

Health and Wellbeing Board

Tuesday 26 July 2016

2.00 pm

Ground Floor Meeting Room G01C - 160 Tooley Street, London
SE1 2QH

Appendices

List of Contents

Item No.	Title	Page No.
8.	Better Care Fund 2016/17 Appendix 1.	1 - 41
11.	Southwark Healthy Weight Strategy 2016 - 2021 Appendix 1.	42 - 75

Contact

Everton Roberts on 020 7525 7221 or email: everton.roberts@southwark.gov.uk

Date: 18 July 2016



Southwark Better Care Fund Plan

2016/17

Introduction

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 put in place a pooled budget of £22m for 15/16 which is jointly governed with the council under a Section 75 agreement. These arrangements will continue in 16/17. Our plan was approved without conditions in 15/16, and our plan for 16/17 looks to build upon this strong platform.

The BCF allows the CCG and Council to jointly commission a range of services which help improve the health and wellbeing of the population, avoid admissions to hospital, and ensure timely and effective services are available in the community when patients are ready for discharge. These schemes are overseen by the Integrated Working Group, comprising Director level leads from both organisations.

Significant progress has already been made on a number of the key objectives:

- Delayed Transfers of Care (DTOCs) have been kept low, with Southwark one of the top 12 performers nationally, with delays less than a third of the national average
- Improvements have been made to re-ablement services, with a reduction in the number of patients re-admitted to hospital. Over 90% of patients remain at home 90 days after discharge.
- Care home admissions have been kept at low levels. Thanks to services such as Re-ablement, Night Owls, and @home, more people are being able to be cared for at home, helping rebuild confidence and mobility and reducing need for long-term placements.

However, we know there is more that we can do. Emergency Admissions, whilst reducing in Q3, are higher for the year as a whole. Although reductions in emergency admissions are no longer a core metric for BCF plans, locally we will maintain our focus on reducing admissions in order to ensure that we continue to develop out of hospital services, and reduce pressure on acute hospitals.

To meet this aim, we have conducted a full review of governance arrangements for the BCF which will see a number of subgroups established around key priorities. These subgroups will look to support BCF scheme-holders in maximising the effectiveness of their schemes, and allow greater opportunities for different schemes to collaborate and ensure that pathways are better integrated. The advent of Local Care Networks also offers an excellent opportunity to ensure that system partners are better sighted and actively inputting in to BCF schemes to ensure their success. The BCF is also a strong starting platform from which to build the Joint Commissioning Unit. This unit will bring together staff from both the Council and CCG, and allow for joint strategies and commissioning to be enacted.

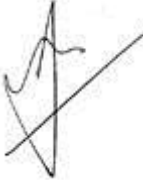
Throughout 16/17 we will continually monitor each BCF scheme and seek to build and develop capacity and capability, with regular reports to key CCG committees and to the Southwark Health and Wellbeing Board.

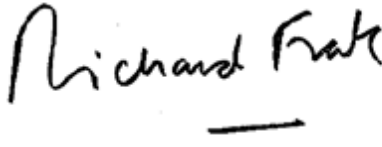
Plan Details

Summary of Plan

Local Authority	London Borough of Southwark
Clinical Commissioning Groups	NHS Southwark CCG
Boundary Differences	No boundary difference
Minimum required value of BCF pooled budget: 2016/17	£21,828,441
Total agreed value of pooled budget: 2016/17	<p>£21,828,441</p> <p>This figure is comprised of £1,149,000 from the London Borough of Southwark and £20,679,441 from NHS Southwark Clinical Commissioning Group. Within this allocation, the CCG and Local Authority can also confirm that the BCF plan is fully compliant with respect to allocations towards Disabled Facilities Grants, Care Act implementation, Carer's funding, reablement funding, protecting Adult Social Care and NHS Out of Hospital services funding.</p> <p>A full narrative on scheme plans is included within this document.</p>

a) Authorisation and signoff on behalf of the Southwark Health and Wellbeing Board

Signed on behalf of the Clinical Commissioning Group	
By	Dr Jonty Heaversedge
Position	Chair, NHS Southwark Clinical Commissioning Group and Deputy Chair of the Southwark Health and Wellbeing Board
Date	29/04/16

Signed on behalf of the Council	
By	Dick Frak
Position	Director of Commissioning, Southwark Council
Date	29/04/16

Vision for Health and Care Services

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services within Southwark

We want to enable the best possible health and social care outcomes for Southwark people and families. We set this out in this *Southwark Forward View* (**attached as Appendix A**). It describes Southwark Council and NHS Southwark CCG's shared vision for local services, the changes needed in our health and care system, and the actions we will take to make this happen. It is a vision for the whole system, not just health and social care, based on evidence of need and the views of our population. In particular it links to Southwark's Health and Wellbeing Strategy (JSNA/JHWS), the vision for Adult Social Care, NHS Southwark CCG's Primary and Community Care Strategy, CCG Operating Plan and Southwark's Housing Strategy and the Council's Fairer Future priorities.

Our vision for integrated care in Southwark is for people to stay healthier at home for longer by supporting people to manage their own health and well-being, by doing more to prevent ill health and by providing more services in people's homes and in the community. We want people to feel in control of their lives and their care, with the services they receive co-ordinated and planned with them around their individual needs.

We will build upon our existing locality and neighbourhood work to integrate services around people's needs, but recognise that we need to transform the way we work together across health and care to really achieve this.

Our ambition for integrated care in Southwark is to deliver:

- More care in people's homes and in their local neighbourhoods
- Parity of esteem between physical and mental health and wellbeing
- Person-centred care, organised in collaboration with the individual and their carers
- Better value care and support at home, with less reliance on care homes and hospital based care
- Better experience of care for people and their carers
- Population based care that is pro-active and preventative
- Less duplication and a more efficient system overall
- Improved outcomes for people's health and wellbeing
- Enabling stronger and more resilient communities
- Southwark as a great place to live and work,

We will know we have achieved our ambition for integrated health and care in Southwark when we need to rely less on hospital-based care and care homes, because more care will be delivered in people's homes and in their local neighbourhoods. People will be admitted to hospital quickly when they need to be, to access our local world class facilities and services. Hospitals will be able to discharge people quicker, because effective and pro active services at home and in the community will help people get back

on their feet and stay healthy and independent for longer.

This vision will deliver improved outcomes for the people of Southwark in areas where we know from benchmarking that improvements can be delivered, as set out in our JSNA, for example in premature mortality linked to long term conditions.

The Better Care Fund (BCF) will continue to play a key enabling role in driving forward this vision by maintaining a substantial £22m pooled budget between the Council and CCG for the delivery of community based services that are strongly focused on shared aspirations. This has, and will continue to, provide a strong platform for developing more integrated approaches to services delivery and integrated governance, and we are looking to build on the achievements that the BCF has helped us achieve over the last 2 years.

The vision is also aligned with our neighbouring borough Lambeth with whom we, and all local provider organisations, collaborated on the Southwark and Lambeth Integrated Care (SLIC) programme. SLIC was a multi agency federation of commissioners, acute and mental health providers, social services and the voluntary sector working together to integrate care. The SLIC programme has been a critical enabling vehicle for agreeing a programme of integration work across Lambeth & Southwark and supporting a shift of resources to support our priorities for the BCF. This is particularly reflected through specific jointly commissioned admissions avoidance services that operate across both boroughs that will be funded through BCF arrangements, and a shared approach to key enablers of integration including the development of an appropriate workforce and information sharing arrangements.

We continue to have a particularly close relationship with our nearest neighbours in Lambeth. 2016/17 will see us embark on a new chapter in this partnership as the SLIC programme transitions into a new Strategic Partnership across both boroughs to embed the transformation that has already taken place; align the strategic direction of commissioners and providers in the local system; deepen patient and public involvement in our plans; and work together to implement changes at a bi-borough scale to support the population based approach to service delivery that we have described in our *Southwark Forward View*.

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

The vision and ambition set out in (a) above will be measured as follows.

Expansion of integrated community support to reduce need for intensive health and social care support will be measured by:

- Increases in the numbers of people benefitting from the community multi disciplinary team approach, and activity levels in the BCF funded services such as home ward, admissions avoidance and re-ablement.
- reductions in the rate of avoidable emergency admissions
- shifting the balance of care away from care homes, including reduced admissions
- impact of re-ablement in reducing the care needs of clients using the service
- delayed transfers of care
- length of stay in hospital and emergency bed days for older people

- people reporting they feel supported to manage their long term conditions

All BCF schemes directly contribute to at least one of these goals.

A key principle of our BCF plan is to ensure that all schemes seek to improve clinical, functional and experiential outcomes for service users. Progressively, both the CCG and Local Authority are including outcome metrics within contracts, with the intention that we ultimately move towards outcome based contracts covering whole population groups.

One of the central tenets of our approach to outcomes is that they should be based on what local people say is important to them. To that end, we have co-developed with the SLIC Citizens Forum a series of 'I statements', based on work compiled by National Voices. By including these metrics in contracts, commissioners, providers and citizens are best able to meaningfully track progress and identify areas where we need to work together to make further progress.

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

All commissioners and providers within Southwark recognise that the only way to make meaningful and sustainable improvements is to work constructively and collaboratively together. Alongside our Strategic Partnership, all providers and commissioners have been active participants in *Our Healthier South East London (see appendices)* programme which is helping design the future model of care across our wider system, and which will help shape our Strategic Transformation Plan.

Instrumental to this will be the continued development of Local Care Networks (LCNs). LCNs bring together local health and social care providers (including the voluntary sector and citizen forums) to work collaboratively to try and address common challenges. By coming together, providers can look at the range of services that they provide for our populations and see how they can work better together to improve and integrate them.

Whilst this sounds simple, it is a very different way of working for many providers. Previously they have been individually paid to deliver services by commissioners and have been rewarded for the amount of activity (e.g appointments, operations, home visits) they have undertaken. Whilst this approach has advantages, it does not reward providers for working together and can unintentionally lead to a situation where providers concentrate on the individual's immediate needs, without seeking to understand the underlying health and social issues that may be impacting on their wellbeing. Instead of paying for activity, we would like to move to a model where providers are paid on the basis of the outcomes achieved. This means that they will be rewarded for helping people to live happier, healthier and more independent lives – and this can only be achieved by working more closely together with each other and our local populations.

Specifically, some of the key aspects of change we are, collectively, working towards include:

- more care for older people and people with long term conditions delivered through LCN based community multi-disciplinary teams with a lead professional responsible for co-ordinating the care of individuals, ensuring an integrated and personalised approach to case management by all services working with each

person - GPs, Community Health, Social Care, Housing, Mental Health workers and hospital services.

- less care needed in acute settings. A&E attendance and avoidable emergency admissions will be reduced across our 2 main acute hospitals as community teams provide more targeted support to those at risk.
- when people do need acute care they will stay in hospital for shorter periods, returning home safely with the help of services such as @Home (Home Ward) and enhanced discharge support.
- re-ablement and intermediate care will increasingly provide effective short term interventions that rehabilitate people, restoring health and independence
- the balance of social care will shift away from care homes towards support in people's own homes and supported housing schemes including Extra Care.
- home care services will be funded with a view to radically improving quality and outcomes, with home carers linked in with other health and care professionals through the multi-disciplinary team approach
- there will be enhanced support for carers in line with our Carers Strategy and the Care Act
- there will be a greater role for technology through telecare to help people live safely at home and investigating opportunities for telemedicine.
- a more integrated and coherent approach to preventative services including the voluntary sector tackling issues such as social isolation
- through BCF and whole systems funding services will be responsive and accessible 7 days a week, including improvements to weekend discharge planning with social care, admissions avoidance community services, as well as primary care
- new focus on developing dementia related services
- developing a neighbourhood model

The BCF will contribute to this vision by funding key community based services on a pooled budget basis using a person centred approach, co-ordinating the input of different support services that need to work together through multi-disciplinary neighbourhood based working.

In all that we do, we are also committed to ensuring that there is parity of esteem between physical and mental health and wellbeing. Whilst we are proud that the BCF funds a significant number of schemes to help support those with mental health issues, the CCG and Council have jointly collaborated to develop strategies to make parity of esteem a reality. Through our Mental Health and Parity of Esteem Programme Board we have established the following principles the following as key features of a parity approach:

- It should apply to people of all ages, including preconception care, and to all groups in the population, including those at increased risk of mental health problems, such as people with intellectual disabilities, asylum-seekers, people in the secure estate, lesbian, gay, bisexual and transgender people, some Black and minority ethnic populations at greater risk, children in care, care leavers and others.
- Equal access to health and social care, including: comparable waiting times; equitable treatment for all, according to their need; the provision of equivalent levels of choice and quality regardless of condition.
- Holistic care – the mind and the body should not be regarded separately but

integrated: professional and public education, public health programmes, social care and treatment. Achieving parity between mental and physical health approaches need to reflect this; an open-minded approach to whole- person care is essential

- Planning for integration – this requires movement away from mental health, physical health and social care ‘silos’; the consideration of mental health should be integral to all health and social care, at any point where someone with a mental or physical health problem comes into contact with a service.
- Investment in the prevention of mental health problems, and the promotion of mental wellbeing, in proportion to need.
- Investment in mental health research, in proportion to need.
- Investment of both funding and clinical/managerial time and attention should be proportionate to the prevalence of mental health problems and scale of mental health need.
- Aspirational outcomes and an expectation that mental healthcare should continuously improve (as is the case for other areas of healthcare).
- Respect and dignity for those with mental health problems across all areas of health and social care.

We will challenge ourselves to ensure we uphold these values, and all schemes will be assessed to ensure that they are consistent with this approach.

The “golden thread” that unites the range of BCF schemes in this plan is that they all help people with health and care needs to live independent, healthy lives in their own homes by providing an integrated approach to meet each persons individual set of needs.

Case for Change

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area

Our work as partners of Southwark and Lambeth Integrated Care (SLIC) has included a detailed programme that has examined the case for change. This work has been supported by all the key local commissioners and providers of acute, primary and community based care services who were involved as the business case has developed. This work has shaped the approach to the pooling budgets in the BCF which is very much the first step in a wider integration agenda. The analysis was based on detailed data on the population needs, current services, demographic projections of need and finance and evidence about what models work.

In **the appendices** there is a summary of some of the **case for change** work including graphical representations of the findings.

The analysis shows that despite the existing configuration of world class health services available in the borough, outcomes remain poor for many local people. An outcomes based approach to integrated commissioning and provision will be developed, including a greater focus on prevention, of which BCF funded services will be one part.

