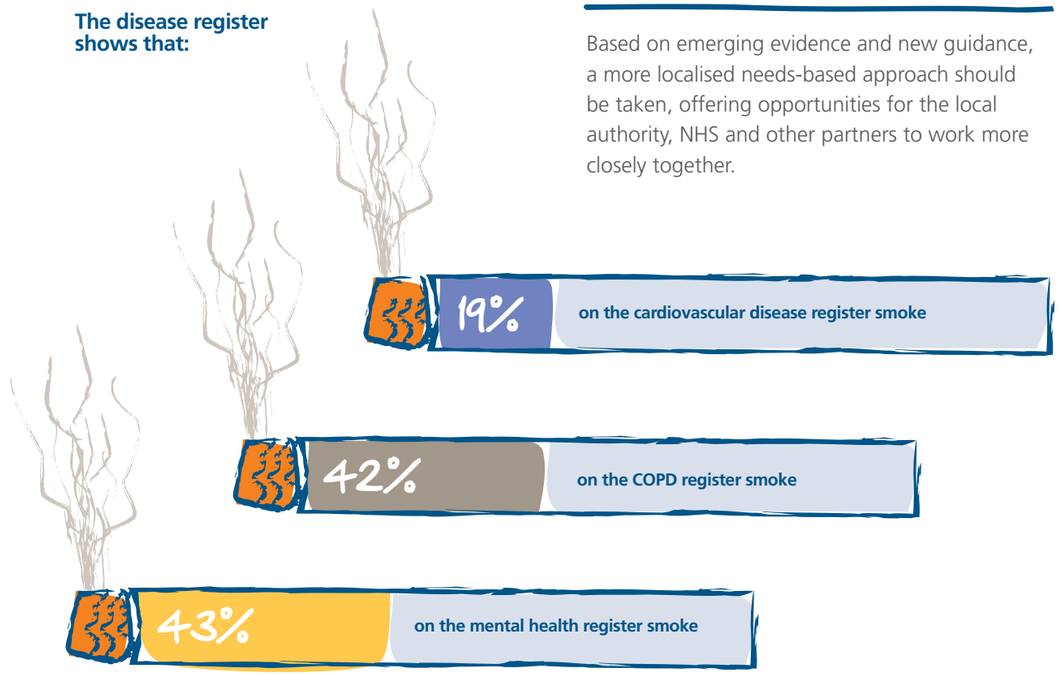
- 43% on the mental health register smoke
- 19% on the cardiovascular disease register smoke
- 42% on the COPD register smoke.

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[2], 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.[3] 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.[6] 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.[7] The Department of Health has recognised that shisha is a health risk warranting attention.[8]

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.[9]

References

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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 Hospital episodes with alcohol related conditions (persons) 2012/13 Vs IMD 2010

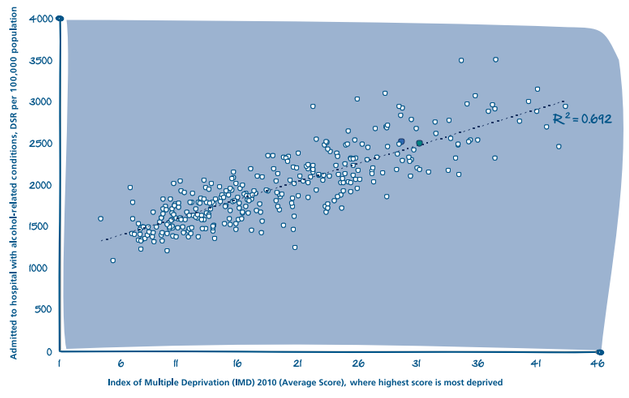
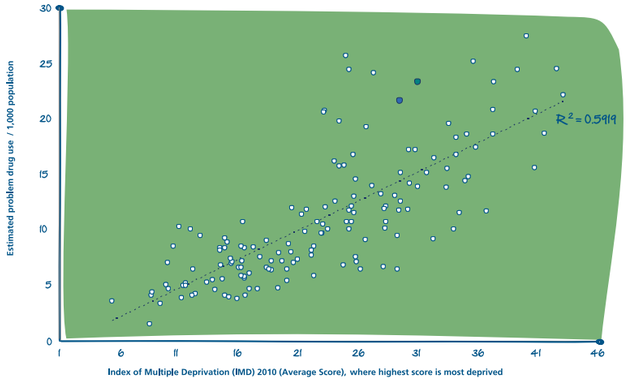


Figure 2 Estimates of problem drug use (PDU): aged 15 to 64 (2006/07) Vs IMD 2010



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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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.

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

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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.

56.5% of adults in Southwark are active

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 signpostin g 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).

4.0

Primary care

INCOME, WORK, HOUSING AND ENVIRONMENT

OUR CHILDREN, OUR FAMILIES, OUR COMMUNITY

STAYING HEALTHY

PRIMARY CARE

Immunisations
Childhood immunisations
Adult immunisations
Cancer screening
Mental Health

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 commited 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

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'[1]. The following areas were highlighted as having particular scope for improvement[1]:

- 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[1]:

- 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

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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'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 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 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.

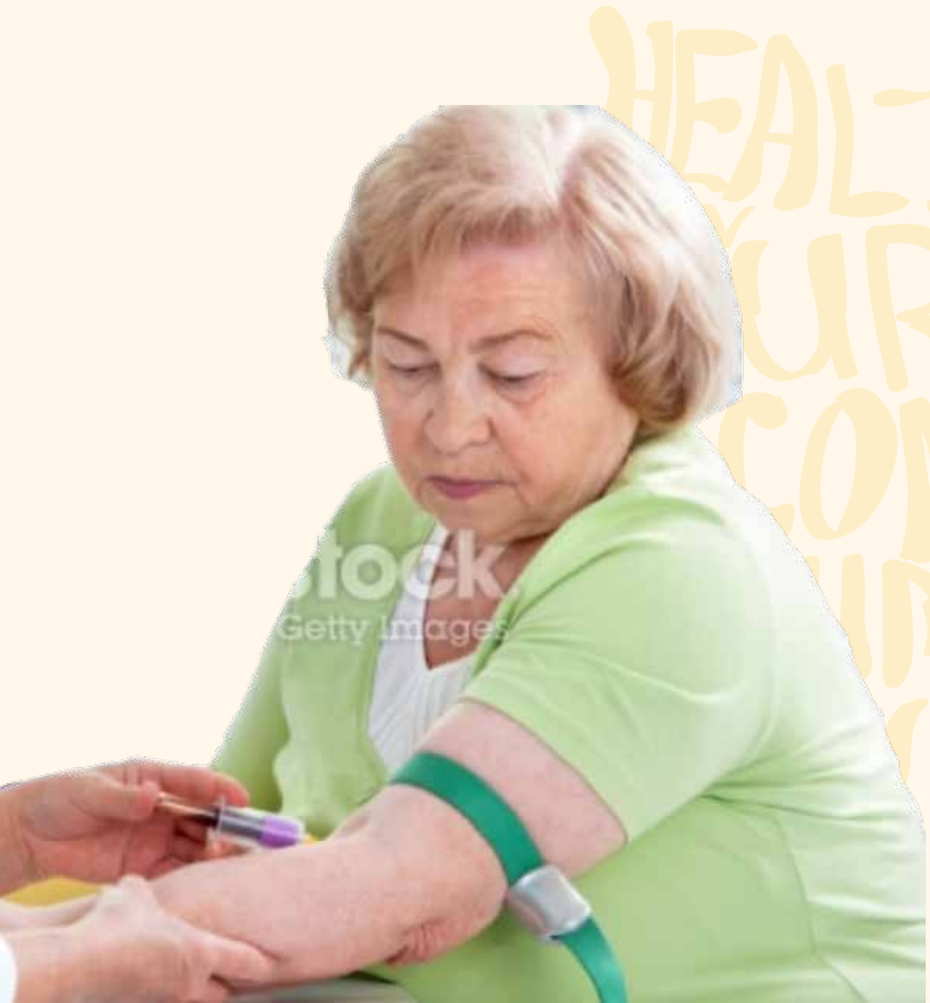
4.2.2 Adult Immunisations

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[1]



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[2]. 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%[3].

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[4].

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)[5].

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 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.

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

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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[1]. 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[2]. Black women on average, present 21 years younger than white women[3].
- 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[4]. Local incidence and mortality from cervical cancer is higher than national and London rates[5]
- 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.

Bowel cancer

- Bowel cancer is the second most common cause of death from cancer in the UK and the third most common cancer[6]. 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[7]. As Southwark has a large Asian population, this may explain in part the low uptake rate in the borough.

What can we do about it?

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

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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.

4.4 Mental Health

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'[1].
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'[2].

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[3]. 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).[4]

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[5]. 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).[6]
- 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)[7]. Nearly 50% of long term sickness absence is thought to be due to mental health problems[8].
- 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[9].
- 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[10].

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[11].

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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5.0 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.
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.

Your comments and feedback are welcomed PHAdmin@southwark.gov.uk
For more information on the health of Southwark www.southwark.gov.uk/jsna

Published by Department of Public Health, London Borough of Southwark
January 2015

Item No.	Classification:	Date:	Meeting Name:
7.	Open	16 March 2015	Health and Wellbeing Board
Report title:		King's Health Partners Tobacco strategy	
Wards or groups affected:		Service users, staff and students at SLaM, King's College Hospital and Guy's and St Thomas' NHS Foundation Trusts and King's College London	
From:		Professor John Moxham Director of Clinical Strategy, King's Health Partners Public Health Programme	

RECOMMENDATIONS

1. The board is requested to:

   - Give feedback on the recommendations;
   - Endorse this strategy;
   - Comment on whether this strategy is consistent with the Health and Wellbeing Board Tobacco strategy

EXECUTIVE SUMMARY

2. KHP Tobacco strategy, which is based on NICE recommendations for smoking cessation in secondary care- acute, maternity and mental health services, recommends that all hospital grounds are smoke-free, and service users and staff who are smokers are offered support to abstain from smoking and offered referral to smoking cessation services. Staff and students will receive education and training to support smoking cessation in patients.

BACKGROUND INFORMATION

3. The purpose of King's Health Partners is to increase the contribution made to improving the health and wellbeing of people and patients locally and globally. Local and global health is massively damaged by tobacco. The strategy of King's Health Partners 2014-2019 includes three themes for which smoking reduction is a core goal: Mind and Body, Value Based Health care and Public Health.

4. King's Health Partners aims make a big contribution to smoking reduction, in patients, staff and students; taking a role as a local leader in this endeavour given our size and our ability to integrate research, education and clinical service for the benefit of thousands of smokers who want to quit and the children and young people who need our support to never start.

5. For the sake of brevity in this cover note, we direct the Board to the summary recommendations of the strategy which can be found in Section 2 in the document on pages 3 and 4.

KEY ISSUES FOR CONSIDERATION

See appendix.

Policy implications

King's Health Partners would expect the KHP Tobacco strategy to be consistent with and supportive of the Tobacco control policy of the Council.

Community and equalities impact statement

A key purpose of the KHP Tobacco strategy is to reduce health inequalities across the community

Legal implications

Nil

Financial implications

Nil

BACKGROUND PAPERS

Background Papers	Held At	Contact
NICE guidance	See link	
Link: https://www.nice.org.uk/guidance/ph48		

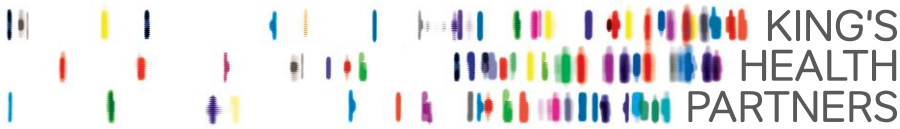
APPENDICES

No.	Title
Appendix 1	King's Health Partners Tobacco Strategy

AUDIT TRAIL

Lead officer	N/a	
Report Author	Professor John Moxham, Director of Clinical Strategy, King's Health Partners	
Version	Final	
Dated	5 March 2015	
Key decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer title	Comments sought	Comments included
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Date final report sent to Constitutional Team		5 March 2015

APPENDIX 1



An Academic Health Sciences Centre for London

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Appendix 4

KING'S HEALTH PARTNERS

PUBLIC HEALTH PROGRAMME DELIVERY

DRAFT

TOBACCO STRATEGY

Helping our patients, staff and students live healthy and longer lives

1. Foreword

The purpose of creating our AHSC was to increase the contribution we can make to improving the health and wellbeing of people and patients locally and globally. Local and global health is massively damaged by tobacco. The strategy of King's Health Partners 2014-2019 includes three themes for which smoking reduction is a core goal: Mind and Body, Value Based Health care and Public Health.

Improving the health of the public, so long a neglected part of health policy, is now centre stage and reducing smoking is a priority.

It is now abundantly clear that the NHS is under intolerable strain, in large measure because of the massive demand for care from an unhealthy population. In his recent report Simon Stevens the CEO of NHS England recognises the reality that ongoing failure to address the health of the public places the future of the NHS in jeopardy.

"The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health.** Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded – and the NHS is on the hook for the consequences. The NHS will therefore now back hard-hitting national action on obesity, smoking, alcohol and other major health risks. We will help develop and support new workplace incentives to promote employee health and cut sickness-related unemployment."
(NHS Five Year Forward View, October 2014)

As ever, good leadership is needed. Driven by the Mayor, smoking has fallen dramatically in the New York city (from 22% in 2002, to 15% in 2012)

"Nothing any of us will ever do will save as many lives as limiting the use of tobacco products".
(Michael Bloomberg, Mayor of New York, Time magazine October 21st 2013)

Inspired by the example of NY, the recent London Health Commission, led by Lord Darzi, gives great emphasis to public health and smoking reduction.

"One of London's big killers . . . is smoking. There are still 1.2 million smokers (18%) and 8,400 deaths a year. . . . Smoking directly impacts on four of the top five biggest killers across London. Over 51,000 hospital admissions per year are attributable to the habit. London boroughs with high smoking prevalence are also some of the poorest boroughs. … stark health inequalities are caused by smoking rates being much higher amongst people who work in manual or routine occupations. For the NHS and wider public services, the lifetime value of a person stopping smoking is huge – that's why stop smoking services must be supported and maintained as great public investment. "
(Better Health for London, London Health Commission, 2014)

King's Health Partners can make a big contribution to smoking reduction, in patients, staff and students. We can and should be leaders in this endeavour given our size and our ability to integrate research, education and clinical service for the benefit of thousands of smokers who want to quit and the children and young people who need our support to never start.

Professor John Moxham
Director of Clinical Strategy
King's Health Partners

2. Recommendations

Integrating and strengthening our treatment pathways for smokers, particularly those who are highly dependent on nicotine

- Effective smoking cessation services are available for all patients treated in our hospitals and clinics.
- Specialist smoking cessation services are available for those patients who are highly dependent particularly those with long term conditions who access the Partner hospitals.
- Specialist smoking cessation advisors are available for those patients who have repeated failed attempts to quit, including mental health patients, pregnant women and mothers with babies and young children.
- All front line staff will receive training to ensure that they ask all service users whether they smoke and offer a referral to specialist support (a key component of making every contact count)
- New mothers who have quit smoking during pregnancy are followed up with continued support to achieve a year's quit target.
- Ensure smokers receive continuous, effective cessation treatment, including at transition points across the pathway
- All partner organisations to implement the NICE Guidelines for smoking cessation in mental health, acute and maternity settings.

Improving our intelligence and informatics about the people we see who smoke

- All Partners electronically record the number of smokers that access care.
- All Partners identify those smokers who wish to receive help either with temporary abstinence, stopping smoking or reducing their smoking and informatics systems are linked to appropriate smoking cessation services
- All Partners to record the numbers of people who have been offered support.
- All Partners record the numbers of patients who have successfully stopped smoking or reduced smoking.

Improving the health of our staff and students

- All staff and health school's students joining the Partners are assessed for smoking and advised of the best way to stop.
- Staff and students wanting to quit smoking have access to stop smoking services and are allowed time to attend these services during work hours.
- Staff and students who do not want to quit smoking are advised on appropriate nicotine replacement products to enable them abstain from smoking during working hours.
- King's Health Partners hospitals and grounds are completely smoke-free in accordance with

NICE guidance.

- Consider the introduction of a smoke-free university at KCL

Educating our staff and students

- All clinical staff are trained to assess patients smoking status, offer brief advice and refer appropriate patients to smoking cessation services.
- Selected staff are trained to level 2, to administer and prescribe smoking cessation interventions
- Teaching on smoking cessation interventions is a significant part of the health schools undergraduate curriculum and graduates are equipped to offer brief advice.

Research

- Develop a systematic approach to identifying opportunities for research and evaluation related to tobacco across KHP to build upon our growing portfolio of research in this area
- Develop a data base for KHP research activities related to tobacco
- On an annual basis, collect naturalistic data using the enhanced informatics systems. Analyse data by patient diagnosis, CAG and partner organisation for:

Smoking demographics and characteristics

Prevalence of smoking of patients, staff and students
Severity of nicotine dependence of patients, staff and students
Prevalence of patients who want to temporarily abstain, with and without support during an inpatient admission, and those who want to make a quit attempt.
Number of referrals made to specialist stop smoking clinics

Efficacy and effectiveness of interventions

Uptake of:
support offered for temporary abstinence during an inpatient stay
support offered for smoking cessation during an inpatient/clinic episode
referrals to specialist stop smoking clinics
support for staff and student smokers

Outcome of above support on:

Four week, six and 12 month quit rates
Smoking reduction rates
Satisfaction with treatment
Cost of treatment

Effect of above support on Health Outcomes

Assess the impact of smoking and stopping smoking on each's CAG's minimum set of health outcomes they routinely measure.

Staff training

Evaluate the uptake of training by CAG and the effect of training on knowledge, skills and attitudes, patient metrics (e.g. referral for specialist support, uptake of support, quit rates)

3. Introduction and background – The health of the public and the impact of smoking

The purpose of King's Health Partners Academic Health Sciences Centre is to improve the health and wellbeing of our patients and population.

Those who smoke die 10 years sooner than non-smokers. As a consequence of the chronic diseases caused by smoking many smokers endure premature poor health and disability for years prior to their premature death. **Smoking is the single greatest cause of premature, preventable death in England and in our local boroughs.**

Life expectancy is much shorter in those who are poor and disadvantaged compared to those who are affluent. Rates of smoking are also very much higher in deprived and poor communities. Lambeth and Southwark have large deprived populations and are the 9th and the 12th most deprived boroughs in London. A stated commitment of the NHS and all levels of government is to reduce health inequalities. **Smoking is the cause of more than 50% of the difference in life expectancy between those who are poor and deprived and those who are affluent** (Figure 1). Although relatively few of the affluent in our society smoke, some do, and like all smokers, they would, as a group, live ten years longer if they did not.

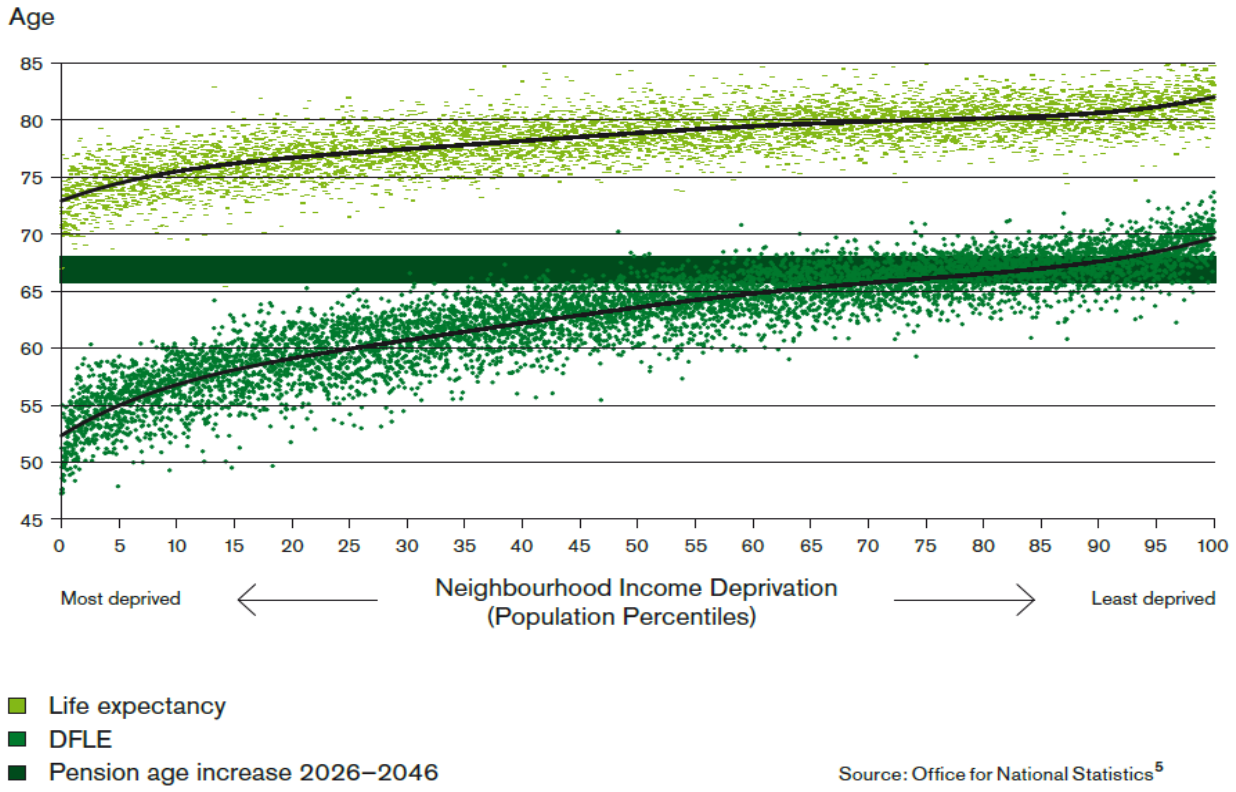


Figure 1: Note the life expectancy of the least deprived (average 82 years) and that of the most deprived (73 years), a difference of 9 years. Living a life free of significant disease and disability is important. The Disease Free Life Expectancy (DFLE) is close to 70 years for the least deprived and is 52 years for the most deprived, a difference of 18 years. More than 50% of these huge differences in life expectancy and disease free life expectancy are due to smoking.

The inevitable and important conclusions from these data is that **reducing smoking presents our health and social care system with a huge opportunity to improve the health and wellbeing of our people, reduce health inequalities, reduce healthcare costs and increase value.** KHP should therefore be striving to minimise smoking across its staff, service users and catchment area.

Tobacco control and smoking cessation is everyone's business, responsibility and

opportunity. King's Health Partners will work closely with colleagues in our local boroughs, primary and community care to reduce smoking. Our Tobacco Strategy will align closely with that of the Lambeth and Southwark Health and Wellbeing Boards, and will be strongly informed by local public health leaders. By achieving smoke-free hospitals and reducing smoking by our patients, staff and students our contribution will be substantial.

Health care treatment systems can have only a limited effect on the health of the public (Figure 2). Hence the importance of Public Health improvements and the need to all work together, all 'do our bit', contributing to the success of an overarching Tobacco Strategy.

EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

Figure 2: The analysis of eleven advanced healthcare systems ranks the UK NHS very highly. By contrast, the health of the UK population ('Healthy Lives') is very poor. These important data highlight, firstly that despite having a good treatment delivery system we have poor health and, further improvements to the delivery system can have only a relatively modest impact (even if we are able to afford the improvements). Secondly, it is our poor health that is putting the NHS under huge pressure, and **it is likely that only improvements in health, through public health and prevention actions, will ensure a future high-quality NHS service to patients that is affordable and sustainable.**

Smoking causes a range of diseases including cancer, cardiovascular and respiratory disease. **These diseases are the greatest cause of death in our local boroughs.** Tobacco smoking is by far the most important risk factor for cancer in the UK. Smoking also contributes to a myriad of health related problems and costs. Smokers undergoing surgery are more likely to have a longer hospital stay and are more likely to need intensive care. Smokers have an increased risk of re-admissions. Smoking is responsible for poor oral and dental health. Smoking causes complications during pregnancy, including an increased risk of miscarriage, premature birth, low birth weight and perinatal death. Second hand smoke exacerbates respiratory symptoms and can trigger asthma attacks. Children are particularly vulnerable to second hand smoke which can cause sudden infant deaths, wheezing, and ear infections.
Currently, most people who smoke have grown up in smoking households. If a mother smokes, her

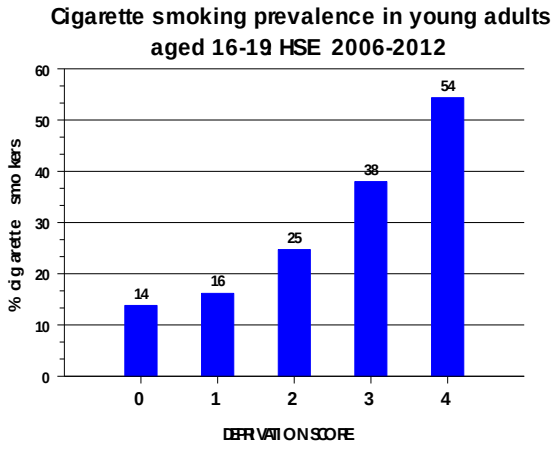
child is twice as likely to become a smoker than if she were a non-smoker. If both parents smoke there is a 3-fold increased likelihood. When young women, who then go on to have children, stop smoking the outcome is healthier women, mothers, babies, children (who are themselves much less likely to smoke) and grandparents who live to a greater age with less disease. **One of the greatest gifts a pregnant smoking mother can give to her baby (and to herself) is to stop smoking.**

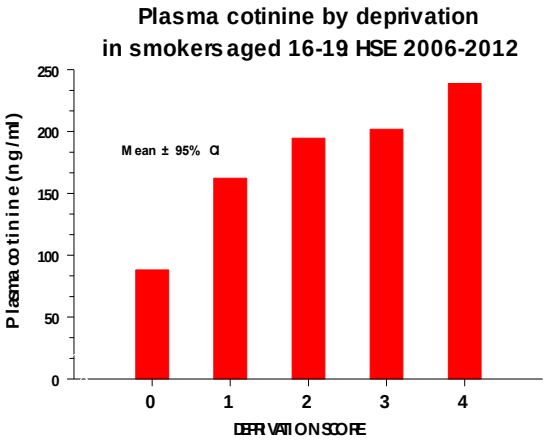
Smoking rates are disproportionately high in every area of mental health care. Adults with common mental disorders such as depression and anxiety are twice as likely to smoke compared to adults who are mentally well. Those with schizophrenia or bipolar disorder are 3 times more likely to smoke. People with mental health disorders consume approximately 40% of the tobacco smoked in the UK. Compared to non-smokers with mental ill health, those who smoke have more severe mental health symptoms, require higher doses of psychotropic medication and spend more time in hospital. Mentally ill smokers use a high proportion of their income to pay for cigarettes and prioritise this expenditure over food and leisure activities. Smokers are more likely to report having suicidal thoughts and have higher suicide rates. People with mental ill health smoke more heavily, have higher blood nicotine levels and are more dependent on nicotine than those without mental illness.

Over the last 50 years smoking rates have gradually fallen across the general population and for England are now 18.4% and in London 18%. **Smoking rates in Lambeth and Southwark are 21.3% and 19.7%.** However, there are wide variations across populations depending on social, economic and health status. At one extreme smoking rates are less than 10% amongst the most affluent members of our community and at the other extreme smoking rates are 60% in those with serious mental illness and up to 90% in those with the combination of serious mental illness and substance abuse. Children and young people from deprived backgrounds are much more likely to take up smoking and are more heavily dependent (have higher blood nicotine levels) (Figure 3). In later life they are less able to quit. Smoking causes ill health and therefore it is not surprising that a high percentage of patients admitted to our acute hospitals are smokers. In a recent audit at King's College Hospital, of patients on acute medical and surgical wards, 42% were smokers.

When does the social gradient in smoking emerge?

The social gradient in cigarette smoking is clearly established by the late teens, as is also the gradient in nicotine intake in smokers





Prevalence of smoking and nicotine intake in 16-19 year olds by deprivation score HSE 2006-2012

Data courtesy of Professor Martin Jarvis, UCL.

The vast majority of people who smoke wish to quit. This applies equally, to those who do not have a health problem, those with physical diseases and those with mental ill health. The

underlying cause of chronic smoking is addiction to nicotine. **Those smokers who are deprived and/or mentally ill have greater addiction and therefore require more help to quit.** Evidence based and NICE recommended treatments for this addiction are well documented and recent NICE guidance has been published to increase smoking cessation in secondary care settings.

The NICE guidance on smoking cessation in secondary care emphasises the importance of achieving smoking cessation in those with mental ill health. For King's Health Partners this is particularly important in view of the high levels of mental ill health in our community and our deep commitment to improving the physical health of those with mental illness.

Patients, carers and mental health clinicians sometimes perceive smoking as beneficial and believe that high rates of smoking are due to patients using nicotine to improve mental health symptoms, particularly negative, cognitive and/or depressive symptoms. They attribute improved mood and reduced anxiety to the effects of smoking rather than the reality that smoking simply medicates the symptoms of nicotine withdrawal that occur many times throughout the day. The 'self-medication hypothesis' is popular among mental health clinicians but has little evidence to support it. Health professionals and patients often view tobacco addiction as less important to treat than alcohol or illicit drug addiction and believe that smoking cessation will impede successful outcomes for their primary drug use. **In addition to the immediate and long term physical health benefits that result from stopping smoking, particularly improvements in cardiovascular and respiratory health, recent evidence suggests people's mental health may also improve.** Depending on the type of psychotropic medication prescribed, some patients may be able to have the dosage of their medication reduced. Treating tobacco addiction at the same time as addiction to other substances is associated with a 25% greater likelihood of long-term abstinence from alcohol and illicit drugs, whereas continued smoking may increase the risk of alcohol relapse among alcohol-dependant smokers. A successful quit attempt can often be a catalyst for other positive behaviour change and the financial savings enable patients to participate more inclusively in society.

King's Health Partners is committed to Value Based Health Care. Value is defined as outcomes that matter to patients and carers, over the full cycle of care, divided by the cost of achieving those outcomes. **Stopping smoking is arguably the greatest achievable value proposition within our gift.**

4. Integrating and strengthening our pathways for smokers, particularly those who are highly dependent on nicotine

Smoking is not a lifestyle choice; it is a chronic addiction, started in childhood or when a young adult. This addiction is treatable. Some individuals can overcome their addiction to nicotine without professional help, but for many the addiction is difficult to overcome. Smoking is best regarded as a long-term condition. Healthcare professionals should offer these patients the evidence-based treatments available, in the same way as they would see it as their role to treat raised blood pressure, diabetes or asthma.

King's Health Partners believes that smoking cessation interventions represent necessary correct treatment for all smokers, particularly those who continue to smoke beyond the age of 30 and younger women wishing to have children. For some people brief intervention and advice from concerned and knowledgeable healthcare professionals can be effective, but many individuals and patients who continue to smoke are heavily dependent on nicotine, live lives that make quitting difficult and require longer and more specialist support to successfully break their addiction.

Working with the Local Authority and in collaboration with Clinical Commissioning Groups we need to consider how smoking cessation services are most effectively commissioned and delivered.
NICE guidance demonstrates that evidence based interventions to help people reduce their tobacco use or stop smoking are clinically and cost effective. The most effective treatment

for smokers is a combination of medications (nicotine replacement therapies (NRT) plus varenicline or bupropion) combined with 6-12 sessions of intensive group or individual behavioural support. Intensive interventions are more effective and more costly than simple interventions, but highly cost-effective. **A tiered approach is appropriate, with the intensity of interventions depending on the severity of addiction and response to therapy. For heavily dependent smokers, including those with mental ill- health, intensive interventions should be offered first.** An analysis of 126,000 intervention episodes in English NHS Stop Smoking Services, showed that varenicline or combination NRT was more effective than single NRT, and specialist clinics achieved higher quit rates than primary care (e.g. practice nurses or pharmacists). **For patients who fail repeated quit attempts there is little point in repeating the intervention that has failed.** Progressively more support should be provided. Specialist cessation teams, working with groups of heavily dependent smokers using the full range of available drug therapies can achieve quit rates of 70% (e.g. Maudsley Smokers Clinic model). To achieve success with "difficult to reach" heavily dependent smokers cessation services need to be proactive, reaching out to patients and engaging with them. There is much good practice to be learned from the KHP 3 Dimensions for Diabetes (3DFD) programme. This innovative programme identified diabetic patients with dangerously high blood sugar levels, engaged with them, understood the multidimensional problems the patients faced and worked with them to reduce these problems, resulting in dramatic improvements in glycaemic control. In the context of an integrated health and social care system the 3DFD intervention is highly cost effective. For highly dependent smokers, including those with severe and enduring mental health problems a similar approach will be required. Commissioners will want to commission the most clinically effective and cost effective smoking cessation intervention for each patient who wishes to quit.

Smoking cessation services are funded by Local Authorities through Public Health England. **King's Health Partners believes that smoking cessation interventions should be included as part of an individual's treatment for their respiratory or cardiovascular condition or their mental health** and that local commissioning of these interventions in primary or secondary care, as part of treatment plans would strongly impact on disease progression, clinical outcomes and health care utilisation. We need to consider how smoking cessation interventions impact along whole pathways of care for all patients. This may require a different commissioning framework and tariff whereby smoking cessation interventions form part of an individual's integrated treatment plan, rather than being seen as a separate intervention.

Finally, for smokers who may not be ready or able to stop smoking in one step or not want to, NICE recently introduced harm reduction guidance. Treatment pathways should also incorporate this guidance.

Much progress has been made recently with the introduction or planned introduction of smoke-free policies in SLaM (led by the Addictions CAG) and the acute trust Partners. It is important to sustain and build on this progress to ensure that we maximise the chances of all smokers entering our Trusts stopping smoking.

Recommendations

- Effective smoking cessation services are available for all patients treated in our hospitals and clinics.
- Specialist smoking cessation services are available for those patients who are highly dependent particularly those with long term conditions who access the partner hospitals.
- Specialist smoking cessation advisors are available for those patients who have repeated failed attempts to quit as identified by smoking cessation services, including mental health patients and pregnant women and mothers with babies and young children.
- All front line staff will receive training to ensure that they ask all service users about

smoking and offer a referral to specialist support (a key component of making every contact count).

- New mothers who have quit smoking during pregnancy are followed up for continued support to achieve a year's quit target.
- Ensure smokers receive continuous, effective nicotine dependence treatment, including at transition points across the pathway.
- All Partner organisations to implement the NICE Guidelines for smoking cessation in mental health, acute and maternity settings.