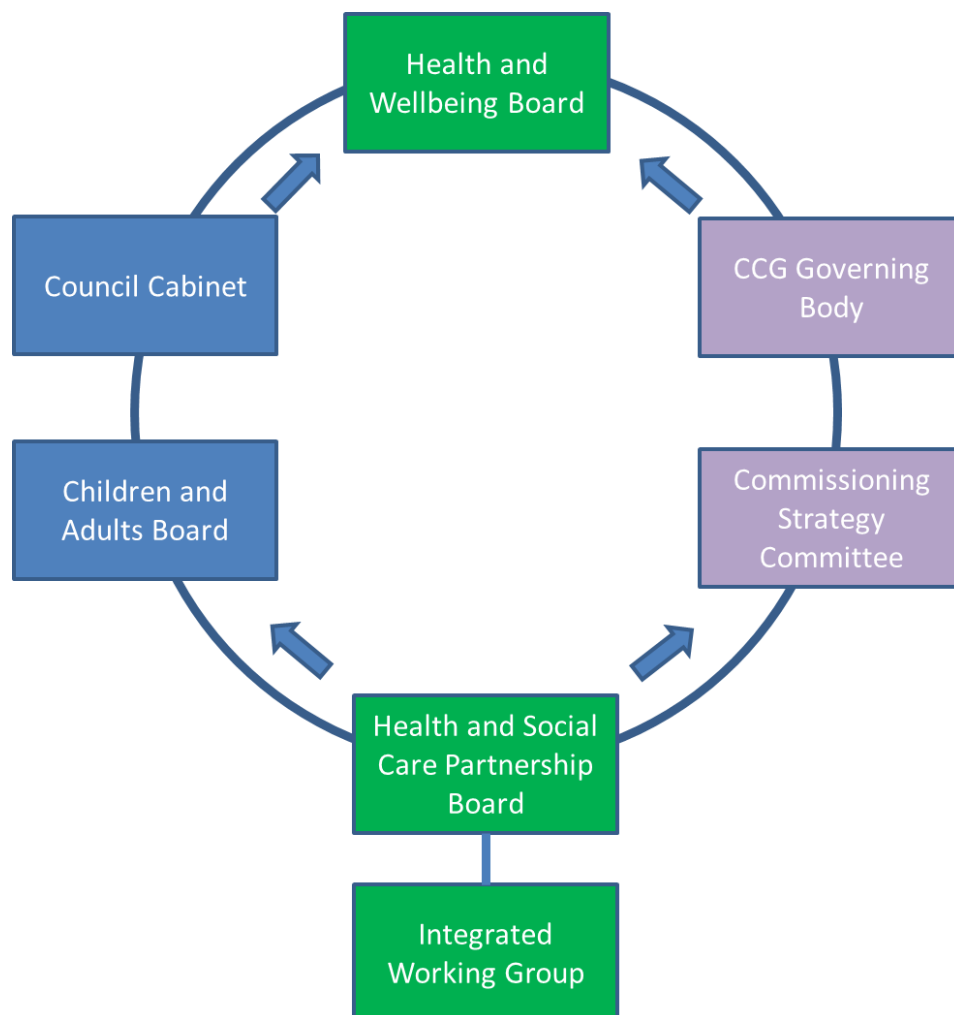
The challenges are also clearly set out in the Health and Wellbeing Strategy. Southwark has an aging population, with an extra 900 people aged 85 or over expected by 2020, which is an increase of nearly 30% on current levels. The number of people with disabilities and learning difficulties is also rising steadily, with those under 65 years predicted to increase to around 20,000 by 2025. There are high levels of deprivation, with almost half of over-65s claiming pension credits, which is higher than the London average. The ageing population brings health challenges, with the estimated 12,500 over-65s in Southwark living with a long term illness rising to over 17,000 by 2025. The borough has a higher prevalence of long term conditions for older people than national or London figures. In addition, there are estimated to be around 1,800 people living with dementia, a figure that is predicted to rise by around 300 by 2020.

A key conclusion of the case for change work is that the current system is financially unsustainable without transformative change. The evidence shows that integration can help bridge that gap by shifting the balance of care towards more preventative community based care, and in so doing improve outcomes. All partners agree that there is scope to improve services and reduce costs by better integrating services. Our risk stratification and population segmentation approach has led to an initial focus on older people and long term conditions, and this has informed the focus of the BCF.

The BCF is one part of the integrated response to making the required changes to achieve sustainability and improve outcomes.

Plan of Action

Governance arrangements for BCF and integrated working in Southwark



The Health and Wellbeing Board will be ultimately responsible for agreeing the Better Care Fund plan and overseeing its successful delivery.

Although jointly responsible for delivering on the objectives of the fund through the Health and Wellbeing Board individual organisations will remain formally accountable for their own expenditure pooled within the BCF through their existing governance arrangements. The accountable officers will be the Council and CCG lead directors.

For different schemes within the fund, management responsibility for delivery will be delegated to different bodies that will be accountable to the Health and Wellbeing Board via relevant CCG and Local Authority management arrangements.

Roles, responsibilities and risk share arrangements will be clearly set out in a Section 75 agreement(s) under which the pooled funding will be managed.

A system of quarterly reporting to the HWB is in place covering all key schemes expenditures, milestones, activity and performance. A Health and Social Care Partnership Board, a sub-group of the Board, is in place to ensure there is capacity to do this effectively, and an Integrated Working Group is in place to develop the programme of work and oversee its effective implementation.

During the course of 16/17, we also intend to set up a Joint Commissioning Unit between the Council and CCG. As part of the planning for this unit, we have ensured that in designating the schemes to be part of the BCF, these align with the proposed structure. Governance arrangements may therefore be amended in year, but will not materially affect the Section 75 agreement, and will only strengthen oversight of the BCF.

As part of the annual external audit, KPMG have reviewed both current and future governance arrangements, which have been fully assured.

It is also recognised that the BCF is only one element in the delivery of integrated care across Southwark. Attached as Appendix 3 is our *Five Year Forward View: into action* document which describes the overarching governance and accountability structures in place locally to support integrated care and how the BCF is fundamental to this.

Alongside this, we are working with all local partners to plan how we can ensure that we support and increase our workforce to ensure that we are able to meet current and future challenges. This includes functional mapping of the existing workforce, both paid and unpaid, and an assessment of what roles and capacity will be needed going forward. This is led through our Community Education Provider Network (CEPN).

The priorities for our CEPN this year are:

- development of a workforce data set which identifies the current skills and competencies of the workforce and helps us to scope the new skills and competencies that are needed to support our vision. This work will start in primary care and then expand to include the Local Care Network workforce
- effective use of indirect and direct funding streams to support the development of the non-medical workforce
- develop a culture of support and clinical leadership within the workforce. creating pre-registration nursing placements in primary care to support recruitment and retention of the primary care nursing workforce; increasing the number mentors to support the learning and development of the existing workforce and the pre-qualified workforce that extends beyond the boundaries of a single GP practice;.
- supporting the management of complex care identified by the presence of 3 or more long term conditions. This work will involve supporting multi-disciplinary learning and development around long term conditions managements, support care coordination and self-management with an aim to achieve the following:
 - Reduce the number of outpatient appointments for patients with LTCs
 - Reduce the number of A&E attendances and unplanned admissions
 - Improve clinical and patient reported outcomes
 - Support and empower the workforce (both paid and unpaid) within our system to deliver care which supports the overall health and wellbeing of patients rather than focus solely on single disease pathways

- Take the learning from this pilot in order to commission regular training on managing LTCs

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

The BCF will be managed through the Integrated Working Group and its delivery sub-group structures. Each BCF scheme has a clear plan setting out the service details, key deliverables in terms of activity and outcomes, named lead organisations and managers, risks, dependencies, milestones and reporting arrangements. These requirements will be reflected in the Section 75 agreement underpinning the governance of the pooled budget. Quarterly exception reporting on all schemes will be required, although care will be taken not to add unnecessary or duplicated reporting burdens. Collated reports will be discussed initially at the Integrated Working Group and the Section 75 review meetings of the Health and Social Care Partnership Board. This will feed into a quarterly report for the Health and Wellbeing Board to assess progress and discuss any areas that need unblocking.

For any scheme element that is not on track a recovery plan will be provided. Particular focus will be given to spending and any variance on plans will be addressed, including consideration of reinvestment of any slippage.

Outcomes will be managed at scheme level and whole system level, with close performance management of key measures undertaken on a monthly basis, including analysis of avoidable admissions, care home placements and delayed transfers of care.

Programme management of the Better Care Fund is overseen by the Head of Integration and System Resilience for the CCG who reports to the Director of Integrated Commissioning of the CCG.

c) Key Milestones

The below table gives details of the key milestones to ensure that our BCF plan is successfully implemented and achieves its core objectives. It should be noted that each scheme will have their own individual milestones dependant on their level of development.

Conduct review of all existing BCF schemes	Q4 2015/16
Discuss results of review and agree spending plan for 16/17	March/April 2016
Commence implementation/continuation of all BCF schemes	April 2016
Conduct 'Star Chambers' for all schemes to formally agree KPIs (where not in place) and identify opportunities for further integration with other BCF/Commissioned initiatives	April/ May 2016
Commence BCF subgroups and monthly monitoring	May 2016
Assess slippage on schemes and reallocate funds where	June 2016

appropriate to maximize impact of BCF	
Mid-year review of BCF to identify what works well, what needs to improve, and to identify areas for development in 2017/18	September 2016
Move to new Joint Commissioning Unit arrangements	September/ October 2016
Second review of slippage and reallocation. Ensure that any funding of schemes is aligned with Winter Resilience Funding Allocations	October 2016
Commence Review of all BCF Schemes	December 2016/ January 2017
Develop initial plan for 17/18 including engagement with key internal and external stakeholders	February 2017
Final plan for 17/18 agreed	March 2017

d) List of planned BCF schemes

Following a year of bedding in BCF schemes, we are planning to continue with all key BCF schemes. The only exception to this is a scheme related to a capital development for a Dementia Centre. As this was a capital allocation, it was a non-recurrent expenditure, and so our plan for 16/17 is not materially different to that from 15/16. However, we feel that now that schemes are fully established, they are likely to have an even greater effect in the coming year.

The list below sets out the individual projects we are planning as part of the Better Care Fund. See the *Detailed Scheme Description* templates (Annex 1) for each of these schemes, and how they will address the issues in our case for change and vision.

Ref no.	Scheme	2016/17 £000
1	Existing NHS transfers: range of social care services that support health care. To be reviewed along with other existing schemes to ensure best integrated approach.	5,521
2	Winter pressure grant funded services: additional social work input to support 7 day discharge & admissions avoidance, mental health re-ablement, enhanced rapid response, care home support, OT, reablement 7 day working, & Nightowls overnight care.	1,221
3	Re-ablement: grant rolled forward, services to be reviewed and further integrated with discharge support, admissions avoidance and enhanced rapid response.	1,813
4	Service development: Change management capacity for the BCF programme.	125
5	Self management including expert patient programme: enhance quality of life and independence of people with long term conditions.	307
6	Home care quality improvement: improving quality and effectiveness of home care to help support people to remain at home as part of approach to integrated community support services.	1,900
7	Psychiatric liaison and related services: aimed at responding to	300

Ref no.	Scheme	2016/17 £000
	people with mental health problems in the acute hospital sector including A &E at King's College Hospital and Guys' and St Thomas' Hospital.	
8	Mental health: strengthen multi-disciplinary working in the community to prevent crisis admissions, and integrating physical/mental health. Includes enhanced psychological support for people with learning disabilities in line with Winterbourne View programme.	870
9	Telecare expansion: supporting people to live at home through assistive technology.	566
10	Carers: investment to support implementing the agreed multi-agency joint carers strategy to help people continue in their caring roles.	450
11	Admissions avoidance services: existing programme including enhanced rapid response services.	2,200
12	@home - Hospital at home service: full year effect of extension to home ward	1,200
13	Care Act Implementation: amount of BCF identified by government as contributing to implementation of Care Bill, including additional assessments, safeguarding and Care Accounts for the care cost cap system.	1,000
14	Disabled Facilities Grant: existing grant for residents not in council housing, enabling disabled people to live at home.	864
15	Protecting Adult Social Care of benefit to health services: further support in line with BCF conditions to maintain key service levels in context of council funding cuts.	500
16	Seven day working: programme to support seven day hospital discharge across primary, community and social care.	1,493
17	Voluntary sector preventative services: existing grants, to be reviewed as part of an integrated approach to prevention.	910
18	End of life care: additional spend relating to end of life care co-ordination to integrate and improve overall approach, to include medicines management.	200
19	Dementia: Enhanced neighbourhood support, navigators and carers support for those with dementia	184.177
20	Consultancy and Contingency: to fund project support to develop plans around areas such as intermediate care, OD and formation of JCU	203.654
		21,828.441

These individual schemes are all closely related aspects of community based support and will be managed in the context of our integrated approaches to multi-disciplinary assessment and care management.

e) Comparison to 2015/16

The BCF pot in 2016/17 is marginally smaller than in 2015/16 (£21,828,441 vs £21,967,610). This is as a result of changes to central allocations to Local Authorities which need to be channelled through the BCF. Previously there has been an allocation for Social Services capital grants which has now been removed, with an increase to the allocation for Disabled Facilities Grant. As the Capital Funding supported the development of a Dementia Centre, this was always going to be a one off cost, so there is no direct impact on the running of any other BCF schemes. There are also a number of other schemes which were granted monies for one off costs in 2015/16, such as £100k for equipment for Telecare. As these schemes were always going to be non-recurrent, they have now ceased, with that allocation now going to support existing schemes, such as Nightowls.

As a result, all BCF schemes that required ongoing finance in 15/16 are being continued in 16/17 with either the same, or increased, levels of investment. Our approach to the BCF is to allow schemes to bed in so that they can fully realise their potential. As such, we feel that it would be inappropriate to make radical changes at this juncture, as many schemes are likely to yield greater results in 16/17.

Regular reviews of all schemes will take place throughout the year, with 'Star Chambers' held with scheme-holders. As such, we can quickly establish whether there is any likely slippage on any plans and reallocate funds accordingly, under the jurisdiction of the Integrated Working Group. The learning from these sessions will enable schemes to identify opportunities where they can work more closely together, and will also inform funding allocations for 17/18.

f) Contingency plans and non-elective admissions

Whilst the BCF plan for 16/17 is not predicated against reductions in non-elective admissions, we are mindful of the national guidance that 'the same pound cannot be spent twice' and the advice that funds are set aside to cover the cost of non-elective admissions should these be above the plan set out in the CCG Operating Plan.

We feel that a formal risk share which would see community services decommissioned in year to fund additional non-elective activity would not be advantageous due to the complexity of decommissioning services mid-year (and the issues that that would bring), and acceptance that scaling back community services would likely lead to a further exacerbation of non-elective activity at acute sites. As such, we feel that the creation of a £1.3m contingency fund which is not committed against any BCF schemes would allow there to be greater flexibility, with the opportunity to either invest more in BCF schemes in year, or fund additional non-elective growth depending on circumstances.

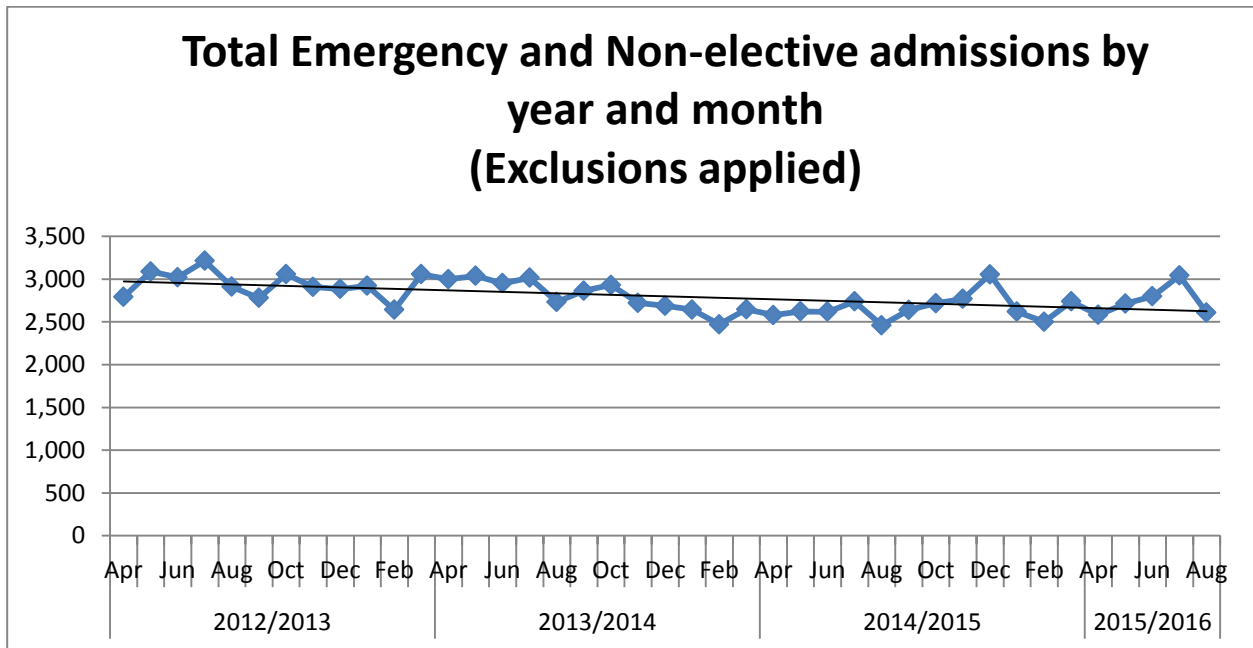
We are confident that we planned responsibly for non-elective activity in 16/17. We have agreed contracts with our main acute providers, which include growth of 7% in elective activity, 4% in non-elective activity and 6% in outpatient activity against 15/16 outturn. As such we feel that we have put in place significant risk mitigation on over performance. However, the £1.3m contingency fund will provide further risk mitigation, whilst also allowing for further investment in community and social care in year, should activity be in line with contracted values.

As such, in 16/17 there is no separate BCF target or trajectory for the reduction of emergency admissions, with this being superseded by overall trajectories within the

Operating Plan. However, we will ensure that at the BCF scheme level, schemes will have KPIs which include targeted reductions in admissions where relevant.

The performance against the non-elective admissions targets in 15/16 are set out below. It should be noted that Southwark opted for a highly ambitious trajectory in 15/16 of reducing admissions by 3.5% - higher than many of our peers across the country. Although missed as whole, an improvement has been noted during Q3, with both November and December seeing the target achieved. Overall admissions grew by 1.8% in the year. As a further mitigating factor, many of the types of schemes that have helped other areas reduce admissions (such as hospital at home schemes and 7 day working) were already in place within Southwark, and it should be noted that despite an increase in admissions, these levels are still significantly lower than 12/13 and 13/14.

	Feb	Mar	2015/16	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Target	2,384	2,553			2,501	2,543	2,538	2,656	2,385	2,560	2,635	2,684	2,961	2,538
Admissions	2,500	2,739		2,590	2,720	2,782	3,000	2,592	2,602	2,748	2,592	2,633	2,592	2,464



Risks and Contingency

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	How likely is the risk to materialise? <i>Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely</i>	Potential impact <i>Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact</i>	Overall risk factor <i>(likelihood *potential impact)</i>	Mitigating Actions
Non-delivery of acute emergency demand reductions results in CCG deficit, non-delivery of community investment and capacity problems in the acute sector	4	3	12	<p>Progress on impact on acute demand reductions will be monitored closely as part of the BCF governance arrangements and recovery plans put in place promptly where necessary.</p> <p>If targets not met, contingency plans a risk reserve of £1.3m has been established which can then be used to fund additional hospital admissions, through year-end agreements with acute providers.</p> <p>Plans to be considered in context of South East London sector wide approach to sustainability of acute expenditure.</p>
Non-delivery of targets to reduce care homes and community demand lead to social care financial unsustainability.	2	2	4	Progress on care home demand and the effectiveness of re-ablement and other services at reducing long term care needs in the community will be monitored closely and recovery plans put in place

There is a risk that:	How likely is the risk to materialise? <i>Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely</i>	Potential impact <i>Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact</i>	Overall risk factor <i>(likelihood *potential impact)</i>	Mitigating Actions
				promptly where necessary. If targets not met, contingency plans to set out how any excess social care costs will be funded whilst protecting the development of community based services.
Acute provider financial stability if shift to community achieved (and freed up acute capacity not taken up by specialised activity, fixed costs not reduced in line with reduced activity)	2	3	6	Close liaison with providers joint planning group, SEL sector planning groups, SRG and contract monitoring to identify issues early.
Data sharing and information governance issues hold up the development of multi-disciplinary working	3	3	9	Existing IT/IS and data sharing strategy – progress and milestones to be closely monitored. Unblock problems at HWB level if necessary.
Project milestones not delivered due to change management / capacity issues/ other demands on the system deflecting resources from delivering programme	2	4	8	Governance and monitoring to underpin programme management, identifying any slippage and addressing underlying reasons.
Better Care Fund overspends / underspends	2	2	4	Close monitoring of expenditure through the governance framework, rapid identification of problems and prompt recovery planning. Risk share arrangements

There is a risk that:	How likely is the risk to materialise? <i>Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely</i>	Potential impact <i>Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact</i>	Overall risk factor <i>(likelihood *potential impact)</i>	Mitigating Actions
				set out in Sec 75 agreement specify arrangements for funding overspends by individual agencies or from with BCF as appropriate.
Workforce development across all agencies does not keep pace with requirements for integrated working	2	3	6	Workforce development issues identified for all schemes and overall requirements captured in programme.
Demographic pressures exceed overall public sector resources available after net reductions in 16/17 and beyond despite improvements in effectiveness arising from integration.	3	3	9	Contingency plans will include evaluation of value for money and continual review and re-commissioning of services within affordability envelope.
Improvements in health and wellbeing required to reduce demand on health and social care not forthcoming at sufficient pace	3	3	9	Review the Health and Wellbeing Strategy
Funding settlement for Adult Social Care requires a level of reduction that the Better Care Fund can not mitigate resulting in loss of access to community based support and undermining Care Act implementation.	3	3	9	Ensuring effective integrated use of resources in the community.
Insufficient input from key partners in the development of	3	3	9	Use HWB and LCNs to help unblock problems. NHSE dialogue.

There is a risk that:	How likely is the risk to materialise? <i>Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely</i>	Potential impact <i>Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact</i>	Overall risk factor <i>(likelihood *potential impact)</i>	Mitigating Actions
integrated approaches, e.g. from GPs in CMDT roll out, as a result of complex commissioning structures.				

b) Contingency plan and risk sharing

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

Although the BCF met the vast majority of its targets in 15/16, we are unlikely to have achieved our target of reducing emergency admissions by 3.5%. It should be noted that the longer term trend is positive, with admissions lower than in 12/13 and 13/14.

Whilst emergency admission reductions are no longer a core part of the BCF national metrics, locally we will maintain a strong focus on reducing admissions by investing in preventative services and a comprehensive suite of primary and community services to increase support to our local population. It should also be noted that the focus on reductions in admissions is a shared target across our system, and will be the focus of a system wide CQUIN in 16/17.

In the CCG operating plan we have forecast a small increase in admissions for 16/17. Whilst we are confident that this plan will be met, the CCG have put aside a risk reserve of £1.3m (matching the risk reserve created in 15/16) to fund additional admissions should they be above plan. By creating this risk reserve, we will be in a position where this money can be released to acute providers as part of year end agreements should admissions be higher than plan. Alternatively, should admissions be lower than or on plan, the risk reserve can be used to bolster or fund new schemes in year, particularly for Q3 and Q4 to support system resilience for winter.

It is felt that this approach fairly balances the need to provide surety on BCF schemes, and recognition that disinvestment in community schemes is likely to exacerbate any increase in admissions. As such, a full years funding will be available for all projects, with increases in allocations possible dependent upon whether operating plan admissions targets are met. This will enable services to be planned with a stable footing and will be reflected in the Section 75 agreement underpinning the pooled budget.

Key to system wide planning is the need to continue the significant progress made on reducing levels of DTOCS and patients that are MFFD. Both Lambeth and Southwark

have, in recent years, had some of the lowest levels of DTOCS anywhere in the country, with the latest figures indicating that the level of delays is a third of the national average. However, as part of 16/17 Better Care Fund plans, both boroughs have committed to trying to reduce these figures yet further.

It is also noted that many of the DTOCS and MFFD patients are from non-local boroughs. The CCG has undertaken extensive work has been undertaken with Lewisham to agree new processes to align pathways into continuing care and re-ablement services with those in place across Lambeth and Southwark. This should significantly reduce delays to Lewisham, with scope to expand this yet further to other SE London boroughs. In addition, the CCG has co-sponsored the Integrated Hospital Discharge programme, which sees senior leads from Community Services, Social Care and the Continuing Health team, alongside clinicians from KCH actively support wards to expedite discharges to community and social care services. Key to this will be an education programme for ward staff to ensure that discharge planning is conducted at the point of admission, to help reduce length of stay and reduce the level of MFFD discharge patients at Denmark Hill.

In 16/17, a new Choice policy will also be formally rolled out across Denmark Hill. This policy gives clearer advice to patients and their carers' and families about what support the patient is likely to need post-discharge to aid forward planning. Underpinning this, a Care Home Selection Service will be in place which will work proactively with families to help choose a care home for their relative. Evidence from elsewhere has demonstrated that that can help significantly reduce bed days for those needing to be transferred to care homes and nursing homes. We will also work closely with the ECIP team to ensure that these protocols are in line with national best practice. a review of data on DTOCs it has been noted that a significant proportion

Alignment

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

We have positioned our response to the BCF as a key enabling element of a wider transformational change in health and care services in Southwark. The Health and Wellbeing Strategy articulates the overall goals of the system and the Vision for integration “Better Care, better quality of life” (**annex 1**) sets out the ambition that the integration agenda has in achieving this.

The Health and Wellbeing Strategy highlights specific priorities under the themes of a) building healthier and more resilient communities, and tackling the root causes of ill health, and b) improving the experience and outcomes for our most vulnerable residents, and enabling them to live more independent lives, that the BCF has a key role in delivering, specifically:

- Provide more services in community settings, reducing the need for specialist or acute support across a range of needs and areas
- Enable more residents with complex and chronic conditions to lead independent and fulfilling lives for longer and enjoy good mental wellbeing
- Give users and carers a seamless, personalised experience, enabling them to have more choice and control over their life, death and support services

There is strong alignment and understanding between the BCF programme and the Social Services vision and associated transformation programme, which has a clear focus on providing personalised services in the community that help people live safely and independently at home, working in an integrated way with all services that support an individual. The key objectives of the social care system include promoting quality of life and preventing, delaying and reducing the need for intensive health and care support. Key shared targets with the BCF include care home admissions reductions, re-ablement effectiveness, user experience and minimising delayed transfers of care.

The local authority budget round for 2016/17 currently underway is based upon a consideration of the impact BCF resources on the overall delivery strategy. On specific areas, Adult Social Care will work closely with other Council departments such as housing, education and community engagement. Strong joint working on BCF programmes already exists through schemes such as Disabled Facilities Grants and Telecare with housing colleagues.

In addition to social care, the Council Plan is well aligned with BCF priorities through the “Healthy Aging” strategy which will seek to ensure a multi-agency approach including Housing, public health prevention strategies and a specific commitment to improve the quality of home care services.

As set out in b) below the BCF is an integral part of the NHS planning at local and regional level, which includes plans for challenged health economies, the primary and

community care strategy and development of the neighbourhood model which is the key building block for integrated services.

The SLIC/Strategic Partnership programme is closely linked to the BCF, with certain key schemes funded directly by the BCF in 2016/17 (@home, admissions avoidance, enhanced rapid response) and other enabling workstreams that are closely related to BCF objectives including Holistic health assessments, Integrated Care Management and CMDT development, homecare workforce development, care home support, consultant community hotline, simplified discharge, falls, infection, nutrition and dementia.

The Carers funding element of the BCF is targeted on funding the agreed multi-agency carers strategy.

The Head of Integration and System Resilience is responsible for identifying all related workstreams and ensure that there is good alignment between these and the BCF.

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

The core schemes included in the Southwark BCF plan are reflected in the CCG's Operating Plan for 2016/17. Our BCF plan reflects the core part of Southwark CCG's current operational and strategic plans as all are centred on enhancing integration, neighbourhood working, reducing unplanned admissions to hospital, enabling community resilience and promoting prevention in line with BCF priorities.

The impact of the Better Care Fund has informed the development of the CCG's financial model and our current QIPP and activity assumptions.

The budget and service planning processes of the local authority reflect the BCF resources available to support integration and wider adult care objectives as set out in the Local Account and the adult care business plan.

National Conditions

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

a) Protecting social care services

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

Protecting social services means ensuring that there are sufficient resources for social services that promote health and wellbeing and reduce demand on health services, in particular those at the interface of health and social care where seamless services are required to improve user experience and promote efficient use of resources.

This means focussing Better Care Funding on areas that would otherwise be vulnerable under current funding reductions facing local authorities, combined with rising demand for services due to demographic factors. This includes maintaining current levels of eligibility criteria at substantial and critical needs, provision of assessment, care packages and personal budgets for home based care, re-ablement, intermediate care and hospital discharge and support to carers, and signposting to prevention and community support services for those below the eligibility threshold.

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

As part of our 16/17 BCF plan, we will continue to support social care services in a manner consistent with that agreed in 15/16.

The Better Care Fund directly funds a range of adult care services, with around 75% (£15m) of the fund being invested in this way. In particular, discharge support services, re-ablement and Intermediate Care Services have assisted social services in providing a level of assessment and care management services, and care packages that is consistent with existing eligibility criteria, and this will continue and expand in 2016/17.

The BCF service proposals generally all have an impact in terms of reducing, delaying or preventing the need for more intensive health and social care services, and hence assist the financial sustainability of the social care as well as health. For example:

- support to carers helps prevent the breakdown of informal care arrangements and so reduces the pressure on statutory services
- self management support to enable people to keep themselves well and increase their levels of independence
- funding quality improvements in home care
- funding 7 day working in hospital social care teams
- funding telecare expansion

The BCF will also help the local authority meet a proportion of the costs associated with implementing the Care Act (£1m, in line with national allocations). In addition there are sums specifically earmarked for the protection of social care (£2m) to help meet budget reduction targets without withdrawing services of benefit to health.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that funding has been allocated for the implementation of Care Act duties.)

The total sum invested in social care services comes to £15m as set out in the allocations template, directed towards a range of services, all of which can be considered as protecting social care. Of this £0.5m has been allocated in 2016/17 specifically as a contribution to the Social Care budget reduction requirement, which will be allocated to specific services at risk in the forthcoming budget round. This adds to the use of £1.5m of the existing NHS transfer previously used in the same way. Without this contribution of £2m Social Care would need to reduce base budgets accordingly and this savings requirement would necessitate a material reduction in access to social services that would have a significant impact on health services.

A sum of £1m has been set in the BCF for the implementation of the Care Act. This is in line with the national guidelines stating the BCF should meet these costs. The Carers strategy funding within the BCF will also potentially assist with Care Act implementation.

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

There is a comprehensive change management programme in place to deliver the Care Act requirements. This is managed through a project steering group chaired by the Director of Adult Social Care.

For details see Care Act implementation scheme in annex 1.13.

The BCF will play a role not just in terms of funding the cost of the changes, but also in facilitating the integrated working required to deliver the agenda.

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

£1.13m (including estimate of Care Act implementation funding costs)

Within the BCF there is a specific sum of £450k in 2016/17 for rolling out the Carers Strategy (see scheme details in annex 1.10) which is consistent with the level of support in 15/16. In addition to this, there is also a potentially significant element of funding within the Care Act implementation budget. The schemes proved to be highly successful in 16/17, and we continue to roll-out personal budgets and carer support packages. This will be further supported by the work of the LCNs and by close working with the voluntary

sector to ensure that the needs of carers are met.

We recognise that the likelihood of hospital admissions and exacerbation of health or wellbeing issues is increased should carers not receive the support that they need. As such, we will maintain a key focus on this area, with dedicated time at IWG subgroups to further explore the issue and to ensure that all possible steps are taken. We will continue to work closely with Southwark Carers to maintain a joint approach and ensure learning is disseminated and acted upon.

As part of our move to outcome based contracts, there will be a series of clinical, functional and experiential outcome measures inserted into contracts so that both the CCG and Council can track progress and take remedial action where necessary.

b) 7 day services to support discharge

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

Within Southwark we already have a range of services working 7 days a week to support discharge and prevent admission, including our admission avoidance service (@Home). Across the health and social care economy, we are now moving beyond simply establishing 7 day services, to a greater cultural shift where 7 day services are seen as the norm rather than the exception. Examples include weekend discharge support within the Supported Discharge Team, along with the mainstreaming of a simplified discharge pathway, which operates 7 days a week interfacing with the @Home service and Enhanced Rapid Response.

Social Care and Guy's and St Thomas' Community Services are also working to establish a single point of access for a range of community and social care services to simplify access, improve responsiveness and joint working, and reduce duplication. As part of this work, both organisations are looking at a joint programme of workforce development to upskill staff and ensure there are shared competencies across the home care and nursing workforce.