Measuring our success

- Year on year quit rates for people with mental ill- health, long-term physical conditions, and pregnancy.
- Year on year quit rates for family members who have young children.
- Reduced repeat admissions and length of stay for those highly nicotine dependant patients who have long term conditions.
- Reduced numbers of admissions locally for attributable smoking related conditions in infants.

5. Informatics

Across KHP we are making progress on our informatics strategy. For our clinicians to be able to assess and plan the right care we need to be able to share our records, ensuring that across Kings Health Partners, primary and social care, we are able to collect and record the same metrics and track the journey of our patients' as they move across the health care providers. **We must be assured that smokers are receiving the most effective care, delivered in the best place at the best time.**

Our informatics systems need to be able to record and identify those patients that smoke, and those who have attempted to quit smoking. We will then be able to measure the number of smokers looked after by our services. Access to a single health record will ensure that patients will be offered the most appropriate treatments along the pathway and inform clinicians of interventions that have been successful and those that have not. Comprehensive data collections will inform our service provision and research strategies. **In the near future the health record will include data from primary care and it will be possible to document our progress in helping smokers to quit along complete care pathways.**

Recommendations

- All Partners electronically record the number of smokers that access care.
- All Partners identify those smokers who wish to receive help either with temporary abstinence, stopping smoking or reducing their smoking and informatics systems are linked to appropriate smoking cessation services
- All Partners to record the numbers of people who have been offered support.

- All Partners record the numbers of patients who have successfully stopped smoking or reduced smoking.

Measuring our success

- We will have accurate data on our local hospital and community prevalence of smoking.
- We will have accurate data on the severity of nicotine dependence of our local hospital and community populations
- We will be able to identify the numbers of patients who want to temporarily abstain or make a quit attempt and to whom a brief intervention and referral to specialist support was offered, by ward, service and hospital.
- We would be able to identify the number of people who quit smoking either during or following a hospital admission.

6. Promoting the Health of our Staff and Students

The health and wellbeing of staff and students must be a priority across King's Health Partners. It is important that we support and encourage our staff and students to lead healthy lives and avoid preventable illnesses. In 2012 KHP gained a competitive grant from NHS London to support the health and wellbeing of staff. As part of that programme a smoking cessation advisor was appointed to support staff to quit. The service reached 99 staff members, was well received, achieved a quit rate of 63% and was cost effective. It is important that across KHP we develop consistent, high quality, accessible, effective smoking cessation support for all staff and students who wish to quit. Staff who smoke lose more work days through illness (more than one working week annually). As NICE guidance demonstrates, staff who smoke are less committed in supporting both smoke-free hospitals and smoking cessation by patients. We should also consider the importance of our Partner institutions offering protection from exposure to second-hand smoke and consideration should therefore be given to all partners becoming completely smoke-free. SLaM and our acute trusts have already started this process. **All staff are carers and their health and attitudes are crucial to our mission.**

Recommendations

- All staff and health school's students joining the partners should be assessed for smoking and advised on the best way to stop.
- Staff and students wanting to quit smoking should have access to stop smoking services and given time to attend these services during work hours.
- Staff and students who do not want to quit smoking should be advised on appropriate nicotine replacement products to enable them abstain from smoking during working hours.
- King's Health Partners hospitals will become completely smoke-free in accordance with NICE guidance (SLaM October 2014; KCH January 2015; GSTT March 2015).

Measuring our success

- Reduction in the year on year prevalence of smoking amongst staff and students

- Across KHP all Partners will provide the same level of support to enable staff and students to quit smoking.
- Reductions in days off sick due to smoking related illnesses.

7. Education of our Students and Workforce

Improving the knowledge and skills of our workforce and students so that they understand and deliver successful smoking cessation interventions, through either brief intervention or more advanced personalised interventions, is essential if we are to reduce future smoking related disease amongst our patients and local population. **Supporting patients and staff across KHP to stop smoking requires a competent workforce.** The attitudes and confidence of health professionals affect their practice and willingness to adopt new ways of working, and are likely to be important determinants of their involvement in this key part of their role. Compared to non-smokers, staff who are current smokers have more permissive attitudes about patients smoking.

A local training programme will need to target knowledge, attitudes, confidence, and clinical skills. It will need to have a demonstrable impact on both clinical competency and patient outcomes (in addition to being cost effective). This will need to move at pace as all KHP organisations are becoming completely smoke-free.

King's Health Partners requires:

- Undergraduate curricula for future healthcare practitioners to include details of best practice smoking cessation interventions
- Training programmes to support Stop Smoking Practitioners deliver evidence based interventions for smokers, to improve knowledge and skills, and to promote standardization of good practice
- The development and implementation of clinical care pathways for tobacco addiction underpinned by a sustainable training programme.
- As well as providing training for staff to deliver very brief advice, brief interventions, and intensive support, KHP should also identify appropriate opportunities to thread information about smoking and cessation into existing internal and externally commissioned training programmes.
- SLaM and Institute of Psychiatry, Psychology and Neuroscience (IoPPN) are currently developing a training pathway to support the implementation and sustainability of smoke free across their sites. This will take a stepped approach using blended learning. Each step of the pathway will have a built in competency assessment. Components of this are being evaluated through the CLAHRC South London project. The learning from this will be shared with Partners.

Mental Health Module

SLaM and the IoPPN have collaboratively developed an E-Learning module to equip mental health workers with the knowledge and skills to engage service users in conversations about smoking and provide brief interventions. Using text, animation, videos and service user narratives, the course content covers:

- Smoking prevalence in mental health settings.
- Why mental health service users smoke and find it hard to stop.
- The impact of smoking and stopping smoking on wellbeing.
- Evidence based interventions for smoking cessation in mental health settings (including how to use NRT).
- How to provide brief interventions and how to refer on for specialist support.

The online course takes 2-3 hours to complete and a randomly chosen 10 item multiple choice questionnaire is completed pre and post training. Results of a preliminary 6 month evaluation of the module showed that 791 mental health staff had completed the module and there was a 37% increase in knowledge scores pre and post training. Completion of the module enabled the Trust to exceed their CQUIN target for level 1 smoking cessation training.

Delivering the training via E Learning rather than face to face enabled wider dissemination and greater uptake. For example, previously 99 staff completed face to face level 1 training over a 5 year period, whereas over 1000 staff completed online training in 12 months.

Recommendations

- All clinical staff are trained to assess patients' smoking status, offer brief advice and refer appropriate patients to smoking cessation services.
- Selected staff are trained to level 2, to administer and prescribe smoking cessation interventions.
- Teaching on smoking cessation interventions is part of the health schools undergraduate curriculum and graduates are equipped to offer brief advice.

Measuring our success

Increase year on year on the numbers of staff trained to both Level 1 and 2 smoking cessation training across all CAGs and services.

Increase in positive staff views on the value of smoking cessation interventions.

8. Research

Our audits in the past have shown that not all our patients were being asked whether they smoke and nicotine dependent treatment not being routinely offered. This demonstrates the need for an improved informatics structure which will enable KHP to routinely collect data on smoking for all patients, new data on the tobacco dependence treatment needs of patients and enable us to evaluate the efficacy and effectiveness of our interventions.

We are also creating as many opportunities as possible to attract funding for service development novel research and policy development and evaluation. In the past our nicotine dependence treatment services have been at the forefront of practice, delivering among the highest success rates and researching novel treatments. This has been allowed to slip. There are many exciting cutting-edge projects in tobacco across King's, and improving our informatics structures and treatment pathways will facilitate our research in the future.

A unified co-ordinated research plan across KHP will enable the Partners to make the best use of our resources and expertise and put King's back at the forefront of nicotine dependence research**.**

Recommendations

- Develop a systematic approach to identifying opportunities for research and evaluation related to tobacco across KHP
- Develop a data base for KHP research activities related to tobacco
- On an annual basis, collect naturalistic data using the enhanced informatics systems. Analyse data by patient diagnosis, CAG and partner organisation for:

Smoking demographics and characteristics

Prevalence of smoking of patients, staff and students
Severity of nicotine dependence of patients, staff and students
Prevalence of patients who want to temporarily abstain, with and without support during an inpatient admission, and those who want to make a quit attempt.
Number of referrals made to specialist stop smoking clinics

Efficacy and effectiveness of interventions

Uptake of:
Support offered for temporary abstinence during an inpatient stay
Support offered for smoking cessation during an inpatient/clinic episode
Referrals to specialist stop smoking clinics
Support for staff and student smokers

Outcome of above support on:

Four week, six and 12 month quit rates
Smoking reduction rates
Satisfaction with treatment
Cost of treatment

Effect of above support on Health Outcomes

Assess the impact of smoking and stopping smoking on each's CAG's minimum set of health outcomes they routinely measure.

Staff training

Evaluate the uptake of training by CAG and the effect of training on knowledge, skills and attitudes, patient metrics (e.g. referral for specialist support, uptake of support, quit rates)

9. Communications

(To be completed)

10. Next Steps

King's Health Partners will consult widely to finalise the strategy and to agree a plan for implementation.

- *Operational Executive – Dec 16th*
- *Board – 17th*
- *CAG leaders in Jan 2015*
- *CCGs, Health and Wellbeing Board, charity*

11. References

Key references:

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Agenda Item 8

Item No.	Classification:	Date:	Meeting Name:
8.	Open	16 March 2015	Health and Wellbeing Board
Report title:		Health and wellbeing strategy – community engagement	
Wards or groups affected:		All	
From:		Aarti Gandesha, Healthwatch Southwark manager Ruth Wallis, Director of Public Health Kerry Crichlow, Director of Strategy & Commissioning	

RECOMMENDATIONS

1. The board is requested to:

   a) Agree the draft of the community engagement report, *1,000 Lives* which together with the JSNA has informed the development of the Health and Wellbeing Strategy.

   b) Agree to host an event for contributors to *1,000 Lives* in early summer at which the document will be launched alongside the Health and Wellbeing Strategy.

   c) Agree the proposed approach to future community engagement of the Health and Wellbeing Board.

BACKGROUND INFORMATION

2. The *1,000 Lives* community engagement exercise took place last year. Health and wellbeing board member organisations supported this initiative which was led by a steering group chaired by Healthwatch Southwark. Southwark Council, the CCG, NHS Trusts, Healthwatch and local groups supported by local volunteers and professionals collected stories from people across Southwark.

3. The stories were collected at public events, shopping centres, schools, libraries, day centres, children's centres, voluntary and community groups, churches, leisure centres, GP surgeries and clinics.

4. These stories reflect the diverse needs and experiences of our communities, from staying fit and active, to preventing isolation, to dealing with long term conditions, disabilities and mental illness.

KEY ISSUES FOR CONSIDERATION

5. Common themes emerging from the stories included:

   - Isolation and bereavement associated with ageing and family breakdown.

   - The value of community support and positive relationships and the importance of personal resilience.

- The wider socio economic determinants of health featured prominently: low income, employment and housing were highlighted. Domestic violence also featured.

- Many people described living with multiple health problems including poor mental health.

- Many people had praise for public, community and voluntary sector services and health professionals who had helped them through a period of illness or supported them in their daily life.

- There was an appetite for more information on how to stay healthy and people valued, for example, health and other professionals talking to them about being active and referring them to the right activities.

- Some stories described some problems in accessing the right services.

- There were stories from people who are carers for children, partners, parents or other family members. Carers also talked about the impact of their caring responsibilities on their own wellbeing.

6. Together with the evidence in the Joint Strategic Needs Assessment, the stories gathered in *1000 Lives* have informed the refresh of the Health and Wellbeing Strategy.

7. We propose that the Health and Wellbeing Board host an early summer event, jointly organised by the Council, the CCG and Healthwatch, to be held at Cambridge House. The purpose of this event would be to thank contributors to *1,000 Lives,* to launch the Health and Wellbeing Strategy and to inform ongoing policy and strategy.

8. The Health and Wellbeing board recognises that to be truly successful, the health and wellbeing strategy needs to be responsive to the changing environment and to engage with and be shaped by local stakeholders and Southwark people.

9. To facilitate this Southwark Council, the CCG, CAS and Healthwatch Southwark are sharing information on the community engagement plans of the various organisations to identify opportunities for the Board to take part in engagement events and to capture what the public and the voluntary and community sector are telling us, so that it can be fed back to the Board at regular intervals.

10. Healthwatch Southwark's public forum on 19th March will be the next opportunity for community engagement on the Health and Wellbeing Strategy and will be attended by Jin Lim and Rachel Flagg.

Policy implications

11. Southwark Council and the Southwark CCG have a statutory duty under the 2012 Health and Social Care Act to produce a Joint Health and Wellbeing strategy for Southwark. The Health and Wellbeing Board leads the production of the strategy. Local health and wellbeing commissioning and service plans have to pay due regard to the health and wellbeing strategy.

Community impact statement

12. There are health inequalities in Southwark: between Southwark and the rest of the country, between geographical areas within Southwark, between women and men, those on lower income, some ethnic groups and those who are vulnerable. The JSNA identifies and describes the inequalities and provides the evidence base to inform the programmes of action in the health and wellbeing strategy. The 1,000 Lives engagement exercise has informed the development of the strategy.

Legal implications

13. The Board is required to produce and publish a Joint Health and Wellbeing Strategy on behalf of the local authority and clinical commissioning group. The proposals and actions outlined in this report will assist the board in fulfilling this requirement and will support the strategy's implementation.

Financial implications

14. The costs of the event proposed at paragraph 7 would be shared between the partners.

BACKGROUND PAPERS

Background papers	Held at	Contact
Southwark Joint Strategic Needs Assessment	www.southwark.gov.uk/jsna	jsna@southwark.gov.uk
Draft Southwark Health & Wellbeing Strategy 2015-20	www.southwark.gov.uk	Public Health 020 7525 0280

APPENDICES

No.	Title
Appendix 1	1,000 Lives - Southwark stories informing the Health & Wellbeing Strategy and Health & Wellbeing Board

AUDIT TRAIL

Lead officer	Ruth Wallis, Director of Public Health for Lambeth & Southwark Kerry Crichlow, Director of Strategy & Commissioning	
Report Author	Jin Lim, Assistant Director of Public Health Rachel Flagg, Principal Strategy Officer	
Version	Final	
Dated	10 March 2015	
Key decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer title	Comments sought	Comments included
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Date final report sent to Constitutional Team		10 March 2015

APPENDIX 1

1,000 Lives

Southwark stories informing the Health & Wellbeing Strategy and Health & Wellbeing Board

Southwark Health and Wellbeing Board
Public engagement 2014

Acknowledgements

This compendium is a selection of the personal and powerful stories told by Southwark people. Every one is sincerely thanked for sharing their unique contribution which will shape how we improve health and wellbeing in Southwark.

1,000 Lives

Our vision for Health and Wellbeing in Southwark

"Every child, family and adult has improved health and wellbeing and has access to high quality local services that meet their needs. Together we will invest to make a difference earlier in the lives of local residents, promoting resilience and self-management of health and giving everyone the best and fairest start. Working together to build a healthier future, we will tackle the root causes of ill health and inequality."

Our vision is informed by the stories you told us about your health and wellbeing. With the help of Healthwatch Southwark, Southwark Council, the CCG and NHS Trusts and local groups supported by local volunteers and professionals, we heard from hundreds of people across Southwark. Stories have been collected from Southwark residents young and old, giving us an insight into the ordinary and extraordinary lives of the people of this borough. The stories were collected from public events, shopping centres, schools, libraries, day centres, children's centres, voluntary and community groups, churches, leisure centres, GP surgeries and clinics.

The stories presented in the following pages are just a few of the many you shared with us. These stories reflect the diverse needs and experiences of our communities, from staying fit and active, to preventing isolation, to dealing with long term conditions, disabilities and mental illness.[1]

Everyone's story is different and what people felt helped them varied depending on their individual circumstances. However, there were some common themes.

- Feeling connected Positive relationships, the support of friends, family, community groups and volunteers were cited by many as integral to their wellbeing and their recovery from health problems. Problems in relationships, family breakdown and bereavement were often talked about as a cause of stress and sometimes a trigger for physical and mental illness. Loneliness and isolation featured in many people's stories and conversely, many people talked about the strength they drew from a supportive social network.

[1] Some of the stories were written by the individuals themselves and others were told to volunteers who wrote them down, so not all the excerpts used in this document are direct quotes.

- **Confidence and coping skills** Some stories highlighted a person's confidence and a sense of being in control of their own wellbeing and optimism about the future. There were many stories from people who were born outside Southwark and the challenges they have faced. Levels of personal resilience had an impact on how people felt about the experiences they described. Some people who talked about suffering traumatic events or being the victim of violence, for example, said that they had struggled to cope.

- **Feeling the squeeze** There were stories highlighting the impact of the current economic climate on everyday lives. Poverty, unemployment and poor housing featured in many of the stories and had a negative impact on health.

- **Living with poor health** Many people described living with chronic poor health and with multiple health problems. People with poor physical health problems also described poor mental health and wellbeing – there being no health without mental health.

- **Valuing local services & praising local professionals** Many people had high praise for public, community and voluntary sector services and the dedicated professionals who had helped them through a period of illness or supported them in their daily life.

- **Valuing support for staying healthy** There was an appetite for more information on how to stay healthy and people valued, for example, health and other professionals talking to them about being active, being healthy and referring them to the right activities. People also valued the local facilities to support them to stay healthy, from the local parks, libraries to leisure services.

- **Access** Some stories described access to services, describing the potential for simplifying access and improving on signposting.

- **Caring & family support** There were stories from people who are carers for their children, partners, parents or other family members. Carers also talked about the impact of their caring responsibilities on their own wellbeing. The important roles that families and friends played in keeping them well featured in stories.

The 1,000 Lives stories reinforce what our JSNA (www.southwark.gov.uk/jsna) is telling us. Local people have shared their experiences to help inform the development of the health and wellbeing strategy and the priorities for the Health and Wellbeing Board. The health and wellbeing strategy will reduce health inequalities, improve outcomes for local people and support integration by:

1. Giving every child and young person the best start in life

2. Addressing the wider socio economic determinants of health which we know determine our life chances: we will maximise opportunities for economic wellbeing, development, jobs & apprenticeships, and make homes warm, dry and safe

3. Preventing ill health by promoting and supporting positive lifestyle changes & responsibility for own health (tobacco control and smoking, healthy weight, physical activity, alcohol, sexual health & HIV) and improving people's wellbeing, resilience & connectedness

4. Helping people with existing long term health conditions to remain healthier and live longer lives by improving detection & management of health conditions including self management & support

5. Tackling neglect & vulnerabilities by supporting vulnerable children and young people and ensuring positive transition, ensuring choice and control for people with disabilities and supporting independent living for older people in an age friendly borough

6. Supporting integration for better health & wellbeing outcomes by integrating health and social care that is personalised & coordinated in collaboration with individuals, carers & families and by shifting away from over reliance on acute care towards primary care & self care.

Improving health in Southwark

THIS IS HOW WE'LL DO IT

Giving every child and young person the best start in life

All children need a good start in life – from antenatal care to early years to when they start school and through their teenage years, giving them a strong foundation for a happy and successful adult life. Mothers contributed stories about the importance of good advice through pregnancy, choice and control of their own childbirth experience, support with breastfeeding and ongoing support through their child's early years. This section also includes stories about post-natal depression and stories from parents whose children have health problems, meaning that they need help from a range of services. There was special praise for our midwives, health visitors and our children centre workers. But there was also a desire to receive clearer, more consistent information. We were reminded of the essential role families play in providing support and the importance of enhancing community based support from professionals and voluntary and community groups especially for people who are isolated, vulnerable and without close relatives.

Young people's own stories focus on their desire to be active and healthy, building their self esteem and helping them to become confident and resilient young adults. The impact of bullying on wellbeing and the responsibility of being a young carer were mentioned by several young people. Young people particularly valued leisure services, swimming and gyms and organized activities such as football clubs.

Pregnancy and early years

- "**I went to the GP early in pregnancy.** In the end I chose a caesarian section because my baby was two weeks overdue. My midwife was very supportive. I was also introduced to the family service. An outreach worker gave me advice where to meet other parents and share good times."

- "**I wanted a natural birth, but I was two weeks overdue and they hadn't induced me**. But I had very positive midwives who, despite me feeling fearful, kept to my wishes we'd previously talked about, keeping my birth natural. They motivated and encouraged me and helped me give birth safely. I have a very positive memory of my son's birth due to their support. Fabulous midwives"

- "**When I gave birth I felt isolated**. I didn't know anyone. At my six week check, the GP gave me a list of all sorts of services. I attended the Stay and Play at a medical centre in Bermondsey. The staff were really helpful and I got to meet other women who have babies and can make friends. And the nutritionist gave me lots of tips about food and weaning".

- **"I visited the breastfeeding café before I had my baby**. I was glad I did because I struggled to breastfeed at first. The midwives kept changing their message about feeding and I kept feeling like a failure. The breastfeeding café made me realise I was normal, that the difficulty initially was normal and helped me to feel better".

- **"I'm on maternity leave** after giving birth. My pregnancy was fine up until the birth of my daughter. The labour was very slow and painful and I had to have a blood transfusion due to losing a lot of blood. The midwife who was mainly looking after me wasn't very sympathetic and I felt patronised by her. I also struggled to breastfeed and apart from a couple of sessions with the midwife to show me how to do it, I was pretty much left to my own devices."

- **"The Outreach worker at the Children's Centre' made the biggest difference to me.** I was 17 when I had my first child. I was scared, but wanted a good future for my children; I wanted to set a good example but did not want them brought up on benefits. When I had my first child I could not find services, I did not know where to go for help. It was very hard to find information."

- **"I am a new mum**. I feel mostly good and had good services but had a bad-ish experience. My GP told me my son was overweight. I thought that was odd as I'm big and my husband is tall. I was told to feed him less. Then I saw the nurse. She measured his height, and said his weight was OK for his height! I was a little angry with the GP about this."

- "**I got pregnant last year** – it wasn't planned but it was with my long term partner, so we were really happy. I went to my GP and he referred me to the hospital where I started to have regular visits and scans. I wasn't given any choice of where I could go but I was happy with the services I was referred to. The people that were involved in my pregnancy was my partner obviously, and the GP, the midwife, the health visitor and my sister – who was really good at cooking food for me when I really didn't want to! I felt like I got all the help I needed – I was given the information I needed as this was my first pregnancy. I am really happy within myself and I have always wanted to be a mum so I am quite pleased. I feel complete – she has taken over our lives."

Parent experiences and support needs

- **"After giving birth to my first child, I had post-natal depression.** The doctor gave me sleeping pills, but it didn't help. I self-referred to the Maudsley and now I am in recovery and hoping to move on. During my second pregnancy I asked for help from the mental health services team and asked social services to help, but they

said no. If things had got worse they would have come but I was trying to avoid that. Southwark Reach were helping me. I was referred to Building Bridges, then Newpin. You can only use Newpin for two years, but there's no where else like it. "

- "**When I had my child two years ago I discovered after having her I felt low all the time.** My husband sorted a doctor's appointment for me and I was diagnosed with post natal depression and started to take anti-depressants. I was scared at first – about feeling numb or having no feelings – but it was the best decision I had made for myself and my family. My doctor also referred me to a mother and baby group, it was a course for 12 weeks and we would discuss our individual coping methods and give each other support and ideas about motherhood. The Health Visitors who ran the group were brilliant. I didn't feel judged by anyone and I didn't feel like I was an alien for feeling the way I felt. I became stronger in myself with time and I recovered. Soon I couldn't get enough of my baby. The group I attended was literally life changing for me and because of them I am a happier person and a stronger Mum".

- **"Before I was introduced to SureStart Aylesbury I felt isolated and lost.** They helped me be a part of the community, gain confidence and be a confident parent. I made friends which I still have, we helped each other and meet all the time. I don't have my family in this country so having good friends are very important for me and my children."

- **"English is not my first language.** I have got support from ESOL classes at Kintore Way. I found out about them in the play group. My health visitor told me about the play group. I have made friends in the play group which is good for me learning English. When I had just had my baby, I got a bit depressed, but the play group helped with that."

- **"I look after my 2 year old son and live in Southwark.** I was in a difficult and abusive relationship. I had many miscarriages. I learnt to accept help. The mother and baby unit helped a lot with practice needs ensuring I take my medication. Therapy through the NHS helped but I had to wait until I got worse, when I was really bad before I got serious help. My Homestart volunteer helps and we will be friends forever. She showed me love and was even there when I was in hospital. "

- **"The Outreach worker at the Children's Centre' made the biggest difference to me.** I was 17 when I had my first child. I was scared, but wanted a good future for my children; I wanted to set a good example but did not want them brought up on benefits. When I had my first child I could not find services, I did not know where to go for help. It was very hard to find information."

- "**Surestart parent course changed my life.** Now I am almost where I want to be which is training as a childcare officer and doing my placement."

- **"I tried seven colleges but there were no crèche places for my son and my English was also a problem**. I finally found a college with a space and I have been learning English. Colleges don't always advise us where to find optional childcare provision. My son's school is very good they are teaching him to speak English and he teaches me. The NHS and school have been very good. People in my community now realise it is very important to learn English because the council does not provide interpreters anymore. English classes are sometimes provided in the evening which is not ideal for parents. It is better to provide English classes during the day in term time. I am good at mathematics and next year I hope to study mathematics to get a job in a bank."

- **"You will see the light of the tunnel in the end.** I was low my partner had been violent and I was in shock as my son's father was in prison. During the violence I called the police and social services, but social services could not help anymore. I referred myself to Homestart. The Homestart worker was lovely and a nice person. They helped me with forms and advice. Sometimes I would just cry and talk – they listened and told me I was OK and would come through. I was a good mum to my son. Now I want to support people the way I was supported."

- **"I was struggling to get my life in order.** I had two children, I was a single parent and I had no family to help me. I got help from Southwark Reach and the personal advisor helped me to set goals. I also had a family support worker who helped me to secure accommodation and make sure I paid my bills on time. She helped me secure a nursery for my son when I wanted to go back to college. When I wanted to start university my family support worker helped me to secure a place in an after school club. The staff at the after school club have helped me a lot and I don't know what I would do if they ever closed down. I am now nearly finished my final year of university."

Parents and carers whose children have health problems

- "**My second child was diagnosed as autistic and it was a total shock**. My depression got worse because I didn't know anything about it. Although I got information about it, the fear grew in me about my son's future and how it would affect my family. My worker at Sunshine has been the only person I know I can get in touch with if I have a question about my son's situation. But I am not happy because I think that there should be more support for parents. Contact a Family is a good support. Southwark Carers as well. But I am feeling isolated. I barely know another family in my same situation. I strongly suggest that Southwark should be giving more support to children with special needs, especially autism. Play groups, workshops, story groups etc. I don't have a place I can take my son where he can understand, with no problems because of his condition, with no judgments from others."

- **"I am the mother of a child with a chronic health condition** – a rare one, that took 18 months to diagnose. Since the diagnosis my daughter has been taking a 'special' order prescription with a short shelf life, which has meant timing her script requests and orders to the day almost. Sometimes the GP has failed to understand this and occasional delays have caused us to panic. A point we parent carers often make is that GPs are not the best people to talk to about or sick and disabled children; consultants generally are. Four years ago, my children's dad and I separated. He has recently been diagnosed with heart failure and diabetes type 2 which has left him very depressed. As for me, I am reasonably healthy but am due to have surgery for a benign tumour. We are reliant on another single parent to look after the kids whilst I'm in hospital. My hopes and aspirations for the future are that health, education and social care worked together more closely to offer seamless services of choice and that they communicate more effectively to reduce the need to repeat our story."

- "**My son when he was two was diagnosed with cognitive communication difficulties.** We are at the stage of waiting for school speech and language therapist to pick it up. He is four now. Health services are quite good. Although there is a gap between Early Years and school picking it up. The school has made the biggest difference."

- "**I take my eldest son to regular visits to the eye specialist.** The hospital has generally been good, but they lost his records twice. We keep having different consultants so we had to explain over and over again. The GP speaks in plain English, but eye specialists did not. My son's glasses have to be changed every 3 months - he doesn't like being teased. I would advise that people take a pad and pen when they go to the GP and consultants and write down notes."

- "**I have no life of my own I am living only for her.** My baby niece has had HIV since birth. It's very traumatic and I have ups and downs. The hospital and local doctors are very good services. No one knows about my niece and this affects me as her carer. Somehow we have managed and things are OK. I don't have transport facilities to take her about to appointments etc. It would help a lot to get a bus pass."

Children and young people and their own health and wellbeing

- **"I couldn't afford to go to the gym because I had no money, so I was down**. I ate out of boredom. I would often come downstairs at 3am to eat snacks. My mum supported me when I was in secondary school. I did not enjoy PE because I don't think I was encouraged to do it enough. No one gave me a kick in the bum. I felt depressed at that time and thought I had bipolar condition. I did have a school counsellor which helped. I was naughty and was kicked out of school for a month. I

also messed up my exams. My doctor told me I'm obese. The thing that made the biggest difference was mum taking me to the gym. Mum and dad separated but I would have liked to have seen more of my dad to support me. My hopes and aspirations for the future are joining the army and keep going to the gym and swimming."

- **"I'm 15. I smoke cigs**. I've been chased by the police because of friends. I've stolen from shops. I would advice someone at the beginning of my journey to find the right friends to be around."

- "**I was the only person from my primary school to start at my secondary**. No one heard me speak in Year 7 because I was so shy. The reason why I was really shy was because I was being bullied. They would take the mick out of me in all my lessons. So I had no self confidence or confidence in general. After a while I found someone who was just like me and we are best friends and we have made more friends."

- **When I was in Africa I was healthy**. I did running there and when I came to England in 2012 and I waited a while to start school. When I did start I had to learn English. I would ask the teacher when I didn't understand something. My mum took me to the doctor when I needed it because I couldn't speak English and she would translate."

- "**I'm a young people who is homeless**, I suffer more now with my health than I did before I became homeless. Being homeless brings a lot of health issues and there is not enough support for a lot of these types of things. I'm still good spirited, but I do feel frustrated and upset that not more is done to help young people like me."

- "**My mum has always had epilepsy**. I'm 10 years old at the moment. I was at home in my room and I just knew that my mum was having a fit. I put her on her side and called 999. They checked if she was OK and she stayed at home. My mum has told me how I should take care of her. I've practiced all the things to do if I find her having a seizure."

- "**We were playing football** and a boy kicked the ball at my stomach and I fell into a ditch. I broke my arm. I was taken to A&E at Kings College Hospital and was given a cast on my arm. I was taken in an ambulance there. The nurses were great. The doctors talked to me as well."

- **"I am a 16 year old male**. I coach football for a local football club. I feel healthy – taking healthy exercise and winning every week. My mindset is to keep fit and I'm able to do that. I feel better about myself when I am doing lots of different activities. Seeing children being active is rewarding, especially when their confidence is very

high. With ten year olds who enjoy playing and learning new skills – it's great to be helping them. I thought I was skinny and should eat more when younger. Felt low when I compared myself to somebody else but now I think differently – about what I'm good at and not how I might look like."

- "**I am 13. I was born healthy and grew up in a clean house**. However I wasn't able to speak until I was 7 because I have a bad lisp. But I knew how to use sign language. This helped me a lot to answer questions. I never got bullied because I had older brothers and a good family who looked after us".

Building healthier and more resilient communities and tackling the root causes of ill health

Being active, feeling positive and having a healthy lifestyle can help prevent us getting ill, but not everyone in Southwark has the same opportunities. Some of the stories in this section describe how people's health has been affected by difficult times in their lives, by domestic violence, by losing a loved one, or following an accident or a crime.

Some respondents shared their experiences of changing their lives, with some moving away from unhealthy behaviour like smoking or abusing drugs and alcohol. Unhealthy weight was raised as a concern. Many people talked about the struggle to lose weight and to become more active, with some highlighting difficulties finding the right services that are affordable and accessible. The vast majority of those who said they did take part in sport, exercise and other activities agreed that taking part in social and physical activities made them feel more connected to the community, prevented feelings of isolation and increased their wellbeing.

Financial wellbeing, money worries, worklessness and the importance of 'good' employment were common themes underpinning many of our stories. Professionals and voluntary organisations as well as friends helping to sign post, navigate and refer to relevant services were especially appreciated. The importance of everyday physical activity as well as affordable leisure services for all, including some specialist services, were highlighted.

Difficult circumstances and health and wellbeing

- "**My story began about ten years ago when I migrated to the UK**. Life was quite difficult as an illegal immigrant. I had no job, I was squatting and did not get or seek information. I got pregnant and had my first child as a result of prostitution. When I had my baby, the health worker was really of help and gave me loads of information. I had no self esteem, I was depressed and poor. It was a struggle. I opened up to my health worker who advised me to seek legal help. My lawyer applied to the Home Office and I eventually got my stay. I am getting ready to get a degree at university. I want to become a nurse."

- **"Depression began in my early 30s**. Arthritis at the same time. I had an unhappy childhood and marriage leading to divorce age 40. I lost my only son to cancer in 2002. I was estranged from dad after he left my mum and estranged from siblings along the way and I've had problems with my daughters. I've had medication for arthritis and depression for many years. I'm very lonely, but I go out to be around people."

- **"I work as a waiter and I have been having really bad toothache and really bad black liquid coming out of my gums**. I'm not registered with a dentist or GP. I tried to access the emergency dentist, but I had to go back to work before seeing anyone. I have to work very long hours in a restaurant because it's expensive to live in this borough".

- **"I had long term substance misuse and I was in an abusive relationship**. My two eldest children are with a foster carer, but I have regular contact. I also have a younger child who is on a supervision order. I was referred to Newpin by my social worker. Newpin helped me know other people that had similar problems. I stopped using. I have been able to make friends from Newpin who we see outside the centre. This has helped me and my son feels more confident and able to lead a normal healthy lifestyle."

- **"After the birth of my second son I had high blood pressure** and went to my doctor who put me on high blood pressure medication. I don't smoke and I take care of my diet and I walk a lot. I still feel unwell and need help. Stress is a problem. I am a single parent, I have 2 children and I have moved. No one can help me. I moved to get a change. I was being harassed by my ex-partner. Now I am safe but lonely. I would like my children to be safe and my health to improve."

- "**I am from Nigeria**. My children and I are in a better place now. My husband left me because he impregnated another lady. My husband was abusive to me and my children and he was always shouting and violent. I was very shy, not confident and could not express myself. I used to cry a lot which really affected my children. My friend recommended I go for counselling with my children, which really helped me."