Our local acute Trusts have also moved to 7 day working, and we will continue to bring together all these plans and reach agreement on how we fund any additional costs in community based services to support these - through redistributing savings from acute bed day reductions, or making new investment across the system. The BCF is aligned to winter planning and targeted plans on 7 day working.

Southwark CCG has commissioned extended primary care working on a 7 day basis since November 2014, which has increased the capacity of primary care to offer both planned and urgent care. Increasing accessibility of GP services should reduce the demand for urgent care services elsewhere on the system, avoid pressure surges on particular days of the week, and improve continuity of care for people who have ongoing

care needs. Since April 2015, primary health care has been accessible to all Southwark residents from 8am to 8pm, 7 days a week.

Our Better Care Funding plans include additional investment to increase the capacity of discharge support services (admission avoidance and other social care support), as well as a contribution towards the costs of extended access to primary care. During 15/16 we significantly increased the level of on-site support at hospitals from social care at weekends to ensure that discharges and packages of care could commence 7 days a week, and we continue to work with our acute providers to ensure that referrals to these services are maintained throughout the week to minimise the levels of medically fit for discharge patients on wards, and smooth out admission and discharge profiles.

Reflecting this strategic commitment to 7 day working, a budget of £1.5m has been set aside in 2016/17 BCF plans specifically for delivering on this priority, supporting developments underway in specific areas. These will be seed funded from winter resilience funding where possible in 14/15 to ensure early progress is made.

Strong progress has been made in ensuring that all local partners across SE London meet the milestones associated with the Clinical Standards for 7 Day Services. This has been a core principle of the *Our Healthier South East London* work, with providers collaborating to see where individual providers need to make progress, and what the interdependences are for services. The requirement to meet these standards has also been included in provider contracts and as such any risk associated with providers being non-compliant will be addressed through strong contractual management.

In May 2016, we will, in conjunction with the Emergency Care Improvement Programme (ECIP) run a workshop on discharge planning and 7 day working. This workshop, and the resulting programme, will focus on how we maximise utilisation of 7 day services that are already in place. The learning from this workstream will inform future BCF plans.

c) Data sharing

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

The NHS number continues to be rolled out as the primary identifier across health and social care services and good progress is being made. Agreement from all partners is in place, and the recording of NHS number in all care records is improving.

The NHS Number has always been identified as the preferred unique identifier for patients / users. All health providers use the NHS Number with excellent progress having been made to maintain data quality. The council went through a NHS number cleansing process during 2012/13 and again in 2015/16 with very good results. Plans are being developed for South London CSU to support the PDS batch processing for the councils.

The Council is to replace its current adult and children's system. The pre-implementation phase is capturing the requirements for health and social care sharing of information (Phase 2 of the Local Unified Care Record project – see below).

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

We have made progress on information sharing within the SLIC programme, including the 'Collaborator' service, which allows members of Community Multi-Disciplinary Teams to share data on case management patients in a secure way, which is compliant with information governance requirements. In 15/16 we moved to the next stage of our development by moving to the LCR (Local Care Record). This has enabled the real time sharing of clinical information between Kings Health Partners (Guy's and St Thomas', King's College Hospital, and South London and the Maudsley) with primary care across the boroughs of Lambeth and Southwark. It recognises the complexity of the various information needs and the technical difficulty of developing integrated systems.

The main health providers are committed to their EPR systems and have instead a clinical portal (across acute, community and mental health). With all GP practices using EMIS Web this is an ideal opportunity to make the 'link'.

LCR allows Primary Care clinicians to view all KHP vital clinical information, including community services from within their EMIS Web. It builds upon local IM&T strategies. It is a portal, based on NHS numbers, follows IG, is fully auditable, ITK compliant, easily accessed from the existing partner EPRs.

The intention is to extend into Social Care during 16/17. With common goals of patient centric care and patient empowerment, the final stage would look to integrate into local patient / public portal. Data Sharing agreements with all partners is approved. LCR aligns to the work underway with the MIG (Medical Interoperability Gateway) for the viewing of primary care records across the patch.

The below table demonstrates the progress made to date and the milestones expected to be achieved over the next year.

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via Open API	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally
From Hospital	Shared via Open API	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Mental Health	Shared via Open API	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Live	Live	In development	In development	Live	In development
Projected 'go-live' date (dd/mm/yy)			01/04/17	01/07/16		01/04/17

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott2.

Work has continued in developing an overarching Data Sharing Agreement (DSA). This has been via a Local Unified Care Record Data Sharing working group, comprising of Caldicott leads, LMC GP leads, and IG leads.

Key principles are:

- A framework to share between the organisations who are subject to the agreement (in accordance to the DPA and Caldicott principles)
- An agreement to share clinical information. The actual data set of information shared will be constrained by the system design and capability.
- A programme of communication to inform patients that in the course of their care data will be shared between clinicians with a legitimate reason to access their records
- Mechanisms to establish and record patient opt out preferences
- Appropriate system logic to exclude patient information on the basis of expressed opt out.

The patient choice not to share their record, expressed to any one or all of the partner organisations (King's, Guy's, SLAM or Primary Care), will be recorded in the partner organisation system and will exclude ALL record sharing for the patient between the partners.

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

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

Currently 3,340 adults have been identified through risk stratification as being at high risk of hospital admission, representing 1.4% of the adult population.

For risk stratification we use the HealthNumerics-RISC system which is a risk identification and stratification tool provided by United Health which identifies patients at risk of a future unplanned hospitalisation due to chronic conditions within the next 12 months. The source of data for the predictive modelling is GP data (register, activity and mediations) and Secondary Care (inpatient, outpatient and A&E). The system produces monthly reports with patient level risk scorings for clinicians.

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

Currently, our approach to care co-ordination and accountable lead professional has been implemented for older adults and led by Primary Care. We have an integrated approach to risk stratification and identification of high risk patients in primary care. In addition to the HealthNumerics risk data, older people will be offered proactive, holistic health assessments (HHAs) by their GP practice to help identify issues and risks early. People will be supported by Integrated Care Managers (ICMs) and GPs where it is deemed appropriate (adding to the support being implemented by NHSE in the national admission avoidance schemes). This care management and co-ordination will aim to ensure people are engaged in their own care and that a full range of support is made available to someone in a proactive way to improve overall wellbeing and outcomes and reduce the need for unplanned hospital admissions. ICMs and GPs will be supported by Community Multi-Disciplinary Teams (CMDTs) who will support complex care management, offer additional advice and support, help to unblock service issues and problems and ensure holistic care is being offered. These CMDT meetings are already established and supporting complex care in each locality. They consist of professionals from acute trusts, mental health, social care and community healthcare.

In 2015/16 GP practices and providers in Southwark are expecting 3324 to have had a HHA and 900 will be supported by Case Management with an Integrated Care Manager. A further 360 people will be discussed at CMDT meetings.

Our intention is to roll this model out to cover younger adults with Long Term Conditions or complex needs.

We recognise that we have further work to do to establish joint comprehensive assessment processes between health and social care and in developing the role of care coordinators or accountable lead professional across Southwark services. We will take this work forward building on what has already been done at a CMDT level to establish trust and relationships, and moving forward our work on neighbourhood level integrated care over the course of the next twelve months. One barrier to joint assessments being undertaken is joint data system and having a shared care record, which professionals can contribute to, being addressed through the data sharing workstream.

As part of the NHSE admission avoidance over 75s will now have a named GP and where appropriate a care co-ordinator. Additionally, as part of the local integrated care programme, all over 80s, those that are over 65 and housebound or haven't seen their GP for 15 months or more, will also be offered a Holistic Health Assessment and care plan. This assessment and care plan also shows the name of the professional undertaking the work and their contact details. On top of this anyone with more complex care, if they fall outside of the NHSE framework, will be supported by an Integrated Care Manager under the local Integrated Care Programme work.

GPs are at the centre of the local and national initiatives, supported to identify, assess and manage the needs of older and more complex people. In doing so they will be offered help, tools and guidance by the CCGs, local provider organisations and the local SLIC Integrated Care Programme. There are now contracts in place for the work, activity and outcomes expected, which have been jointly agreed by all parties. These targets and expectations are reported to a Governance Board each month which contains GPs, providers and commissioners.

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

27% of high risk people (900) are subject to case management with a community multi-disciplinary team.

e) Agreement to invest in NHS commissioned out of hospital services which may include a wide range of services including social care

As part of planning for 16/17 Southwark can confirm that £6.1m has been allocated for NHS commissioned services, comfortably above the £5.9m minimum ring fenced allocation proposed as part of BCF planning guidance. As with all other parts of our plan, this expenditure has been jointly agreed between the Council and CCG. NHS commissioned out of hospital services from 15/16 will continue for 16/17 ensuring consistency of approach, and it is hoped will yield further benefits given that schemes are now better established.

As detailed in the risk share section, a risk reserve of £1.3m is in place so that should activity levels at acute providers be higher than anticipated, the risk reserve can be drawn down to cover this additional expenditure through year-end agreements. Should activity be below expected levels, this funding will be able to be released to further bolster out of hospital schemes ahead of the winter period.

This approach is in line with our payment for performance arrangements in 15/16 whereby a risk reserve was established between the Council and CCG which could be drawn down upon should admissions targets fail to be met. This allowed for surety on expenditure against BCF plans, but also allowed for there to be a reserve in place which could be used to fund additional acute activity where needed. It was therefore felt that this approach ensured a balanced approach to managing risk, as it was agreed between all parties, that reducing expenditure on agreed schemes was likely to further exacerbate any increase in admissions or attendances in hospital.

A number of schemes are supported through the out of hospital allocation, but in particular:

@home – Supporting around 400 patients a month, the service supports those that are at risk of a hospital admission or who have had treatment but need more care when they return home from hospital. There are 85 virtual beds available, with numbers able to flex as demand increases. Usage is increasing month-on-month, and local hospitals are being supported by on-site in-reach @home nurses who help ‘pull’ patients from the acute setting in to the community. Further work is planned with both GSTT and KCH to ensure consistent use of the service, particularly over weekends.

Pal@home – Introduced in Q3 15/16, Pal@home, helps support those at the end of life to ensure that they are able to die in their own home. The service, run in conjunction with St Christopher’s Hospice and Marie Curie Cancer Care, also offers night time rapid response services, to ensure that those that need overnight care are able to receive this outside of a hospital setting. 16 virtual beds were in place during Q4, but now that this service is being mainstreamed, it is envisaged that capacity and utilisation will increase.

Children@home – Launched in January 2016, Children@home, expanded @home services to children and young people. The service has been running as a pilot, but will be fully mainstreamed during 16/17, and expanded to run 8am-10pm, 7 days a week from Q1. Successful recruitment has now taken place, with staff coming into posts progressively over the coming months. It is hoped that between 60-100 paediatric admissions a month will be avoided, the equivalent of 12-16 beds.

Analysis of these schemes has shown that:

- Over 500 LAS conveyances to hospital have been averted thanks to the use of the Alternative Care Pathway established between @home and LAS
- Over 3000 patients have been supported by @home during the course of 15/16, with an average length of stay of 6 days. This has led to a material reduction in admissions at local hospitals and a reduction in length of stay for patients who are admitted as they are able to access enhanced out of hospital support
- Less than 10% of patients referred to @home are admitted or re-admitted to hospital, demonstrating the effectiveness of the service and its ability to provide acute care at home

f) Delayed Transfers of Care

Key to system wide planning is the need to continue the significant progress made on reducing levels of DTOCS and patients that are medically fit for discharge (MFFD). Southwark have, in recent years, had some of the lowest levels of DTOCS anywhere in the country, with the latest figures indicating that the level of delays is a third of the national average. However, as part of 16/17 Better Care Fund plans, we have committed to trying to reduce these figures yet further. This is consistent with our CCG operating plans, and the plans of the Lambeth, Southwark and Bromley System Resilience Group.

15-16 actual (Q1 & Q2) and forecast (Q3 & Q4) figures			
Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
501.7	408.2	280.7	390.9
1,228	999	687	971
244,755	244,755	244,755	248,374

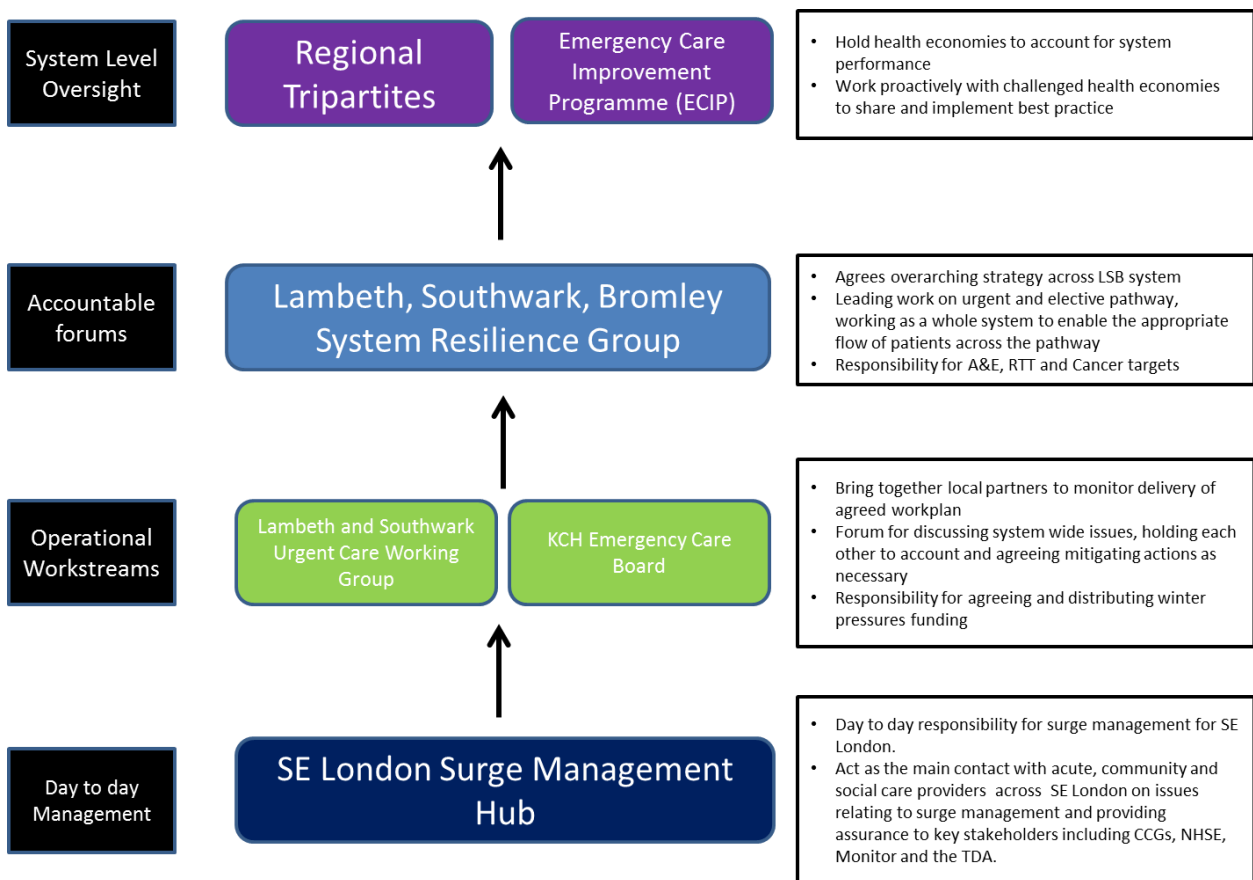
16-17 plans			
Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
352.3	352.3	352.3	347.5
875	875	875	875
248,374	248,374	248,374	251,777

It is also noted that many of the DTOCS and MFFD patients are from non-local boroughs. As part of our DTOC action plan, the CCG has undertaken extensive work with Lewisham to agree new processes to align pathways into continuing care and reablement services with those in place across Lambeth and Southwark. This should significantly reduce delays to Lewisham, with scope to expand this yet further to other SE London boroughs. In addition, the CCG has co-sponsored the Integrated Hospital

Discharge programme, which sees senior leads from Community Services, Social Care and the Continuing Health team, alongside clinicians from KCH actively support wards to expedite discharges to community and social care services. Key to this will be an education programme for ward staff to ensure that discharge planning is conducted at the point of admission, to help reduce length of stay and reduce the level of MFFD discharge patients at Denmark Hill.