- "**About three years ago, my husband left me and our daughter.** Since then, it has been a struggle. I got really depressed, as coping bringing a child by myself and working at the same time is so difficult. The money issue is always there – after paying my bills, rent and travel I'm left with £150 to survive until next pay. It puts enormous strain on me as I want all the best for my child. At the moment I'm getting counselling at my GP's surgery and it's really great to have someone to listen. As well, I've been referred to the exercise programme. I got a bit stronger and it was great interaction, but I wasn't able to attend as often as I wished because of money. Today I had my three month review and I didn't even notice, but apparently, my outlook to the world changed a lot, in three months exercising. I started to feel more open, more positive about the future and even more relaxed. I won't be going to the gym now, but I asked the instructor for advice and she told me lots of ways to keep going at home. Talking with people helped, but what really surprised me was that becoming more physically active changed me so much. And I even lost some weight and inches from my waist! The thing that made the biggest difference was going out of the house, interacting with others and getting distracted, even for a short time, forgetting about my problems. My hopes and aspirations for the future are for my

financial situation to improve so I can provide for my daughter. If someone was at the beginning of my experience, my advice would be to seek help – don't suffer in silence."

- "**I'm a recovering alcoholic, but have stress related binges sometimes**. Fifteen years ago I was a domestic violence victim. My child's father assaulted me several times and I was depressed with my life. I began to have anxiety and nightmares. I got married to a man that I met, but we are now going through a separation after ten years. I have a very good job which I have been with for about 20 years – I enjoy it very much."

- "**I had a car accident and had some injuries and whiplash**. Where I live was not helping the situation and I turned down a few properties that were offered to me and I think that was a bad choice. The hospital has been excellent. I'm slowly recovering but I cannot work fully. Every day is a challenge healthwise."

- **"My friend died of cancer two years ago.** After she died, my car was clamped just before her funeral so I was unable to go – this depressed me very badly. I was grieving for two years, but did not understand these feelings, so it developed into depression."

- **"I came to this country, I had no family and felt very alone**. A family friend had brought me here and was sexually abusing me since the age of 17. But I spoke to the college I was attending and they helped me and got me counselling. Then I met my partner and we now have 3 children. I joined Newpin as per advice from my psychologist which is helping my children play nicely together and with other children. I was finding it a problem coping. My GP was helpful when I was pregnant she referred me to a social worker for 6 months because of my mental health problems."

- **"I was lucky to have Homestart.** I became ill after I lost my twins, I started avoiding my friends and felt that people were laughing at me. I had immigration problems and they stopped me from working - that depressed me even more. My doctor prescribed me antidepressants, which I took regularly. I was hearing voices and felt I was worthless. I had no family in this country and my relationship broke down with my baby's father. I got help from Homestart before my son was born, then registered at Newpin. I became happy, I socialise with friends. I still at times get agitated and panic but I have built up confidence in looking after myself and my son better."

- "**I became depressed about 18 years ago after the death of a very special little someone.** I was scared of everything. The sun did not shine so bright. I got counseling but it did not really help. I had panics attacks. No sleep, no dreams - how can you have hope if you don't have dreams? Then a few stars came along to help

me climb the ladder - they live in my heart. Love and support help and I've realised how much a good day means to me and how powerful it is."

Lifestyles and behaviour and taking positive steps to improve our own health

- "**I am at the beginning of my weight loss journey.** I am 40 years old and been trying for a baby for over five years. I've got polycystic ovary syndrome and my GP advised me that reducing my weight might increase my chances of conceiving. I was really apprehensive about going to the gym and starting to exercise, so my doctor referred me to an exercise programme, where I get more support, not just about exercise but about health living, diet and making small changes all the time. It is really helping me with my confidence."

- **"About ten years ago I had a bad chest**. I got a cold that went to my chest and that affected my breathing. I was a carpenter – the sawdust affected me. The nurse at Albion Street suggested doing exercise. If I don't exercise, my chest clogs up with phlegm. I've just had a grandson and I want to be there for him. What helped? My family, exercise, friends – a bit of banter does you good."

- "**I was in the cafe at St Thomas' when I had a heart attack,** 12 months ago. I'm suffering with SAD and depression and feel low when I'm on my own. Family and friends, exercise class and being active helps. I manage my normal activities and look after someone as a volunteer. Having the heart attack changed my life. I'm trying to get back to full fitness and my hopes and aspirations are to get back to normality. If someone was at the beginning of my experience, my advice would be, 'Take it a day at a time. Don't rush things.'"

- "**My doctor advised me to take up exercise to improve health and wellbeing because I was overweight**. I don't feel different at all; I just feel if the local gym was more affordable, I would use it more frequently. It's cheaper only for people on benefits Why?"

- "**I don't have health problems, but do feel the necessity of taking care of myself** and that goes with instructive and nice pilates courses. Since I attend pilates courses I have less pain and apprehensions with my body and social relations at large."

- "**I used to work 12 hour shifts and came home to eat and sleep and discovered I couldn't**. I was tossing up and down and feeling tight in my chest. My wife thought it was heartburn and she was busy massaging my chest. Then it occurred to her that it was getting worse and it may be something else. She quickly dialed 999 and in ten

minutes the ambulance was at the door. They quickly examined me and lifted me into the ambulance and throughout the trip to Kings College they were attending to me and telling me what was happening to me – I was having a heart attack. When I was wheeled into the theatre I was a bit scared, whether I was going to make it or not – I was apprehensive. My daily life now consists of healthy eating, healthy living and exercise and I care about everything I do."

- "**I've been smoking since I was young** – always smoked but never around my kids or grandkids. Smoking has been part of my coping, especially during the grieving process (I lost my husband)."

- "**I was married but used to use cocaine and heroin**. Because of my drug use I lost my family and was put in prison for theft. I was very violent and unstable. At points I felt like committing suicide. My daily life was messed up. My mum helped me. She tolerated me and would visit me in prison. A few of my friends directed me to the right services. When I went to prison I found out I could stop my habit. My hopes and aspirations for the future are to be totally clean and go back to school and have my chance to see my son."

- "**I went for a health check and was told I was obese and that my health was at risk**. I was referred for another appointment and they talked me through my options. I decided to attend the Shape-Up programme and it has been great and really helped me to change my lifestyle. Sometimes I find it hard to attend the group, though, because I work long hours."

- "**Right from when I came to London I had made up my mind that I would pursue a healthy lifestyle and this is what I've been doing.** I try to eat wisely, small portions of healthy home-made meals, fruits and vegetables and exercise. I feel great and on top of my world".

- "**About 7 years ago I was in my mid 20s and felt really unfit** – I didn't want to get fatter and fatter so I entered the London Triathlon as a challenge. Found a local triathlon club helped me to stay focused. Being fit and healthy makes me feel much better about myself and my mood is always much better after a run or a cycle. I work exercise into life – cycle to work, run home etc. otherwise I have no time."

- "**I'm a stay at home busy mum with three children aged nine, seven and three**. I wanted to find some 'me time' and do an enjoyable exercise activity as well. I always liked the noise tap shoes make, but I never tried it until now. I love my tap dancing classes. I love the routines and making new friends."

- "**I'm a pensioner**. I live at home and look after myself and my partner. I'm relatively healthy, but I had bronchitis recently and I was not informed whether I can get a flu jab. Can I?"

- "**I'm visually impaired**. I use 'Wheels for Wellbeing' to cycle every week and keep fit and healthy. My doctor told me about it. I love it. I come every week."

- "**I'm a parent wanting to introduce fitness and healthy eating to my children**. I live near Burgess Park and there isn't a Leisure Centre close by."

- "**I went to the GP, who said that my blood pressure was getting high but did not really say much in the way of guidance**. This went on for a number of years until I changed to a lady doctor and she explained everything and said that my blood pressure was high and damaging my heart. I was referred to the gym and sent to have tests, as I felt my heart was not quite right. I had an ECG which showed a weakness. Then I had a scan which showed an enlarged heart, weak on the left side. My family was supportive and the GP was helpful, but mostly I found things out and did things myself. I was pleased with myself when the GP said I had lost a lot of weight and did well with exercising for an hour every day. Having to keep to a new lifestyle is difficult. I have lapsed into some bad habits again. Eating healthily is really difficult as it costs a lot of money to eat fresh vegetables etc. Also life does not allow time to prepare healthy food every day. My first GP could have explained all the long term effects of having high blood pressure. "

- "**I have problems with sleeping**. This has been going on for 15 years or more. I've tried everything – exercise, relaxation techniques and been to the GP, but I'm not keen on taking sleeping tablets. I've tried it, but it made me sick. I work part time now to have less stress. I notice as I'm getting older more and more health issues are appearing. Is that natural or not??"

- "**I moved to Southwark four years ago and haven't needed to use the health services**. I keep healthy by using the Southwark swimming pools. The scheme that means students can swim for 60p with a Fusion card is great, as it makes keeping fit affordable and accessible."

- "**I am 69 and am looking forward to playing cricket again in April**. Since I took early retirement in 1994, I have spent seven days a week doing voluntary work for various organisations. I last drank alcohol and smoked when I was 13. I have benefited in many ways from those decisions. I have a lot of fun every week in ordinary situations."

Improving the experience and outcomes for our most vulnerable residents and enabling them to live more independent lives

Older people, people with health conditions and people with disabilities may require a range of services to help meet their health and wellbeing needs. People talked about the effect of long term conditions and the impact of multiple health conditions on their lives. Many stories featured a desire for more choice and control over what happens to them and others talked about health, social care and other services needing to work better together to provide a better service for the individual.

This section also includes stories from people who have been affected by mental illness. They talked about their experiences at times of crisis and the support they continue to need to stay well.

The stories especially emphasised the importance of local professionals, voluntary and community groups and carers for this group. Worries about ageing, bereavement and isolation were common themes.

People who need care and support to help them in their every day lives

- "**I find it hard to get about on my own - my carer helps me here;** I love it, I feel free and the exercise is good for my lungs and also for my mental health, it makes me feel better about things. My GP, hospital and family are all great, the only one I didn't like was when I saw a different doctor, he didn't really listen, it seemed like he was too busy. My physiotherapist pushed me but in the right way made me believe in myself. I'd love to work - get a job where I can help people like me move on and move around. Take every bit of help you can get, but in the end it's down to you to just do it!"

- **"I like coming to Bede House.** They showed me how to cook for myself – cakes and wholefood. I am helped to know how to shop and housekeep, it keeps me busy."

- "**I had acid thrown into my eyes more than 20 years ago in a pub**. And I'm diabetic, too. Social services have looked after me and visited me. And they've helped me decide what sorts of help are relevant to me. It's hard. It felt like I was starting at stage one again. I feel like a bird whose wings have been clipped. When you've got a white stick, people look down on you and some people don't understand. But the carers visit me every day and help with my insulin. And I go to day centres and play games and meet other people."

- "**I am 53 years old**. I am from Southwark. I do voluntary work and help out in the club and I come to Speaking Up. I have learning disabilities. Back in December I collapsed and fainted. I was taken to Guys and St Thomas Hospital. I had pain in my stomach and wasn't feeling well. I am well now. I feel lonely at the moment. I lost my partner last year. I go to counselling at Guys. I've been to six sessions where she helps me with breathing and relaxation. I have a key worker who helps me with a lot of stuff. I wish I had my partner back, but I can't do anything about that."

- "**I had an accident and I'm paralysed** – over a year ago it happened. My wheelchair was nicked and I can't afford a new one."

- "**I am a pensioner with ulcerated legs**. I need compression and steroid cream once a week. Booking GP appointments is not good. 10 minutes is not enough for a consultation. GPs are stressed and they're doing too much. And there aren't enough district nurses. And they need to share information. I'm constantly telling my story over and over again"

- "**The doctor could have given more information.** While waiting for the appointment at hospital I did not have much knowledge about what was going to happen at the appointment.**"**

- "**I'm a woman who's just turned 50 and am having a rotten 50th year**. I had operations to both hips to realign a defect and lack of at home service resulted in attending the hospital just to get the wound cleared. There was a lack of communication between Southwark Council and health services to provide information on my case. The nurses turned up without equipment. Doctors, nurses, consultants; some can't wait to get rid and cannot fully explain their reasons for increasing your medication. Since contracting epilepsy I've had very low self esteem and felt unable to cope, but family support was key. I'm now very anxious and stressed due to lack of understanding by my organisation. I need to help myself or continue on a downward spiral. Therapy to be undertaken soon which may raise my sprit. My hopes? That I grow old without the illness dragging me down."

- **"I do not get any help for my wife**. We are 82. I would like to see more done to pensioners especially the older people."

- **"I am a pensioner**. I use the gym, computing and pilates. I have type 2 diabetes. I have a cancer diagnosis but five different opinions and need to go out of borough. I don't mind dying but don't want pain. I was taking tablets / meds for diabetes but stopped. I also have osteoarthritis, but can't do anything. I need help on nutrition. Pills make me feel bad."

- **"I am a disabled elderly person** who has just moved into Dulwich. I am exploring what is available and accessible for disabled people and above all else what people's attitudes are to disability. I am an independent feisty lady who is determined to live life to the full and what is more, wants to improve conditions so that all disabled people can have the opportunity to do the same. I have great admiration for all those who put up with my many bad tempers. Those nurses who smiled, listened, doctors, consultants and physios; how would I have managed without them? I have been involved with disability organisations. We have made a lot of difference to disabled people's lives. This work will never end until disabled people are treated as equal members of society."

- **"I am full time carer for my wife who has had a stroke and now has dementia**. Sometimes I need help just at night or early (very early) in the morning and people won't help at this time. Our children have moved away so no support from family. We have had 50 years of happy marriage, it's only the last year where things have got difficult. My hobbies are fishing, which I have had to give up. There is not much support for me to know what I'm entitled to. I play chess on the computer when my wife goes to bed, now I have no one to play with. A neighbour told me about disabled living allowance. No one had told me about this before - why did it take a neighbour to tell me this?"

- **"I'm not disabled I'm differently abled**. I can do anything, in a different way."

- **"I used to live with my mum and dad, but they died**. It was sad. Then I moved in here, over 30 years ago. A lot of people have died. A lot of people are still here as well. I did not like school. I don't like going to the doctor. I take medication. I like knitting. I like going to the pub. I like to have a pint. I like eating fish and chips most. I like peeling the potatoes. I like going to my brother's. I go on Sundays. I go for Christmas. I like doing what I am doing. I don't want to change anything."

- **"The day centre is great** – I come twice a week. They pick you up – there's a hot cup of tea – toast and marmalade – I love it. I had a stroke in my sleep about two years ago and I worry about having another one. I've got carers who give me breakfast and get me ready. In the evening they microwave a meal for me. My daughter's coming tonight – I managed to cook a chicken stew so she'll be pleased. My daughter comes twice a week with shopping and pays the bills."

- **"I don't know when I came here**. The care worker says that I came two months ago but I can't remember. I am in good health. I don't like it here. Nothing to complain about but I miss my home. My family doesn't visit me very often. I'd like to know when I'm going home – I don't know what it's costing me, you see."

- **“Mum’s been taken off the dementia tablets, she’s fully disabled and bed bound**. I think Mum had many mini strokes. She fell off a bus, then began repeating herself, stopped going out and forgot she used to smoke. It has been so hard accessing services. I have been angry and cried rivers. Things could have been different if Mum had been diagnosed earlier.”

People with long term health problems or conditions, some with multiple concerns

- “**I am 67 and I have type 2 diabetes** and my blood pressure and cholesterol are controlled by drugs. I had one knee replacement. I think most of my problems stemmed from being seriously overweight from about the age of 30 onwards. When I was diagnosed with diabetes I decided to take it seriously and find out about the disease and the best ways of controlling it. I lost 3 stone, firstly with the medication and then being careful about the things I ate. I also had some difficulties with my lungs and I was diagnosed with sleep apnoea. I was put on medication, but when I lost the weight the symptoms disappeared and the doctor took me off the medication for sleep apnoea I have always found that whatever brand of the NHS I have dealt with, has been extraordinarily helpful. Doctors need to be honest and advise people to take their diabetes seriously. I have not allowed this condition to affect my life or slow me down and always say that ‘the problem with retirement is you can’t take a day off!’”

- **“I was the victim of a mugging and I was shot**. The bullet is still in my spine. My walking is not strong – I use a walking stick. I had a lot of help from the NHS with counsellors and other professionals. I go out socially when I can afford it. Friends and family help me. You have to be careful not to demotivate yourself. I was 17 stone, now I am 15. I am also diabetic and have high blood pressure after retiring. My ill health affects my movements and way of life. I can still get around and the diabetes and high blood pressure seem to be controlled. I used to drive but I can’t any longer. I come to the gym two or three times a week for sessions with a trainer and have reduced my weight, blood pressure and sugar levels. I would like to lose another stone at least.”

- “**Employers need to look past physical problems.** They are not insurmountable”.

- **“I first became seriously ill shortly after moving to London in my early 20s**. I found myself suffering from severe fatigue, barely able to keep myself awake in the late afternoon, despite going to bed around 9pm every evening. On top of that I started suffering sever bouts of insomnia as well as panic attacks that left me unwilling to undertake new activities and experience a proper social life. After almost two years of tests and examinations, I was put on medication to try and help and over the following few years my health started to improve as the doctors found the

appropriate levels of medication for me to take. Certainly, the high point was meeting my future wife, although I remember suffering a terrible panic attack on our first date and thinking I'd completely messed up the evening. She was the first person I confided in with regards to how I was feeling and what I'd been going through and it was actually an incredible feeling to be able to share that with someone and not to be shunned by them."

- "**I was diagnosed with diabetes at 35 I am now 65.** My GP is very helpful and encourages me to stay healthy and gives me hope".

- "**I am glad I got tested at the right time as a lot of people were dying at that time.** I was able to access the treatment and support services when I was diagnosed with HIV in 2001. I have been living with HIV for 13 years and still feel as fit as a fiddle. I have improved my health with the help of medication and I feel very healthy and fit probably compared to someone who does not know his/her status. I would like to be known as the one who has lived the longest with HIV positive."

- "**I have Asperger's syndrome**. I was born with it. Me and my mother were not getting along and I moved out. I started to follow my friends and made some good choices and some bad ones. II got my own flat, but I didn't like living by myself. I was lonely. It was hard. My mother took me to the GP and that's when I was diagnosed by mental health services with ADHD. Being diagnosed helped because I could understand why I was a certain way. If someone was at the beginning of my experience my advice would be to never miss out on an opportunity, follow your inner voice and try not to be distracted if you have a special need. There are services that can help you."

Dealing with mental health problems

- "**I was 17 when I had my first breakdown**. My mum had left home. She left my Dad with seven children when I was at boarding school. I was 14 at the time. My dad was amazing. He raised the whole family on his own. I have in and out of institutions all my life because of special needs and mental health issues. Until two months ago I was living in a shared house with a key worker. I always need reminding to take my medications and keep out of hospital."

- **"I lived on the streets for years** battling drugs. I didn't know why and I didn't know where to get help. I found out I have Post Traumatic Stress Disorder and personality disorders. Because I'm not dangerous I don't get any treatment. I'm not anti-social, I'm a-social. I'm predisposed to being a hermit. All I can do is use exercise to try and get better. It also gets me out of the house. It takes every bit of effort. I have to get

up and love swimming. In the past I would have had 6 months intensive treatment. Now I don't get anything – programmes have been reduced from 6 months down to 2, so they can't do deep work. I know what's wrong with me but it's hard to do what I need to without the support I need."

- "**I am suffering from mental illness**. While at home I felt isolated as my flat was in disrepair very badly. I put my name down on the housing list in other areas. My cousin did a mutual exchange with me and I moved closer to my family. The new GP who I joined has helped a lot and I have cognitive behaviour therapy at the moment. I have better feelings about myself now. I'm not sure how I let my flat get to me. Therapy helped me to see that loads of things can sometimes get you down, but your home is where it starts. You must be comfortable. I hope to buy a house of my own – I'm working towards it."

- "**I was diagnosed with chronic depression**. The mother of my children stopped me from seeing my kids for no reason at all. I had children at a young age and separated from their mother. We did not get along. I then stopped eating food. I didn't know what was wrong with me. The mental health services came to my home and took me to hospital. I then moved to another hospital for an assessment. I was only at the hospital for a short while, but I didn't like being moved around so often. I'm now eating and feel much better and stronger. My mother stayed strong throughout the whole process and she had a very good support network. I hope to start afresh one day and forget about it all, so I help my mother around the home, watch movies and take it easy."

- "**I am on the road to recovery.** I attend groups, meetings, events, everything possible to get better. I have a family who I need to get better for. A situation at work pushed me mentally, I left my home one night to commit suicide, but something made me think of my children and I phoned 111 and asked for help. They advised to go to A&E. When I went they were fantastic. A mental health nurse was on shift. This was the start of my recovery the big part is admitting that I had a problem. I take medication now which is helping. Being mentally ill is not wrong – more awareness of mental health please and support for families dealing with a mental illness. People need to know that if they are feeling suicidal there is help out there."

- "**I still have a job but I suffer from anxiety and stress because of financial difficulties**. I moved over from Nigeria and my marriage fell apart. I stopped seeing my children, as the mother would not allow this. I feel a bit better now, as my job still calls me for work. I feel like I have let my family down sometimes. It causes me to be very worried and I don't want to have a heart attack."

- "**I am much calmer, but still hearing the voices**. I never told my GP until it got really bad. I started to feel enclosed, isolated and that people were staring at me.

Finally, I had a panic attack. What helped was my GP and the hospital staff who put me on medication. I love when my family are around and I have just started going out. I want to drive my car, but I'm not allowed due to the medication. I'm sorry I never got to see my son graduate from university the other day and my other younger son needs my support. I need to get stronger. I would love to get better, go back to church and to normal life."

- "**I have Post Traumatic Stress Disorder,** but I'm not getting the anti-psychotic drugs I need. I am outraged; I'm one of many of hundreds and thousands in the land suffering. I would have had 6 months intensive treatment pre-2008 but I'm getting nothing now. A lot of the voluntary sector programmes have closed down too or have been reduced. I know I've got a lot to do but it's tough to do with no support."

- "**My schizophrenia was diagnosed when I was 19, thirty years ago.** When I was diagnosed I received wonderful support at the Maudsley. I get stressed sometimes, but I manage well. I get medication from my GP and my community psychiatric nurse helped a lot. The family and church also help a lot. The NHS has helped me considerably and I can't thank them enough. I don't have a nurse or consultant anymore. I'm glad as it means I'm well."

- "**I had a traumatic experience nine years ago**. I had an assault on me and suffered from Post Traumatic Stress Disorder and depression. My GP referred me to Cognitive Behaviour Therapy and counselling. I struggle a bit from saying no to people and trusting them. I feel at peace in myself now. What helps is going to the gym, taking a steam and sauna, swimming, visiting old friends, socialising, helping people in need and going to church. If someone was at the beginning of my experience, my advice would be to take time to heal and it is good to talk – don't hold it in."

The Health and Wellbeing Board welcomes your views.
You can email us at PHadmin@southwark.gov.uk

Item No. 9.	Classification: Open	Date: 16 March 2015	Meeting Name: Health and Wellbeing Board
Report title:		Southwark and Lambeth Early Action Commission update	
Wards or groups affected:		Southwark wide	
From:		Gordon McCullough, CEO, Community Action Southwark	

RECOMMENDATIONS

1. The board is requested to:

   a) Note progress made on the Southwark and Lambeth Early Action Commission.

   b) Note that the Health and Wellbeing Board will receive recommendations from the Commission in July 2015.

BACKGROUND INFORMATION

2. In July 2014 the Southwark Health and Wellbeing Board approved of the creation of an independent Early Action Commission. The broad aim of the Commission is to make a series of recommendations about how organisations such as the local council, NHS, police and voluntary sector can work together to prevent problems that damage people's lives and trigger future demand for services.

3. Following a competitive procurement process the New Economics Foundation (nef) were appointed to carry out the secretariat, research and engagement functions of the Commission.

4. The commission is chaired by the Rt. Hon. Margaret Hodge MP and is composed of a range of experts in early action and intervention across a range of policy areas. The commissioners are Dr Sue Goss (Office for Public Management); Carey Oppenheim (Chief Executive, Early Intervention Foundation); Dr. Jonty Heaversedge (Chair, Southwark CCG); Prof. David Colin-Thome (Trustee, Guy's and St Thomas' Charity); Helen Charlesworth-May (Strategic Director of Commissioning, Lambeth Council); and, David Robinson (Community Links).

5. An Implementation Advisory Group, of key decision makers, budget-holders and other key stakeholders in Southwark and Lambeth, has been established. Its role is to advise on the practicalities of implementing the recommendations developed by the Commission and suggest practical interventions to embed the outcomes of this initiative.

6. In January 2015 it was agreed that Lambeth would join the Commission and the local authority and CCG in Lambeth have contributed additional resources to cover the expansion of the commission. The inclusion of Lambeth has meant the overall reporting timetable for the Commission has been amended with a final

report/recommendations being presented in July 2015.

KEY ISSUES FOR CONSIDERATION

7. Between October and November 2014 nef conducted secondary data analysis to pinpoint local problems that the Commission could focus on. Four policy areas emerged: childhood obesity; unemployment /employment insecurity; social isolation among older people; and violent crime. Lambeth concurred these were problems that were consistent with their own assessment of local issues. The four themes have been used to think about the upstream links between problems and to provide a way to ground the theory of early action into policy and practice.

8. The researchers have also mapped and reviewed council strategies, initiatives and a range of activities and services (which are preventive in nature and draw on local assets) offered by community organisations in Lambeth and Southwark.

9. Around 140 cases, across the four policy areas, are currently under review in order to:

    - assess the level of or prevalence of prevention and early action elements; and,
    - inform the development of lines inquiry with relevant stakeholders to explore barriers and opportunities for early action

10. An engagement event was held in November 2014 with over 50 participants from the voluntary and community sector in Southwark in attendance. The aim of the event was to gather information on the prospects, barriers and current experiences of early action and prevention.

11. At the engagement event, upstream causes of social problems and barriers to early action were discussed. The barriers identified by participants included:

    - **Information limitations**: this was conceptualised in terms of demand-side and supply-side information limitations. On the demand side, participants pointed to a lack of information on patterns of need and at risk groups. On the supply side, participants noted a lack of information / awareness of available services and / or local assets that can be mobilised.
    - **Organisational siloes**: linked to the above is the perception of a silo culture among statutory agencies. As well as leading to a lack of information sharing, participants argued that a silo culture leads to: service delivery that is responsive to the needs of government agencies and not service users; generates co-ordination problems between agencies; and, counter-productive incentives for service commissioners and providers.
    - A culture of **short termism and risk aversion** as a barrier to prevention. This is because early action strategies deliver results in the long-term which may come at short-term costs, and risk aversion obstructs innovation which is what many felt was needed in order to move towards prevention.

12. A number of early recommendations (based on the research and engagement events) have begun to emerge. These include:

    - **Changes to commissioning and assessment of services:** through (a) more strategic and long term approaches to commissioning and evaluating services, which would provide time for preventive action to demonstrate

outcomes, (b) decreasing risk aversion and encouraging innovation amongst commissioners and service providers in ways that incentivise upstream investment, and (c) the use of approaches to evaluation such as social return on investment to capture the value of preventive services more fully.

- **Joining up and integrating agencies**: through (a) information sharing initiatives such as networking events, 'community asset atlases', (b) the pooling of budgets, (c) multi-agency service delivery and strategic oversight of early action initiatives and (d) a shift to an outcomes-based culture.
- **Citizen participation and engagement** was seen as a good way to gather information on local needs and assets, and participants felt that prevention would be realised through community development processes that build social capital through participatory and place-based.

13. The Commissioners have instructed the researchers to focus on the community and asset based approach to prevention with a view to exploring how it builds the resilience, capacity and autonomy of communities and of individuals.

14. The next stage is to identify two sub-localities in Southwark and Lambeth. The aim will be to bring people together to get them to design and consider what an 'early action place' would look like and what assets exist to help achieve this. The exercise will also look at what are the barriers to prevent this from happening and what could the system do to help communities to flourish and build resilience.

15. Following this stage the Commissioners will consider the evidence and respond to the following questions in order to begin to frame their recommendations:

    - **Systems and structures**: how preventive are local policy frameworks, strategies, organisational structures and practices, in Lambeth and Southwark? How far are the policies and governance arrangements relating to the sources and destinations of local government funding, costs, and savings conducive to prevention?

    - **Local assets and activities:** What is already happening at local level that is actually or potentially helping to prevent harm? How can this be harnessed?

    - **Relationships between formal systems and structures, and local assets and activities:** To what extent do systems and structures in the two boroughs help these local assets and activities to flourish and fulfil their potential? How far do they constrain them?

Next steps

16. The Commission will meet again once the engagement exercise in the two sub-localities has been completed. The Commission will meet three more times between now and July 2015, when it will provide its final report and recommendations to the Health and Wellbeing Boards in Lambeth and Southwark.

BACKGROUND PAPERS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
None	

Lead officer	N/a	
Report author	Gordon McCullough, Chief Executive, Community Action Southwark	
Version	Final	
Dated	5 March 2015	
Key decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer title	Comments sought	Comments included
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Date final report sent to Constitutional Team		5 March 2015

Agenda Item 10

Item No.	Classification:	Date:	Meeting Name:
10.	Open	16 March 2015	Health and Wellbeing Board
Report title:		NHS Southwark Clinical Commissioning Group (CCG) Operating Plan 2015/16 (DRAFT VERSION)	
Wards or groups affected:		All wards and all Southwark residents	
From:		Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group	

RECOMMENDATIONS

1. The board is requested to:

   a) Review and comment on the attached draft of the CCG Operating Plan and outline of the CCG's Strategic Framework.

   b) Note the mandatory requirements of the CCG included in the Operating Plan and the plans the CCG has put in place to meet these objectives.

   c) Note that the locally-determined and agreed plans set the foundations for transformational change in local health and care services and deliver improved outcomes for the people of Southwark. The trajectory for change is set out in both the draft Operating Plan and the CCG's Strategic Framework.

   d) The Health & Wellbeing Board should seek assurance that the CCG's Operational Plan sufficiently demonstrates a credible plan, which will ensure Southwark patients receive the services they are entitled to; that we are planning appropriate interventions to improve the outcomes of Southwark's residents; and that our plans are aligned with the objectives of the Health & Wellbeing Strategy and Better Care Fund in Southwark.

   e) The Board should note that a final version of the CCG's Operating Plan will be presented to the Health & Wellbeing Board for endorsement at the meeting scheduled for June or July 2015.

EXECUTIVE SUMMARY

2. The CCG's Governing Body resolved to develop a strategic document with the purpose of clearly articulating to local people and partners what the CCG will do over the course of the next five years to transform commissioning and improve patient outcomes in Southwark. The short outline (Appendix 1) of this document is provided for information and provides the context for the draft Operating Plan 2015/16 (Appendix 2).

3. The CCG draft Operating Plan is written as a plan for the first year of the CCG's strategic planning period. It responds to local drivers of change and also to national planning guidance.

4. *The Forward View into action: planning for 2015/16* (commonly known as the national Operating Framework) published by NHS England on 23 December 2014 sets a mandate for CCG's to deliver next year. This guidance sets the national 'must dos' for the NHS in England.

5. This draft version of the CCG Operating Plans is written to describe how over the course of the next year we will:

   a) Commission services in a way that improves outcomes and access and address health inequalities

   b) Ensure key programmes and headline commissioning intentions for 2015/16 are delivered as the initial stage in a medium-term pathway of strategic change.

   c) Commission high performing services and secure patients' NHS Constitution rights and pledges

   d) Commission high quality and safe services

   e) Support local financial sustainability, delivering value for money and invest to improve health outcomes.

   f) Maintain the appropriate governance and risk arrangement to support delivery of our plan.

6. Health & Wellbeing members should note that the Operating Plan is an assurance document focused on addressing the 'must do' aspects of CCG business and also the work we are leading to improve the quality of care commissioned in Southwark.

7. The draft CCG Operating Plan 2015/16 articulates our major commissioning intentions and work programmes over the planning period and identifies the planned impact of these on the local system and consequently health outcomes for our population. In the context of our draft Strategic Framework The document describes how we will take steps in 2015/16 to initiate a transformation in the way we commission services in Southwark.

8. The plan also demonstrates how our major work programmes have been developed to align with the Health & Wellbeing Strategy and Better Care Fund for Southwark.

BACKGROUND INFORMATION

9. The CCG presented a briefing on the *NHS Forward View* to the Health & Wellbeing Board's January 2015 meeting.

10. In March 2014 the Health and Wellbeing Board endorsed the CCG's two year Operating Plan covering 2014/15 and 2015/16. The enclosed draft is a revision of year two of the original two year plan.

KEY ISSUES FOR CONSIDERATION

Policy implications

11. National requirements of local NHS services include those set out in the NHS Constitution and the national planning guidance published by NHS England – *The Forward View into action: planning for 2015/16*.

12. Use of the Better Care Fund in Southwark in 2015/16.

13. The draft Operating Plan has been developed in alignment with the current priorities included in the Southwark Health & Wellbeing Strategy 2015/16.

Community and equalities impact statement

14. The CCG will complete an equalities impact assessment as part of the strategic planning process. This will include assessment at both a borough and south east London level. The assessment will determine the extent of any differential impact of proposed strategic changes on various groups in Southwark.

Legal implications

15. None at this stage

Financial implications

16. The finance section of the draft Operating Plan set out in headline form, the CCG's budgets and investments that underpin the delivery of national and local requirements whilst supporting financial sustainability. Full financial plans are available.

BACKGROUND PAPERS

Background Papers	Held At	Contact
Southwark JSNA	www.southwarkjsna.com	Kieran Swann Head of Planning & CCG Assurance 020 7525 0466
Southwark CCG Operating Plan 2014/15 & 2015/16.	www.southwarkccg.nhs.uk	
Southwark Health and Wellbeing Strategy 2015/16.	http://moderngov.southwark.gov.uk/documents/s51406/Appendix%201%20Health%20and%20Wellbeing%20Strategy%202015%20-%202020.pdf	
The NHS Five Year Forward View *The Forward View into action: planning for 2015/16.*	http://www.england.nhs.uk/ourwork/forward-view/	

APPENDICES

No.	Title
Appendix 1	Outline of DRAFT CCG Strategic Framework 2015-2020
Appendix 2	DRAFT VERSION 4 - NHS Southwark CCG Operating Plan 2015/16

AUDIT TRAIL

Lead Officer	Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group
Report Author	Kieran Swann, Head of Planning & CCG Assurance NHS Southwark Clinical Commissioning Group
Version	Final
Dated	11 March 2015
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Strategic Director of Children's and Adults' Services	No	No
Date final report sent to Constitutional Team		11 March 2015

NHS Southwark Clinical Commissioning Group

Appendix 1

Approach to developing the CCG Strategic Framework 2015-20

9 March 2015

CCG Strategic Framework

NHS Southwark Clinical Commissioning Group

- The CCG agreed to develop a new strategic document covering the period 2015-2020.
- Our Governing Body endorsed an approach and structure for the development of the document. It was considered that a concise strategy written to be accessible to the lay reader would best suit our purpose.
- The purpose of the document is to clearly describe the impact on the health of people living in Southwark we plan to make over the course of the next five years.
- We want our Strategic Framework to clearly describe how we move from where we are today to a situation where we are commissioning integrated services based on locality geographies with contracts in place that are outcome-focussed and funded on a capitated basis.
- We recognise that it is essential that we talk about the practical steps we will take to transition to our goal of commissioning integrated care and explain the benefits of this approach for the people of Southwark.

High level outcomes and key health issues

NHS Southwark Clinical Commissioning Group

- We have developed an early draft of the CCG's strategic framework, which focuses on taking action to improve four strategic health outcome areas:
  1. An increase in healthy life expectancy for people in Southwark
  2. A reduction in health inequalities in Southwark, with those on the lowest incomes achieving better health outcomes than they do now five years into the future.
  3. An increased level of 'patient activation', with more patients engaged in their healthcare.
  4. More patients reporting a better experience of healthcare services.

- In thinking about the best way to maximise impact on the four outcomes, we have used the JSNA and Health and Wellbeing Strategy to identify the key health issues that contribute most to determining our four strategic health outcomes. These include things such as childhood obesity; preventable liver disease; variable GP access; outcomes for people with mental health conditions; dementia diagnosis.

- What we want to determine now are the specific things we will do (concrete actions) in order to be in a position to support our ambition to commission integrated services within a locality geography within the next 5 years.

Transforming our approach to commissioning

NHS Southwark Clinical Commissioning Group

We know we will have to continue to develop our approach to commissioning NHS services if we are to secure the future of the NHS in Southwark and to make improvements to health outcomes. Primarily we will need to ensure that the services we commission continue to be safe and effective; provide best value for money; and are continually monitored and developed through engagement with people in the borough. Importantly, we will work to ensure that our commissioned providers consistently achieve NHS Constitution and other national mandatory standards for NHS patients in Southwark.

Beyond this, we will develop our approach to commissioning so that we improve the quality of local care and patient outcomes. We are absolutely clear that in order to our strategic aims we will need to consistently adopt the following approach, which represents a fundamental change from the way we commission services at present:

1. Develop and then commission integrated models of care that enable a population-based approach to the management of our patients along the entire pathway of care. Rather than just treating ill-health and disease, we recognise and address the wider determinants of ill-health across Southwark.
2. We need to commission on the basis of outcomes and not through focusing on process or activity measures. A focus on outcomes means we place the notion of value at the centre of our commissioning activities. Southwark CCG's mission is 'To achieve the best possible health outcomes for Southwark people'. We will do this by commissioning services which focus on targeting health inequalities and by ensuring that services are strong and able to deliver consistently high quality care for all patients. The way that services are organised will need to change to make this a reality.

Transforming our approach to commissioning

NHS Southwark Clinical Commissioning Group

3. We need to focus more on prevention and early intervention so that people get the right help when they need it and we need to ensure that people who have more complex conditions receive an integrated and personalised service.

4. We must increasingly move to a model where local our residents are seen as people who can contribute and exercise control over their own lives, improving their own health and well-being. We need to invest in the development of social capital across the borough, with a particular focus on enabling people to take control and giving them the tools to manage their conditions effectively. This will incorporate carers.

5. We need to change the models of care we commission so they increasingly are focussed on pro-active stratification and management of patient cohorts.

6. We will develop and commission services structured around primary and community care neighbourhood geographies. The aim of this is to commission holistic care with doctors, nurses, social workers, therapists, housing support workers and home carers will be able to work in a more integrated way, with common objectives to improve health outcomes for local people.

7. We will enhance community capacity and improve access for our patients. We believe that all patients should have access to the same range of and quality of services to meet their health needs. We also plan to make it easier for patients to get the care they need when they need it, as close to their home as possible. This should mean less care needed in acute settings as primary and community based services are accessible for more hours seven-days-a-week.

NHS Southwark Clinical Commissioning Group

Appendix 2

NHS Southwark CCG Operating Plan 2015/16

- Draft (v4) -

8 March 2015

Contents

NHS Southwark Clinical Commissioning Group

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Introduction and context

Introduction to NHS Southwark CCG

NHS Southwark Clinical Commissioning Group

NHS Southwark Clinical Commissioning Group (CCG) is a membership organisation of all general practices serving people in the London Borough of Southwark. The combined registered population of Southwark's 44 general practices is approximately 290,000 patients. The CCG operates with the strong clinical leadership of local practices to commission to improve local services.

Clinicians from member practices have been involved throughout the year in the development of the CCG's major programmes of transformational change. These programmes of transformation constitute the core components of this Operating Plan and have informed the development of a broader piece of strategic planning across health and social care in south east London. The CCG has run borough-wide clinical engagement events; monthly locality member practice meetings; the CCG's Council of Members as well as targeted multi-disciplinary focus groups to develop the content of the Operating Plan.

The CCG is also committed to understanding the views of local people about the NHS in Southwark. We have a well-developed network of local people, who help us to better understanding prescient issues in health and social care. This network is based on practice-based Patient Participations Groups, which feed the views of members through locality groups and into the CCG's Governing Body. The CCG also runs a wide range of engagement events and operates web-based interactions with people in Southwark and other community organisations.

Our Population:

- 288,300 patients registered with Southwark practices.
- Young and ethnically diverse population.
- Significant disparities in levels of deprivation across the borough and health inequalities.

Key health issues in Southwark include:

- Premature cardiovascular mortality.
- Preventable respiratory mortality and morbidity.
- Diabetes management and under-detection.
- Liver disease and alcohol related illness.
- High prevalence of patients with mental health problems.
- Very high levels of childhood obesity.

Our organisation and local context

- 44 GP member practices.
- 4 geographically coherent neighbourhoods (Dulwich, Peckham and Camberwell, Bermondsey and Rotherhithe, Borough and Walworth) served by two locality groupings (north and south Southwark).
- 2 GP provider organisations (north and south) covering every practice holding population based contracts for services including integrated frail elderly care, access and population health.
- Vast majority of acute care provided locally by GSTT and King's College Hospital NHS FT (Denmark Hill) with even split between both.
- Community services provided from GSTT and acute and community mental health services by SLaM.

The health context in Southwark

NHS Southwark Clinical Commissioning Group

Since 2010 life expectancy has continued to rise for people living in Southwark and over the last few years there has been a trend towards diminishing inequality in health outcomes between different socio-economic groups within the borough. Progress has been made on improving health outcomes in a wide variety of areas, including reductions in infant mortality; better, more comprehensive care for people at the end of their live; and improved outcomes for people living with HIV.

However, in Southwark and across NHS there are a number of problems that we need to solve. And the longer we wait to respond to these challenges, the more difficult these problems become. In essence, we know that health outcomes here in Southwark are not as good as they could be:

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

These issues are challenges faced by health economies across London and the country. The response to these challenges is outlined in a number of regional and national strategic documents, which we need to reflect and implement where they are relevant for people in Southwark. We are an evidence-based commissioning organisation and as such work to accurately understand the health of our population and to ensure that solutions to key health issues reflect what works.

The local planning context

NHS Southwark Clinical Commissioning Group

This Operating Plan describes the actions the CCG will take in 2015/16 to deliver on our responsibilities and make progress in transforming the system to improve quality and outcomes. The context for this year's work is therefore important to note. The CCG's commissioning intentions, financial plans, and approach to performance, quality and safety in 2015/16 reflect the context and requirements of a number of national and local strategic frameworks.

Southwark CCG 5 Year Strategic Framework (draft, scheduled to be published Q1 2015/16)

The draft strategic framework is founded on the Southwark JSNA and Health and Wellbeing Strategy to identify the key health issues that contribute most to determining population-wide health outcomes in the borough. The strategy document will describe how the CCG plans to lead transformational change in health and social care so as to improve four key strategic health outcome areas over the course of the next five years:

- An increase in healthy life expectancy for people in Southwark
- A reduction in health inequalities in Southwark, with those on the lowest incomes achieving better health outcomes than they do now five years into the future.
- An increased level of 'patient activation', with more patients engaged in their healthcare.
- More patients reporting a better experience of healthcare services.

Five Year Strategic Plan for the NHS in South East London

The south east London strategy has been developed across the region by building on the common elements of CCG plans with a particular focus on those areas where improvement can only be delivered by collective action or where there is added value from working together.

The south east London plans seeks to respond to local needs and aspirations, to improve the health of people in south east London, to reduce health inequalities and to deliver a health care system which is clinically and financially sustainable. The south east London plan focuses on six priority pathways: Long term conditions (physical and mental health); Planned Care; Urgent and emergency care; Maternity; Children and Young People; Cancer.

A full description of the strategy can be found here: http://www.ourhealthiersel.nhs.uk

The regional and national planning context

NHS Southwark Clinical Commissioning Group

NHS Five Year Forward View

The NHS Five Year Forward View was published on 23 October 2014 and sets out a vision for the future of the NHS. The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. The Five Year Forward View starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England. It defines the framework for further detailed planning about how the NHS needs to evolve over the next five years. The Forward View argues for:

- A radical upgrade in prevention and public health focussing on smoking, alcohol and obesity.
- Patients taking more control over their care.
- Action to break down the barriers in how care is provided including new models established either as Multispecialty Community Provider or vertically integrated Acute and Primary Care Systems organisations.
- Improvements to urgent care systems; maternity services; care homes and smaller hospitals.

London Health Commission's Better Health for London Report

The Mayor of London established the London Health Commission in September 2013 to review the health of the capital, from the provision of services to what Londoners themselves can do to help make London the healthiest major global city. In November 2014 the commission published *Better Health for London*, which proposes a series of measures to improve Londoners' health. Together the proposals amount to the biggest public health drive in the world, with a strong focus on reducing harm from tobacco, alcohol, obesity and in promoting exercise and healthy living. The Better Health for London report contains over 60 recommendations and sets out 10 ambitions for the city. The full document is at: http://www.londonhealthcommission.org.uk/wp-content/uploads/Better-Health-for-London-report-revised-November-2014.pdf

The Mayor of London has now published his response supporting many of the recommendations and with a commitment to work with the NHS and London boroughs to reduce harm caused by poor health and to progress the ambitions in the report. The Mayor will chair a refocused London Health Board to oversee progress.

What is an Operating Plan?

NHS Southwark Clinical Commissioning Group

The Operating Plan is an assurance document, which sets out how the CCG plans to meet mandatory requirements set by NHS England in the annual operating framework planning guidance. The document sets out our locally-defined response to these requests. The Operating Plan is a declaration of the CCG's commitment to meet national requirements; establish the extent of our ambition for the improvement of certain performance and outcome indicators; and provide a view of the programmes of work underway and planned to ensure these targeted improvements happen. The Southwark Operating Plan 2015/16 describes the CCG's response to the requirement included in planning guidance published in December 2014: *The Forward View into Action: Planning for 2015/16* and *Supplementary information for commissioner planning, 2015/16*. The guidance sets out the first steps the NHS should take in 2015/16 towards implementation of the vision set out in the Forward View document.

Both the CCG Council of Members and NHS England are responsible for assuring and endorsing CCG plans and the CCG submits detailed planning templates to NHS England. These templates include the CCG's detailed financial plans; monthly activity and performance trajectories; quality and outcome indicator trajectories; and details of the borough's Better Care Fund Plan. This document summarises these detailed submissions and supplements this information with further description of the key actions and activities the CCG plans to complete in 2015/16 to deliver an improved NHS in Southwark.

Planning guidance stipulates that the 'fundamental elements' of CCG operating plans must address the following:

- An approach to improving outcomes as set out in the NHS Outcomes Framework.
- The CCG's approach to improving health and reducing health inequalities (linked to the local Health and Wellbeing Strategy).
- The CCG's approach to ensuring a 'parity of esteem' between physical and mental health commissioning.
- The CCG's approach to improving access to local services for everyone.
- Details of how the CCG will meet NHS Constitution standards and performance trajectories.
- Details of the CCG's response to the Francis, Berwick and Winterbourne View reports.
- The CCG's approach to safeguarding.
- Approach and improvement ambitions in relation to patients safety and patient experience.
- Planned progress towards seven day working.
- To understand staff satisfaction and workforce Compassion in Practice at commissioned providers and assure local improvement plans.
- To present financial plans that meet NHS business rules; deliver efficiency and clearly link to service and activity plans.

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Commissioning to improve outcomes and access and address health inequalities

Focussing on outcomes

NHS Southwark Clinical Commissioning Group

Southwark CCG has expressed a clear wish to modify the way the way that it commissions services by moving from an activity based model to an outcome based system. We recognise that activity based contracts can offer perverse incentives, and do not always promote joined up care. An unintended consequence of such contracts is that they address only the patient's immediate needs without seeking to prevent ill health or address the underlying health and social issues that the patient may be experiencing.

We are thus seeking to incentivise providers to work collaboratively to redesign care pathways that prioritise clinical and functional outcomes that are meaningful to patients, enhance patients experience of care and promote prevention, wellness and well bring in order to reduce the burden of disease and health inequalities. At a population-wide level we are specifically looking to make progress on 4 key domains over the next 5 years:

1. Healthy life expectancy
2. Reduction of health inequalities
3. Increased 'patient activation' so more people are engaged in their healthcare
4. More patients reporting a better experience of healthcare services

To support this we will look to change the way that we contract services with our providers, and move to alliance based contracts whereby a group of providers are collectively contracted to deliver agreed outcomes on a population and/or condition specific basis. As part of the transition, we will track a set of population outcome indicators in order to set benchmarks and track progress, These indicators are a composite list of the 15/16 National Outcomes Framework indicators, Public Health Outcomes Framework and Social Care Outcomes Framework. The purpose of drawing these three frameworks into one scorecard is to enable all commissioners across health and social care to have a joint frame of reference – a crucial step on our path to full joint commissioning of services over the next few years.

Focussing on outcomes

NHS Southwark Clinical Commissioning Group

Whilst it is helpful to establish population level measures we recognise that outcomes can usually only be successfully defined, measured and interpreted when applied to segments of the population which share similar needs – based on their condition, symptoms, or demography. In some areas this work has already commenced. For example, the Southwark and Lambeth Integrated Care team have worked with patients to develop a series of experiential outcomes for the frail elderly pathway that will begin to be tracked in the coming year. Further examples of areas for outcome development include diabetes, severe mental health problems, circulatory problems, or breathlessness. By identifying outcomes that are specific to the needs of particular groups of people in our population, we will contract with groups of providers in such a way that they come together around the needs of these groups of people – thus stimulating integration and innovation whilst also incentivising prevention.

As a result, during 2015/16 more work will be done to identify patient cohorts and establish appropriate outcome measures. This will be done in conjunction with clinicians and patients to ensure that we are capturing both clinical and experiential outcomes. Whilst we will develop these locally where necessary, we will also draw on evidence based research conducted by organisations such as the International Consortium for Health Outcomes Measurement (ICHOM). This dual approach will enable us to move expediently towards outcome based commissioning, but also ensure that we are using measures that enable us to benchmark ourselves against peer groups locally, nationally and internationally.

Setting the foundations for Local Care Networks

NHS Southwark Clinical Commissioning Group

A key mechanism through which we will drive the integration of services will be through our emerging Local Care Networks (LCNs). LCNs bring together all local providers from across the health and social care spectrum, including acute, community and mental health services, our GP Federations, the voluntary sector and patient groups, to deliver services based on local needs. LCNs have shared accountability for the whole population based around registered practice lists and are the local interpretation of the Multispecialty Community Provider as described in the Five Year Forward View.

LCNs seek to build on the work of the Southwark and Lambeth Integrated Care Programme (SLIC), and embed locally accountable bodies which have delegated responsibility (and budgets) to improve the health of the population they serve. The key priorities for the LCNs are to:

- improve health and wellbeing through effective prevention at all stages of the life-course, including strong interventions on risk factors such as alcohol, depression, smoking and obesity;
- support individuals and communities to feel well and be well, to identify their needs early and respond quickly, and to help people to better manage their health conditions, taking into account both mental and physical health needs and the important connections with other services, such as employment, housing and financial advice;
- significantly improve people's experience of care and ensure more consistent quality, reflecting the diverse needs of different groups in our population to ensure fair access, personalised care and choice;
- address the fierce operational and financial pressures the local system is under – delivering better value as well as better outcomes

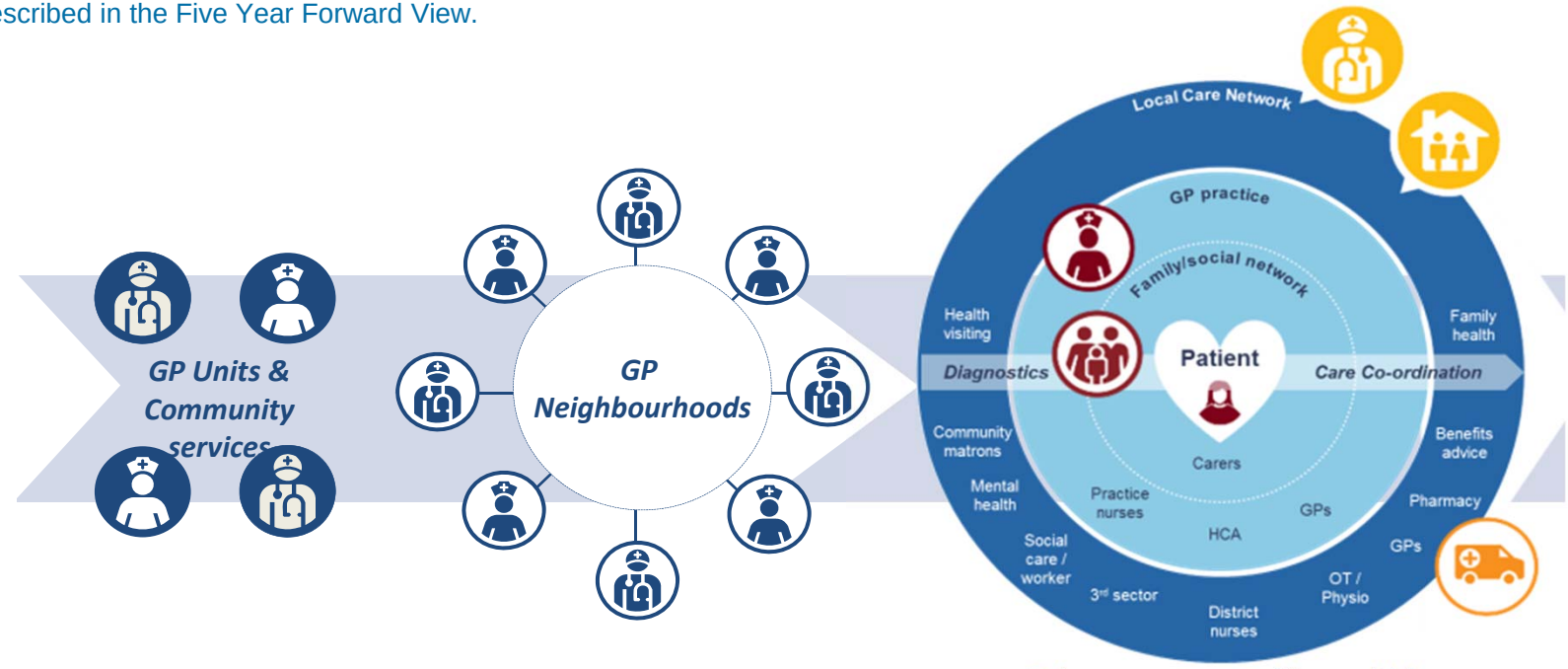
Setting the foundations for Local Care Networks

NHS Southwark Clinical Commissioning Group

Through our integrated care programme, we have already begun to make tangible progress:

- All GP Practices have now become part of Federations and are working together to deliver extended access and a greater range of integrated, community services.
- Our approach to diabetes addresses the medical, psychological, and social needs that a person has. 98% of our GP practices signed up in 2013/14. Independent evaluation shows that, over two years, our practices have seen a ten percentage point increase in detection and have moved from the bottom to the top of comparison groups for HbA1c control
- In 2014/15 we re-allocated funding from acute contracts to community-based services to deliver: risk-based holistic assessments, care management, community multi-disciplinary team review, a consultant-delivered A&E triage hotline, a rapid response nursing service and therapy/rehabilitation services with capacity of up to 200 places. We are beginning to see a real change: non-elective admissions for >65s have plateaued in Southwark and Lambeth compared to continued double-digit growth in other areas.

To help accelerate our progress further we have submitted a bid to NHS England to be a 'forerunner' site for the new models of care described in the Five Year Forward View.



Primary care working within LCNs

Collaborating on transformation

NHS Southwark Clinical Commissioning Group

London-wide Transformation Programmes

In August 2014 the Commissioning System Design Group (CSDG) was established with the remit to develop a proposal on future transformation in London; in particular to consider outline responses to the recommendations in the Better Health for London report, and the implications and context of the *NHS Five Year Forward View*. In developing these proposals the CSDG has sought to address many of the requirements of CCGs detailed in the 2015/16 planning guidance – The Forward View into Action: Planning for 2015/16 – including, for example, meeting the Seven Day Services clinical standards; implementing the national urgent and emergency care review; achieving parity for mental health; and developing fully interoperable digital records. The CSDG initially set out a six step process to define the future transformation requirements for London and the final output of this process demonstrates a clear vision and a robust, collaborative plan for whole system transformation and put London's commissioners in a strong position to draw on additional national resources signalled in the *NHS Five Year Forward View*.

Clinical and enabler programme areas have been agreed (as below) and the CCG has committed to an investment in 2015/16. The CCG Commissioning Strategy Committee received an business case in February 2015 and has endorsed the investment and governance structure of the programmes. CCG staff and clinicians are involved in the development and delivery of the London-wide programmes.

Clinical programmes

Urgent and emergency care
Children and young people
Mental health
Cancer
Prevention
Homeless healthcare services

Enabler programmes

Primary Care
Business Intelligence and Interoperability
Estates
Engagement and personalisation
Payments and funding
Specialised commissioning
Workforce

'Forerunner' bid

Southwark and Lambeth CCGs, in partnership with the two Local Authorities, King's Health Partners, general practice and citizen's forums have forwarded a submission to be considered for 'forerunner' status. Our bid seeks the support of national bodies in how we continue our approach to more preventative and integrated care, aimed at adding value through delivering improved health outcomes for people across the two boroughs. Our submission is now being considered as part of the national process to determine a small number of national 'forerunner' sites and we expect to hear the outcome of this during March 2015.

Commissioning through the Better Care Fund

NHS Southwark Clinical Commissioning Group

The Better Care Fund (BCF) was announced by the government in June 2013 with a purpose of driving the transformation of local services to ensure that people receive better and more integrated care and support. The fund is designed to be deployed on health and social care through pooled budget arrangements between local authorities and Clinical Commissioning Groups. In Southwark we have identified a pooled budget of £22m jointly governed with the council under a Section 75 agreement will be in place and progress on delivery will be monitored through the Health and Wellbeing Board.

The BCF will fund a wide range of community based health and care services with a view to ensuring these are operating in a more integrated, person focussed and preventative way. The effectiveness of the funding is linked to the key enablers of joint assessments, care co-ordination, MDT working and data sharing being pursued through our wider integration agenda, including Local Care Networks. The BCF provides a considerable level of support to social care, protecting key services of benefit to health, particularly around supporting discharge and preventing re-admission.

Preparatory work during 2014/15 has included the seed funding of a number of BCF schemes from winter resilience and other non-recurrent monies, helping ensure the BCF will make a stronger impact from April onwards. Work is also being undertaken to develop further options for pooling more budgets, and developing more joint commissioning arrangements. Southwark is fully on course to implement the Better Care Fund arrangements from 1st April 2015.

In line with the original national BCF guidance, the Southwark BCF contains a key target to reduce non-elective admissions by 3.5% which was supported by our providers. Southwark chose not to exercise the option of making a special case for a lower target, and this decision was recently confirmed as part of the current planning round. Whilst challenging, we believe this target to be realistic as BCF schemes and other initiatives begin to have further impact on avoidable admission rates for older people that are currently relatively high. High rates of avoidable admissions as evidenced by benchmarking suggests this scale of change is achievable, particularly given that the Southwark BCF and slippage/winter monies create genuine new investment in community services. An ambitious level of change was considered appropriate, and arguably necessary to achieve transformation and financial sustainability.

Southwark's BCF was one of only 6 nationally to receive full approval in the national assurance process directly after the September submission, indicating it is a robust plan.

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Key programmes and headline commissioning intentions for 2015/16

Embedding prevention and building community resilience

NHS Southwark Clinical Commissioning Group

Tobacco smoking prevention and cessation:

- Review primary care, GP practices and community pharmacies approaches and remodel services and approached across the system at Level 1, 2 and 3.
- Complete segmentation of the smoking population according to level of addiction and risk of relapse.
- Commission a neighbourhood stop smoking referral programme, with highly activated and trained nurses and other workers providing leadership and support to groups of practices.

Preventing and reducing obesity for adults and children in partnership with Southwark Council:

- Conduct a focused review and change in emphasis to strengthen level 1 and 2 obesity services in support improved management and contribute to a reduction in use of secondary care services in the medium term.
- Commission a level 3 service to deliver a targeted interventions for patients with high level needs

Preventing and reducing the use of alcohol:

- Developing approaches with our providers to influence employee behaviours and attitudes to the use of alcohol.
- Formally review the impact of prevention and treatment services for patients misusing alcohol.

Building community resilience:

- Systemise access to good information and advice.
- Developing the system workforce to signpost effectively.
- Develop ‘human resources’ in the community (champions/navigators/nodes) and social resilience ‘networks’ between people/public and volunteering and voluntary services/physical resources/community assets.
- Commission targeted interventions for schools and workplaces that focus on families as well as individuals.

Establishing a foundation for integrated care

NHS Southwark Clinical Commissioning Group

Work with partners to identity and implement commissioning approaches which enable outcomes based and integrated care models to invest in and develop Locality Care Networks (LCNs) which will be an enabler for the majority of our integrated care agenda. There has been good momentum in Southwark to develop locality based working at a neighbourhood level. This will inform and shape LCNs, which will build on a platform of general practices working together at scale. LCNs will be geographically coherent, serving natural communities, planned against a deep understanding of that population's need, and focused on prevention and a narrowing of health inequalities.

Establish locality models of clinical support & education for referral decisions & care management of patients in primary care as a long term sustainable service model by implementation of a Community Education Provider Network in partnership with Federations of Practices and other providers.

Review 7 day working and further implement across the whole health and care system. The objective is to enable admission prevention, reduce emergency re-admission, speed up hospital discharge and ensure everyone can leave within 24 hours of being "ready to go' by the extending 7 day working to all services focusing on the frail elderly. The CCG will work Lambeth and Lewisham Commissioners and community and acute providers to refine the integrated care pathways relating to paediatrics to prevent unnecessary demand for unplanned care and ensure that children are seen and treated in the right place at the right time.

Review the population based contracts and development plans with GP Federations against expected outcomes and investment in line with the Locality Care Networks and Populations Health Outcomes with Commissioner partners.

Guy's and St. Thomas' (GSTT) to complete a full review of the effectiveness, integration and impact of patient care resulting from admissions avoidance schemes in partnership with the commissioners and SLIC. This will include the development of patient outcome measures. In partnership with Southwark Council, Lambeth CCG and Lambeth Council, review 'beds' required in the community which reduces pressure on in-patient care when they can best be cared for at home. This will include consideration of rehabilitation and intermediate care services with delivery of quality patient outcomes enabling independence

Review of current community nursing service to promote equality of access, improved coverage over twilight / weekend hours and care closer to home best practice model in partnership and full cooperation of all relevant stakeholders including referrers and families.

Establishing a foundation for integrated care (contd.)

NHS Southwark Clinical Commissioning Group

Procure a software solution which will be integrated into the GP clinical systems enabling access check-lists, referral guidance, peer review and support to share learning and best practice.

Review pathways for patients with common health conditions for adults (notably respiratory illness, diabetes and MSK) and children (notable respiratory illness, diabetes and sickle cell) to improve community services and reduce hospital outpatient activity.

Ensure that commissioned providers review delivery and implement the pan-London Children's Standards; London Asthma Standards for children and Young People (when finalised) to include inclusion of a named lead for all organisations. Continue active engagement with on-going evaluative programmes such as Children's and Young Peoples Health Partnership and London Clinical Network.

Jointly implement Healthy Living Pharmacies with Southwark Council to enhance prevention services in the community and reduce variation in primary care service delivery.

Investing in mental health and achieving parity of esteem

NHS Southwark Clinical Commissioning Group

Implement CAMHS service development plans in 2015/16 to provide an increased focus on prevention, intervening early to reduce escalation of need and developing integrated care pathways to address holistic needs of individuals. Consideration is also being given local pooled budgets though Section 75 agreement for CAMHS in 2015/16. In addition a four borough CQUIN to develop innovative, community based practice to address demand and local waiting times is being adopted for 2015/16

Take forward plans to develop a community based specialist eating disorders service for children and young people as part of 2015/16 Service Development plans.

Make a £200k investment into Psychiatric Liaison during 2015/16 to support further enhance Psychiatric Liaison provision to ensure a sufficient and responsive single Liaison Psychiatry offer for all care groups appropriate to the size, acuity and specialty of the acute trusts locally responding to urgent and unplanned care demand and providing proactive in reach to acute inpatient wards in line with effective models of care.

Complete evaluation of 2014/15 winter pressures and additional local investment through the mental health urgent care subgroup to understand the impact on performance across emergency departments and support effective planning in 2015/16.

Run a procurement for IAPT services ensuring we improve access and outcomes for Southwark patients.

Commission a personalised accommodation-based support services and time limited transition service to support the review of people currently in the mental health rehabilitation care pathway.

Re-commission community based drug and alcohol infrastructure in partnership with Southwark Council to support improved outcomes in treatment and recovery for people with addictions

Commission assessment and treatment for people with Autism / Asperger's in line with the requirements of the Care Act 2014 and the Autism Act 2009 to enable independent living.

Commission additional specialist community-based crisis care capacity to intervene earlier in the escalation of mental ill health.

Invest in an expanded Family Nurse Partnership programme to promote positive parenting, good family health and improved well-being for vulnerable young mothers and their families.

Improving primary care and enabling transformation

NHS Southwark Clinical Commissioning Group

Review of the outcomes of year 1 of the Neighbourhood Development Plan as part of the development of GP practice federations and commissioning on a population outcomes basis ensuring that all contracts are embedded and fully delivered i.e. all new contracts commissioned from the GP federations. Part of this review will establish to maturity of the organisations to deliver further high quality population services.

Plan an approach to commissioners and providers can support the transition needed within the changing landscape of primary care; including the implementation of the primary care standards, shared learning and further developments across practices. This will include developing the neighbourhood development plan in year 2 to include cross partnership working with other organisation for the benefit of our population working across the 4 localities. This will include, amongst others, community pharmacies and voluntary organisations.

With our co-commissioners NHS England and Southwark Council align and prioritise joint incentives and service improvements areas for GP practices, community pharmacies and other stakeholders including the voluntary sector who contribute to the current identified priorities to deliver services which improve our population's health and wellbeing focusing on:

- Dementia identification and management. The CCG will ensure there is sufficient capacity within the diagnosis pathway and services to meet this increased demand
- Identification of appropriate patients for referral into IAPTs ensuring sufficient capacity exists in the system at the right level of intervention in partnership with SLAM
- Admission avoidance schemes including the national enhanced services and local SLIC initiatives
- Implementation of the primary care workforce plan.

Building the workforce plan will further develop GP practice staff to be able and willing to deliver high quality services commissioned by NHS England, CCG, the Council or other partners. This will include the development of Community Provider Education Network which will be support by the CCG in the first year to be handed over to providers to deliver a network that supports this outcome sustainably. This will encompass all providers including voluntary sector.

Improving primary care and enabling transformation (contd.)

NHS Southwark Clinical Commissioning Group

Implement the strategic commissioning framework for primary care transformation in London, working closely with NHS England and member practices. This will include the enablers, related funding streams and agreed prioritisation and sign off processes agreed i.e. estates, IT, workforce, contracting and financial implications.

Continue to commission for quality will be integral to our commissioning decisions and contracts. This will include developing provider quality leads, that communication and information which provides assurance to the CCG is available and timely, and the development of focused quality improvement plans in partnership with NHS England which compliments current planned work. Continue to use and develop within contracts to focus on quality improvements.

The CCG will review extended medical services contracts in homes with nursing beds in partnership with Lambeth CCG. This review will be comprehensive including the multidisciplinary team approach and how these work together to deliver a high quality services for our complex patients in nursing beds. This review will also consider what model might support residential homes in the future.

Lead the development of community pharmacy federations in line with established GP federations to deliver a robust quality infrastructure to commission population health services from in partnership with NHS England and Southwark Council.

Support Southwark Council to develop a procurement strategy to improve the reproduction and sexual health services offer in the primary care (pharmacies and GP practices) and community care which is accessible to our local population and reduces the impact and cost of Genito-Urinary Medicine (GUM) activity.

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Commissioning high performing services and securing patients' NHS Constitution rights and pledges

Meeting NHS Constitution standards

NHS Southwark Clinical Commissioning Group

Performance

The CCG is committed to meeting NHS Constitution and national performance standards over 2015/16. However the expected performance at the end of 2014/15 at King's College Hospital (KCH) related to RTT admitted patient care, diagnostic and A&E waits means that the Trust will to not be in a position of compliance for the whole 2015/16.

Discussions are currently taking place between NHS Southwark CCG, the Trust's Coordinating Commissioner, other CCG and NHSE commissioners and tripartite panel members to determine system performance expectations for KCH. These discussions have not yet concluded but it as anticipated that a time limited planned failure for part of 2015/16 will be agreed by commissioners and tripartite panel members for these targets, with recovery trajectory and action plans signed off by all parties and reflected in 2015/16 contracts with KCH. Planning assumptions in relation to the expected return to compliance by target are as follows:

- RTT Admitted - recovery by end Quarter One 2014/15 for each of the Denmark Hill and Princess Royal University Hospital (PRUH) sites and Trust wide. Full compliance with other RTT national standards.
- Diagnostic waits - recovery by end Quarter One 2014/15 for each of the Denmark Hill and PRUH sites and Trust wide.
- A&E - full compliance for A&E at Denmark Hill and recovery by end Quarter Two for the PRUH and Trust wide.