From analysis of DTOCS in 15/16, it is noted that a significant proportion of DTOCs stem from patient and family choice, particularly where patients and their families have not made, or been supported in making, decisions about care arrangements post hospital. To help reduce these delays, in 16/17, a new Choice policy will also be formally rolled out across GSTT and KCH. This policy gives clearer advice to patients and their carers' and families about what support the patient is likely to need post-discharge to aid forward planning. Underpinning this, a Care Home Selection Service will be in place which will work proactively with families to help choose a care home for their relative. Evidence from elsewhere has demonstrated that that can help significantly reduce bed days for those needing to be transferred to care homes and nursing homes. We will also work closely with the ECIP team, who are supporting the local health economy, to ensure that these protocols are in line with national best practice.

There is a robust governance and accountability structure in place through which DTOCs are analysed and managed. The diagram below depicts this structure.



Through the System Resilience Group we will be monitoring progress on DTOCs and MFFD, and this is also picked up on daily surge management calls with all providers, where partners collaborate to rapidly troubleshoot issues related to discharge and ensure all necessary support is given.

The BCF also funds a number of voluntary sector initiatives which help manage DTOCs. An example of this is Southwark Wellbeing Support at Home (SWiSH) which helps patients to remain at home, living their own lives safely and as independently as possible by avoiding unnecessary or unplanned hospital admissions. SWiSH provides support for up to 12 weeks including home visits, drop-in sessions, advice and signposting to other services, practical support, advocacy and home audits.

g) Performance from 2015/16 and plans for 2016/17

Re-ablement

The re-ablement team work to support an individual to regain skills, confidence and independence, often following a specific period of illness or injury and hospital admission. It is a key service for supporting safe discharge from hospital and preventing admissions or re-admissions to hospital of people at risk, and reducing the need to use care homes.

The services is provided as a short-term, intensive alternative in the persons home, usually for up to 6 weeks (although can be less, dependent on goals achieved or appropriateness to the service). The team can provide short term care and support or assistive equipment to increase independence/safety with activities of daily living, transfers, and improving confidence.

The service is also the default assessment service for Southwark, and combined with the Supported Discharge Team facilitates 70% of all discharges from hospital.

In 2015/16 we set a target of 90% of all residents requiring re-ablement to still be at home 90 days after discharge from the service. This would represent an increase on the 87% achieved in 2014/15. Although we are awaiting the final results from 15/16, as of the end of Q3 2015/16, we had exceeded our target, with 92% of service users remaining at home 90 days after discharge. Given strong performance in this area, our target will be to maintain this achievement in 2016/17, whilst still seeking to improve wherever we can.

We believe that the BCF has been a key factor in meeting the re-ablement targets. By allocating £1.8m in 2015/16 (a figure which has been maintained in 16/17), we were able to ensure that the service could continue to meet demand, with sufficient resource to enable staff to give service users the care and support that they needed, and to liaise effectively with colleagues in acute and community settings to ensure that there was effective joint working and seamless handovers. In addition, the effectiveness of the service, has helped reduce the level of admissions to residential care.

Admissions to residential care

One key target has been to reduce the need for residents to be admitted to residential care, by being able to support them to live independently in their own homes. The re-ablement service, alongside health services such as @home have been instrumental to this, allowing patients to be supported at home and promoting discharge to assess models.

As of the end of Q3 we have met our targets for residential home admissions (see below table)

	Oct	Nov	Dec	Jan	Feb	Mar	2015/16	Apr	May	Jun	Jul	Aug	Sep	
Target	13	13	13	13	13	13			13	13	13	13	13	13
Admissions	12	7	7	7	16	6			13	8	10	13	6	12

Although our population is ageing, our ambition for 16/17 is to continue to meet our target of no more than 13 admissions to residential care per month. Should there be any signs that the target is in danger of not being met in 16/17, the Integrated Working Group will request that a deep dive is undertaken to review each admission to establish whether there are any lessons that can be learnt regarding how the admission could potentially be avoided.

In addition, as part of winter resilience schemes, Southwark Local Authority piloted 2 step down flats for patients no longer requiring hospital care, but who were not yet ready to return home. In other circumstances, these residents may well have needed to be admitted to residential care either temporarily or permanently. Instead, these step flats allowed for a 'discharge to assess' model to be introduced, whereby residents were given intensive support to establish whether they would ultimately be able to live independently. This model has proved to be highly effective, with over 70% of service users able to return home after this respite support. This scheme has now been mainstreamed in 16/17, and further evaluation will be undertaken to establish whether there is sufficient demand for capacity to increase further.

Engagement

a) Patient, service user and public engagement

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

The plan is underpinned by a vision for improving services in the community through better integrated working that has been developed over several years and shaped by a range of engagement activity.

Our integration project (SLIC), which has developed much of the thinking behind our approach has actively consulted with the public through its Citizen's Forum over the past 30 months. For example, Southwark and Lambeth commissioners, working with the SLIC team, held engagement events with residents to identify what people wanted as outcomes from integration and to help us articulate those outcomes from a resident's perspective. This work supports our vision document, but will also help us as we work to further develop our local outcome measures for integrated care. This events included Healthwatch and the representatives of other engagement groups linked to the CCG and LA. The selection of our local metric (people feeling supported to manage their long term conditions) was informed by this engagement event.

Healthwatch have been closely involved through the various BCF and integration discussions at HWB, HWB workshops and CCG Boards and other events. The Director of Adult Care recently addressed a Citizens Forum event on social services and integration plans.

There will be further engagement activity as detailed implementation plans for 2016/17 are developed.

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

Our local acute trusts have been key members of the Southwark and Lambeth Integrated Care (SLIC) programme and are part of the Strategic Partnership and have been closely involved in producing and delivering the integrated care strategy to date, as well being involved in delivering some of the new integrated service models, for instance the admission avoidance programme. As part of planning for 16/17 a system wide CQUIN on supporting those with long term conditions and avoiding admissions will be in place which is actively supported by all local providers.

Regular reports on the BCF go to contract meetings with acute providers, and the findings are discussed to ensure that all parties are not only sighted, but actively involved in the design and delivery of BCF plans.

Our detailed proposals for integration in Southwark, including the schemes to be funded from the BCF, have been shared and discussed with acute providers in a number of fora including; the Health and Well Being Board, SLIC meetings and a Southwark and Lambeth joint planning meeting which includes CCG and Local Authority commissioners as well as representatives from our local providers (GST, KCH and SLAM).

Service providers have also been active participants in a number of change programmes and consultations that together help form our local integration programme. For instance, Social Care providers have been involved in My Home Life and other quality initiatives that form part of this wider plan, including the development of the re-ablement service model and home care redesign.

Our plans and trajectories for the BCF and, specifically our plans regarding Delayed Transfers of Care, have been presented at the Lambeth and Southwark Urgent Care Working Group – a subgroup of the System Resilience Group, featuring representation from all of our acute, mental health, community and social care partners and have been endorsed.

ii) primary care providers

As per acute providers as set out above, our primary care providers are CCG council members and key members of the SLIC and Strategic Partnership programme which has shaped our approach to integration which has shaped the BCF.

As part of the PMS review, Primary Care will also be incentivised under the system wide CQUIN.

See also 6(c) on alignment with primary care plans.

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

Social Care has been closely involved in the BCF preparations and the wider integration agenda from the offset. The SLIC Sponsor Board, and its successor in the Strategic Partnership includes the Strategic Director of Children's and Adults services. The SLIC Operations Board is jointly chaired by the Director of Adult Care and there is a provider group workstream which includes the Director of Adult Care representing social care from the provider perspective.

Community Action Southwark, representing the voluntary sector, are represented on the Health and Wellbeing Board and have been involved in the development of the BCF as a result. Partnership Boards all include voluntary sector representation and integration is frequently on the agenda.

We have engaged with providers and the community sector in a focussed way on specific

BCF themes, for example a detailed consultation on the carers strategy, home care quality etc, and will continue to do so as plans are implemented.

In Southwark there is an Early Action commission looking at the role of the voluntary sector in the prevention and care agenda. This will include the services funded from the £910k BCF budget for community support services delivered by the voluntary sector for info and advice/befriending services and how we need to ensure these fully contribute to the overall outcomes for the BCF.

c) Implications for acute providers

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

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2016/17 consistent with the BCF plan set out here?

The impact of our plan on NHS services will mean:

1. Expanded community based admission avoidance and discharge support services, preventing emergency admissions and reducing length of stay
2. Support for 7 day working from integrated social care and community services, which will enable more efficient discharge processes and shorter hospital stays
3. Extended access to primary care, 7 days a week, supporting improved health outcomes for local people and reduced reliance on urgent care services/A&E
4. More support to keep people living independently in their own homes, including self management support, telecare, increased community mental health services and better quality home care

Savings will be realised in acute hospital services, largely at Kings College Hospital and Guys and St Thomas NHS Foundation Trusts. Savings will come, primarily from reductions in emergency admissions and readmissions and shorter length of stays, as well as lower A&E attendances and reduced elective cancellations. The details of these savings are being agreed with providers both as part of our contractual negotiations and QIPP plans.

It should be noted that Southwark and Lambeth's main acute providers, Guys and St Thomas NHS Foundation Trust, and Kings College Hospital NHS Foundation Trust, are tertiary providers covering a large geographical catchment area, and the proportion of their work relating to the two boroughs is less than 50%. Although Southwark is an important local referrer and partner to the two hospitals in the integration programme, the impact on our providers of changes to local demand is not as significant as it would be for district general type hospitals.

Within our local acute providers, capacity will be rebalanced to reflect the reduced use of emergency services by Southwark people. This will be through a combination of increasing the amount of tertiary work undertaken, through specialised services growth and consolidation, as well as bed reductions in some acute medical and older people's

wards. This rebalancing of capacity will be agreed and tracked through the Strategic Partnership programme.

There are two key risks for acute providers:

1) That the bed savings do not materialise, in which case there would be a cost pressure within the local health economy. We are seeking to mitigate this in a number of ways:

- Proactively taking acute capacity out of service as the new integrated capacity is developed, or redeploying capacity in the community
- Performance managing the integration programme to deliver agreed benefits, and holding partners in the system to account through the Strategic Partnership
- Entering into risk management agreements between commissioners and providers
- Evaluating the impact of the overall integration and admission avoidance programme, and amending components of the programme where there is shown to be low impact or less value for money

2) That the programme does release acute capacity, but this is not taken up by more profitable specialised activity. In this case there would need to be rationalisation of total acute capacity and reductions in fixed costs to create efficiencies.

The impact on service delivery targets if savings and activity reductions do not materialise would include pressures on emergency capacity, leading to pressures on A&E performance and possibly also referral to treatment times for elective work. However, the comment re the proportion of our FTs' activity which relates to Southwark patients means that this impact is diluted by other demand and volume of activity from other commissioners, including other boroughs and NHS England specialist work

Appendices

Document or information title	Synopsis and links
1. Southwark Five Year Forward View	<i>Attached appendix 1, 3</i>
2. Health and wellbeing strategy	http://moderngov.southwark.gov.uk/documents/s51406/Appendix%201%20Health%20and%20Wellbeing%20Strategy%202015%20-%202020.pdf
3. JSNA	http://www.southwark.gov.uk/jsna
4. CCG Primary and Community Care Strategy	http://www.southwarkccg.nhs.uk/our-plans/out-of-hospital-care/strategy-2013-18/Documents/Southwark%20Primary%20and%20Community%20Care%20Strategy.pdf
5. Our Healthier South East London Strategic Plan	http://www.ourhealthiersel.nhs.uk/Downloads/Strategy%20documents/Our%20Healthier%20South%20East%20London%20Full%20Strategy%20v2.pdf
6. Local Account – Adult Social Care	http://www.southwark.gov.uk/localaccount
7. SLIC website and project plans and reports	http://slicare.org/
8. Carers Strategy	http://www.southwark.gov.uk/downloads/download/3605/our_draft_carers_strategy_2013
9. Adult Social Care Vision	<i>Attached appendix 2</i>

Everybody's Business

Southwark Healthy Weight Strategy 2016-2021

Southwark Health and Wellbeing Board

Contents

Contents	2
Foreword	3
Executive summary	4
1. Obesity	6
1.1 What is a healthy weight?.....	6
1.2 Causes of overweight & obesity.....	6
1.3 Impact of overweight and obesity.....	7
2. Setting the scene in Southwark	9
2.1 Who is at greatest risk of overweight and obesity?.....	9
2.2 Child overweight and obesity.....	9
2.3 Safeguarding and overweight and obesity.....	11
2.4 Adult overweight and obesity.....	11
3. The evidence, the now and the future	13
3.1 Maternity and early years (0-4).....	13
3.2 Children and young people (5-19).....	14
3.3 Adults (19+).....	16
3.4 Healthy weight environment.....	17
3.5 Treatment.....	18
4. Southwark healthy weight strategy	20
4.1 Overview.....	20
4.2 Strategy development and implementation.....	20
4.3 Strategy framework.....	21
4.4 Five year ambitions.....	21
4.5 Other linking strategies.....	22
5. Southwark healthy weight action plan	23
Appendix 1	29
Local Qualitative Findings.....	29
Appendix 2	31
Southwark healthy weight referral and care pathway for children aged 0-4 years.....	31
Appendix 3	32
Southwark healthy weight referral and care pathway for children aged 4-12 years.....	32
References	33

Foreword

Southwark Council is committed to ensuring a 'Fairer Future for All' and supporting our residents to achieve and maintain a healthy weight is a key part of achieving this goal. Being a healthy weight enables you to live a longer, healthier life and to fulfil your potential.

At the moment, however, Southwark has some of the highest rates of obesity in the country: 56% of all adults and 43% of children in year 6 are classified as being overweight or obese. This not only impacts on the quality of life that our residents are experiencing, but also on their health and productivity.

This strategy sets out our bold ambitions and planned actions to help our residents to maintain a healthy weight throughout their lives.

We know that being obese or overweight is more common in certain groups and communities. Therefore this strategy is focused on those living in socially deprived areas and belonging to ethnic groups that are at a higher risk of becoming overweight or obese. There is also a focus on children, young people and families.

The causes of unhealthy weight are complex: an individual's weight is influenced by a range of individual, cultural, social, economic and political factors. As a result, a wide range of prevention and treatment services are required.

There are already plenty of examples of good practice in promoting healthy weight in Southwark. This includes the implementation of the UNICEF Baby Friendly Initiative and Healthy Start programmes, Free Healthy School meals, Healthy Schools London, and age appropriate weight management services. We are also working to support individuals to be more physically active through our free swim and gym offer as well as active travel and transport plans.

However, with this strategy we are challenging ourselves to raise the bar and to identify further opportunities to ensure a joined up approach across the whole borough. This includes ensuring that professionals in the community feel competent to raise the issue of healthy weight provide advice and signpost to local services. There is also more work to be done to ensure that healthy weight initiatives are embedded in all Council services. From school provision to planning, housing, sports and leisure services – everything we do must be geared up to help prevent and reduce obesity in our local communities.

An effective strategy needs engagement and buy in from a range of partners. This requires all local authority departments to work together in partnership with the CCG, schools, acute trusts, local employers, voluntary and community organisations. I warmly welcome the Southwark Health and Wellbeing Board's Healthy Weight Strategy 2016-2021.

Everyone has a role to play in empowering our residents to be healthier. Southwark should be a place in which 'the healthy choice is the easier choice'. Tackling healthy weight truly is **everybody's business**.