Southwark's CCG's performance against the above standards will be impacted by the KCH performance position. As a consequence of the KCH position, the CCG expects to breach some targets in line with the Trust performance breaches with a return to compliance from end Quarter One for RTT admitted patient care and diagnostics.

Important note: The current draft of the Operating Plan submission shows the CCG's as planning to meet all performance standards. This is a '**holding' position** pending the tripartite agreement of performance expectations in 2015/16.

Meeting NHS Constitution standards

NHS Southwark Clinical Commissioning Group

Operational Resilience

Our activity plans for 2015/16 are predicated on an assessment of expected demand and ensuring an alignment of demand and capacity across the whole system to support both activity and performance targets. Key to our planning for 2015/16 is a focus on winter resilience and ensuring that we have plans in place to support the flexing of capacity to support effective delivery over the period of peak winter demand.

The System Resilience Group has reviewed the impact of the 2014/15 winter initiatives to assess the extent to which any of the schemes implemented for winter might optimally be commissioned on a full year basis. Our 2015/16 contracts will include provision for the funding of a number of key schemes on this basis e.g. neurorehabilitation capacity, expansion of the Enhanced Rapid Response service, the development of the palliative care at home service.

Start contracts will also include a winter allocation with agreed contractual terms related to planned utilisation of these funds to secure enhanced capacity over the period December 2015 to March 2016. The System Resilience Group review of the 2014/15 winter initiatives will be utilised to inform the most effective utilisation of these funds, driven by an assessment of the extent to which the schemes had a demonstrable impact on improving flow, reducing acute demand and providing resilience. The allocation of winter funds in April 2015 up front in our start contract agreements, linked to strong whole system resilience planning, will enable the timely agreement and implementation of winter schemes for 2015/16.

In overall terms, whilst our planning has been robust, we are aware of specific services where there are problems in securing aligned demand and capacity, driven in the main by non local flows to local hospitals. We continue to work with our providers to refine demand and capacity plans at a granular level to ensure that we are flexing and ensuring the optimal utilisation of available capacity to secure demand and capacity balance wherever possible. CCG demand management initiatives will further support these processes.

Local health economy alignment

2015/16 Operating Plans and 2015/16 contracts reflect CCG strategic plans and commissioning intentions that have been shared with the CCG's key local providers, with whole system agreement to both the medium term strategic direction and 2015/16 implementation plans. 2015/16 activity and financial plans reflect a joint assessment of underlying demand and contracted activity and Trust business plans will reflect this assessment as well as the activity required to deliver and sustain national access targets. Contract negotiations with providers are progressing well and we do not anticipate at this point requiring either mediation or arbitration with a joint commissioner and provider commitment to securing a timely and robust signed contract for 2015/16.

Meeting NHS Constitution standards: A&E

NHS Southwark Clinical Commissioning Group

A principal role of the CCG is to act to ensure that the providers it commissions consistently deliver services in accordance with standards laid out in the NHS Constitution and associated national guidance. CCG clinical and management staff are involved in the performance management and oversight of providers. Together with colleagues at the South East Commissioning Support Unit, the CCG leads the planning, monitoring and in-year performance management of providers against NHS Constitution standards.

The following pages set out the activity and performance trajectories for Southwark CCG for the year 2015/16. Plans are forecast from actual performance in 2014/15 (year to date) and is aligned to provider plans; the CCG's financial and QIPP plans; the Southwark BCF plan and to the contracts in place with providers for 2015/16 (subject to final agreement).

Please note: current data is subject to revision pending final acute contract agreements. Trajectories for A&E; RTT admitted and diagnostics are provisional at this point in time.

A&E waiting times		Quarter 1	Quarter 2	Quarter 3	Quarter 4
2015-16 Plan	Number waiting > 4 hours	TBC	TBC	3,760	3,627
	Total Attendances	76,771	73,358	75,209	72,541
	% < 4 hours	TBC	TBC	95.0%	95.0%

Data is for all patients attending King's College Hospital emergency department (both at Denmark Hill and PRUH sites). Southwark CCG is the co-ordinating commissioner for King's and so is required to submit this trajectory. At the time of writing (February 2015), the tripartite panel and King's had yet to finalise a trust-wide performance trajectory for Q1 and Q2 2015/16.

Meeting NHS Constitution standards: RTT and diagnostics

NHS Southwark Clinical Commissioning Group

Diagnostic waiting times		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2015/16 Plan	Number waiting > 6 weeks	TBC	TBC	TBC	42	38	40	39	41	37	40	40	40
	Total Number waiting	4,293	4,406	4,373	4,467	4,085	4,319	4,194	4,381	3,954	4,298	4,319	4,338
	%	TBC	TBC	TBC	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%

It is anticipated that trust-wide King's College Hospital will not meet diagnostic standards until the end of Q1 2015/16. The scale of this variance from target is greater at the PRUH site (with very few Southwark attendees) relative to patients attending Denmark Hill. The performance trajectory above is for Southwark patients receiving diagnostic tests at any hospital site. The CCG's final position will be determined following agreement of a trust-wide performance trajectory for Q1 2015/16 by the tripartite panel and King's.

RTT Admitted		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2015/16 Plan	Completed pathways < 18 weeks	TBC	TBC	TBC	1,267	1,058	1,165	1,149	1,224	993	1,056	1,122	1,132
	Total Completed Pathways	1,295	1,147	1,343	1,407	1,175	1,294	1,276	1,360	1,103	1,173	1,246	1,257
	%	TBC	TBC	TBC	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.1%

It is anticipated that trust-wide King's College Hospital will not meet RTT admitted standards until the end of Q1 2015/16. The scale of this variance from target is forecast to be greater at the PRUH site (with very few Southwark attendees) relative to patients attending Denmark Hill. The performance trajectory above is for Southwark patients receiving elective care by all providers. The CCG's final position will be determined following agreement of a trust-wide performance trajectory for Q1 2015/16 by the tripartite panel and King's.

Meeting NHS Constitution standards: RTT

NHS Southwark Clinical Commissioning Group

Non-admitted RTT		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2015/16 Plan	Completed pathways < 18 weeks	4,489	4,173	4,942	4,868	3,989	4,921	5,037	5,140	4,328	4,527	4,530	4,605
	Total Completed Pathways	4,724	4,392	5,201	5,124	4,198	5,179	5,301	5,410	4,555	4,765	4,768	4,847
	%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet this target for its patients throughout 2015/16.

Incomplete pathways		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2015/16 Plan	Incomplete Pathways < 18 weeks	12,837	12,018	13,890	13,399	13,843	14,169	13,446	13,956	13,854	13,002	14,301	13,846
	Total Incomplete Pathways	13,952	13,062	15,096	14,562	15,045	15,399	14,614	15,168	15,058	14,132	15,544	15,050
	%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%

The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet this target for its patients throughout 2015/16.

Meeting NHS Constitution standards: cancer

NHS Southwark Clinical Commissioning Group

Cancer - 2WW		Quarter 1	Quarter 2	Quarter 3	Quarter 4
2015/16 Plan	Number waiting < 2 weeks	1,662	1,713	1,764	1,815
	Total number waiting	1,787	1,841	1,896	1,951
	%	93.0%	93.0%	93.0%	93.0%

The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet this target for its patients throughout 2015/16.

Cancer – 31 days		Quarter 1	Quarter 2	Quarter 3	Quarter 4
2015/16 Plan	Number waiting < 31 days	183	183	183	182
	Total number waiting	190	190	190	189
	%	96.0%	96.0%	96.0%	96.0%

The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet this target for its patients throughout 2015/16.

Cancer – 62 days		Quarter 1	Quarter 2	Quarter 3	Quarter 4
2015/16 Plan	Number waiting < 62 days	89	90	91	92
	Total number waiting	104	105	107	108
	%	85.0%	85.0%	85.0%	85.0%

The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet this target for its patients throughout 2015/16.

Meeting NHS Constitution standards: IAPT

NHS Southwark Clinical Commissioning Group

IAPT		Quarter 1	Quarter 2	Quarter 3	Quarter 4
2015-16 Plan	The number of people who receive psychological therapies	1,573	1,573	1,573	1,573
	The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	41,929	41,929	41,929	41,929
	% per quarter	3.75%	3.75%	3.75%	3.75%
2015-16 Plan	The number of people who completed treatment having attended at least two treatment contacts and are moving to recovery	350	350	350	350
	The number of people who finish treatment having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	700	700	700	700
	%	50.0%	50.0%	50.0%	50.0%

The CCG uses the results of the Psychological Morbidity Survey to estimate a prevalence of IAPT-eligible patients in the borough. We are required to commission services so that15% of these patients access IAPT services each year. To achieve this the CCG will have to commission capacity, which delivers 3.75% IAPT access in each quarter. The CCG is also expected to ensure that a minimum of 50% of patients receiving services record a 'recovery' following treatment. The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet this target for its patients throughout 2015/16.

Meeting the new NHS Constitution standards for IAPT

NHS Southwark Clinical Commissioning Group

IAPT - Access		Quarter 1	Quarter 2	Quarter 3	Quarter 4
2015-16 Plan	The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 6 weeks of referral	638	638	638	638
	The number of ended referrals that finish a course of treatment in the reporting period.	850	850	850	850
	%	75.1%	75.1%	75.1%	75.1%
2015-16 Plan	The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 18 weeks of referral	808	808	808	808
	The number of ended referrals who finish a course of treatment in the reporting period.	850	850	850	850
	%	95.1%	95.1%	95.1%	95.1%

In October 2014, NHS England and the Department of Health jointly published Improving access to mental health services by 2020. This document outlined a first set of mental health access and waiting time standards for introduction during 2015/16 and set out an ambition, to introduce access and waiting time standards across all mental health services between 2016 and 2020. These commitments were reflected in the joint planning guidance for 2015/16, *Forward View into action 2015/16*.

As part of these new standards, CCGs are required to ensure that 75% of people referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral. This standard applies to adults. The above trajectory refers to Southwark patients accessing services at all providers. The CCG is currently planning to meet this target for its patients throughout 2015/16.

Meeting the new NHS Constitution standards for IAPT

NHS Southwark Clinical Commissioning Group

Delivering the new standards for commissioned mental health services

Introduction of new access and waiting time standards for IAPT and psychosis in 2015/16 and consistently achieved from April 2016:

IAPT Access

Additional investment of £400k to increase capacity across talking therapies provision to meet demand and achieve waiting times requirements

In year retendering of the Talking Therapies in 2015/16 with a view of the new service being up and running from February 2016 with an increased focus on improved access and responsiveness.

On-going monthly monitoring of IAPT performance data including forecasting and trajectories to ensure local delivery against national requirements

Started in 2014/15, the on going piloting of digital technologies to increase the options and range of services available within the IAPT provision is being made available. In addition the increase in self referral options and innovative delivery models for people with long term conditions and medically unexplained symptoms is being made available.

Psychosis Access

An additional £98k investment to provide evidence based interventions within 2 weeks of referrals (in line with the national requirements) in first onset psychosis services to , and a further £230k investment in prevention and early onset services to reduce escalation of need and demand on local services.

Full implementation of the Crisis Care Concordat

Southwark CCG have signed up to the Crisis Care Concordat and are developing, with our partners, a robust action plan to achieve the delivery against the best practice and national standards. The action plan and associated action addresses gaps in local provision including the development of a 24/7 crisis helpline going live from April 2015 and further enhancement of the Home Treatment Team to support more people in crisis in the community, reducing the demand on hospital based care

Meeting the NHS Constitution standards for dementia and *c.difficile*

NHS Southwark Clinical Commissioning Group

Dementia diagnosis		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
2015-16 Plan	Number of People diagnosed (65+)	988	988	988	988	988	988	988	988	988	988	988	988
	Estimated dementia prevalence (65+ Only (CFAS II))	1480	1480	1480	1480	1480	1480	1480	1480	1480	1480	1480	1480
	%	**66.76%**	**66.76%**	**66.76%**	**66.76%**	**66.76%**	**66.76%**	**66.76%**	**66.76%**	**66.76%**	**66.76%**	**66.76%**	**66.76%**

A national dementia tool provides the CCG and each general practice member with a predicted number of people on lists estimated to have dementia. The CCG is to commission sufficient capacity from specialist providers to see that a minimum of 66.76% of those thought to have dementia are referred for diagnosis, diagnosed, and then added to their registered practice's dementia register for on-going management and care planning. Building on strong performance and significant investment made in 2014/15, the CCG is aiming to meet this target in 2015/16.

c.difficile	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Total
2015-16 Plan	4	4	4	4	3	4	4	4	3	4	3	4	45

There is a national target for the number of c.difficile cases recorded for Southwark patients across all healthcare settings. In the previous two years we have worked with provider infection control and public health colleagues to monitor infections, complete post infection reviews and implement action plans following them. Southwark has recorded low rates of c.difficile in the years 2013-15 and plans to continue to meet the target of 45 next year.

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Commissioning high quality and safe services

Response to the Francis and Berwick reports

NHS Southwark Clinical Commissioning Group

In February 2013 the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry – known as the Francis Report – was published . The seminal review looked at the failings of the regulatory and supervisory infrastructure around the Mid Staffordshire Trust and set out a number of recommendations to be adopted by NHS and other arms-length organisations. The CCG has implemented a full response to the findings of the Francis Report - http://moderngov.southwark.gov.uk/documents/s41341/Francis%20report%20SCCG.pdf.

The key themes emerging in the report and others looking at care quality (Berwick Report, Winterbourne View, Clwyd and Hart Report and Bruce Keogh's review of acute quality and safety indicators) include the care of older people; the prevention of premature deaths; protection of vulnerable people; taking steps to listen to patients and carers and acting to ensure people have a positive experience of care.

The CCG recognises the particular importance of meeting our statutory responsibilities whilst retaining a full focus on ensuring commissioned providers deliver the highest quality of patient care. As part of the CCG's March 2013 response to the Francis Report, we set an over-arching recommendation to develops a 'Commissioning for Quality' Framework, as a set of standards and practices that the our organisation should have in place to ensure that all commissioned services consistently provide safe and clinically effective care and deliver good patient outcomes and experience.

The CCG's Quality Framework has been developed within the context of the national response to the above referenced events. It looks at how the CCG 'does quality' across all of its areas of work over the full course of the commissioning cycle, considers what the CCG does at present to commission for quality and also sets out what else the CCG could do to strengthen its approach. The framework has been developed into a clear CCG Quality Action Plan for 2014/15 and 2015/16, which is over seen by a dedicated Quality and Safety Programme Board, the Integrated Governance and Performance Committee and ultimately, the CCG's Governing Body.

The Quality Action Plan 2015/16 is appended to this document, and it describes the main pieces of work the CCG will complete in the timeframe. This includes the following:

- Further develop our channels of communication and engagement with people using the services we commission and therefore seek to significantly increase the number of local patients we hear from on a regular basis.
- Complete engagement and 'listening exercises' to develop our understanding of how patients experience pathways of care rather than experiences of particular episodes of care or particular NHS services.
- Adopt outcome-based performance indicators in new contracts with providers. Performance management should include regular review of improvement in outcome indicators and delivery of specified clinical standards of care.
- Take further steps to triangulate data it receives from providers with the feedback it receives from patients and increasingly use comparative benchmarking to appraise provider performance. The CCG should also regularly review provider staff survey data.
- Complete regular quality visits with SLaM, GSTT and KCH.

Delivering effective safeguarding

NHS Southwark Clinical Commissioning Group

Meeting the requirements of the Accountability and Assurance Framework for Protecting Vulnerable People

NHS Southwark CCG's Chief Officer has overall responsibility for safeguarding arrangements in the CCG. Safeguarding leadership is provided in the CCG through the Chief Officer, Director of Quality and Safety and the Head of Continuing Care and Safeguarding (Adults and Children). The CCG clinical lead and Governing Body member, who has the lead for safeguarding for both adults and children, provides clinical expertise in partnership with the Designated Doctor, Named GP and Designated Nurse. In addition there are commissioned designated professionals in respect of Looked After Children and Designated Paediatrician for unexpected child deaths

Safeguarding children is part of Southwark CCG's Business Plan and Operating Plan objectives and key areas of delivery to improve the quality and safety of local services. More widely Southwark CCG participates in the South London Quality Surveillance Group which looks more broadly at quality issues across the regional CCG and provider landscape and includes relevant safeguarding issues.

The CCG has a bi-monthly Safeguarding Children and Adult Executive Committee. Members include Clinical Leads, Accountable Officer, CCG Director, Local Authority, designated professionals and providers of NHS services. This group reports into the CCG Integrated Governance and Performance Committee for decisions and endorsement of relevant actions plans. The CCG Safeguarding Executive is well attended by all organisations and considers key documents from both the Southwark Safeguarding Children Board (SSCB) and the Adults Partnership Board

CCG Chief Officer, Director of Quality and Safety, Head of Continuing Care and Safeguarding (Adults and Children), CCG Clinical Lead and Governing Body member for Safeguarding and Designated Professions are members of the Southwark SSCB and Safeguarding Adult Boards.

Supporting quality improvement in application of the Mental Capacity Act

The CCG is working in partnership with the Local Authority to support quality improvement in the application of the MCA and have been successful is bidding for monies from NHSE to support his work. Key areas of work include:

- A conference for primary care, social care, community nursing and acute care on MCA
- Development of a MCA eLearning tool for primary and community care
- Development of bespoke training to be provided in primacy care building on the awareness raising at the conference
- Increase in best interest assessors across acute and community settings

Measuring the requirements to meet the standards in the prevent agenda

The CCG is working with its commissioned providers to support the implementation of the Prevent Agenda. Overall monitoring of compliance is through the CCG Safeguarding Executive Committee. The Prevent agenda is included in contract monitoring and Clinical Quality review Groups (CQRG) meetings and the CCG is raising awareness of the Prevent Agenda with commissioners through the implementation of an eLearning tool

Delivering the Winterbourne View Concordat

NHS Southwark Clinical Commissioning Group

The Winterbourne Concordant set a target for registers to be developed and reviews and personalised care planning to be in place for all clients meeting the Winterbourne View criteria by 1 June 2014. The Concordant also required that 'health care commissioners will review all current hospital placements and support everyone inappropriately placed in hospital (assessment & treatment) to move to community-based support as quickly as possible and no later than 1 June 2014'.

In October NHS England advised of a new combined target for London. This target requires 50% of individuals who were in assessment and treatment units as at 1 April 2014 are discharged to community placements by 31 March 2015.

By December 2014 Southwark CCG working with Southwark Local Authority (LA) developed registers for all clients with a learning disability. These registers include all learning disability clients in assessment and treatment funded both by the CCG and NHS England Specialist Commissioning, all clients funded by the CCG through continuing healthcare, all clients funded in out of borough placements funded by the LA. All clients were reviewed and have detailed care management plans in place.

Assessment & Treatment Reviews: Southwark CCG working jointly with Southwark LA community learning disability team reviewed all CCG funded learning disability clients in assessment & treatment settings.

Southwark CCG are compliant with reporting requirement s for Transforming Care for People with Learning Disabilities. At the end of January 2014 Southwark CCG reported on eleven clients meeting the reporting criteria i.e. people in in-patient beds for mental and/or behavioural healthcare who have either learning disability and/or autistic spectrum disorder (including Asperger's syndrome). This submission included one client admitted during January and one client discharged back to KCH. The submission includes the four clients who meet the criteria for the London Target (50% of individuals who were in assessment and treatment units in April 2014 need to be transferred by March 2015).

NHS England have established a London-wide target that 50% of patients meeting the concordat criteria in April 2014 should be supported to transfer to community accommodation before the end of March 2015. Southwark CCG have 4 clients who were in assessment and treatment on 1 April 2014 and therefore meet the criteria for the London target. Care Treatment reviews have been completed on three of these clients. The fourth CTR is scheduled for 9 March 2015. A report has been produced for each of the CTRs which includes an action plan with clear dates for completion. The Community Learning Disability Team is working with the provider MDTs, the clients and their families to implement these action plans and progress will be monitored by commissioning via the Southwark Winterbourne View Steering Group. The CTRs have confirmed that these three clients will not be discharged prior to 31 March 2015 but have indicated that the achievement of specific actions may achieve an earlier discharge date than was being predicted.

Improving patients' experience of primary care

NHS Southwark Clinical Commissioning Group

Satisfaction with the quality of consultation at GP practices			
The aggregated percentage of patients who gave positive answers to five selected questions in the GP survey about the quality of appointments at the GP practice	2015/16		395 (out of 500)
Satisfaction with the overall care received at the surgery			
The percentage of patients who gave positive answers to the GP survey question 'Overall, how would you describe your experience of your GP surgery?'	2015/16	Numerator - The number of patients who answered 'very good' or 'fairly good' to the question, 'Overall, how would you describe your experience of your GP surgery?'	3,629
		Denominator - The number of patients responding to the question 'Overall, how would you describe your experience of your GP surgery?'	4,377
		%	82.9%
Satisfaction with access to primary care			
The percentage of patients who gave positive answers to the GP survey question 'Overall, how would you describe your experience of making an appointment?'	2015/16	Numerator - The number of patients answering ''Very good' or 'Fairly Good' to the question 'Overall, how would you describe your experience of making an appointment?'	3,050
		Denominator - The number of patients responding to the question 'Overall, how would you describe your experience of making an appointment?	4,301
		%	70.9%

NHS
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Supporting financial sustainability, delivering value for money and investing to improve health outcomes

2015/16 financial plan

NHS Southwark Clinical Commissioning Group

Financial context

Southwark CCG has a good history of financial achievement, having achieved all of its financial duties in 2013/14 and forecasting to achieve the same again in 2014/15, including exceeding the requirement to achieve an increased surplus of £5.97m (increased by £2m in 2014/15).
Our current plans for 2015/16 include:

- maintaining a surplus of £7,141k (1.8% compared to the requirement of 1%);
- holding a contingency of £1,981k (meeting the 0.5% target); and
- holding a reserve for non-recurrent spend of £3,962k (meeting the 1% target)

Our historic record in QIPP delivery is equally robust, forecasting to deliver the full £15.5m QIPP programme for 14/15 and having delivered over 99% of the 13/14 programme. The strong history of financial and performance achievements have enable the CCG to be in a position where it is able to reduce the level of QIPP required to just under £8m for 2015/16. This is a reduction of over 50% of the 14/15 target.

Financial planning for 2015/16

In its original 5 year plan submitted at the beginning of 2014/15, the CCG had assumed an allocation increase of 2.78%. The revised allocation calculation resulted in an actual allocation increase of 3.61%. This change resulted in the CCG receiving circa £3m more than had originally been planned, but there were additional commitments tied into this increase, such as winter resilience funding. The increase has an implication for future years as well, as it means that the CCG will be almost 0.6% above target, and so is only expected to receive national average minimum growth beyond 2015/16.

We are continuing to work closely with providers in agreeing the assumptions to be included within 2015/16 contracts including baseline activity assumptions, seasonality & volume growth changes, service developments and the impact of KPI/ QIPP and transformation initiatives. The 2015/16 tariff decision and the resulting uncertainty is inevitably impacting on progress in negotiations. Budgets are based on 2014/15 forecast outturn, a tariff deflator assumption, population & incidence growth and QIPP plans. 2015/16 budgets are based on realistic planning assumptions are we are working closely with providers to jointly agree and manage transformation initiatives to manage activity levels.

The detailed financial plan has been submitted to NHS England and is appended to this document.

2015/16 financial plan

NHS Southwark Clinical Commissioning Group

Opening Budget Envelopes 2015-16 (£000s)	2014-15	2015-16
Acute services	207,663	209,724
Mental Health services	52,408	53,663
Community services	32,935	34,185
Primary care prescribing	31,200	32,485
Re-ablement with Local Authority	1,844	0
Continuing care and Free nursing care	16,944	15,650
Better Care Fund	0	20,478
Corporate costs and property costs	5,015	5,838
Total Budget envelopes	348,009	372,023
Reserves and Contingencies	14,458	10,331
Total Programme Budget excluding running costs, net of QIPP savings	**362,467**	**382,354**

The CCG is using the currently agreed national assumptions with regards to uplifts and efficiencies (net tariff has reduced by 0.8%), releasing resource to commissioners, this is a combination of inflation of 1.9%, increased clinical negligence premiums of 1.1%, and net of 3.8% efficiency savings. It is important to note that the national tariff has not been agreed by providers and on that basis, providers have been given 2 options to choose from. The results of this are as yet unknown and are likely to affect the assumptions just discussed. The CCG has included these in its plans a risk, but has enough mitigations in place to cover the worst case scenario. This is a national issue rather than an individual CCG issue.

We have included assumptions for acute growth, for 14-15 outturn, unwinding of non-recurrent funding, demographic growth and meeting Referral to Treatment targets (RTT), although there are still concerns about maintaining performance and of delivering sustained quality. Areas within mental health such as external placements continue to overspend. Significant service change is planned for 2015-16 and the CCG needs to continue its past good performance on achieving QIPP programmes. The CCG had identified substantial risks related to the transfer of specialised services such as renal dialysis and bariatric surgery, but this risk has abated with the deferral of this transfer until 2016/17.

The submitted financial plan templates demonstrate the link between activity and financial plans for the CCG's main acute contracts.

Investing to improve local services

NHS Southwark Clinical Commissioning Group

Investment in 2015/16	£'000
Adult mental health and IAPT Transformation	1,089
Dementia diagnosis and care	100
A&E transformation – Liaison Psychiatry	200
Mental health of older adults SLIC investment	81
Street Triage service	65
Early Intervention in Psychosis	336
Children's Community Team to deliver 7 day services	300
Early Start children's services	441
Children's nutrition and dietetics services	45
Adults dietetics redesign	40
Interpreting services for patients accessing GP services	45
Support Integrated neighbourhood models	500
Southwark group supporting primary care quality	173
Community pharmacy development	125
Enhanced incentives to GPs to improve prescribing	200
Data analyst/intelligence support officer to Medicines Optimisation Team	50
Creation of Better Care Fund- net effect	6,000
Total Investments	**9,790**

The CCG will increase investment in mental health services .The *NHS Five Year Forward View* requires CCG's to demonstrate that they are investing an amount equivalent to the growth in their allocation, which is 3.6% in Southwark, to ensure these services are not eroded in real terms. This can be shown in our work on IAPT and early intervention in psychosis, and in redesign of Adult Mental Health services-these total almost £1.9m, slightly exceeding this requirement.

For the coming year we will continue to invest in improving the quality of community and primary care services, and achieve safety and quality improvements in all our contracts.

We received the benefit of £1m non-recurrent Challenge Fund funds in 2014-15, and will have two Urgent Access centres in operation at the end of February 2015. These are dealing with patients referred from other practices in their neighbourhood, ensuring people get seen the same day, rather than using other parts of the health system. These are an investment of over £2m recurrently, offset by savings on the former Walk in Centre and other areas.

We are also continuing a programme of development with all member practices and in forming neighbourhood development plans. Two GP led neighbourhood companies have been set up, and are delivering services for population health and in the urgent access centres. We are also seeking to support practices in their proposals to look at mergers, and in evaluating their future plans.

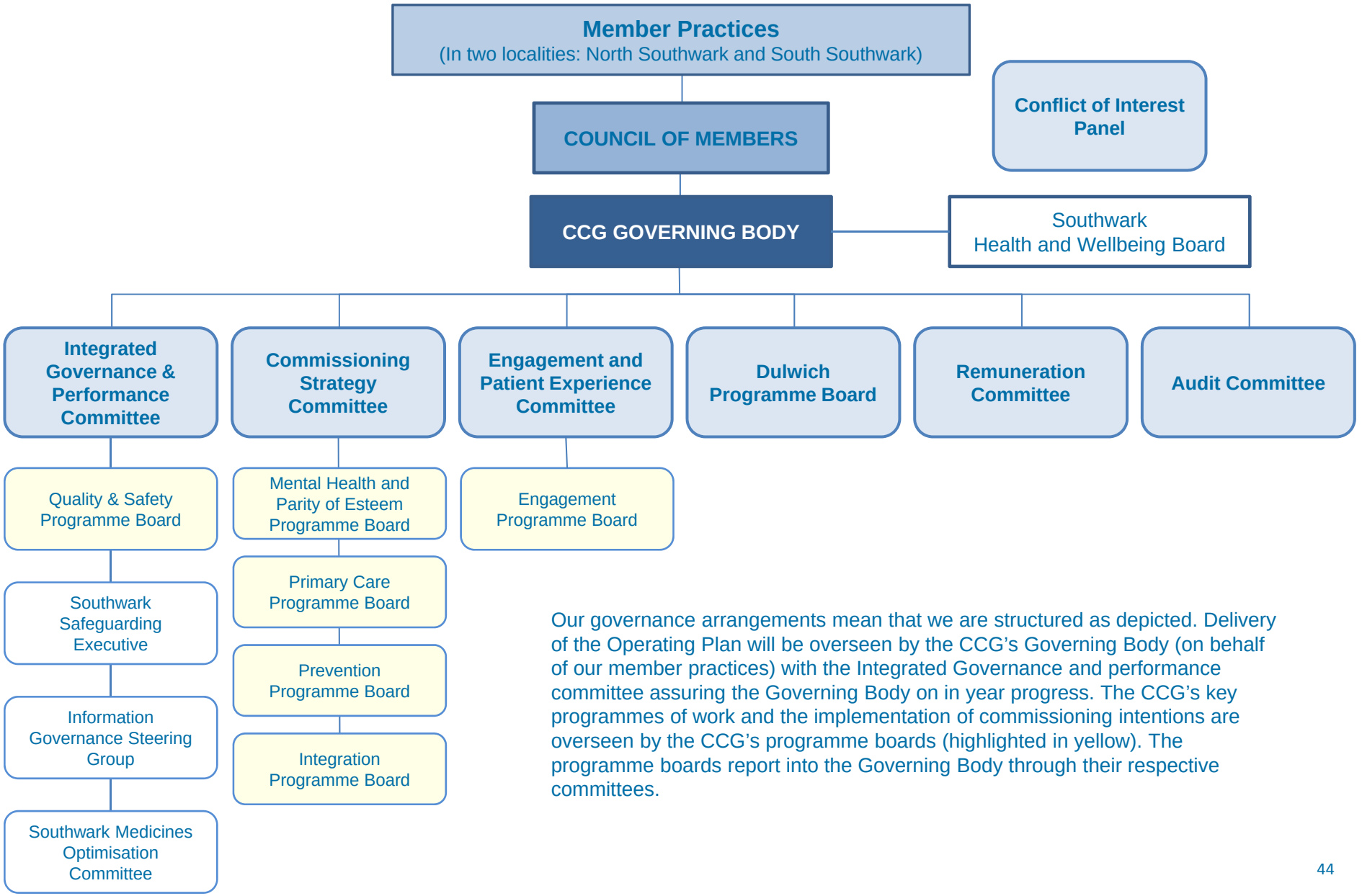
Further detail of all CCG investments and also the key cost pressures for 2015/16 can be viewed in the detailed financial plan appended to this document.

NHS
Southwark
Clinical Commissioning Group

Delivering the Operating Plan: Governance and Risk

CCG governance structure for implementation

NHS Southwark Clinical Commissioning Group



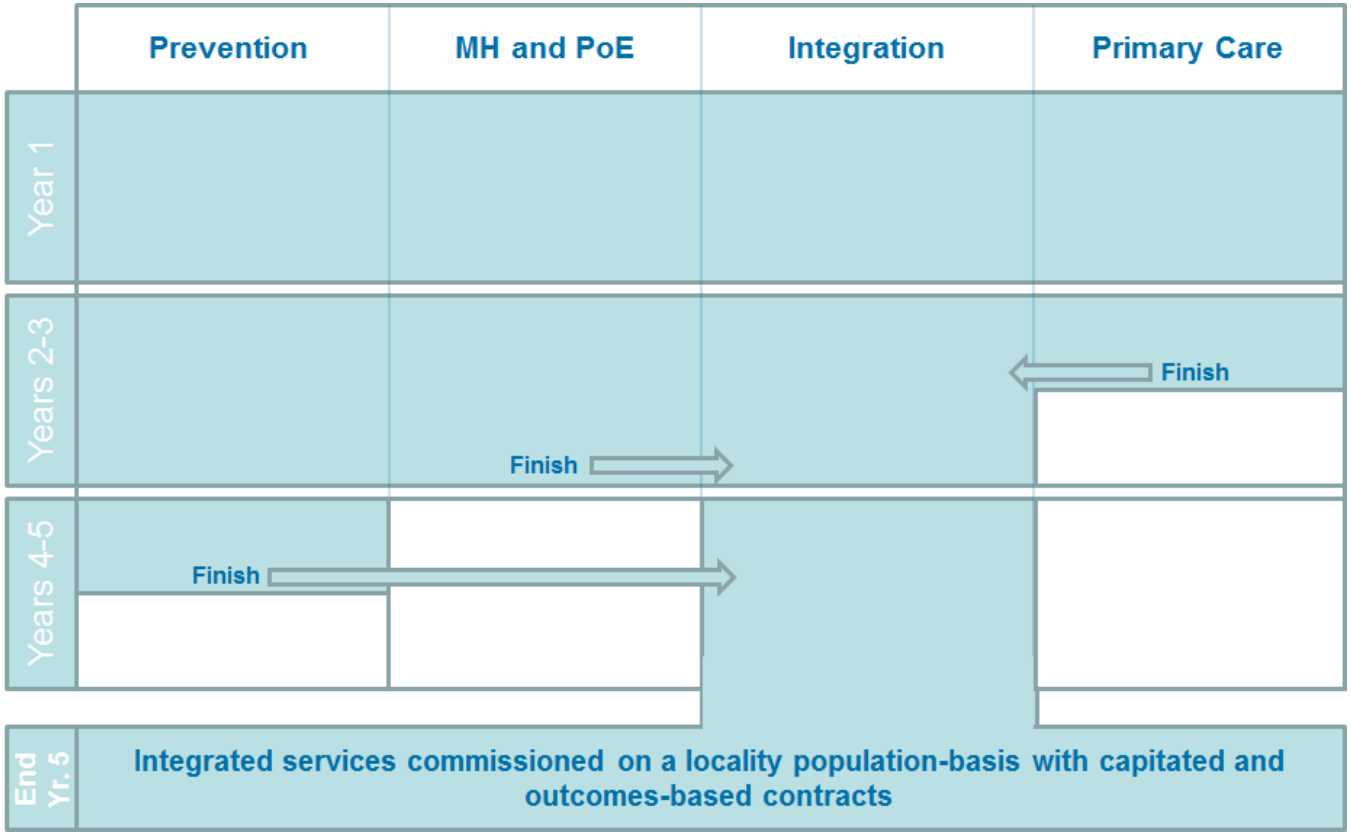
Our governance arrangements mean that we are structured as depicted. Delivery of the Operating Plan will be overseen by the CCG's Governing Body (on behalf of our member practices) with the Integrated Governance and performance committee assuring the Governing Body on in year progress. The CCG's key programmes of work and the implementation of commissioning intentions are overseen by the CCG's programme boards (highlighted in yellow). The programme boards report into the Governing Body through their respective committees.