Councillor Maisie Anderson- Cabinet Member for Public Health, Parks and Leisure

Executive summary

Southwark has some of the highest rates of overweight and obesity in the country, with **56% of adults** and **43% of children** (year 6) classified as obese or overweight. Not surprisingly, our most vulnerable populations are at increased risk of becoming overweight and obese.

This document pulls together what we know about obesity in general and specifically to Southwark. It also examines the services and initiatives currently happening in the borough and recommendations for future plans. We know that overeating and physical inactivity are risk factors for overweight and obesity. We also know that maternity and early years are the best time for intervention in these areas. If we are successful, we can prevent children from becoming overweight or obese adults.

Based on this the Southwark Healthy Weight Strategy has been put together in an effort to tackle Southwark's obesity using an evidence based, life-course approach which is family focused and brings all partners together in a whole systems approach. The strategy includes both prevention and treatment services and is divided into four key areas:

1. **Maternity and early years**
2. **School aged children**
3. **Adults**
4. **Environment**

There are currently a number of services and initiatives in Southwark. This strategy aims to ensure that new services are commissioned where needed, that all Council partners take ownership of the problem and that our work is evaluated thoroughly.

The strategy also provides the first year's action plan which has key actions for each of the four areas. These will be implemented by various groups made up of essential and committed partners. The action plans will be monitored quarterly to ensure progress and tracking.

The strategy actions for each group are summarised below:

Maternity and early years - key actions:

A comprehensive care pathway of tier 1 – 3 services will be established for children aged 0-4 and 5-12. This will require all professionals working in maternity and early years services to be provided with comprehensive training to ensure they are fully prepared to raise and tackle the issue of healthy weight including making appropriate referrals.

The UNICEF Baby Friendly Initiative aims to enable health and education settings to support healthy baby feeding, particularly with regard to breast feeding.

Children's Centres will be supported to take a 'whole settings approach', providing healthy food and physical activity options, along with suitable information and advice to parents and families.

Children and young people - key actions:

A school healthy weight programme will be developed, which will also require all professionals working with children, young people and families to be provided with healthy weight training.

School nurses support effective implementation and monitoring of the NCMP programme including a support offer to all families with overweight children.

Schools will be supported to promote healthy weight by adopting a 'whole school approach' through the London Healthy Schools programme.

Adults - key actions:

A healthy weight care pathway for adults will be developed and implemented including tier 2 and 3 weight management programmes. Overweight adults can also be referred to the exercise on referral scheme or commercial slimming groups.

Environment - key actions:

All future Council strategies, plans and planning applications will be developed in consultation with public health to ensure they support a healthy weight environment. Public events will provide healthy food whenever possible. Parks and leisure centres will provide healthy and affordable food and beverages, while local restrictions will be placed on hot food takeaway outlets on high streets and in close proximity to schools. The Council will also continue to deliver the cycling strategy and promote active travel to all residents. Safe, clean and attractive parks provide opportunities for Southwark residents to be physically active including active travel and play.

The strategy aims to achieve our agreed child obesity ambitions. By 2020 the strategy aims to reduce the proportion of children in reception year with excess weight from 26.4% to 23.6%, and from 42.7% to 24.9% in year 6 children. The strategy is bringing obesity to the fore in Southwark and is a comprehensive plan for uniting everyone together in its prevention and treatment.

1. Obesity

1.1 What is a healthy weight?

A healthy weight is defined as one that does not increase an individual's risk of health problems such as heart disease, Type 2 Diabetes and cancer. For adults and children, weight is assessed by body mass index (BMI) which compares people's weight to their height. BMI is calculated by dividing a person's weight in kilograms by their height in metres squared. For children, the body mass index (BMI) is plotted onto a gender-specific BMI chart and children over the 85th centile, and on or below the 95th centile, are categorised as 'overweight'. Children over the 95th centile are classified as 'obese'. Obese adults are defined as having a BMI of over 30 and overweight is a BMI of 25-30.¹ Excess weight is defined as anyone with a BMI over 25, i.e. the sum of all overweight and obese people together.

1.2 Causes of overweight & obesity

The causes of overweight and obesity can be described on both simple and complex levels. At a simple level excess weight is caused by more energy being taken in through eating and drinking than is used up through metabolism and physical activity – imbalance between 'energy in' and 'energy out'. Our energy balance is determined by an individual's biology (genetics) and behaviour (eating and physical activity habits). At a complex level our energy balance is shaped by our environmental, societal and cultural influences.²

1.2.1 Biology

There is an increasing body of evidence which suggests that nutrition of both the mother and father during conception and pregnancy influences the likelihood of offspring becoming obese due to genetic transformations. A smaller body of evidence examining the interaction between genetics and the environment is available and growing.³

1.2.3 Environment, societal influences and behaviour

Environmental factors influence our behaviour and contribute to our energy balance and weight status. The increase in overweight and obesity has been linked to our obesogenic environment affecting both our eating habits and physical activity. This situation has become so normalised that adults do not recognise they or their children are overweight or obese.¹¹

Food

The food environment is known to influence the food choices of individuals as well as the quality, and quantity (portion sizes) of the food, as well as eating patterns. Calorific, large portioned and affordable foods and beverages are readily available. Their availability has increased significantly over time with studies showing that a wider range of food leads to more calories being consumed^{7,43}

The prevalence of marketing and promotions also persuades us to make poor food choices. Evidence shows there are more food promotions in Britain than any other European country and account for 40% of food and drink expenditure.⁸ Food-related images like logos and packages trigger our desire to purchase and consume food, regardless of how hungry we are.⁹

Breastfeeding and healthy weaning or the introduction of solids reduce the risk of childhood obesity.⁵ Healthy weaning should begin at 6 months of age and earlier introduction of solid foods has been found to be associated with obesity in later childhood and adolescence.⁶ In addition, the biggest risk factor for being an obese child is living in a family where a parent is obese.⁴

Physical activity

The physical activity environment influences an individual's activity behaviour.⁴³ The current obesogenic environment has contributed to a decline in physical activity with more time being spent on screen based and sedentary leisure activities. Unfortunately, social, cultural and economic trends have removed physical activity from daily life. Fewer of us have manual jobs and technology dominates at home and work or education settings, the places where we spend most of our time. It encourages us to sit for long periods – watching TV, at the computer, playing games or using mobile phones and tablets. Over-reliance on cars and other motorised transport is also a factor. Many features of cities and towns do not encourage physical activity. The design of schools, public buildings and urban spaces prioritise convenience and speed ahead of walking or cycling.¹⁰

1.3 Impact of overweight and obesity

The impact of overweight and obesity harms our resident's health and wellbeing, our economy and our community as a whole.

1.3.1 Cost of overweight and obesity

Obesity impacts society as a whole as increased sickness increases costs to health and care services. Overweight and obesity costs the NHS over £5 billion per year and costs the wider economy £27 billion.¹⁶ The government's commissioning support toolkit for healthy weight interventions estimates the costs in Southwark to the NHS of diseases related to overweight and obesity to be £86.1 million in 2010 and £92.1 million in 2015.¹⁷ More generally, obesity costs to Southwark and the local economy is predicted to reach over £127 million in 2016, a 21% increase on 2015.¹⁷

Separately, the annual health costs in Southwark of physical inactivity are estimated as £1.7 million per 100,000 people. Increased sickness and reduced physical activity also means a less productive community, impacting economic growth in Southwark.¹⁷

1.3.2 Maternal overweight and obesity

Approximately half of all women of childbearing age in Southwark are either overweight or obese. A pregnant woman who is overweight or obese has an increased risk of developing gestational diabetes, high blood pressure and depression during pregnancy. Her baby is more likely to be stillborn, born with a high birth weight, heart or neural tube defects. Maternal obesity has also been linked to low breastfeeding rates and higher rates of childhood overweight and obesity.¹²

1.3.3 Childhood overweight and obesity

Being overweight or obese in childhood and adolescence has consequences for physical and psychological health and academic achievement. It also sets children up for a lifetime of being overweight or obese with studies suggesting that at least 70% of obese children will become obese adults.¹³ Once established, obesity is difficult to treat, so prevention and early intervention are very important.

Some obesity-related conditions can develop during childhood. Type 2 diabetes in overweight children has increased, as have asthma and other respiratory problems, and some musculoskeletal

disorders. There is also evidence of increased school absence through illness compared to healthy weight children which could lead to an impact on school readiness and future educational performance.¹⁴

The emotional and psychological effects of being overweight include discrimination and teasing by peers; low self-esteem; and anxiety and depression, potentially impacting educational performance. Obese children may also suffer disturbed sleep and fatigue impacting quality of life.¹⁴

1.3.4 Adult overweight and obesity

Nearly one in ten deaths in England and Wales are attributable to being overweight or obese.⁵ This is due to the link between obesity and a wide range of diseases, most notably diabetes (type 2), hypertension, cancer, heart disease and stroke. Similar to children, obesity is associated with poorer psychological and emotional health⁶. The negative health impacts increase with greater levels of obesity.¹⁵

Further evidence shows overweight or obese adults:

- Are less likely to be in employment
- Are more likely to suffer discrimination and stigmatisation
- Have an increased risk of hospitalisation
- Have a reduced life expectancy by an average of 3 years, increasing to 8-10 years in adults with severe obesity.¹⁵

2. Setting the scene in Southwark

2.1 Who is at greatest risk of overweight and obesity?

Some population groups are at higher risk of overweight and obesity than others. These include:

- Families with a low income
- Communities with high deprivation (mainly Walworth, Rotherhithe and Peckham) ²⁴
- Those who identify as Black African, Black Caribbean and mixed race ²⁰
- Those with a limiting illness or disability. ²⁶

2.2 Child overweight and obesity

Southwark Year 6 excess weight prevalence is the highest in the country at 42.7%. Data from the most recent NCMP (2014/15) show that excess weight in Southwark children at Year 6 is 5.5% higher than the London average and 9.5% higher than the England average.

This equates to 1500 children of this age being identified as overweight or obese each year and for many of these children, they begin the pathway to become overweight and obese for life. In Southwark, rates of obesity rise as children get older and there is a slightly higher prevalence in boys than girls.

NCMP data from 2006/07 showed that 13.2% of children at Reception year, and 27.0% of Year 6 children were obese. NCMP data from 2014/15 indicates that there has been no significant change in obesity prevalence over this period, with 13.0% of children at reception year, and 27.9% of children in Year 6 being obese.

Nationally, the NCMP shows a strong, positive relationship between deprivation and excess weight for children in each age group. In Southwark the correlation is less apparent as relative deprivation is masked by relative affluence, side by side within small geographies.

Table 1: Southwark Children Weight Status Percentage at years reception and six*

Year	Underweight		Healthy weight		Overweight		Obese		Excess weight**	
	Reception	6	Reception	6	Reception	6	Reception	6	Reception	6
Southwark	1.6	1.1	72.0	55.3	13.4	15.7	13.0	27.9	26.4	42.7
London	1.5	1.6	75.4	60.7	12.0	14.6	10.1	22.6	22.2	37.2
England	0.9	1.4	76.5	65.1	12.8	14.2	9.5	19.0	21.0	33.2

*2014/15 National Child Measurement Programme (Reception and Year 6)

** Excess weight is equal to overweight and obesity

Figures 1 and 2 highlight the unequal prevalence of obesity for different ethnic groups, with the highest prevalence in black groups.

Figure 1: Prevalence of obesity in Reception year per ethnicity

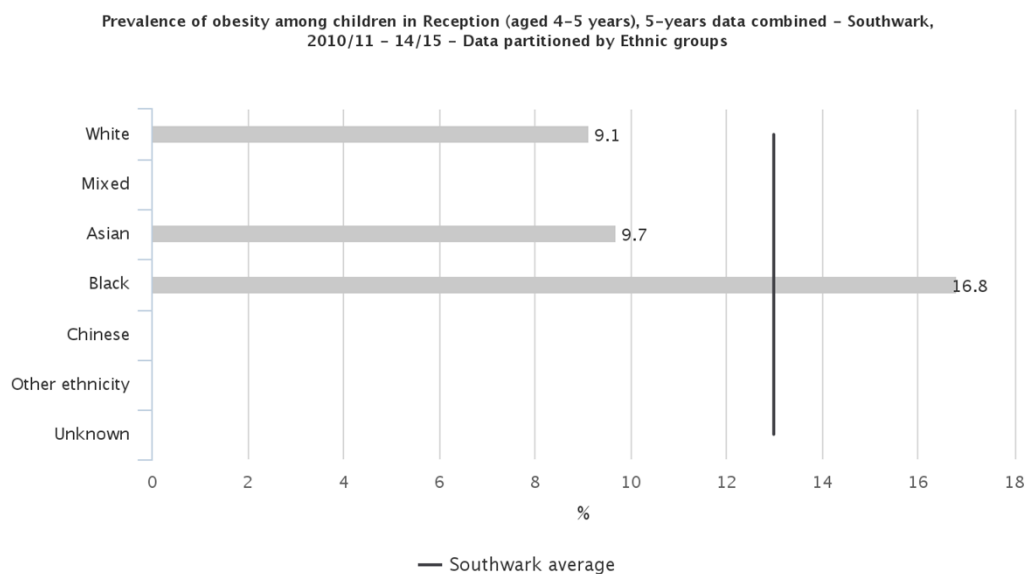
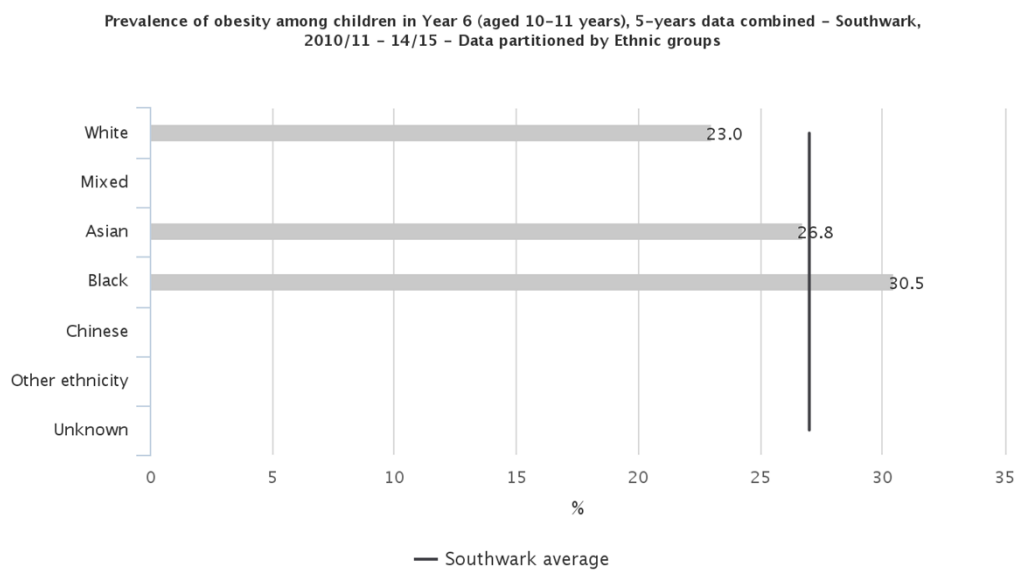


Figure 2: Prevalence of obesity in year 6 per ethnicity



The Chief Medical Officer's report (2011) recommends that children aged 2 -4 years should engage in at least 180 minutes activity spread throughout the day and that children aged 5-15 years should engage in at least 60 minutes and up to several hours physical activity per day.

	2-4 years girls meeting CMO guidelines	2-4 years boys meeting CMO guidelines	5-15 years girls meeting CMO guidelines	5-15 years boys meeting CMO guidelines
London	-	-	16%	24%
England	9%	10%	16%	21%

England and London data: Health Survey of England 2012²¹

2.3 Safeguarding and overweight and obesity

It is important to consider safeguarding and social care surrounding the issue of excess weight. Children under protection plans would be considered some of our most vulnerable children. The Southwark Social Care Assessment Framework used by Social Workers as a tool for practice, lends itself to healthy weight and wellbeing. Within the threshold document, weight and health issues due to neglect are a level 3 issue meaning that referral to social care can be made.