Managing transformation in commissioning

NHS Southwark Clinical Commissioning Group

The CCG's programme boards have been established as multi-disciplinary commissioning groups with responsibility for leading the CCG's operational business. The Quality and Safety and Patient Engagement boards each offer an assurance and planning role to see that the CCG and commissioned providers are fulfilling obligations and making improvements in these areas. The remaining four programme boards are focussed on delivery of the CCG's main programmes of transformation.

The CCG's ambition is that these programme boards will work to implement the initial stages of commissioning transformation and lead the key programmes of work required to achieve this. The CCG's ultimate aim is that as we embed our transformed approach to commissioning (i.e. outcomes and population based, commissioned from alliances of providers) the role of the programme boards alter as we converge on a standard approach to all of our commissioning. This is depicted below.



Understanding and mitigating risk

NHS Southwark Clinical Commissioning Group

The CCG takes all reasonable steps to manage risks in order to protect the Southwark population, patients, staff and assets and to ensure appropriate protections are in place benefits realisation of appropriate risk-taking. The CCG's Governing Body sign-off a Risk Management Framework on an annual basis. The framework document describes the systems and processes in place to that enable the CCG to:

- Ensure all risks are identified and managed through a robust Board Assurance Framework and accompanying Risk Registers. These include corporate, strategic, operational, clinical, financial, information and reputational risks,
- Integrate risk management alongside quality and governance issues and established local risk reporting procedures to ensure an effective process flows throughout the CCG's activities and business,
- Ensure that the Governing Body and its delegated committees are kept care kept suitably informed of significant risks facing the organisation and associated mitigation plans.

The Governing Body is responsible for setting the strategic direction for risk and overseeing the integrated risk management arrangements across the organisation and the Integrated Governance Committee (IG&P) is responsible for the oversight of all risk and for implementing the strategic direction for risk within the organisation. The IG&P assists the Audit Committee in assuring the Governing Body in this respect.

NHS Southwark CCG has adopted the Australia/New Zealand (AS/NZS 4360/1999) standard which is internationally recognised standard providing a generic model for the identification, analysis, prioritisation, treatment, communication and monitoring of risks across clinical and non-clinical services and activities at local and corporate level.

The Board Assurance Framework consists of principal strategic and corporate risks directly affecting the corporate objectives as well as those risks escalated from CCG's Risk Register by the Governing Body, the Audit Committee, IGPC or other committees. Directorate Risk Registers capture operational risks are supported by individual team/project Risk Registers. Monthly risk reports from the Directorate Risk Register and quarterly review of the Board Assurance Framework (BAF) will be presented to the Integrated Governance & Performance Committee and also the CCG's Governing Body.

Agenda Item 11

Item No.	Classification:	Date:	Meeting Name:
11.	Open	16 March 2015	Health and Wellbeing Board
Report title:		Integration Update	
Wards or groups affected:		All	
From:		Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group	

RECOMMENDATIONS

1. The board is requested to:

   a) Note the updates on progress of the development of Local Care Networks, GP Federations and the Better Care Fund

   b) Note the expression of interest to be a 'Forerunner' site for the new models of care as described in the 'Five Year Forward View'

   c) Note the review of governance arrangements for Guy's and St Thomas' Charity funded projects – notably the Southwark and Lambeth Integrated Care Programme.

EXECUTIVE SUMMARY

2. The **Better Care Fund** is being implemented as per the plan agreed with the health and Well Being Board in October and as such there are no material variations to report to the Board. Quarterly reports on progress will be provided to the Board during 2015/16.

3. All local health and social care organisations have nominated their representatives for the **Local Care Networks** and two workshops have been arranged in March to bring together all participants. These workshops will seek to allow members to get to know each other, understand what each organisations priorities are, and begin to discuss what priority areas should be addressed by the LCN in their first year of operation.

4. An expression of interest has been made through the Southwark and Lambeth Integrated Care Programme for Southwark and Lambeth to be a '**Forerunner Site'** for the new models of care described in the *Five Year Forward View (2014)*. If successful, we will receive additional support and resources to accelerate progress on delivering integrated care, and will contribute to national learning and evaluation programmes.

5. All GP Practices in Southwark have now become part of **Federations**. This will enable practices to work more collaboratively and provide additional services across the neighbourhoods that they serve. Extended access services operating from 8am-8pm are now in place in South Southwark, with similar services going live in North Southwark on 1st April.

6. The Guy's and St Thomas' Charity commissioned the law firm Wragge Lawrence Graham & Co to undertake a **review of governance** arrangements for the Southwark and Lambeth Integrated Care (SLIC) programme, the Primary Care Development programme and the Children and Young Peoples Partnership programme. The review recommended broader alignment between the three programmes and for more formal governance structures and organisational vehicles to be put into place.

7. In line with the overall vision for integration the Council and the CCG will be looking at options for further aligning resources and commissioning arrangements where this will help ensure a stronger whole system approach to health and care. This will include opportunities to expand the range of pooled budgets and looking at possible approaches to ensuring commissioning arrangements are aligned, including the option of establishing an **integrated commissioning function** or other joint arrangements.

BACKGROUND INFORMATION

Better Care Fund

8. The Better Care Fund (BCF) plan sets out a range of community based health and care services to be funded from a pooled budget of £22m in 2015/16 to help deliver the local vision for integrated services "Better Care, Better Quality of Life in Southwark". A key objective of the plan is to help shift the balance of investment from acute care to community based care services that are more focussed on supporting people in a co-ordinated, person centred and effective way, preventing the need for more intensive health and social care support. The effectiveness of the BCF will be closely linked to the key enablers of joint assessment, care co-ordination, data sharing and multi-disciplinary team working through the development of the Local Care Networks.

9. In October 2014 the Board agreed a report setting out the detailed BCF plan. This was the second BCF submission, the original being agreed by the Board in March 2014. A change in national policy on the BCF required all plans to be resubmitted in line with enhanced requirement following concerns that the plans were not robust.

10. Following the first stage of the stricter national assurance process it was announced in November that Southwark was one of just 6 boroughs nationally to be given full unqualified approval for its BCF plan, indicating that the national team are confident that our plans are strong.

Local Care Networks

11. Local Care Networks (LCNs) will be introduced during 2015/16, and will bring together all health and social care organisations within Southwark to develop and transform services for the populations they serve. They will be centred around the needs of patients and aim to ensure that all providers provide joined-up holistic care for all residents.

12. There will be two LCNs within Southwark, one serving the north of Southwark (Borough, Walworth, Bermondsey and Rotherhithe, and one serving the south of Southwark (Peckham, Camberwell and Dulwich).

13. It is hoped that Local Care Networks will have the autonomy to act to improve health and wellbeing outcomes for their designated population with a strong emphasis on prevention and early intervention.

Forerunner Bid

14. Following on from the publication of *The Five Year Forward View* (co-authored by NHS England, Monitor, NHS Trust Development Authority, Care Quality Commission, NHS Health Education England and Public Health England) health economies were invited to register interest in becoming a 'vanguard site' for new models of care.

15. Applications were invited to develop one of four new models – i) a Multispecialty Community Provider (MCP), which envisages Local Care Networks will have the autonomy to act to improve health and wellbeing outcomes for their designated population with a strong emphasis on prevention and early intervention; ii)an integrated Primary and Acute Care System (PACS), which allows a single organisation to provide GP, hospital, mental health and community services; iii) a model offering an approach to improving the viability of smaller hospitals or iv) models that enhance health of patients in care homes.

16. The guidance for applications makes clear that those applying should already have a clear vision on what change they are looking to achieve and be able to demonstrate credible plans and a track record of progress towards improved integrated working

17. Successful bids would receive a share of a £200m investment fund to accelerate existing plans, and receive bespoke support from national bodies. Alongside this there would be an expectation that local learning would be extensively tracked and analysed to support national development plans.

GP Federations

18. Southwark CCG has supported general practice to develop geographically coherent neighbourhood GP provider organisations, where practices work collectively to improve the quality of services and outcomes for their combined registered populations. These GP provider organisations are collaborations of the 20 practices in the South, and 24 practices in the North, and have successfully bid to deliver a range of population based services; including 8-8pm 7 day Primary Care Services, and Population Health Management (e.g. NHS Vascular Health Checks, Smoking Cessation, Holistic Assessments and Case Management for over 65s).

KEY ISSUES FOR CONSIDERATION

Better Care Fund

19. Preparations for the full implementation of the BCF plan and associated pooled budget arrangement have been under way since the approval and Southwark is fully on course to deliver the plan. This preparation has included seed funding of BCF related schemes from non-recurrent winter resilience monies to ensure a strong start when the pooled budget formally commences on 1st April 2015.

20. The Better Care Fund is being implemented as per the plan agreed in October and as such there are no material variations to report to the Board. The governance arrangements for the pooled budget described in the plan will be reflected in a pooled budget agreement known as a Section 75 agreement (using flexibilities from the Health and Social Care Act) which will be hosted by the Council. A risk reserve approach has been agreed that addresses the risk associated the "performance related payment" to the BCF.

21. Quarterly reports on progress on the BCF will be provided to the Board during 2015/16, including progress on the key outcome measure to reduce emergency admissions to hospital by 3.5%.

22. Looking ahead to 2016/17, the national arrangements for the BCF are unlikely to be clarified until after the general election. In the meantime the Council and CCG will be developing options to further extend the range of pooled budget and joint commissioning, using local and national evidence emerging on the effectiveness of the Better Care Fund and other integrated approaches.

Local Care Networks (LCNs)

23. A vision for Local Care Networks has been established across partners and we are now moving into the final stages of the design process, with the aim of implementing LCNs during the first part of 2015/16.

24. A Local Care Network Delivery Group was convened in early February. The purpose of this group was to help bring together representatives from local health and social care organisations to co-design Local Care Networks and oversee their formation. This group agreed the need for representatives from all organisations to participate in workshops in order to increase familiarity between representatives, gain a greater understanding of different organisations services, structures and plans, and agree both initial priorities and governance and leadership arrangements.

25. The two workshops will be held during March, and will be externally facilitated; this is in recognition that the development of LCNs needs to be provider led, and that all participants are there on a 'equal party' basis. It is intended that following the workshops, LCNs will be formally formed.

26. A report on the structures, governance arrangements and work plans of LCNs will be presented to the Health and Wellbeing Board as part of the formation.

Forerunner Bid

27. Following discussion between all local health and social care organisations through the SLIC Provider Group, agreement was reached for Lambeth and Southwark to submit an application to be considered a 'Forerunner' site

28. The application was made on the basis of Lambeth and Southwark adopting a Multispecialty Community Provider – recognising our broad coalition of organisations working together to improve, and integrate, services. The application sets out both our achievements to date, our plans for the next year, and our long term objectives. A copy of the application is attached as part of this paper.

29. Over 200 applications were made nationally, and we have now received confirmation that our bid has been shortlisted. The next step was for all applicant areas to put forward a delegation to present their bid, and participate in a workshop which allows for applicants to critically appraise, review and constructively challenge each other's' bids; this took place on 4 March. Following the workshop, the national panel will make final decisions over which bids to support, with a decision expected by the middle of March.

30. It should be noted that the plans for integrated care within Lambeth and Southwark will not be materially affected should we be unsuccessful in our application. The additional funding and support should allow the health economy to develop at a faster pace, but the underlying direction of travel would remain the same.

General Practice Neighbourhood Working

31. Southwark CCG has supported general practice to develop geographically coherent neighbourhood GP provider organisations, where practices work collectively to improve the quality of services and outcomes for their combined registered populations. These GP provider organisations are collaborations of the 20 practices in the South, and 24 practices in the North, and have successfully bid to deliver a range of population based services; including 8-8 7 day Primary Care Access, and Population Health Management (e.g. NHS Vascular Health Checks, Smoking Cessation, Holistic Assessments and Case Management for over 65s).

32. Following a review of urgent care services across the borough, Southwark CCG agreed to commission an Extended Primary Care Access Service from the two neighbourhood provider organisations in the North and South of the borough. This service enables patients to access pre-booked appointment slots at a local Access Clinic via telephone assessment through their GP practice or SELDOC.

33. The CCG was one of 20 successful pilots within the Prime Minister's Challenge Fund, which enabled the CCG to secure £975k to support general practice engagement, infrastructure and set-up costs associated with this service. In addition, the CCG agreed to invest £2.1 million to fund recurrent service costs, to enable the delivery of sustainable high quality 8-8 7 day primary care access in the borough.

34. The first Extended Access Service was launched in the South of the borough on 11 November 2014 at the Lister Health Centre, and replaced the pre-existing Walk-in Centre on that site. To date, approximately 4500 patients have seen a GP or a nurse at the Access Clinic; however, service utilisation across south Southwark practices remains variable. A second service will launch in the North of the borough on 1 April 2015, and will be based at Bermondsey Spa Health Centre.

35. In 2014/15, Lambeth and Southwark CCGs were successful in securing £728,000 from Guy's and St Thomas' Charity to support primary care development across the two boroughs. This resource has enabled both CCGs to build capability within general practice to deliver new ways of integrated working that will ultimately improve outcomes for patients and reduce pressure on general practice providers. The programme has centred around the

development of 18 general practice 'emerging leaders' who have been leading on the development of neighbourhood working across the two boroughs, including engagement with general practice peers and wider primary care, as well as other health, voluntary and social care partners more broadly.

Policy implications

36. Integration of services involves agreeing shared policy goals with partners as set out in the draft vision, developing neighbourhood multi-disciplinary team models with care co-ordinated by a lead professional, and jointly agreeing how pooled resources will be invested under the Section 75 pooled budget arrangements. Specific policy implications will be identified during the detailed design phase and agreed through integrated governance arrangements.

Community and equalities impact statement

37. The health and care related services covered by the integrated care plans should have a positive impact on the community as a whole. In particular it will impact on older people and people with long term conditions (many of whom have disabilities or mental health problems) who are most at risk of admission to hospital or needing intensive social care support. The plan aims to promote the health and wellbeing, independence and quality of life of these groups who are recognised groups with protected characteristics under Equalities legislation. The informal carers of these groups will also benefit, who are disproportionately female. The draft vision will also contribute to the wider prevention and public health agenda benefitting the population as a whole in the longer term, and reducing health inequalities. Plans are being co-designed with patient groups, notably through Patient Participation Groups, and the SLIC Citizens Board.

Financial implications

38. The BCF totals £1.3m in 2014/15, increasing to £22m in 2015/16. The majority of the BCF represents existing budgets transferred directly from the NHS, where there are existing commitments from both the CCG and the council. The BCF is now included in the council's overall settlement and spending power calculation.

39. The BCF schemes proposed include a mix of existing funding, recognising the financial pressures experienced by the Council and CCG, as well as investment in new schemes. In 2015/16, a total of £2m is explicitly labelled as contributing to maintain social care services, an increase of £500k from the 2014/15 level. In total £15.5m is to be used for funding social care services. It is hoped that the impact of integration across the Council and CCG, including investment in schemes to reduce length and number of hospital and residential homes stays, will result in enduring savings for both organisations.

40. The pooled governance and financial arrangements for the BCF remain under discussion and will be agreed over the coming year.

41. Should the 'Forerunner' application be successful, additional financial resources may be made available from the £250m national fund. A further update will be given to the Health and Wellbeing Board if our application is successful, and further financial details are available.

BACKGROUND PAPERS

Background Papers	Held At	Contact
Better Care Fund – supporting documents	160 Tooley Street	Adrian Ward 020 7525 3345

APPENDICES

No.	Title
Appendix 1	SLIC Forerunner Application

AUDIT TRAIL

Lead officer	Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group	
Report Author	Paul Jenkins, Director of Integrated Commissioning	
Version	Final	
Dated	9 March 2015	
Key decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer title	Comments sought	Comments included
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Date final report sent to Constitutional Team		9 March 2015

APPENDIX 1

New Models of Care Programme

An Expression of Interest from the Southwark and Lambeth Integrated Care Partnership

February 2015

NHS Southwark
Lambeth
NHS Lambeth
Southwark Council
GUY'S & ST THOMAS' CHARITY
Citizens' Forum
KING'S HEALTH PARTNERS
Guy's and St Thomas' NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
King's College Hospital NHS Foundation Trust

Q1. Who is making the application?

This application is made by Southwark and Lambeth Integrated Care, a strong partnership of local citizens, all 92 general practices, all three foundations trusts (covering community- and hospital-based mental and physical health), both local CCGs and both local authorities (including Public Health). Our partnership involves the wider voluntary and community sector (VCS) including the Guy's & St. Thomas' Charity, and our AHSC (King's Health Partners). This mature partnership has worked together for four years, with active leadership from chief officers, senior clinicians and citizens. Together we are responsible for combined resources of more than £1bn covering a population of 604,000 people.

Our nominated leads for the bid are our Sponsor Board Co-Chairs: Sir Ron Kerr (CEO, Guy's and St Thomas' NHS Foundation Trust), Dr Adrian McLachlan (Chair, NHS Lambeth Clinical Commissioning Group), and Helen Charlesworth-May (Strategic Director - Commissioning, Lambeth Council)

Our nominated contact for the bid is: Merav Dover (Chief Officer, Southwark and Lambeth Integrated Care) – merav.dover@nhs.net.

Q2. What are you trying to do?

Our vision is simple, but its delivery is hard: we want to increase the value of care we provide for the people of Lambeth and Southwark so they can lead healthier and happier lives. Our objectives are to:

- **improve health and wellbeing** through effective prevention at all stages of the life-course, including strong interventions on risk factors such as alcohol, depression, smoking and obesity;
- **support individuals and communities** to feel well and be well, to identify their needs early and respond quickly, and to help people to better manage their health conditions, taking into account both mental and physical health needs and the important connections with other services, such as employment, housing and financial advice;
- **significantly improve people's experience of care** and ensure more consistent quality, reflecting the diverse needs of different groups in our population to ensure fair access, personalised care and choice; and
- **address the fierce operational and financial pressures** the local system is under – which means closing an efficiency gap that would be £339m by 2018/19.

To do this we will work as one system with one budget, moving towards an outcomes-based capitated contracting model. The existing system inhibits this so we are developing deep relationships across the NHS, local authorities and our communities to break down silos and to radically redesign our models of care, our commissioning approaches and our provider partnerships.

Ours is a strategy about relationships and culture change. It requires us to work differently and in a way which will energise and liberate our staff to put people at the heart of care. Professionals will be supported to think creatively about a wide range of responses to a person's needs; and responsibilities and leadership will operate across our local networks and settings of care rather than through orthodox hierarchies and within the traditional confines of buildings.

Importantly, it also means reimagining our workforce and engaging with the fact that our citizens – as users of services, parents or carers – have significant capabilities and want to feel in charge.

Q3. Which model(s) are you pursuing?

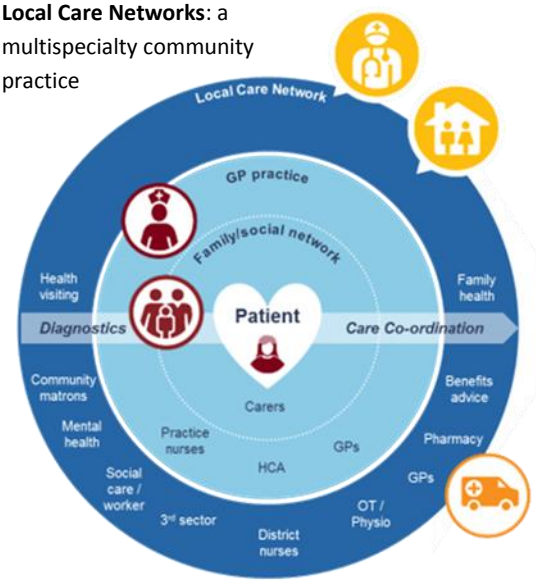
Our partnership is now developing five Multispecialty Community Practices, described locally as Local Care Networks (LCNs). Each of these covers a natural geography of 100,000-150,000 people. They will bring together providers to deliver services based on local needs, with shared accountability for the whole population, based around registered practice lists. This 'placed-based' approach will shape our neighbourhoods and our care systems so that the urban environment and all local services can maximise their contribution to the development of resilient communities. This is particularly important at a time when our boroughs are undergoing large regeneration and demographic change, with expected population growth of 15% by 2021.

In practice our LCN arrangements will break down existing silos further so that care is designed around the

needs of our local communities and the different patient groups within them, ensuring that people can:

- feel empowered and supported to manage their lives well, making the most of their own capabilities with additional support from resilient social and community networks;
- consistently access high quality, effective and continuous primary care, delivered by practices within GP federations, with extended services for people with complex conditions (so that these people have clear on-going relationships with a named GP and care coordinator);
- access a range of wider services involving the extended primary care team (e.g. community pharmacies), social care, community physical and mental health services, and specialist out-of-hospital diagnostics and treatment – these teams will genuinely work together, and with the VCS, to access and resolve the small scale issues that make a big difference to people's lives; and
- access excellent hospital-based specialist and tertiary mental and physical health services provided within the AHSC partnership.

Local Care Networks: a multispecialty community practice



We think that our unique partnership and its LCN model offers a strong point of differentiation: our partnership spans, at scale, all aspects of mental and physical health and social care for two densely populated and vibrantly diverse urban boroughs that are experiencing wide inequalities and demographic change; and our LCN model offers a common platform within which each locality can use different commercial arrangements to deliver the personalised and integrated services we need.

Q4. Where have you got to?

We have made tangible progress towards instituting the MCP model and in delivery against our main objectives. Our collaboration to date demonstrates the **ambition**, practical **action** and wider **adoption** of our integrated working.

Ambition: we have received national recognition for the short and long-term plans we have developed to put the building blocks of MCPs in place.

- The innovation and delivery capability of our GP federations is exemplified by our successful bid into the first wave of the Prime Minister's Challenge Fund. 7-day-a-week 8am-8pm access is now 'up and running' in one LCN (with a second beginning later this month), and we are actively spreading the learning from this across our SE London Strategic Planning Group (SPG).
- Through our Lambeth Early Action Partnership (LEAP) we secured funding for a 10-year multi-agency action research programme to identify long-term outcomes from improved services from pre-conception to 4th birthday – we are one of five sites nationally selected for this Big Lottery funded programme. This complements our Children & Young People Health Partnership (CYPHP), a programme that is about improving outcomes by developing new care models to integrate our capabilities across the spectrum from primary and community care through to our tertiary children's hospital.
- Both of our boroughs were two of only six areas nationally to secure Better Care Fund assurance with no conditions – a demonstration of the maturity of our commissioning and provider systems. This was based on significant joint work to analyse system-wide quality, financial sustainability and integration.

Action: we have turned plans into practical action with significant impact already being seen. Over the past four years we have implemented strong multispecialty community models to improve care for people living with diabetes, for older people, and for people who need continuing mental health support. These are now

in a good position to converge within our LCN model.

- Our approach to diabetes addresses the medical, psychological, and social needs that a person has. 98% of our GP practices signed up in 2013/14. Independent evaluation shows that, over two years, our practices have seen a ten percentage point increase in detection and have moved from the bottom to the top of comparison groups for HbA1c control (ONS, London and England comparator groups).
- In 2014/15 we re-allocated circa £9m of funding from acute contracts to community-based services to deliver: risk-based holistic assessments, care management, community multi-disciplinary team review, a consultant-delivered A&E triage hotline, a rapid response nursing service and therapy/rehabilitation services with capacity of up to 200 places. We are beginning to see a real change: non-elective admissions for >65s have plateaued in Southwark and Lambeth compared to continued double-digit growth in other areas.
- Over 1800 people have participated in co-designing new mental health services. There have been over 1200 introductions to the new 'front door' of mental health services – *The Living Well Network*; and hundreds of people have now benefitted from new integrated community and primary care services, as well as from holistic crisis support (e.g. an out-of-hours peer-support network). 110 people within the service have received personal budgets. As a result of these interventions we expect initial assessment in secondary care to fall by 25%, and long term care coordination from secondary care to fall by 50%.
- These projects are supported by functional integration of IT, for example we now have a comprehensive use of the EMIS Web system in primary care, and we have developed linked clinical data systems across the three foundation trusts (allowing a clinician to see, at the point of care, patient data from the other trusts). We are in the process of expanding this functionality to form a Local Unified Care Record incorporating general practice, and of implementing new technologies to enable better mobile working for staff in community settings.
- These projects also exemplify a genuine and deep engagement of citizens including, for example, through our Patient Participation Groups, the SLIC Citizens' Board, the Diabetes User Group and the Big Lambeth Health Debate.

Adoption at scale: We have committed to develop the robust governance and leadership required to make decisions about reshaping care and to successfully manage clinical and financial risk. Already:

- *We have undertaken difficult organisational change* – our GP federations have moved beyond concept and into delivery: all of our 92 GP practices are part of these federations – set up expressly as a vehicle to help integrate care (beyond extended access alone). They are now legally incorporated with nominated lead directors, which means federations are able to negotiate care models on behalf of member practices enabling GPs to be an equal partner in our system transformation.
- *We have established new contractual mechanisms* – our mental health services now include alliance contracting arrangements (including with housing providers) to integrate these complex continuous support services.
- *We are strengthening partnership accountability* – an independent review we commissioned noted our impressive leadership relationships and citizen involvement ("collaboration in a way that no-one else in the UK has tried to date"), and highlighted options to further strengthen accountability. We are now deciding which formal mechanisms might further enhance this, such as establishing an alliance contract across our partnership.

Overall our progress results from our intensive investment of energy and our own financial resources in the slow, hard and reflective processes of relationship building, leadership development and joint learning. In doing this we now understand – at a profound level – that our success depends upon supporting a deep and genuine culture change across our staff, and the 'informal' workforce in its widest possible sense. Ours is a mature and capable partnership and our learning to date and strength of relationships is a factor that we think differentiates us nationally and demonstrates a very high state of readiness to implement new care models.

Q5. Where do you think you could get to by April 2016?

Based on formal joint-commissioning intentions and provider plans, and with support through the New Care Models Programme, by April 2016 we will:

- fully establish LCNs across all five localities, with clear leadership, nominated clinical directors and general management capacity. In practice we anticipate that some local areas will want to move rapidly to become 'deep dive' sites of intense development including, for example: joint work on new integrated workforce arrangements (e.g. exploring cross-cover between primary and secondary care); embedding interoperable clinical information systems; and potentially exploring deeper relationships as part of commercially integrated primary and acute care systems;
- fully implement population health management, risk-based holistic assessment, community multi-disciplinary teams and chronic conditions management (including wide use of social prescribing):
    - In practice this means that all people with complex needs will have a personal care plan which meets the specific needs of them and their carers, genuinely informs future care provision, and actively empowers them to self-care and live well;
- fully utilise our new community capacity to support urgent care pathways, admission avoidance, timely discharge and recovery, linked via a unified point of access – which together will ensure delivery of our BCF commitments on reducing emergency admissions;
- roll-out of the Local Unified Care Record spanning health and care providers, and make demonstrable progress on transferring this system across our SPG;
- agree new contractual arrangements between commissioners and providers, and between providers themselves, based on outcomes developed with local people and professionals, and on capitated budgets, with devolution of responsibilities and budgets;
- engage in multiple opportunities to learn from and share with other systems implementing new care models, with a demonstration of success in spreading lessons on LCN development across our SPG and beyond; and
- further develop ways of energising and engaging our population in co-design and co-production, such as the successful work with peer supporters and health champions, and show demonstrable efforts to learn from and share with others – e.g. through the NHS Citizen network.

We operate within one of the five DH-accredited AHSCs (King's Health Partners); this gives us access to dedicated change management and evaluation capacity (through King's Improvement Science) as well as to novel workforce development programmes (e.g. KHP Education Academy). Drawing on those resources, alongside our AHSN (The Health Innovation Network) and LETB, we will be well placed, throughout 2015/16, to share evidence-based insights from our work and to learn from other Vanguard sites.

Our Lambeth and Southwark approach also supports the delivery of our six-borough strategy "*Our Healthier South East London*". Through our SE London leadership and our "shared standards, local delivery" transformation model we will work with the 'fast followers' and challenged health economies across our Strategic Planning Group to embed LCNs for all of our combined population of 1.8m people. We see this as a critical enabling step to ensure our future sustainability within a highly interconnected SE London health and social care economy. And we are well placed to share our learning through the pan-London transformation programme to deliver against the challenges set out by the London Health Commission.

Q6. What do you want from a structured national programme?

To move beyond the real and perceived barriers which hinder transformation at scale we now require co-investment and the expert technical insight available from NHS England, Monitor, CQC and DH.

Large scale co-investment is needed to:

- **Support organisational development and wider citizen participation** – this work cannot be successful if it is always an 'add-on' to the day job, but embedding service transformation within core roles requires investment (e.g. to release people's time). It also requires considerable support for organisational development and communications at a transformational scale. Through the Vanguard Programme we will seek co-investment and technical advice for this type of large scale cultural change.

- **Support workforce development** – we need to fundamentally redefine what we mean by 'workforce' so that we can really make use of our local professional and informal resources. Through the Vanguard Programme, and with the LETB, we will seek co-investment as well as engagement with national bodies (e.g. Royal Colleges) to undertake a systematic analysis of the functions that are needed in the delivery of different types of care, and to determine how best to use and develop a formal and informal workforce to have the skills, capabilities and behaviours needed to deliver those functions effectively.

Close working relationships with you are needed to:

- **Create an explicit mandate to be bold and to 'break rules'**, both real and perceived, that currently force retrenchment to narrowly defined interests. This will involve working through detailed technical minutiae as well as confronting large strategic choices, for example balancing means-testing and universal provision, or resolving funding coverage for registered or resident populations. We want to offer to the different departments within your organisations a close partnership that can anticipate and solve problems pragmatically which help navigate the conflicts and trade-offs between system-wide imperatives and institutional level regulatory requirements.
- **Develop and support the roll-out of our Local Unified Care Record** – we have already made very significant strides towards linking clinical records across the three foundations trusts; we now need clear support from NHS England to develop common approaches to data sharing (e.g. standard agreements and fair processing guidance) so that the GP practices and the public feel aware and assured about the use of their data.
- **Create system-wide PLICS and value-based costing systems** – we now need intensive support from Monitor, NHS England and HSCIC to ensure that, on a regular basis, we can specify, collect and link activity, cost and outcomes data across all providers. This is vital to any understanding of effectiveness and to evaluate the true 'value' of interventions (i.e. essentially creating a system-wide Patient Level Information and Costing System (PLICS) to support allocative efficiency). In doing so we would expect to work closely with Monitor and NHS England to shape Information Governance, and to support the technical implementation challenges of outcomes development, cost allocation, and data linking and analysis.
- **Use robust economics to shape LCN service offerings** – building on Monitor's marginal cost work, we would like to access dedicated experts to undertake detailed economic modelling to identify the economies of scale and scope that should inform design of our LCNs.
- **Develop effective strategies for provider and market development** – moving towards outcomes-based commissioning and alliance contracting is relatively uncharted territory nationally; we want to work proactively with Cabinet Office (OGC), NHS England and Monitor to navigate procurement and competition issues and to clarify the most effective strategies to manage complex provider eco-systems.
- **Explore legislative/regulatory changes to support joint-commissioning** – we are already integrating our commissioning across health and social care, but existing regulations mean that local authorities and CCGs are unable to establish formal joint-committees, which creates bureaucratically cumbersome 'committees in common' – duplicating the management and administration of this work.

These are complex and technical tasks that can only really be addressed within systems that have laid the considerable groundwork to tackle them. We are a partnership that has done that. We now need specialist skills and partnership with national bodies to test new models and refine regulatory frameworks. By working with us you will be able to explore and resolve these issues within a large scale urban environment that is committed to securing change for the benefit of local people. We offer a credible 'test bed' to identify and demonstrate how to integrate services in practice and at scale, and as a Vanguard site we will commit to work intensively to learn along with others and to transfer our practical insights to other health and social care economies.

Appendix: Letter of endorsement from the Citizens' Board

Dear Sir/Madam,

Southwark and Lambeth Citizens' Board wish to support the application to the New Care Models Programme. The Citizens' Board was established in July 2013, following an open recruitment process, and meets monthly. The Board's role is to guide how evidence of citizen experience and views are gathered and analysed and how citizens are involved in the coproduction of integrated care.

The Citizens' Board is a core part of the SLIC governance, and is represented as full members on all the SLIC Boards and working groups. We are committed in our wish to build the strong relationships and trust across the workforce, both paid and unpaid, that lead to culture change. We no longer want services to be created for patients, but with and by citizens, in association with the strong voluntary, community and faith organisations in our rich and diverse boroughs.

We lead the quarterly public meetings of the Citizens' Forum, a public meeting that is open to all, and report to the Forum on our work. The Citizens' Board includes Healthwatch Southwark and Healthwatch Lambeth, and we have good connections with CCG Lay members and councillors. We attend CCG and Health and Wellbeing Board meetings regularly.

The Citizens' Board are proud to have jointly produced the Commissioning Intentions for 2015/16, with attributes of care and 'I statements' that are central to the outcomes in provider contracts, and we support the desire to develop alliance contracting.

We are working with the Local Care Networks, and are focused on ensuring that equalities issues are addressed and local assets used. We are determined to ensure that all Southwark and Lambeth citizens get opportunities to be involved in ways that suit them and are truly meaningful.

It is this genuine coproduction that makes us keen to use citizen networks to share our successes and failures, and will add to this bid by working with other Vanguard areas. We have already connected through NHS Citizen, and wish to utilise links with our local academic partners, HEE and CLAHRC to "arm the citizens" with education and training , alongside the paid workforce, to support our wellbeing and self care, and to play a role as equals in the governance of integration.

We are pleased to support the bid on this basis.

Yours sincerely

Nicola Kingston and Elizabeth Rylance-Watson (and 17 others)

Southwark and Lambeth Citizens' Board

Integration with empowerment and equality

Agenda Item 12

Item No. 12.	Classification: Open	Date: 16 March 2015	Meeting Name: Health and Wellbeing Board
Report title:		Our Healthier South East London	
Wards or groups affected:		Southwark wide	
From:		Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group	

RECOMMENDATIONS

1. The board is requested to:

   - Note the development of the five-year strategy to date and the iterative nature of strategy development

   - Discuss and comment on the development and content of the strategy, the process to date and the next steps set out in the paper

EXECUTIVE SUMMARY

2. The six Clinical Commissioning Groups (CCGs) across south east London, in partnership with NHS England are developing a joint commissioning strategy.

3. The Health and Wellbeing Board has received regular updates on progress and had the opportunity to review and comment on the draft case for change in March 2014.

4. Health outcomes in south east London are not as good as they could be and the longer we leave these problems, the worse they will get. We all need to change what we do and how we do it:

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

BACKGROUND INFORMATION

5. This more detailed report summarises the progress made on the strategy in the last six months and the next steps.

6. The strategy is being developed in partnership with local authorities, NHS providers, patients, local people and other key stakeholders. Its development is

overseen by a programme board, the Clinical Commissioning Board, comprising the chairs and chief officers of the six Clinical Commissioning Groups with colleagues from NHS England and representation from local authority chief executives, plus Healthwatch and patient and public voices. The Clinical Commissioning Board is in turn supported by a Partnership Group, bringing together local authority chief executives, NHS providers and other partners. Clinical leadership from CCGs, NHS providers and social care/children's services is provided by the Clinical Executive Group and six Clinical Leadership Groups.

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

8. The strategy is being developed through an iterative process, so this report reflects the progress to date. It sets out the progress in developing a whole system model for south east London and the six priority areas for intervention: community-based care, children, maternity services, cancer, urgent and emergency care and planned care. Each of these priority areas has a Clinical Leadership Group drawn from local NHS organisations, local authorities, Healthwatch and members of the public. This paper describes the current position in relation to the development of whole system outcomes and modelling the impact of the strategy across health and social care. The strategy is broadly consistent with the recommendations of the London Health Commission and the NHS Five Year Forward View, but further work will be undertaken to ensure alignment and to take account of further national and London wide policies as they develop.

9. There is further work required to develop the models in more detail and to engage widely in this, then to consider the implications in practice, again with extensive engagement in each borough and across south east London. Feedback from this engagement and involvement will continue to inform development of the strategy and will be published in a series of regular 'You Said, We Did' reports. Should any significant service changes be proposed as a result of the further development by the clinicians, patients and local people working on the strategy, consultation on these would take place, potentially from the end of 2015. In the meantime, each CCG is continuing to develop its operational plans and local strategies, and the south east London strategy had been tested to ensure consistency and to identify the progress already made towards implementation.

KEY ISSUES FOR CONSIDERATION

10. The board is asked to note the update and to discuss and comment on the development and content of the strategy and process.

Policy implications

11. The strategy addresses issues that require collaboration at a south east London level and will sit alongside the CCG's local borough-based strategy.

Community and equalities impact statement

12. A first equality analysis was carried out in 2014 and a response to this is currently being produced for May and a further analysis, building on the initial analysis will be carried out.

Legal implications

13. Should the proposals that are currently being worked through indicate major service change, a public consultation under section 14Z2 of the Health and Social Care Act 2012 will be carried out in the future.

Financial implications

14. The report includes an update on the financial modelling and the financial implications at a south east London level. The strategy programme is funded jointly by the six south east London CCGs and NHS England.

BACKGROUND PAPERS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	Our Healthier South East London – Summary Pack

AUDIT TRAIL

Lead officer	Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group	
Report Author		
Version	Final	
Dated	5 March 2015	
Key decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer title	Comments sought	Comments included
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Date final report sent to Constitutional Team		5 March 2015

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Update Southwark Health and Wellbeing Board - summary pack

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Our Healthier South East London – summary report January 2015

- A draft strategy for south east London was presented to the Health & Wellbeing Board in March 2014 and submitted to NHS England
- Significant work since then has been undertaken to develop the strategy further through the Clinical Leadership Groups, Clinical Executive Group, Partnership Group, Clinical Commissioning Board, which include colleagues
- There has been extended Public and Patient Voice (PPV) input to these key groups and the Patient and Public Partnership Group is now very active. A number of wider engagement events have also taken place, feedback from which has been used throughout the development of the strategy
- This paper is a six month summary of all this activity and includes updates on the detailed work carried out by each of the 6 CLGs to date as well as the significant areas where progress has been made:
  - Population segmentation
  - Local Care Networks
  - Whole System Model
  - Forward planning

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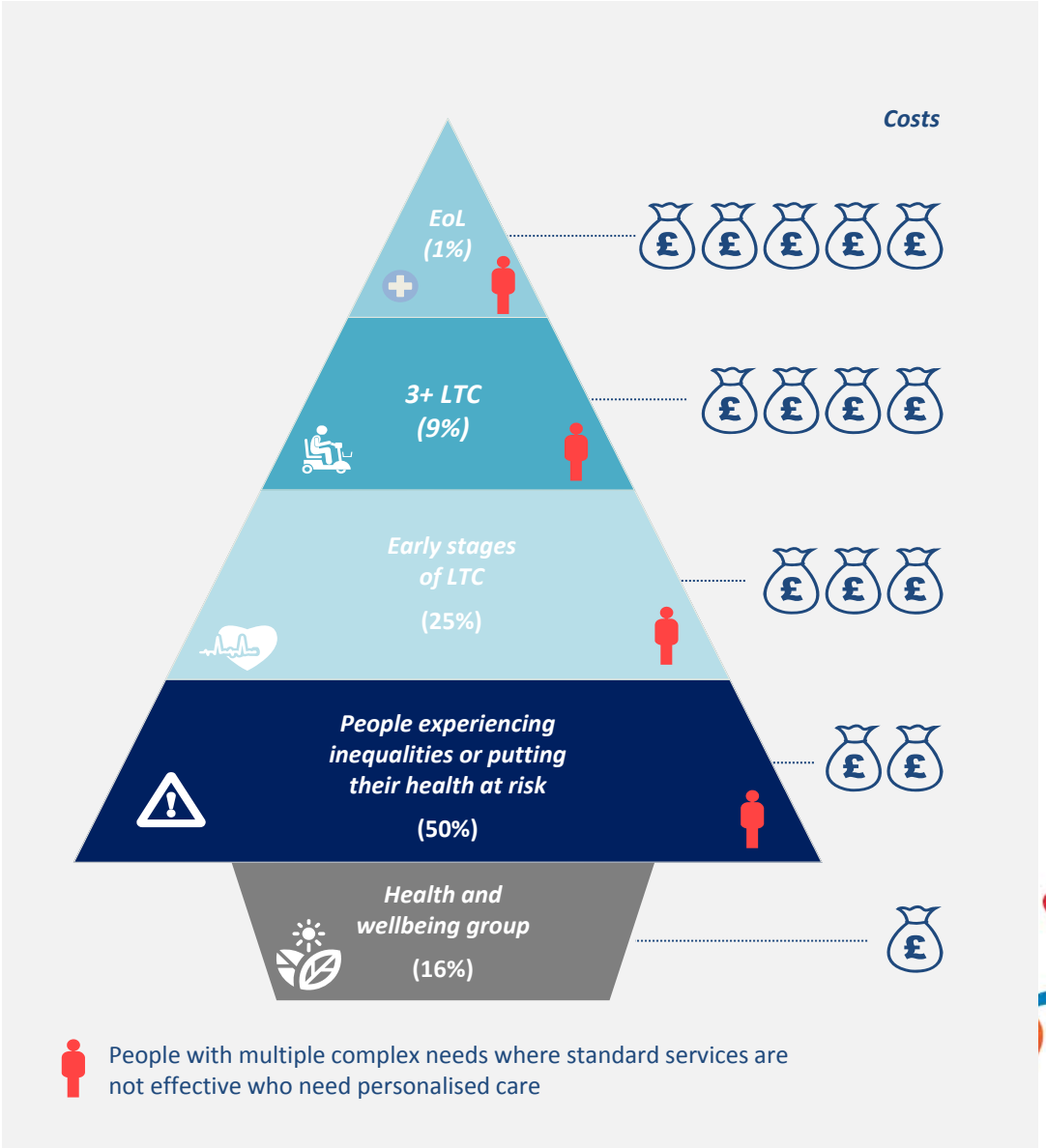
Our Healthier South East London: population segmentation

NHS

- The population of South East London has been segmented to show: people living healthy lives; those at risk of developing a long term condition (LTC); and those who are living with LTC.

- Local Care Networks will support people to live healthier lives and reduce the risk to people exposed to risk factors either by birth or behaviour. For people with a long term condition, LCNs will take a rehabilitative/ reablement approach enabling people to manage their own health positively and to prevent deterioration wherever possible. For those people with complex LTC or who are in the last year of life, support will be available to enable them to lead as full and active life as possible.

- The services available will be proactive, accessible and coordinated; with a flexible, holistic approach to ensure every contact counts; whilst still encouraging self-reliance. This will be delivered to geographically coherent populations, at scale..



A partnership of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups and NHS England

Local Care Networks are the foundation of the whole system model providing person centred services to populations

Strong confident communities

Self care

Proactive, Accessible , Coordinated, Continuous Care

- Health coaching
- Self management tool kits
- Social prescribing
- Optimising neighbourhood assets

Population needs and ***budget***

Managed care

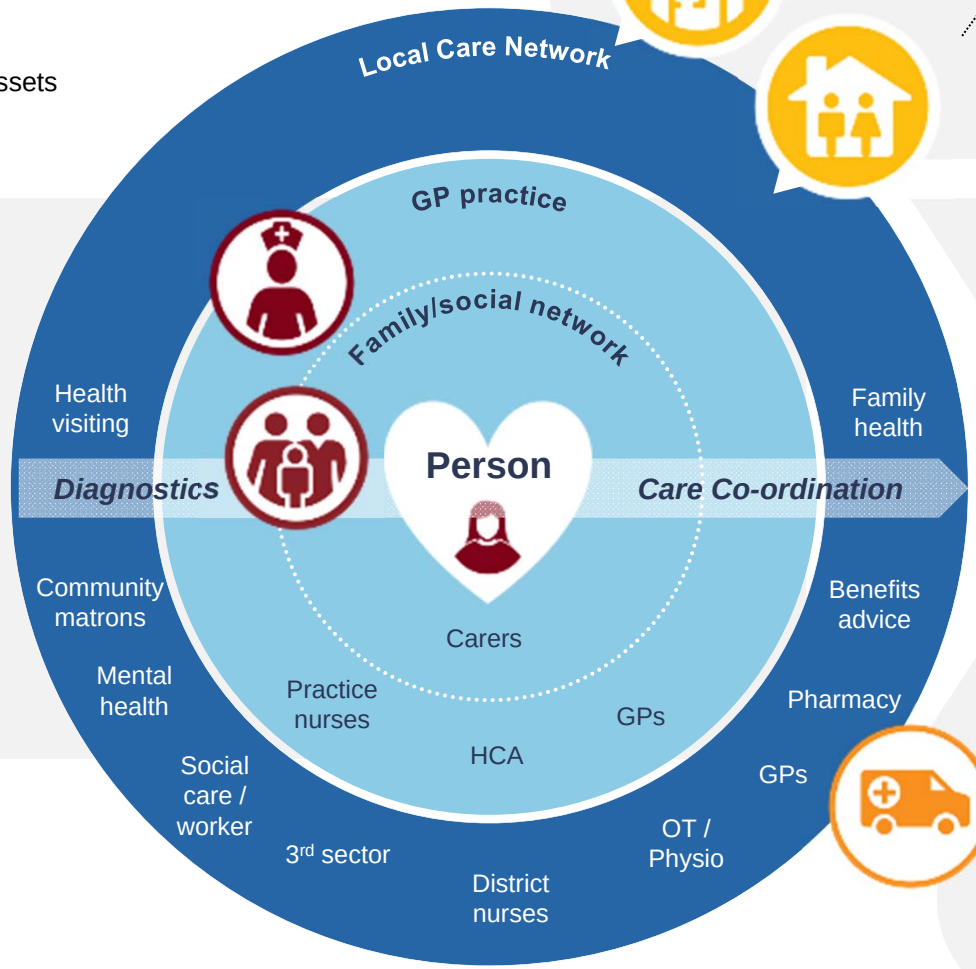
- Anticipatory care planning
- Active case management
- Disease management
- Public health programmes

Specialist input *shared between LCNs:*

Pulled into care delivery from outside the network: Virtual clinics | Specialist nurses | Consultants | Geriatricians | End of Life expertise | Specialist rehab

Wider community infrastructure:

Police | fire service | schools | Housing



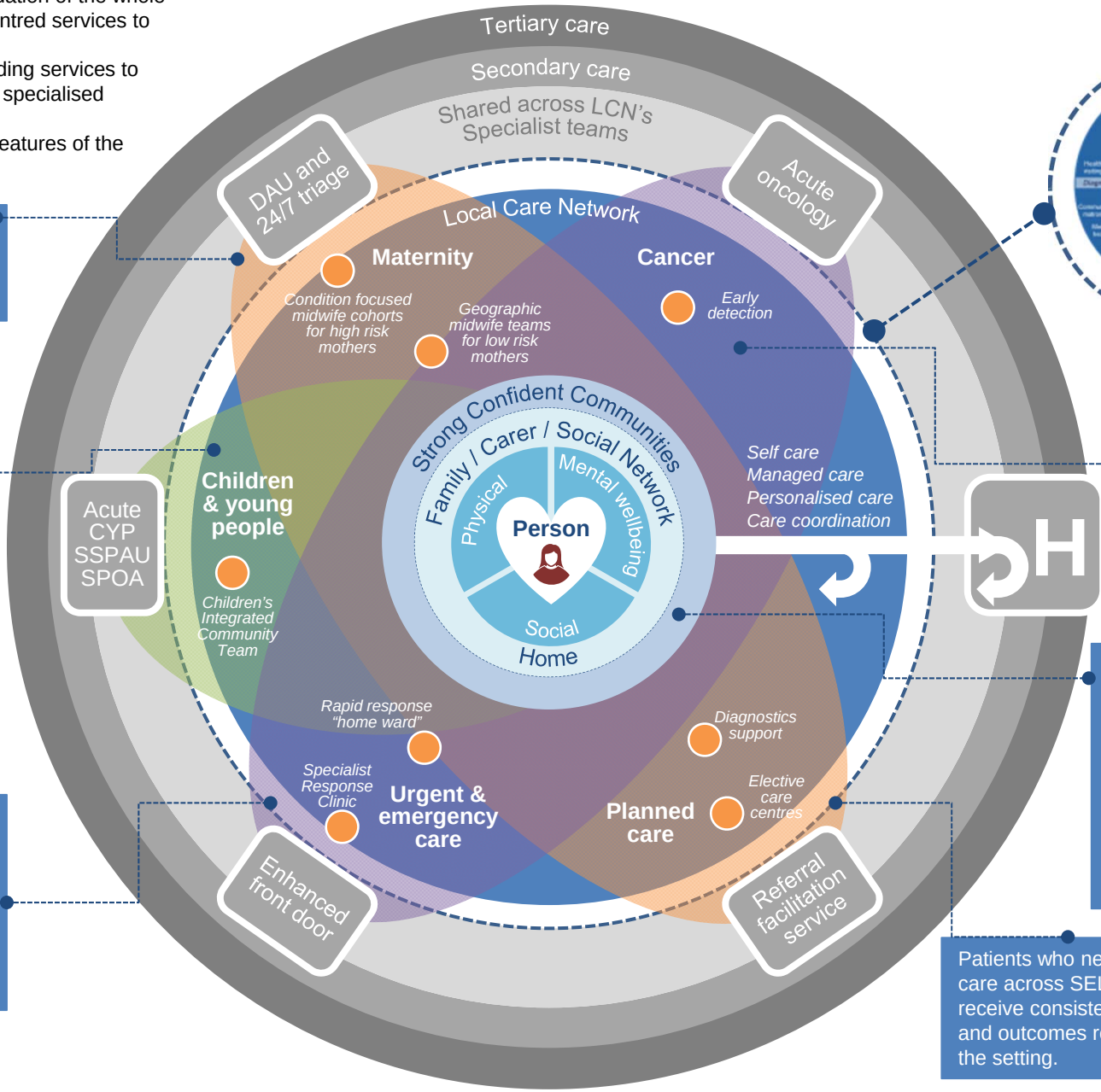
Affordable high quality outcomes

Urgent and emergency

Local Care Networks will operate beyond usual GP hours in order to reduce referrals to emergency care

This is Our Healthier South East London health and care whole system model

- This is our integrated system model.
- Local Care Networks are the foundation of the whole system model providing person centred services to populations
- The petals are the pathways providing services to cohorts of people and drawing on specialised services
- The orange circles represent key features of the model



Mums-to-be will receive a personalised service, continuity of care and a range of birthing options

Children and young people will be able to access more specialised services through children's integrated community teams

A rapid response team will make sure patients who need urgent and emergency care will receive the treatment they need in the right place at the right time and will support patients to return home and move back to local health and care services

Improve patient outcomes through prevention and early detection and diagnosis of cancer; stronger support for people living with and beyond cancer

Strong confident communities are a critical part of the foundation of the model. Initiatives will seek to build community resilience so that they support local people to be physically and mentally healthy and take care of peoples social needs.

Patients who need planned care across SEL will receive consistent quality and outcomes regardless of the setting.

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Our Healthier South East London Whole System Outcomes (1/2)

Domain	Outcome/Impact	Example Indicator(s)	Metric/Target
Population Health	Preventing people from dying prematurely and supporting them to live longer and healthier lives	• Extended years of life • Potential years of life lost (PYLL) from causes considered amenable to healthcare for both adults and children & young people • Life expectancy at 75 for both males and females • Levels of confidence • Feeling empowered to make healthy decisions • Reduction in obesity • Reduction in alcohol misuse • Reduction in smoking • Reduction in emergency admissions	
	Reducing differences in life expectancy and healthy life expectancy between communities- starting with quality early childhood education and care	• Reduced gap in life expectancy at birth • Improvements in wider factors which affect health and wellbeing and health inequalities	
Quality of Life	Supporting people feel independent, in control of their health, and able to access personalised care to suit their needs	• Population reported outcome measures (not patient) • Living in my own home • Reduction in permanent admissions to residential and nursing care homes, per 100,000 population • Number supported to die at home if they wish	
	Provision of health and care that enables people to live a good quality of life with their long term condition	• Health-related quality of life for people with long-term conditions • Quality of extended years of life • Patient activation	

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Our Healthier South East London Whole System Outcomes (2/2)

Domain	Outcome/Impact	Example Indicator(s)	Metric/Target
Effectiveness of Care	Treatment that is effective, efficient and delivers the best results for patients including rapid reablement	• Reduction in the variation of service quality and clinical outcomes • 1 year survival rate for cancer • Care meets the best evidence-based standards (clinical protocols followed) • Reduction in emergency readmissions within 30 days of discharge from hospital • Sustainable provision of health and care	
	Delivering the right care, at right place, at the right time along the whole cycle of care	• Increased proportion of care delivered in the community • Reduced length of stay • Reduced A&E attendances and emergency admissions	
Quality of Care	Commitment to people having a positive experience of care	• Patient experience of primary care (GP services, GP OOH services, NHS dental services) • Patient experience of hospital care • Staff experience / satisfaction • Friends and family test • Overall satisfaction of people who use services with their care and support • Overall satisfaction of carers with social services • Patient Experience Headline score for Focus on Dignity and Respect Customer Service: • Waiting time • Convenience • Accessibility (carers) • Respect (care givers/experience) • Safe (measure) • There is appropriate care planning	
	Caring for people in a safe environment and protecting them from avoidable harm	• Reduced variation of care • Reduced avoided harm • Reduced late complications • Patient safety incidents reported • Safety incidents involving severe harm or death • Reduced hospital deaths attributable to problems in care	

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Next steps

Next three months:

- Refinement of the whole system model and the models of care
- Modelling expected impacts for providers and commissioners
- Further development of the supporting strategies.
- Testing refreshed CCG Operating Plans against the strategy to ensure that there is consistency between the short and longer term plans
- Presenting the developing strategy to Health and Wellbeing Boards and other key meetings for review and input
- Further wide engagement

Summer 2015 – mid 2016

- Development of options & criteria to assess options for implementation
- Modelling to support option appraisal
- Business case development
- Consultation, if required.
- Continuing implementation of elements not requiring consultation, such as the development of the local care networks, community based care and improved clinical pathways

DRAFT – WORK IN PROGRESS

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Programme Plan

Phase 1 (January – May 2015)	Phase 2 (May – August 2015)	Phase 3 (September – November 2015)	Phase 4 (December 2015 – March 2016)	Phase 5 (April – June 2016)	Phase 6 (July 2016 - 2019)
Key Activities					
• Further refinement of the Whole System Model and the models of care, including testing with providers, partners and wider stakeholders • Modelling expected impacts for providers and commissioners • Further development of the supporting strategies • Clinical model implementation • Workshops– CO discussion on commissioner models , Provider and CLG	• Identification of potential for significant service change. • Developing criteria to assess options for implementation • Developing options • Option appraisal • Decisions on reference cases/preferred options • Modelling to support option appraisal and decision making • Further support to implementation: CBC and LCN • Continued work with partners to ensure ownership and wider engagement to test and develop	• Development of business cases. There will need to be agreement as to the business cases required and who will lead them (commissioners or providers). • Modelling to support development/review of business cases • Decisions making processes for business cases • Continued wide engagement	• Any consultation, if required. *Note: In the event that consultation is not required, and for any elements of implementation where consultation is not required, the timetable will be shortened, but for planning purposes this paper assumes that there will be some formal consultation, although the subject of such consultation has yet to be established.*	• Conclusion of any consultation • Further modelling if required • Decision making • Preparation for implementation	• Continuation of strategy implementation. *Note: as per CCG level implementation roadmaps*
Key Outputs					
• Detailed implementation plan • Presentation to NHSE • Provider outline of steps required to operationalise the Whole System Model • Development of the supporting strategy by providers • Equality Impact •	• Modelling Impact Assessment • Publish Equalities Impact Assessment and action plan • Refinement of implementation plan • Recommendation options	• Refinement of detailed implementation plan • Gateway review • Business Case sign off			• For mobilisation of the strategy

Live implementation and continuous quality improvement

Governance Groups	Continuous input throughout the process with regular meetings
Comms & Engagement	Continued aligned plan to ensure the programme continues with a high level of engagement
Finance & Modelling	Modelling to establish the baseline position, required investment and quantify benefits to be realised
Supporting Strategies	Continue the commissioning framework, LCN, workforce, IM&T systems and estates configuration needed to realise the change

A partnership of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups and NHS England

Agenda Item 13

Item No. 13.	Classification: Open	Date: 16 March 2015	Meeting Name: Health and Wellbeing Board
Report title:		Southwark Pharmaceutical Needs Assessment (PNA) Final	
Wards or groups affected:		All	
From:		Director of Public Health	

RECOMMENDATIONS

1. The Southwark Health and Wellbeing Board (HWBB) review the feedback received from the consultation on the Draft PNA.

2. The HWBB agree and sign off the amendments required to comply with the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349).

3. Agree a process for the final sign off the revised PNA so that it can be published on the Southwark Council website on the 30 March 2015.

EXECUTIVE SUMMARY

4. Southwark's Health and Wellbeing Board (HWB) has a statutory responsibility for developing a Pharmaceutical Needs Assessment (PNA) as set out under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349). A PNA is a document which records the assessment of the need for pharmaceutical services within a specific area. The same Regulations require NHS England to use the PNA to consider applications to open a new pharmacy, move an existing pharmacy or to commission additional services from pharmacy. The consultation of the draft Southwark PNA ended on 28 February 2015. This paper outlines the feedback received and the proposed amendments to the draft PNA and associated appendices for the Health and Wellbeing Board to consider and sign off.

BACKGROUND INFORMATION

5. Southwark's Health and Wellbeing Board (HWB) is developing a new Pharmaceutical Needs Assessment (PNA). This is a statutory HWB responsibility, as set out under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349).

6. A PNA is a document which records the assessment of the need for pharmaceutical services within a specific area. As such, it sets out a statement of the pharmaceutical services which are currently provided, together with when and where these are available to a given population. The same Regulations require NHS England to use the PNA to consider applications to open a new pharmacy, move an existing pharmacy or to commission additional services from pharmacy.

7. Southwark's HWB established a PNA Steering Group to oversee the development of the new PNA. This group includes membership from our partner organisations and the Local Pharmaceutical Committee.

8. As part of the development process, the Regulations require that the HWB undertakes a formal consultation on a draft of its PNA. This ran from 19 December 2014 until midnight on 28 February 2015. All responses to the consultation were requested in writing, using the standard questionnaire which has been developed to facilitate comment and feedback.

KEY ISSUES FOR CONSIDERATION

9. This section outlines in summary the key issues we have taken into consideration in amending the draft PNA following feedback from various stakeholders.

10. We responded to NHS England's checklist on whether the PNA met the regulations (summarised in appendix 1).

11. NHS England provided an assessment of the draft Southwark PNA against Schedule 1 paragraph 1 to 6 (14 sub-sections altogether). One sub-section requires completion as part of the final report (reporting on the consultation feedback). The draft PNA was deemed by NHS England to fully meet 7/13 other regulations; partially meet 2/13 and not meet 4/13.

12. For the 6 areas partially or not met we have amended the draft PNA to reflect the comments from NHS England so that the final PNA fully meets the regulations.

13. As part of the consultation feedback to the draft PNA there were 21 responses altogether (including from 17 local pharmacies, the Local Pharmaceutical Committee (LPC), the Local Medical Committee (LMC), NHS England, and South London and Maudsley (SLAM) NHS Trust. In addition there were 98 qualitative responses which we have grouped together in the table below.

14. Summary feedback from the consultation shows:

- the purpose, scope and local context of the PNA been explained sufficiently within the draft PNA document
    - All respondents agreed that the PNA had covered the purpose and scope and the majority (19/21) agreed that the local context was also covered (2 were not sure).
- there is a reasonable description of what is currently provided by pharmacies currently and if anything is missing from the document that is currently provided
    - The majority of respondents (17/21) agreed that the PNA provided a reasonable description of what is currently provided – 3 were "not sure" and 1 reported "no".

- In addition the majority (17/21) were not aware of any pharmaceutical services currently provided which have not been included within the PNA. Two were unsure and 1 was aware but there was no qualitative feedback as to what this service was.

- the accuracy of understanding of the pharmaceutical needs of the population clearly reflected in the draft PNA

  - The majority of respondents (15/21) felt that the pharmaceutical needs of the population have been accurately reflected throughout the PNA; 6/15 were not sure. We have responded to all comments received about this.

- respondents agree with the conclusions reached and any additional information required

  - Essential services - 17/18 agreed; 1 not sure
  - Medicines Use Reviews - 19/19 agreed
  - New Medicine Service - 17/19 agreed; 2 not sure
  - Appliance Use Reviews - 16/19 agreed; 2 not sure; 1 no
  - Stoma Appliance Customisation Services - 16/19 agreed; 1 not sure; 2 no
  - Seasonal Influenza Vaccination Service - 19/19 agreed
  - Stop smoking - 18/18 agreed
  - Sexual health - 17/18 agreed; 1 no
  - NHS Health Checks - 17/18 agreed, 1 not sure
  - Supervised administration service - 15/18 agreed; 3 no
  - Needle and syringe exchange service - 17/18 agreed; 1 no
  - Free (vitamin) D distribution - 18/18 agreed

- sufficient information has been provided for market entry and how service commissioners may wish to commission services from pharmacies in the future.

  - The market entry question was specifically for NHS England and its response was “not sure” for the reasons outlined in its checklist above. We have now addressed all these areas and are amending the draft PNA to reflect this feedback.
  - We had one commissioning response back which agreed that there was sufficient information in the draft PNA on how commissioners may want to commission pharmaceutical services in the future.

- A summary of the thematic issues from the qualitative feedback is given in the table below. There were 98 qualitative responses altogether.

15. Themes emerging from the feedback consultation:

Theme	Count	%
Consideration commissioners / providers (out of PNA scope)	40	41%
Ammendment	23	23%
Response	11	11%
Missing Information	11	11%
Clarity / Interpretation / Wording	10	10%
Gap analysis	2	2%
Additional Analysis	1	1%
Grand Total	**98**	**100%**

16. The majority of the comments were out of scope of the PNA but important for further consideration by commissioners, providers or both. The feedback also has led to a number of amendments being made in the final PNA, completion of missing information, further clarity and some responses. A full list of qualitative responses is given in appendix 2 for the HWBB to consider and a summary will be published in the final PNA.

Policy implications

17. Not applicable

Community and equalities impact statement

18. The PNA identifies and describes the pharmaceutical services in Southwark and their accessibility (location and opening times) to the local population. The PNA seeks to ensure better access to pharmacy services across Southwark. Equalities impact statements are described with the draft PNA in section 3.

Legal implications

19. As of the 1st April 2013 the Health and Wellbeing Board has a statutory responsibility to assess the needs for pharmaceutical services in Southwark. There is a legal requirement for Southwark's Health & Wellbeing Board to publish a new PNA by the 1st April 2015. The PNA report will assist the board in fulfilling this requirement. The PNA has to be refreshed every three years or earlier if there are any major changes. For minor changes supplementary information can be published in between the 3 year cycle.

Financial implications

20. There are no direct financial implications contained within this report. However, the PNA will inform the services commissioned in pharmacies by the local authority (Public Health), NHS England and NHS Southwark Clinical Commissioning Group.

BACKGROUND PAPERS

Background Papers	Held At	Contact
Draft PNA	www.southwark.gov.uk/pna	Claudia Graig

APPENDICES

No.	Title
Appendix 1	Southwark Health and Wellbeing Board response to London Region Pharmaceutical Services Regulations Committee 23 February 2015
Appendix 2	Draft Consultation Report

AUDIT TRAIL

Lead Officer	Dr Ruth Walls, Director of Public Health
Report Author	Dr Hiten Dodhia, Consultant in Public Health Medicine
Version	Final
Dated	11 March 2015
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Strategic Director of Children's and Adults' Services	No	No
Date final report sent to Constitutional Team		11 March 2015

Appendix 1: Southwark Health and Wellbeing Board response to London Region Pharmaceutical Services Regulations Committee 23 February 2015

Does the PNA include a statement outlining this provision?	NHS England Officer Response	Southwark Health and Wellbeing Board Response
Schedule 1, paragraph 1- necessary services: current provision		
1a)	Partially met (3 points - 1 met)	2 points amended to fully meet the regulation
1b)	No (3 points)	1 point amended DAC – Distance appliance contractor – being reviewed Analysis of prescriptions outside area being reviewed
Schedule 1, paragraph 2 – necessary services: gaps in provision		
2a)	Yes (2 points)	1 point amended for further clarity
2b)	No (2 points)	2 points amended to fully meet the regulation
Schedule 1, paragraph 3 – other relevant services: current provision		
3a)	Yes (4 points)	
3b)	No (1 point)	1 point amended to fully meet the regulation
3c)	Yes (1 point)	
Schedule 1, paragraph 4 – improvements and better access: gaps in provision		
4a)	Yes (6 points)	
4b)	No (1 point)	1 point amended to fully meet regulation

Does the PNA include a statement outlining this provision?	NHS England Officer Response	Southwark Health and Wellbeing Board Response
Schedule 1, paragraph 5 – other services		
5a)	Yes (3 points)	
5b)	Yes (1 point)	
Schedule 1, paragraph 6 – how the assessment was carried out		
6a)	Yes	
6b) Locality Protected characteristics	Partially Yes	1 point being amended to fully meet regulation
6c) Consultation report	To be completed	Being completed as part of the report to HWBB
Does the PNA consider the following factors in terms of "benefits of sufficient choice"?		
Access	Yes	
Choice – additional facilities	Yes	
Choice – additional providers	Yes	
Locality – changing needs	No	Amendments made to reflect this.
Vulnerable group	Yes	

Does the PNA include a statement outlining this provision?	NHS England Officer Response	Southwark Health and Wellbeing Board Response
HWB assessment	Yes	Amendments made for greater clarity
Does the PNA demonstrate that the following have been taken into consideration with regard to "identifying future needs"?		
Planned development housing/population changes	Yes	
JSNA/JHWBS	Yes	
Planned developments primary care	No firm plans have been identified	One amendment made for greater clarity
Planned developments -shopping	Yes	
Planned developments NHS services	No firm plans have been identified	
Planned developments special services by CCG	No firm plans have been identified	
Plans for social care/occupational health to provide aids/equipment	No firm plans have been identified	
Pharmacy opening hours	Large number of discrepancies	All amended to reflect NHS England core and supplementary hours.
Additional information	12 points	All amended

APPENDIX 2

Draft Consultation Report

Method: A 60 day statutory consultation occurred between 19 December 2014 and the 28 February 2015. Table 1 outlines a list of stakeholders to be consulted on the draft PNA was developed and following the regulations relating to the development of the PNA. An email was sent to all surrounding Chairs and support officers of each Health and Wellbeing Board with a link to the PNA document. In addition to this, the draft PNA was promoted by the Local Pharmaceutical Committee (LPC). The consultation was also open to members of the public (although a separate consultation was carried out with the general public and this has already been incorporated into the draft PNA).

Table 1: List of stakeholders invited

Response sent to	Detail	Response received
Local community Pharmacies	62 Pharmacies	Yes (18/62)
Local Pharmaceutical Committee (LPC)	1 LPC	Yes
Local Medical Committee (LMC)	1 LMC	Yes
London-wide (LMC)	1 London-wide LMC	No
Local Patient Groups	Community Action Southwark	No
	Health Watch Southwark	No
Neighbouring HWBB	Bromley HWBB	No
	Croydon HWBB	No
	Lambeth HWBB	No
	Lewisham HWBB	No
Local Hospital trusts	Guys and St Thomas'	No
	Kings NHS Trust	No
	SLAM	Yes
Local CCGs	Southwark CCG	Yes
NHS England		Yes

Local Councils	Southwark council	No
	Lambeth Council	No

The following questions were posed in the consultation. Responders were invited to leave additional comments/feedback.