2.4 Adult overweight and obesity

Adult obesity levels in Southwark are measured by the Health Survey for England and outlined in Table 2.²³ The 2014 survey showed that 55.7% of adults (aged 16+) are classified as overweight or obese, this includes 21.1% that are classified as obese. The consumption of fruit and vegetables is also concerning with only 46.9% of adults (aged 16+) meeting government recommendations of 5-a-day fruits or vegetables.²³

While there is limited local data on disability and obesity, it is known that people with disabilities and learning disabilities are more likely to be obese and have lower rates of physical activity than the general population. People with a limiting illness are also more likely to be obese or overweight. This relationship varies according to age and gender.²⁵

The Chief Medical Officer guidelines for physical activity recommend adults should aim to be active every day.²¹ Over a week, activity should add up to at least 150 minutes (2 ½ hours) of moderate intensity activity in bouts of 10 minutes or more – this could include 30 minutes on at least 5 days a week.²¹ The percentage of adults who meet this guideline in Southwark is higher than the national average at 62.6% compared to 57.0%. However, over one in four adults in Southwark are classified as 'inactive' meaning they are active for less than 30 minutes a week.²³

Table 2: Southwark Adult Overweight and Obesity Percentage

Outcome indicator	Southwark	London	England
Obesity (2012 -14)	21.1	20.2	24.0
Overweight & obesity (excess weight) (2012-14)	55.7	58.4	64.6

Population meeting the recommended '5-a-day' (2014)	46.9	50.3	53.5
---	------	------	------

Table 3: Southwark Physical Activity Levels Percentage

Outcome indicator	Southwark	London	England
Percentage of adults achieving at least 150 minutes of physical activity per week	62.6	57.8	57.0
Utilisation of outdoor space for exercise and health reasons	9.6	11.8	17.1
Percentage of physically inactive adults	26.2	27.0	27.7

The evidence, the now and the future

3.1 Maternity and early years (0-4)

3.1.1 The evidence

- Evidence shows effective interventions in early years settings use a ‘whole settings approach’ and ensure appropriate policies and procedures are in place and followed by staff.³³
- Healthy physical activity and eating habits are developed early in life and can set the foundation for life-long behaviours and disease risk.²⁸
- Spending on effective early year’s interventions delivers greater return on investment than most other public programmes.²⁹

3.1.2 What are we doing?

- The Healthy Child Programme offers universal and targeted support to families from 0-19 years. It provides a framework of services that offer an holistic approach to assessing family health through contact with health professionals.³⁰
- Early Intervention and prevention programme: Nutrition training as well as prevention programmes in the form of group and practical cooking sessions are delivered by the Community Children’s Nutrition & Dietetics service, for Early Years settings. Training to support physical activity and play has also been delivered.
- A localised, bespoke healthy weight training package is being commissioned to ensure all early years’ practitioners feel competent and confident to support children and families to achieve a healthy weight and settings are supported to develop a healthy weight environment.
- A programme of work to support physical activity and play in early years will also be included in Southwark’s future Sport and Physical Activity Strategy.
- The national Healthy Start scheme provides vouchers to families on low-incomes and mothers under 18. These can be exchanged for fresh or frozen fruit or vegetables, milk and infant formula and vitamins.³²
- The universal supplementation of the Vitamin D programme which provides free Vitamin supplements including Vitamin D to pregnant women, new mums and children under four.

3.1.3 What more can we do?

- Through the Healthy Child Programme, we will support women to maintain a healthy weight during pregnancy, new parents with breastfeeding and healthy weaning, and establishing healthy eating and physical activity habits for the whole family.
- Embed the UNICEF Baby Friendly Initiative throughout the borough which provides a set of standards for health and education settings to support and promote healthy baby feeding.³¹
- Offer training to all health professionals to ensure they feel confident and competent to provide appropriate, up to date, consistent and evidence based lifestyle advice as well as being able to sign post families and children to the appropriate national and local services.
- Monitor initiatives and services more effectively to ensure uptake by priority groups.
- Better align local interventions with the Early Years Foundation Stage and Healthy Child programmes, and include the 'Eat Better, Start Better' voluntary food and beverage guidelines for early years.³⁴
- Develop a new integrated Early Years pathway which is needed in Southwark to ensure health professionals and services are prioritising healthy weight.
- Ensure that safeguarding is incorporated into the healthy weight care pathways and is part of healthy weight training for health professionals.

3.2 Children and young people (5-19)

3.2.1 The evidence

- Evidence shows schools are an effective setting to shape children's healthy eating and physical activity habits.³⁵
- A local survey indicated Southwark parents wanted meals and other food provided in schools to be healthy. Schools are required to provide food that meets the compulsory national school food standards and work towards improving their school food culture outlined in the School Food plan.³⁷
- Schools play a key role in supporting children to achieve the recommended 60 minutes of moderate to vigorous physical activity and evidence shows this can help children maintain a healthy weight.³⁹
- Food provision of healthy food in schools is only one part of supporting children to achieve a healthy weight. Evidence shows a 'whole schools approach' is needed to create an environment that supports healthy eating and physical activity as the most effective intervention type. A whole school approach involves addressing the needs of pupils, staff and the wider community and implementing healthy eating and physical activity practices through leadership, policies, curriculum teaching, and staff professional development (CPD).

3.2.2 What are we doing?

- All Southwark children are provided with a healthy and free school meal at lunchtime. Current uptake is high with 94% and 92% of children receiving free school meals in key stage 1 and stage 2 respectively.³⁶
- Southwark schools provide free fruit to all children aged 4-11.
- At some schools in Southwark, children are provided with breakfast through a breakfast club.
- The Healthy Schools Programme provides a framework for schools to assess their current practice in supporting a healthy weight including strategies to promote healthy eating, physical activity, active travel and emotional wellbeing.³⁸ Schools then create an action plan to work towards criteria for either a Bronze, Silver or Gold award. At present 74% of Southwark schools are registered to the programme and 44% of schools registered have achieved an award.
- The National Child Measurement Programme is an annual measure of height and weight of children in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) in state maintained primary schools across England.¹⁸ Southwark parents and carers receive a letter to inform them of the weight status of their child and are signposted to relevant services to support achievement and maintenance of a healthy weight. The NCMP is useful for engaging with children and families about healthy lifestyles and weight issues.
- Training is delivered to schools by the London PE & School Sports Network which provides education to staff, students and parents on the importance of physical activity and healthy eating.

3.2.3 What more can we do?

- Support the monitoring and evaluation of school catering services in meeting the School Food Standards and School Food Plan.
- Support schools in achieving the Healthy Schools London accreditation through advice, support, and training, as well as resource provision and support for school caterers to ensure the full implementation of the School food plan and School Food Standards.
- Provide training for health and education professionals on how to raise healthy weight issues, appropriate advice and communication tools, and signposting to local and national services for children identified as obesity or obese through the NCMP.
- Support schools through existing networks to evaluate their current sport and physical activity programme, identify needs, and develop ways of engaging the least active children and families, including the vulnerable.
- Develop and implement targeted marketing on healthy eating, physical activity and available activities for children, including those that are least active and most vulnerable.
- Ensure that safeguarding is incorporated into the healthy weight care pathways and is part of healthy weight training for health professionals.

3.3 Adults (19+)

3.3.1 The evidence

- There is good evidence for a workplace based approach for health improvement. Additional benefits will include increased staff engagement, and better staff retention.
- In reference to the Southwark Economic Wellness Strategy, we know that a crucial part of having an active, healthy lifestyle is being employed.
- While it is important to enable everyone to be active, it is important to target those who are least active.
- There is evidence to suggest that the most effective form of behaviour change is through peer support based initiatives.

3.3.2 What are we doing?

- Some of the family based and universal services targeting children reach parents. For example: advice is offered by health professionals through an integrated early year's pathway.
- For adults aged 40-75, the NHS Health Checks programme is available in the borough⁴⁰. This provides a free health check and an individual identified as overweight or obese will be referred to an appropriate programme. This includes: Weight Watchers on Referral BMI 30-35, Slimming World on Referral BMI 30-35, Shape Up BMI 30+, Changes for Health BMI 30+, Community Dietetic Service BMI 35+, Exercise on Referral –Active Boost and Kickstart BMI 30-45, Fitness Passport BMI 30+, Walking Groups which are open to all, Community Physical Activity Classes, Stepometer Programme BMI 30+ or CVD risk score 20%+.
- To develop healthier workplaces, Southwark Council offers employers support to achieve the London Healthy Workplace Charter.⁴² Employers complete a self-assessment framework and work towards a series of standards to create a health-enhancing workplace. Major local employers are now signed up including Southwark Council, the CCG, local hospitals, universities and some large businesses.
- The Southwark Physical Activity and Sport Strategy has seen considerable progress towards improving access and participation levels of physical activity in Southwark. There are excellent parks and leisure centre provision in the borough. Southwark is also providing free swimming and gyms to all residents with an enhanced offer to people who are less likely to be active or with poorer health.
- A local CQUIN provides a brief intervention programme in hospital settings to screen for and assess smoking, alcohol and physical activity levels. This is followed by an offer of appropriate intervention by trained staff and referral to local services.

3.3.3 What more can we do?

- Promote the London Healthy Workplace Charter more effectively to increase participation rates.

- Continue to target those people who are least active. Consultation with these groups is needed to identify their needs and current gaps in provision. Alignment with national priorities, campaign work, the Government's new Sport Strategy, and Southwark's own Cycling, Walking and Transport plans is needed.
- Effective social marketing campaigns are needed to promote the services available and the benefits of achieving a healthy weight.
- A healthy weight care pathway for adults is urgently needed. This needs to be developed and commissioned in partnership with local CCGs, NHS and healthcare professionals. This should be informed by NICE guidance, include Tier 1 to 4 services (including bariatric surgery) and the existing local National Diabetes prevention programme 'Healthier You'.
- A healthy weight and referral care pathway should be included in training for health professionals.
- Promote services to health professionals so they are aware of what is available for referral to. This would help to increase referrals from GPs to healthy weight services.

3.4 Healthy weight environment

3.4.1 The evidence

- Environmental and planning strategies that increase access to healthy food and physical activity encourage healthy weight.
- Transport and built environment plans that promote physical activity including active travel and play encourage healthy weight.
- Leisure and culture strategies to improve access to facilities for structured leisure programmes and unstructured opportunities for physical activity (e.g. access to parks, open spaces and safe play areas, ensuring access to all including those with disabilities) encourage healthy weight.
- Community led initiatives using community assets can promote healthy weight (e.g. community gardens, cook and eat clubs).²

3.4.2 What are we doing?

- The Free Swim and Gym initiative provides free access for children, adults and families to attend pool and gym facilities at leisure centres on Friday to Sunday (afternoons). This offer is extended to seven days a week for people with disabilities.
- To support the urban planning environment, public health advice is sought in all council led planning and policy development.
- There is work currently underway to regulate the availability of hot food takeaways in Southwark high streets or in close proximity to secondary schools. This will be included in the new Southwark local plan.
- Strategies are already in place to increase active travel, walking and cycling in the borough.

- To support a healthier food environment, community edible gardens and food growing projects in schools exist in the borough. To help address food poverty, healthy eating on a budget training has been delivered to food bank staff.

3.4.3 What more can we do?

- Strengthen appropriate planning and policy regulations supportive of healthier food provision, active travel and access to sport and physical activity.
- Planning and public health will continue to work together to ensure advice is provided on how council planning can support a 'healthy weight environment'.
- Increase the uptake of the Healthier Catering Commitment programme through increased promotion to local businesses.
- Support all council services and events to promote health including providing healthier food and promoting physical activity.
- Embed a health improvement approach into every department of the council.

3.5 Treatment

3.5.1 The evidence

- Although prevention is vital, effective referral and care pathways and treatment services are an important part of any healthy weight strategy. This includes the provision of specialist weight-management services that are age appropriate for individuals identified as overweight or obese.
- Effective weight management services are part of an age appropriate healthy weight care pathway developed and commissioned in partnership with local CCGs, NHS and healthcare professionals. Pathways are informed by NICE guidance and include Tier 1 to Tier 4 services.
- Tier 1 services include all activities that aim to prevent obesity and maintain a healthy lifestyle to help prevent everyone, from becoming overweight or obese. These include the services highlighted in the previous sections.
- Tier 2 weight management services focus on supporting people to have healthier lifestyles and these require the identification of excess weight, using BMI, and a primary assessment.
- Tier 3 specialist weight management services requires specialist input and assessment, and is multi-disciplinary, including input from dietitians, psychologists and physical activity specialists.
- Tier 4 services include Bariatric surgery and are only appropriate if the individual is considered morbidly obese with a BMI of 40kg/m² or more, or between 35 kg/m² and 40kg/m² or greater in the presence of significant comorbidities.

3.5.2 What are we doing?

- In Southwark, a Healthy Weight and Referral Care Pathway has been developed for children aged 0-4 (Appendix 2) and 5-12 (Appendix 3).
- Tier 2 weight management programmes have been commissioned targeting children aged between 4 and 12. These programmes provide education and practical sessions to families to increase knowledge of nutrition and encourage participation in physical activity. Further communication of these pathways is needed to ensure all professionals are aware of these services.

3.5.3 What more can we do?

- A healthy weight care pathway for adults is needed as an urgent priority. This needs to be developed and commissioned in partnership with the CCG, NHS and healthcare professionals. This should be guided by NICE guidance and include Tier 1 to Tier 4 services including bariatric surgery. The pathway should include the existing local and new National Diabetes prevention programme 'Healthier You' as overweight and obesity is a risk factor for diabetes. The programme sees patients identified as at risk of Type 2 diabetes receive tailored, personalised help to lose weight including education on healthy eating and lifestyle and bespoke physical activity programmes. It should also include the brief intervention programmes in Southwark hospitals. These programmes screen to assess smoking, alcohol and physical activity levels, offer an appropriate intervention by trained staff and refer/signpost to local services.
- A Healthy Weight and Referral Care pathway will need to be included in training for professionals and further promotion is needed to both healthcare professionals and target groups to increase programme uptake. Consistent monitoring and evaluation is also needed to ensure these services are effective and reaching priority groups.

4. Southwark healthy weight strategy

4.1 Overview

The Southwark Healthy Weight Strategy is informed by the points in Section 3. It takes an evidenced based, life-course approach implemented across all community settings. It includes targeted prevention and treatment services and a range of strategies to develop an environment that ensures that the 'healthy choice is the easy choice' in Southwark. There are currently a number of initiatives in Southwark to help address obesity and further co-ordination and work is needed to ensure these are effective and scaled up for our priority groups. These include: pregnant women and families, children aged 0-19, low socioeconomic groups and BME groups such as Black African, Black Caribbean and mixed race as well as those with limiting disability.

This strategy will be underpinned by the principle of taking a partnership approach as everyone has a role to play in raising the issue of overweight and obesity and driving change. This means engaging and securing the contribution of partners in all parts of the system, ensuring they share ownership of the issue and are fully committed to this strategy. This includes the planning, commissioning and monitoring of services by Southwark Council and the Clinical Commissioning Group (CCG), service providers and acute trusts, health and education professionals, local employers, childcare settings, schools and voluntary and community organisations. Effective monitoring and evaluation is crucial to measure impact to ensure our strategic ambitions and objectives are achieved.

This strategy will be supported with actions plans over the next five years- the first year's action plan follows. Key actions have been developed based on the evidence and advice from national bodies on what works to support a healthy weight and an assessment of current activities in Southwark.

4.2 Strategy development and implementation

The Southwark Health and Wellbeing Board set up a Senior Leadership Obesity Strategy group which has worked to develop this strategy.