1. Has the purpose of the PNA been explained sufficiently within section 1.1 of the draft PNA document?
2. Does Section 1.2 clearly set out the scope of the PNA?
3. Does Section 2 clearly set out the local context and the implications for the PNA?
4. Does the information in Sections 3.2 (Essential Services); 3.4 (Advanced Services); 3.5 (Enhanced Services) and 3.6 (Locally Commissioned Services) provide a reasonable description of the services which are provided by pharmacies and dispensing appliance contractors in Southwark?
5. Are you aware of any pharmaceutical services currently provided which have not been included within the PNA?
6. Do you think the pharmaceutical needs of the population have been accurately reflected throughout the PNA?
7. Please indicate below if you agree with the conclusions for the services described (in the PNA).
8. Do you agree with "The Future" section as set out in section 3.8?
9. Is there any additional information which you think should be included in the PNA?
10. Has the PNA provided adequate information to inform:
    - Market entry decisions (NHS England only)
    - How you may commission services from pharmacy in the future (All service commissioners)
11. Does the PNA give enough information to help your own future service provision and plans (pharmacies and dispensing appliance contractors only)
12. Community pharmacies & Dispensing Appliance Contractors only. Please can you review the information in Appendix E (Summary of services by pharmacy) for accuracy?
13. If you have any further comments, please enter them in the box below (question applies to all)
14. About you – please can you provide the following information (respondent details)

Each response received was reviewed and analysed to identify any issue raised, which was then considered in relation to the draft PNA. The draft PNA was amended to reflect any changes arising from the consultation responses received. In addition NHS England provided an assessment of the draft Southwark PNA against Schedule 1 paragraph 1 to 6 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349).

Findings: There were 23 responses overall (18 were from community pharmacies and 5 from other stakeholders). Within specific questions valid responses varied depending on the nature of the question being asked as well as the respondent. Two pharmacies only responded to questions related to their services. Table 2 provides a summary of the overall response from all stakeholders and table 3 provides all the qualitative responses and proposed feedback for these from the Southwark Health and Wellbeing Board.

Table 2: Summary of overall response by each question.

Question	Responses (valid responses only)	Number of respondents with comments
1. Has the purpose of the PNA been explained sufficiently within section 1.1 of the draft PNA document?	21/21 yes	None
2. Does Section 1.2 clearly set out the scope of the PNA?	21/21 yes	None
3. Does Section 2 clearly set out the local context and the implications for the PNA?	19/21 yes 2/21 not sure	Two
4. Does the information in Sections 3.2 (Essential Services); 3.4 (Advanced Services); 3.5 (Enhanced Services) and 3.6 (Locally Commissioned Services) provide a reasonable description of the services which are provided by pharmacies and dispensing appliance contractors in Southwark?	17/21 yes 3/21 not sure 1/21 no	Four
5. Are you aware of any pharmaceutical services currently provided which have not been included within the PNA?	17/21 not aware 2/21 not sure 2/21 aware	None
6. Do you think the pharmaceutical needs of the population have been accurately reflected throughout the PNA?	15/21 yes 6/21 not sure	Six
7. Please indicate below if you agree with the conclusions for the services described (in the PNA).		
• Essential services	17/18 agreed; 1 not sure	One
• Medicines Use Reviews	19/19 agreed	None
• New Medicine Service	17/19 agreed; 2not sure	One
• Appliance Use Reviews	16/19 agreed; 2 not sure; 1 no	Two
• Stoma Appliance Customisation Services	16/19 agreed; 1 not sure; 2 no	Two
• Seasonal Influenza Vaccination Service	19/19 agreed	One
• Stop smoking	18/18 agreed	One
• Sexual health	17/18 agreed; 1 no	Two
• NHS Health Checks	17/18 agreed, 1 not sure	Two
• Supervised administration service	15/18 agreed; 3 no	Two
• Needle and syringe exchange service		None

Question	Responses (valid responses only)	Number of respondents with comments
• Free (vitamin) D distribution	17/18 agreed; 1 no 18/18 agreed	
8. Do you agree with "The Future" section as set out in section 3.8?	16/21 agreed 4/21 not sure 1/21 no	Five
9. Is there any additional information which you think should be included in the PNA?	11/21 no 3/21 not sure 7/21 yes	Eight
10. Has the PNA provided adequate information to inform:		
• Market entry decisions (NHS England only)	1 not sure	One
• How you may commission services from pharmacy in the future (all service commissioners)	1 yes	One
11. Does the PNA give enough information to help your own future service provision and plans (pharmacies and dispensing appliance contractors only)	15/17 yes 2/17 not sure	Two
12. Community pharmacies & Dispensing Appliance Contractors only. Please can you review the information in Appendix E (Summary of services by pharmacy) for accuracy?	11/17 yes 6/17 no	Six
13. If you have any further comments, please enter them in the box below (question applies to all)	9/21 provided additional comments	Nine

Table 3: Qualitative responses and draft feedback from the Southwark H&WBB

Ref .	Qualitative response	Response of the Southwark H&WBB
3. Does Section 2 clearly set out the local context and the implications for the PNA?		
1 (F)	Information given is very good, the graphs provided are a bit complicated to understand.	Thank you – Where possible graphs and maps have been modified to aid clarity. Contact details have been included to support interpretation and additional information.
2 (F)	The PNA uses the localities as a means to explain distribution of pharmacies and services rather than take into account the different needs in each locality	Thank you – we have now taken into account the different needs of each locality.
4. Does the information in Sections 3.2 (Essential Services); 3.4 (Advanced Services); 3.5 (Enhanced Services) and 3.6 (Locally Commissioned Services) provide a reasonable description of the services which are provided by pharmacies and dispensing appliance contractors in Southwark?		
3 (NS)	Interested in providing the following services: Stop Smoking; Supervised Administration; Needle Exchange; Vitamin D	This comment is out of scope of the PNA – (issue should be raised with relevant commissioner).
4 (F)	There is enough information on advanced and enhanced services but I feel not much detail given on locally commissioned services	Services included in the PNA reflect the scope of the PNA as set out in the regulations.
5 (F)	The PNA does not name or list providers that lie outside in neighbouring HWB areas or those further afield who may contribute towards meeting the need for pharmaceutical services to the population of Southwark.	Thank you – Pharmacies names and addresses located within 1km of Southwark LA now included in appendix.
6 (F)	There is no analysis of number of Southwark generated prescriptions that are dispensed in neighbouring HWB, and vice versa.	Thank you – at the time of drafting the PNA we are not aware that this data is available. NHS Business Services Authority (NHSBSA) may be able to

Ref .	Qualitative response	Response of the Southwark H&WBB
		provide in future).
7 (F)	The PNA states that there are no distance selling pharmacies or DACs located within Southwark, however, no statement or analysis is contained which does/does not identify if distance selling pharmacies or DACs located outside the HWB provide any services to residents of Southwark	Thank you – at the time of drafting the PNA we are not aware that this date is available (NHSBSA may be able to provide in future).
6. Do you think the pharmaceutical needs of the population have been accurately reflected throughout the PNA?		
8 (F)	There are gaps in pharmaceutical provision in a few areas which the PNA states are residential areas and the access routes to them pass existing pharmacies and when other community pharmacies in neighbouring HWB areas are taken into account that the provision is adequate for the population.	Gaps in Southwark pharmaceutical provision, North East of Southwark bordering river Thames, East of Southwark bordering Lewisham and South Southwark are served adequately by providers from neighbouring H&WBB.
9 (F)	It is not clear to the LMC this decision has been reached – for instance is it known if patients in these areas call 111/their GP/attend casualty more frequently because they have less access to a pharmacy?	This comment is out of scope of the PNA – (issue should be raised with relevant commissioner).
10 (F)	Many pharmacies appear in clusters while the east of Southwark, notably the wards of Nunhead and Livesy, which has a wide area of deprivation, has relatively fewer pharmacies. In addition, although these are the areas in which sexual health issues and drug/alcohol abuse are likely to be higher, there is less availability of pharmacies providing sexual health and supervised administration/needle exchange in these areas.	Clustering of pharmacies is often the result of the alignment with GPs and location to communication / business centres. As a result of this alignment provision for sexual health and drug services around Nunhead & Livesy, could be perceived as a gap. Southwark pharmacies and pharmacies in neighbouring H&WB currently deliver an adequate service to those areas.
11 (F)	The three 100 hour pharmacies are located within supermarkets. This is ideal for shoppers. However, there is possibly a conflict because these environments are probably not ideal places to deal with sexual health and drug related issues. These are the sorts of issues that are	Each of the 100hr pharmacy have a consultation area which is a closed room. Relevant commissioners have taken into consideration the location of a pharmacy and suitability to deliver commissioned services.

Ref .	Qualitative response	Response of the Southwark H&WBB
	likely to benefit from extended hours help, and provision of supportive extended access help outside a shopping area should be considered.	
12 (NS)	Should notices be placed (within pharmacies that have their own consultation rooms) that customers could request a confidential discussion with the pharmacist, so that queries regarding sexual health and other conditions are more likely to be raised?	This comment is out of scope of the PNA, issue should be raised as best practice guidelines pharmacies need to follow for discreet / confidential services and for quality assurance for commissioners.
13 (NS)	It is not clear in the PNA if the new GP extended access clinic positions have been take into account when looking at the provision of pharmacies. These clinics will be open for extended hours on weekdays and at weekends. It will be important that there is close provision of an open pharmacy for maximum effectiveness of these clinics.	Thank you this has been identified as a future need and amended in the PNA. The case for extended GP times in line with pharmacy opening times should be considered by commissioners and providers.
14 (NS)	There is a need for there to be better publicity to the population of Southwark as to which pharmacies are open at weekends and late in the evening, residents do not seem to find this information easy to access. In addition sign posting to the general public and GPs/clinicians with a simple and updatable means of finding out which chemist provides which help including their opening hours.	This comment is out of scope of the PNA, issue should be raised as best practice guidelines and should be considered by commissioners and providers.
15 (NS)	There is also a need to try to increase the numbers of pharmacists who will visit/deliver medications to the population in their own homes. A pharmacy delivery service for housebound patients needing emergency medication (and within extended hours) may also be worth considering, especially in the light of the focus on increased care at home.	This comment is out of scope of the PNA, issue should be raised as best practice guidelines and should be considered by commissioners and providers.
16 (NS)	The LMC is surprised that so few pharmacists have access to NHS-net email. This has a significant impact, if not increased, in terms of trying to improve communication between primary, secondary care and pharmacies. Potentially this limits what might be delegated to pharmacists unless communication links can be improved.	This comment is out of scope of the PNA , issue should be raised as best practice guidelines and should be considered by commissioners and providers

Ref .	Qualitative response	Response of the Southwark H&WBB
17 (F)	No specific mention of mental health from what I can see, though a suggestion for improving adherence mentioned in the 'Future' section.	Mental Health is mentioned in other considerations in section 2.3.5 page 30 of draft PNA Additional text to include Pharmacy staff can play a role in promoting awareness of good mental health, for example, signposting to information about local support networks, mental health helplines etc. Community pharmacists can also help by promoting simple mechanisms to help people understand and take their medicines as intended. If necessary, the patient could receive medication by instalment dispensing or through supervised administration.
18 (F)	Some areas like Cathedrals will be changing its demographic in the next few years which may not have been addressed fully	Thank you, ward population change has now been included in the PNA.
19 (F)	Difficult to look at the data provided clearly	Thank you – Where possible graphs and maps have been modified to aid clarity. Contact details have been included to support interpretation and additional information.
20 (F)	With regards to 2.3.4 and Alcohol/Sexual Behaviour and Drug Misuse the pharmaceutical need in Southwark may not have been expressed strongly enough in these 3 areas .The statistics given in all 3 areas clearly show they are all areas for concern vs national and London performance. It would have been helpful if in 2.5 What this means for the PNA and again in 3.8 The Future this had been projected more strongly. It is good that both Sexual Health and Substance Misuse have both been rated 'necessary' and I note the review which is underway in Sexual Health.	2.3.4 refers to lifestyle issues; Wording has been modified and linked to other sections as suggested.

Ref .	Qualitative response	Response of the Southwark H&WBB
21 (F)	We are aware that the CCG, the council and Healthwatch carried out patient and public engagement during the development stage of the PNA. Would it be possible to include more analysis and breakdown of the findings from the engagement in the final PNA.	Thank you – we have incorporated the key elements of the patient and public engagement survey as part of the PNA. (We will review and plan to publish any other element later this year for commissioners).
7. Please indicate below if you agree with the conclusions for the services described (in the PNA). • **Essential services / Medicines Use Reviews / New Medicine Service / Appliance Use Reviews / Stoma Appliance Customisation Services / Seasonal Influenza Vaccination Service / Stop smoking / Sexual health / NHS Health Checks / Supervised administration service / Needle and syringe exchange service / Free (vitamin) D distribution**		
22 (F)	Page 51 states: the percentage of people satisfied or very satisfied with opening hours……36% satisfaction Monday to Friday early morning (before 9.00am).	Thank you – these were incorrectly reported and have been corrected by excluding people who had "no comment". So for the early morning opening 43% people had no comment on this opening time. Excluding these 64% were either very satisfied or satisfied and 36% not satisfied.
23 (F)	Page 57 states: 51% of respondents said they had been unable to get a prescription dispensed because the pharmacy was closed or out of stock. This is over half of respondents, is this not a significant gap, and if this is a gap then the PNA is required to explain why this does not translate into a need?	Thank you we have modified this section as the question for this in the survey was worded as follows: When asked in the survey: "Have you **ever** been unable to get a prescription dispensed?": 56% of respondents answered "Yes"; 39% answered "No" and 2% "Did Not Know". • Of those who answered yes 40% said this happened once only and 37% said it happened twice (i.e. 77% said it happened only once or twice; 23% said it happened more than twice. • 78% of those who answered yes were not able to get a prescription dispensed as the pharmacy was out of stock and 10% the pharmacy was closed.
24 (F)	The PNA does not name or list providers outside the area of the HWB	Thank you – Pharmacies names and addresses located within 1km of Southwark LA now included in appendix.

Ref .	Qualitative response	Response of the Southwark H&WBB
25 (F)	NMS-I am disappointed this is rated relevant not necessary. I recognise the uncertainty about the future of the service however the findings from an evaluation were published in August 2014 and were overwhelmingly positive, with the researchers concluding that as the NMS delivered better patient outcomes for a reduced cost to the NHS, it should be continued. This was the basis for NHS England's firm decision to continue commissioning the service. Whilst activity in pharmacy may have been low this was due to the uncertainty of the continuity of the service earlier in the year.	Thank you – We have modified wording based on the available evidence and response to consultation.
26 (NS)	As we do not deliver the Service, feel unable to respond	N/A
27 (F)	In the section 3.4.3 it mentions that no pharmacies in Southwark provide ARUs but there is not a gap in service as patients access these at the relevant specialist clinic. However in 'The Future' section it describes how all pharmacies will be prepared to offer AUR to patients. In the conclusion section of 3.4.3 should it acknowledge that although no service gap is recognised to increase patient access it would be encouraged that pharmacies offer this service so the sections are linked?	Thank you – Modified wording based on evidence and response to consultation.
28 (NS)	Stoma Appliance Customisation Service: Have the services that are commissioned in secondary care been looked at and could this be better more convenient and cheaper through pharmacies?	This is not in the scope of the PNA; issue should be raised with commissioners and providers of this service to review.
29 (NS)	As we do not deliver the Service, feel unable to respond	N/A
30 (F)	BUT timely information needs to flow to primary care. The LMC queries the figures quoted in relation to the under 65 at risk group with primary care only immunising 17% as this is not correct.	Thank you – This section has been reviewed and modified to remove any confusion.

Ref .	Qualitative response	Response of the Southwark H&WBB
31 (NS)	The system used by pharmacies to record immunisations does not use NHS numbers and it is difficult for practices easily to see who has been immunized. There are a significant number of inaccuracies which creates work for practices and there have also been several incidents where people being given pneumovac vaccine this year by pharmacies that should not have been given it.	This comment is out of scope of the PNA, issue should be raised as best practice guidelines and should be considered by commissioners and providers.
32 (NS)	But must communicate with primary care (refers to stop smoking services)	This comment is out of scope of the PNA, issue should be raised as best practice guidelines and should be considered by commissioners and providers.
33 (NS)	Definitely need to stop age restriction for EC (emergency contraception)	This comment is out of scope of the PNA, issue should be raised as best practice guidelines and should be considered by commissioners and providers.
34 (F)	Sexual Health- approaching 100 hour pharmacies and extended hours pharmacies is a good solution to the gaps-it would also be appropriate that all pharmacies open on a Sunday should be commissioned to meet the demand over the weekend.	This comment is out of scope of the PNA, issue should be raised as best practice guidelines and should be considered by commissioners and providers.
35 (NS)	NHS Checks by pharmacies is good but when problems are found, such as obesity, which requires lifestyle changes e.g. diet and exercise, ways of dealing with this could be initiated by the pharmacist rather than be considered as a GP action.	This comment is out of scope of the PNA, issue should be raised as best practice guidelines and should be considered by commissioners and providers.
36 (NS)	As we do not deliver the Service, feel unable to respond	N/A

Ref .	Qualitative response	Response of the Southwark H&WBB
37 (NS)	We supervise one client but this is not recognised as we do not open on Saturday	This comment is out of scope of the PNA , issue should be considered by commissioners and providers
38 (F)	Supervised Administration-it is hard to agree with the conclusions as I calculate 18 pharmacies are commissioned+10 provide outside of contract (and therefore unpaid) and 33 pharmacies ticked the 'Supervised Methadone' column Appendix E?! A very confusing picture. Does the PNA use only the 18 commissioned pharmacies to identify the gaps or is it using all the pharmacies? This is important if this document will be used for future commissioning and the 10+ pharmacies offering the service at no cost will be distorting the figures. Given that Substance Misuse is such a problem in Southwark it is important that these numbers are accurate and should only include the commissioned pharmacies this will enable commissioners to make the correct decisions to fill the gaps in service and ensure that the pharmacies are being appropriately remunerated for the service.	Service data original included a mix of commissioned and private services collected by the PNA survey. Data now only contains commissioned data. Supervised Methadone has been removed from appendix E .
39 (NS)	Again, this supported Community Pharmacy, However needs to be supported with Training, Funding & futures Services	This comment is out of scope of the PNA , issue should be raised as best practice guidelines and should be considered by commissioners and providers
40 (NS)	But needs to increase commissioning of services through current pharmacy's Minor Ailments/Health Checks/Methadone Supervision/Contraception	This should be considered by commissioners of services.
8. Do you agree with "The Future" section as set out in section 3.8?		
41 (NS)	The LMC has significant concerns about pharmacists taking on children's immunisations because this can be complex and recently there have been frequent changes to the regimes. It is not clear how pharmacists will know what is needed and how will the notes be updated? Currently communication in relation flu immunisations is not particularly good and it there is the potential for more significant errors to be made in relation to childhood immunizations.	This comment is out of scope of the PNA, issue should be raised as best practice guidelines and should be considered by commissioners and providers.

Ref .	Qualitative response	Response of the Southwark H&WBB
42 (NS)	There are similar concerns with regard to screening and diagnostic work and it would be better to communicate using NHS Numbers as a way forward using nhs.net email addresses.	This comment is out of scope of the PNA , issue should be raised as best practice guidelines and should be considered by commissioners and providers
43 (NS)	The Minor Ailments service sounds a very positive service but appropriate communication with primary care will be essential.	This comment is out of scope of the PNA , issue should be raised as best practice guidelines and should be considered by commissioners and providers
44 (NS)	Is the provision of naloxone injection packs, to be given by pharmacists to high risk groups, going to be under consideration in the future?	This comment is out of scope of the PNA; issue should be considered by commissioners and providers
46 (F)	The future predictions, support Pharmacy, however, strategy changes often mean that this does always translate.	The PNA is a 3 year market entry document. Over the course of the PNA supplementary submissions will be made to address strategy which may change the context of the document.
47 (F)	The Futures section includes “Aspirations for pharmacy….” The purpose of the PNA is to assess current provision and future provision. The PNA needs to be specific as to the current and future needs if any and also in specified circumstances. Aspirations relate to hope and desire it is not clear if these are specific needs?	Thank you – This section has been reviewed and modified
48 (F)	It has been confirmed that the Minor Ailment Scheme will be commissioned from April 2015. All but 8 pharmacies want to provide this service at present but we will be working to a universal service.	Thank you for this feedback.

Ref .	Qualitative response	Response of the Southwark H&WBB
9. Is there any additional information which you think should be included in the PNA?		
49 (F)	There is no real mention of the development of Local Care Networks (LCN) in this document and as a provider of services in Southwark the LMC wonders how pharmacy is going to be brought in alongside the development of LCNs. Up until now there has not been any pharmaceutical input from pharmacy into the local provider group that has been working alongside SLIC (Southwark and Lambeth integrated service) – involvement of pharmaceutical services in the LCN providers is essential	Thank you – we have added the following: Locality Care Networks (LCN) are a cohesive population-based network of all professional involved in a person's care with the person at the centre. LCNs are developing across SE London and Southwark CCG has two (North and South). LCNs provide an opportunity for providers to work together at greater scale, through collective working, collaboration or formal merger. Locality models of care could include 'core' GMS/PMS services and cover a range of extended services, including enhanced and non-core services, as well as some community specialist services, depending on the scale that these services are offered at (i.e. borough, locality or other). Opportunities exist for pharmacies to work strategically within these LCNs in Southwark to improve patient centred care and reduce health inequalities. Commissioners and providers need to review these in the light of the PNA.
50 (NS)	With an ageing increasingly housebound population the option for a community based home visiting pharmaceutical service to look after those housebound delivering meds (*medicines*) with transport would be worth exploring. It is not infrequent that patients are not able to access meds (*medicines*) until a carer comes after another 24 hours during which time they may get more ill and hospital admission becomes unavoidable. If there was access to a pharmaceutical service that could potentially deliver medication to patients in their own home this might avoid some of these instances.	This comment is out of scope of the PNA , issue should be raised as best practice guidelines and should be considered by commissioners and providers.
51 (NS)	Point of care testing – this would be useful for patients with an SMI. Would the service be available to all? Do patients need to be referred	This comment is out of scope of the PNA , issue should be raised as best practice guidelines and should be considered by commissioners and

Ref .	Qualitative response	Response of the Southwark H&WBB
	by GP or community mental health team?	providers.
52 (NS)	Supervised administration of opiate substitutes – there should be a system for community pharmacies reporting errors to the trust and NHSE.	This comment is out of scope of the PNA , issue should be raised as best practice guidelines and should be considered by commissioners and providers.
53 (NS)	Mental health - Alerting community mental health teams when patients do not collect medication is a great idea.	This issue should be raised as best practice guidelines and should be considered by commissioners and providers.
54 (NS)	How are all these aspirations to be funded as some changes require some investment?	This comment should be considered by commissioners of services in the light of priorities for meeting these needs.
55 (NS)	Interested in providing the following services: Stop Smoking; Supervised Administration; Needle Exchange; Vitamin D.	This comment is out of scope of the PNA.
56 (F)	There needs to be an appendix for individual pharmacy opening hours. It has been impossible to check opening hours are correct using this document as the maps and tables do not give enough detail.	Thank you for this comment – we have amended the PNA to reflect this. The amended PNA uses total opening hours (core and supplementary as held by NHS England). Discrepancies between NHS England held data and locally collected PNA survey data has been shared with NHS England.
57 (F)	In addition the maps and tables seem to be giving different information e.g. the tables look at opening 8.30am or earlier and closing 19:00 or later but the maps look at opening 9am or earlier and closing 6pm or later. As opening hours are so critical to both market entry and commissioning decisions these need to be absolutely crystal clear to anyone reading this document.	Thank you for this feedback – we have now checked this and amended.
58 (NS)	How to access these services and get more involved contact details	N/A

Ref .	Qualitative response	Response of the Southwark H&WBB
59 (F)	In 'The Future' section it could be added that it is envisaged that community pharmacies will work in an integrated way with other health and social care providers to meet the health needs of the population e.g. Local Care Networks.	Thank you for this – we have now amended the PNA to reflect this comment.
10. Has the PNA provided adequate information to inform: • **Market entry decisions (NHS England only)** • **How you may commission services from pharmacy in the future (All service commissioners)**		
60 (F	PNA has mapped current providers and premises within the HWB area (pages 49 & 72); however no list is available with full address of providers' premises.	Thank you for this comment – we have amended this.
61 (F)	The PNA does not name or list providers that lie outside in neighbouring HWB areas or those further afield who may contribute towards meeting the need for pharmaceutical services to the population of Southwark. There is no analysis of number of Southwark generated prescriptions that are dispensed in neighbouring HWB, and vice versa.	Thank you for this comment – we have amended the list of pharmaceutical providers in neighbouring HWBB areas. At the time of drafting the PNA information on prescriptions generated that are dispensed in neighbouring areas and vice versa is not available. We can do a supplementary statement in the future should this information become available to us.
62 (F)	The PNA states that there are no distance selling pharmacies or DACs located within Southwark, however, no statement or analysis is contained which does/does not identify if distance selling pharmacies or DACs located outside the HWB provide any services to residents of Southwark.	At the time of drafting the PNA, information on distance selling pharmacies or DACs located outside the HWB that provide any services to residents of Southwark, is not available. We can do a supplementary statement in the future should this information become available to us.
11. Does the PNA give enough information to help your own future service provision and plans (pharmacies and dispensing appliance contractors only).		
63 (NS)	But needs to increase commissioning of services through current pharmacy's Minor Ailments/Health Checks/Methadone Supervision/Contraception	This comment is out of scope of the PNA , issue should be raised as best practice guidelines and should be considered by commissioners and providers.

Ref .	Qualitative response	Response of the Southwark H&WBB
64 (NS)	Again, this supported Community Pharmacy, however needs to be supported with Training, Funding & futures Services	This comment is out of scope of the PNA , issue should be raised as best practice guidelines and should be considered by commissioners and providers.
12. Community pharmacies & Dispensing Appliance Contractors only. Please can you review the information in Appendix E (Summary of services by pharmacy) for accuracy?		
65 (F)	Missing EHC / Don't provide contraception Missing Flu / Chlamydia Test Missing Smoking Cessation / EHC Missing Supervised Administration	Commissioning data has superseded PNA survey data.
66 (F)	As commented earlier in response to Q7 there is a column for Supervised Administration and a column for Supervised Methadone – what is the difference here? It would also be helpful to highlight the commissioned and non-commissioned pharmacies as I note there has been a positive discrepancy in both supervised consumption and stop smoking services.	Thank you this has now been amended - supervised methadone has been removed from the table.
13. If you have any further comments, please enter them in the box below (question applies to all).		
67 (NS)	Southwark LMC would like to see pharmacists provide a free service whereby patients with mild eczema/dermatitis can try out some of the less expensive emollients so patients can choose which emollient is preferred by them and works best for them. This might reduce a huge waste of emollients as large tubs tend to be prescribed which the patients might decide they do not like and so do not use them.	This comment is out of scope of the PNA , issue should be raised as best practice guidelines and should be considered by commissioners and providers
68 (F)	Page 8: Can the Health and Wellbeing Board conclude that there are no gaps in provision of Essential Pharmaceutical Services?	Following amendments to the draft PNA yes SHWBB can conclude this to be the case.

Ref .	Qualitative response	Response of the Southwark H&WBB
69 (F)	Page 45: Can the Health and Wellbeing Board conclude that there are no gaps in provision of Essential Pharmaceutical Services?	Following amendments to the draft PNA yes SHWBB can conclude this to be the case.
70 (F)	Page 60: Can it be assumed or confirmed that with respect to gaps identified with reference to extending opening hours at weekends that NHSE or local commissioners will seek to commission this as a service from the existing network of pharmacies to ensure good alignment of access with GP opening hours.	This issue should be considered by all relevant commissioners.
71 (F)	Page 73: Did the Health and Wellbeing Board conclude that there is a good spread of service provision for this service and also if there is a significant scope for existing pharmacies to increase uptake for MURs?	This refers to MURs. As highlighted in the PNA MURs have been identified as necessary to meet the pharmaceutical needs of the population but there is significant room for improvement in Southwark within existing providers.
72 (F)	Page 80: Did the Health and Wellbeing Board conclude that there is a good spread of service provision for this service and also if there is a significant scope for existing pharmacies to increase uptake for NMS?	This refers to NMS. The HWBB can conclude that there is a good spread for this service. The 2012-13 data on NMS suggested there was some room for increase uptake although the further analysis is required for more recent data.
74 (F)	Page 89: Item 3.5.1 'LCP' should be included in the References under the Glossary	Amended.
75 (F)	Page 100: Other Southwark Pharmacy Contractors have expressed an interest to take up the service if commissioned.	(Refers to Stop Smoking Services). This issue should be considered by commissioners as part of the review of the service.
76 (F)	Page 109: Are there gaps in this service? If so, existing Southwark Pharmacy Contractors are willing to take up the service if commissioned. Are the current numbers of providers meeting current needs?	(Refers to Sexual Health Services). This issue should be considered by commissioners as part of the review of the service.
77	Page 122: Existing Southwark Pharmacy Contractors have expressed	(Refers to Supervised Administration). This issue should be considered by

Ref .	Qualitative response	Response of the Southwark H&WBB
(F)	an interest to provide this service to fill any gaps identified by the commissioners if the service is wider commissioned.	commissioners as part of the review of the service.
78 (F)	Page 128: Existing Southwark Pharmacy Contractors have expressed an interest to provide this service to fill any gaps identified by the commissioners if the service is wider commissioned.	(Refers to Needle and Syringe exchange). This issue should be considered by commissioners as part of the review of the service.
79 (F)	Page 129 – 132: 3.6.6. – suggest rename as Healthy Start Vitamins.	The local scheme is a universal compared to the national scheme which is more targeted – hence we have kept the name.
80 (F)	Page 134: Does the current location of pharmacies across the borough supports the population, providing adequate access to pharmaceutical services as currently provided.	Following amendments to the draft PNA yes SHWBB can conclude this to be the case.
81 (F)	Page 136: Sub title: 'Free (Vitamin) D Distribution' – rename as Healthy Start Vitamins	The local scheme is a universal compared to the national scheme which is more targeted – hence we have kept the name.
82 (F)	It was difficult to read the maps.	Thank you – Where possible graphs and maps have been modified to aid clarity.
83 (F)	EPSR2 (*Electronic Prescription Service Release 2*) beneficial but fails when GP prints px (*prescriptions*) and does not inform pharmacy - GPs may need further training.	This comment is out of scope of the PNA, issue should be raised as best practice guidelines and should be considered by commissioners and providers.
84 (NS)	Please also note the services not ticked Bonamy Pharmacy is more than willing to provide then if the commissioner decides to commission them from us. We are ready and accredited.	This comment is out of scope of the PNA, issue should be considered by commissioners and providers.
85	For supervised administration of methadone consumption of methadone	This comment is out of scope of the PNA should be considered by

Ref .	Qualitative response	Response of the Southwark H&WBB
(NS)	we currently do not have access to how to claim for payment	commissioners and providers.
86 (F)	In the conclusions 3.7 under Essential Services there is a line stating- 'There is no access to dispensing services in the overnight period'. Is this viewed as a Pharmaceutical Need-the patient survey did not suggest it was a need. What is the purpose of this statement? If this were ever deemed to be necessary I would hope all current providers would be consulted before a decision to agree a new contract was agreed.	Thank you - Amended paragraph to highlight while no service this is not a need.
87 (F)	In summary the Southwark PNA, whilst long, is logically set out and a very informative document. Well done for pulling all this information together in one place.	Thank you for your feedback – the length of the document is inevitable due to all the technical requirements.
88 (F)	The maps within the PNA are too small for the level of detail they intend to display; in the printed paper version the detail cannot be seen; online as the magnification increases they become "grainy" and are unable to be read. The use of grey for the 500m and 1km zones is very difficult to read.	Thank you – Where possible graphs and maps have been modified to aid clarity.
89(F)	Not certain what "Pharmacy 800m Southwark" means.	Thank you - A description is now included.
90 (F)	Page 41 states: The primary source used in the assessment is the Southwark Community Pharmacy Survey....Any inaccuracies within the Community Pharmacy Survey are not the responsibility of the HWB… This may be the case, however; it is the responsibility of the HWB to ensure that the information contained within the PNA is accurate.	Thank you – Commissioned data on services and times held by NHS England have now been used. Best efforts for locally collected data have been made to validate however this could be subject to change.
91 (F)	Page 41 the statement "where differences in data were identified this is highlighted": These differences in data need to be reported and verified with NHS England and not reported in the PNA.	Thank you this had now been amended. Opening times use NHSE data, data held by commissioners has been used for services. Text changed "Where differences in data were identified this was reported to NHS England for verification."

Ref .	Qualitative response	Response of the Southwark H&WBB
92 (F)	Page 44 states: clinical governance arrangements which came into effect from July 2012…Clinical Governance arrangements were introduced as part of the 2005 Regulations, there were amendments in 2012 and there have been further amendments agreed in 2014.	Thank you this has now been amended to: …. "which were introduced as part of the 2005 Regulations, with amendments in 2012 and further amendments agreed in 2014."
93 (F)	Page 51 states: the percentage of people satisfied or very satisfied with opening hours……36% satisfaction Monday to Friday early morning (before 9.00am). This means that 74% are not satisfied, is this not significant gap, and if this is a gap then the PNA is required to explain why this does not translate into a need?	Thank you this had now been amended as previously stated.
94 (F)	Page 57 states: 51% of respondents said they had been unable to get a prescription dispensed because the pharmacy was closed or out of stock. This is over half of respondents, is this not a significant gap, and if this is a gap then the PNA is required to explain why this does not translate into a need?	Thank you this had now been amended as previously stated.
95 (F)	Pages 74 & 146 regarding MURs, the identified gap(s) are not clear to the reader, any gaps will need to be explicitly identified and supported by a determination of need.	Thank you this has been amended.
96 (F)	The heading on page 87 is incorrect.	Thank you this has been amended.
97 (F)	Page 89 refers to the LCP Vaccination Service as providing – seasonal influenza vaccination, the service also provides - Pneumococcal polysaccharide vaccine. There is no analysis of number of influenza or PPV vaccinations provided by Southwark pharmacies.	Thank you we will amend to reflect - pharmacies contracted by NHSE to provide seasonal flu vaccination 14/15 were also expected to offer alongside this PPV-23 for pneumonia to 65s and over and those aged 2-64 in clinical at risk groups (who had not already had it).

Ref .	Qualitative response	Response of the Southwark H&WBB
		So yes, commissioned alongside seasonal flu. Currently there is no activity data available for either. This has been requested
98 (F)	Page 146 states: that the influenza vaccination service is not targeted at all risk groups, this is not correct	Thank you this has been amended.
99 (F)	Table E – Summary of Services by pharmacy – contains Contractor Codes.	Thank you this had now been amended.
100 (F)	It would be helpful if any reference to NHS England could be written in full and not as NHSE.	Thank you this had now been amended.

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