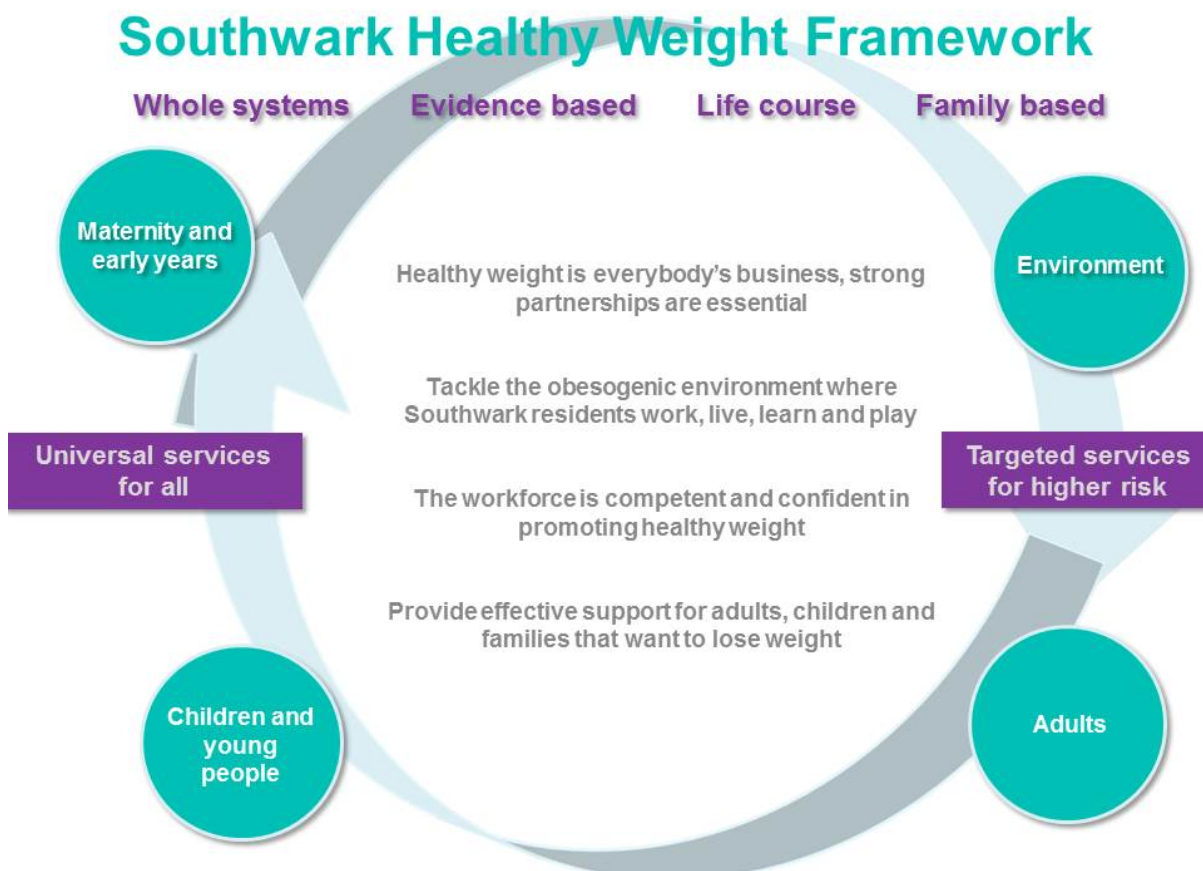
Two strategy implementation groups will now take forward implementation of the strategy. These will deliver actions related to people (life-course) and place. The targets and implementation will be reported biannually to the Health and Wellbeing Board as well as subject to rigorous performance challenge.

A wide range of partners and individuals have input to the development of the strategy and action plan including:

- Southwark Health & Wellbeing Board
- Southwark CCG
- Southwark CCG Children & Young People Development Group

- Southwark Active Travel
- London PE and School Sports Network
- Southwark Transport Teamouthwark Local Economy Team
- Southwark Communications Team
- Southwark Planning Teamouthwark Parks and Leisure Team
- Southwark Events and Arts Team
- Southwark Healthy Schools Team

4.3 Strategy framework



4.4 Five year ambitions

Our strategy and vision to support healthy weight in Southwark is guided by the following ambitions. These ambitions had been set using the National Child Measurement Programme trends, and by modelling different options. The following 5 year ambitions were adopted by the Southwark Health & Wellbeing Board in January 2016. By 2020 we will:

1. Reduce obesity of children at Reception year from 13% to 11.3% at Reception Year
2. Reduce excess weight in children from 26.4% to 23.6% at Reception Year
3. Reduce obesity of children from 27.9% to 24.9% at Year 6
4. Reduce excess weight in children from 42.7% to 24.9% at Year 6

4.5 Other linking strategies

A number of Southwark strategies & plans are already in place that will support a healthy weight strategy in Southwark including:

- Southwark Health & Wellbeing Strategy
- Southwark CCG Operating Plan
- Southwark CCG & Council Children & Young People Framework
- Southwark Five Year Forward view
- Southwark Young People Policy
- Southwark Physical Activity & Sport Strategy
- Southwark Transport Strategy
- Southwark Travel Plans
- Southwark Children and Young People's Plan
- Children & Young people's Wellbeing strategy
- Southwark Economic Wellbeing Strategy

5. Southwark healthy weight action plan

Maternity and early years		
Key actions	Lead organisation and partners	Key performance indicator
1. The UNICEF Breastfeeding Baby Friendly Initiative is implemented and monitored to support evidenced based advice and to support mothers and babies to achieve the best start in life.	Lead: Commissioning Partners: Public Health, CCG, BFI steering group	1.1 The UNICEF Breastfeeding Baby Friendly Initiative Certificate of Commitment is achieved. This included the implementation and monitoring of the Baby Friendly Initiative action plan and the developed KPIs.
2. All families are supported to achieve a healthy weight with practical, evidenced based advice and support offered by health professionals throughout maternity, and the early years through effective implementation and monitoring of an integrated early years pathway.	Lead: Commissioning Partners: Public Health, CCG, Health Professionals	2.1 Quality standards for healthy weight are established and prioritised in the early year's integrated pathway e.g. service specifications for health visitors and school nurses. 2.2 Training and promotion of the Healthy Start and Vitamin D programme is included in mandatory training developed and delivered to all health professionals working to support early years including midwives, health visitors, GPs.
3. An effective healthy weight programme is implemented and monitored for post natal services and children aged 0-4 across all priority groups.	Lead: Commissioning Partners: Public Health, CCG, Community Nutrition team	3.1 The Healthy Weight Referral and Care pathway (Appendix 2) for post natal and early years is implemented and communicated to all stakeholders to increase referrals and uptake of weight management services. 3.2 A process for monitoring referrals to Tier 2 weight management services and monitoring of effectiveness established.
4. All professionals working with children and families are provided with workforce training to ensure evidenced based, practical advice is offered to support families preparing for pregnancy, breastfeeding, weaning and establishing healthy eating and physical activity for children under five.	Lead: Commissioning Partners: Public Health, CCG, Training provider, Healthy Schools lead, Health and Education Professionals	4.1 Commissioning of a healthy weight training provider is completed with the implementation of healthy weight training packages delivered to professionals working with families, early years and school aged children. 4.2 The training is included as mandatory in future service specifications for health visitors and school nurses working with children, young people and families. 4.3 Training provided to priority groups including GPs, school nurses, health visitors and schools.
5. Early years settings are supported to take a whole settings approach to develop a healthy weight environment that supports healthy eating, physical activity, active travel and emotional wellbeing.	Lead: Commissioning Partners: Public Health, CCG,LGA, Healthy Schools lead, Active Travel team, Early Years settings	5.1 Needs assessment completed to identify current support and resource available for early years settings. 5.2 The healthy weight training offered to early years settings includes voluntary 'Eat Better,

		Start Better' guidelines to support a whole settings approach to healthy eating.
6. Families are supported to be physically active through parks and leisure services, active travel and play.	Lead: Parks and Leisure Services Partners: Public Health, Active Travel	6.1 A programme of work to support early years and families to be physically active including active travel and play found in the Southwark Sport and Physical Activity Strategy, Southwark Play Strategy and, Southwark Council's Parks investment programme.
7. Residents and key stakeholders know about the services available to them.	Lead: Public Health Partners: Campaign Manager	7.1 A Southwark Healthy Weight communication engagement project is initiated, with scoping and mapping of existing communications.

Children and young people		
Key actions	Lead organisation and partners	Key performance indicator
1. Southwark schools are supported to adopt a whole school approach to provide an environment that supports a healthy weight. This includes strategies to promote healthy eating, physical activity, active travel and emotional wellbeing through the Healthy Schools London programme.	Lead: Healthy Schools Lead Partners: Public Health, schools	1.1 Increase the number of schools registered to the Healthy Schools London programme from 74% to 85%. 1.2 Increase the number of schools with a Healthy Schools London accreditation (bronze, silver, gold) from 44% to 55%.
2. Free Healthy School Meals are provided to all children aged 4-11 and the free fruit scheme offered to children aged 7-11 in all Southwark Schools.	Lead: Commissioning Partners: Healthy Schools lead, Public Health, Schools	2.1 Participation in the free healthy school meals programme is sustained at 94% for key stage 1 and 92% for key stage 2. 2.2 Participation in the free fruit scheme is sustained at 100%. 2.3 Updated evaluation on the effectiveness of the free healthy school meals and impact on prevalence of overweight and obesity developed. 2.4 School caterers are supported to meet the School Food Standards and national School Food Plan.
3. Commissioning of the schools healthy weight programme is completed and implemented to increase awareness and capacity of schools to promote a healthy weight.	Lead: Commissioning Partners: Public Health, CCG, Training provider, Health Professionals	3.1 The healthy weight programme for school aged children is communicated to all and effectiveness evaluated.
4. All health and non-health professionals working with school aged children, young people and families are provided workforce training to give them confidence to raise the issue of weight in an appropriate manner, provide	Lead: Healthy Schools lead Partners: Public Health, CCG, Training provider, Health Professionals	4.1 Healthy weight training provider commissioned and training developed and delivered to priority groups including school nurses, health visitors, GPs and school.

evidenced based advice and signpost to relevant local and national services.		
5. Effective implementation and monitoring of a NCMP programme to identify children with excess weight and support into healthy weight and care referral pathways.	Lead: Commissioning Partners: CCG, Health Professionals, School Nursing Service, Public Health	5.1 There is an increase in the percentage of eligible schools participating in the NCMP. 5.2 Families of children identified as overweight or obese are proactively followed up, signposted or referred into Tier 2 or Tier 3 weight management services.
6. All schools are supported to develop and evaluate a targeted sport and physical activity programme to engage those children who are identified as least active e.g. children identified as vulnerable.	Lead: Public Health Partners: Healthy Schools lead, London PE & School Sports Network	6.1 Provide support to schools to identify those children that are least active and develop a physical activity and sport programme to target this group. 6.2 Support is offered to schools to monitor the effectiveness of their physical activity and sport programmes through assessment, recording and reporting on pupil progress and achievement. 6.3 A new programme of work to target school aged children identified as inactive is outlined in the Southwark Sport and Physical Activity Strategy.
7. All schools are supported to promote Active Travel and achieve accreditation.	Lead: Active Travel Team Partners: Transport, Healthy Schools lead	7.1 Increase in the number of schools registered to the Active Travel programme. 7.2 Increase in the number of schools achieving Active Travel accreditation.
8. Residents and key stakeholders know about the services available to them.	Lead: Public Health Partners: Campaign Manager	7.1 A Southwark Healthy Weight communication engagement project is initiated, with scoping and mapping of existing communications.

Adults		
Key actions	Lead organisation and partners	Key performance indicator
1. A locally agreed, evidence based, multi-agency healthy weight care pathway for adults aged 16+ is implemented to provide guidance on identification, assessment, advice, and signposting/referral.	Lead: Commissioning Partners: CCG, Public Health, Service Providers, Health Professionals	1.1 A review of the evidence is conducted and used to inform the development of an evidenced based locally agreed, multi-agency healthy weight and referral care pathway for adults aged 16+ to provide guidance on identification, assessment, advice and signposting to relevant local support for underweight, healthy weight and overweight adults. 1.2 A Tier 2 and Tier 3 multidisciplinary service targeting residents who are identified as morbidly obese or obese with related co-morbidities is fully integrated into the healthy weight pathway, targeting those identified to be at high risk of complications from obesity and those that are

		<p>potential candidates for bariatric surgery.</p> <p>1.3 The healthy weight care and referral pathway is implemented and monitored for effective uptake by priority groups.</p>
<p>2. All health professionals are supported to MECC and provide brief advice to patients identified as overweight or obese to signpost/refer to local services and support behaviour change.</p>	<p>Lead: Public Health</p> <p>Partners: CCG, NHS acute trust</p>	<p>2.1 All staff and patients at Southwark hospitals are offered screening and brief intervention on smoking, alcohol and physical activity levels (as part of weight management services) as part of the local CQUIN incentive scheme in Southwark.</p> <p>2.2 Consideration for further MECC training roll-out to Social Care and potentially wider workforce.</p>
<p>4. Residents who are identified as inactive, overweight or obese and other vulnerable groups will be supported to engage and participate in regular physical activity including active travel.</p>	<p>Lead: Public Health</p> <p>Partners: PRO-ACTIVE</p>	<p>4. 1 A new programme of work is developed to target those adults identified as least active is included in the new Southwark Sport and Physical Activity Strategy.</p>
<p>5. Residents and key stakeholders know about the services available to them.</p>	<p>Lead: Public Health</p> <p>Partners: Campaign Manager</p>	<p>5.1 A Southwark Healthy Weight communication engagement project is initiated, with scoping and mapping of existing communications.</p>

Environment		
Key actions	Lead organisation and partners	Key performance indicator
<p>1. All future major Southwark Council led strategies and plans will be developed in consultation with Public Health to ensure they support a healthy weight environment e.g. provision of and access to safe green open spaces, opportunities for play and physical activity, food growing and working with food businesses.</p>	<p>Lead: Public Health</p> <p>Partners: Southwark Council, Planning</p>	<p>1.1 An effective consultation process between Public Health and Planning is developed to ensure coordination of major Planning and Public Health policies to ensure all future Council led strategies and plans are developed to support a healthy weight environment.</p> <p>1.2 Public Health to provide evidence based recommendations, national and local data, new guidelines and resources to support effective strategy and planning as needed.</p>
<p>2. All new Southwark planning applications are assessed to ensure they support a healthy weight environment including the six elements: movement and access, open spaces, recreation and play, food environment, neighbourhood spaces, building design, and local economy.</p>	<p>Lead: Public Health</p> <p>Partners: Southwark Council, Planning, Highways</p>	<p>2. 1 Development of an agreed process to ensure Public Health is consulted in the development management process and all local planning applications are assessed to ensure they support a healthy weight environment.</p> <p>2. 2 An agreed local planning and health checklist is developed and aligned with existing guidance for internal use. Align with Transport and Highways review processes for assessing planning applications (design principles set out in</p>

		Southwark's Streetscape Design Manual). 2.3 Public Health supports work to enhance the impact of Planning policy on health outcomes and health inequalities.
3. All events and sponsorship promote and support residents to achieve a healthy weight e.g. provision of healthy food and activities to support physical activity including active travel and mental and emotional wellbeing.	Lead: Events and Arts Partners: Public Health	3.1 Development of agreed local guidance to support healthy procurement, catering, sport and physical activity provision and promotion at all local Council run events to ensure they support a healthy weight environment.
4. All Council owned buildings, parks and leisure services provide and promote healthy and affordable food and beverages where available.	Lead: Parks and Leisure Services Partners: Public Health, Catering Providers	4.1 Work is commenced to identify levers for influencing Council owned buildings to support healthier food provision and advertising. 4.2 Caterers in all new Council run parks and leisure services are committed to achieving the Food for Life charter mark and signing up to the Healthily Catering Commitment. 4.3 Providers are supported to meet healthy catering guidance and provide a range of healthy, affordable food and beverages at all applicable council parks and leisure services.
5. Local restrictions are placed on hot food takeaway outlets on high streets and in close proximity to schools.	Lead: Planning Partners: Public Health	5.1 Legislation is included in the new Southwark Council plan to restrict the concentration of hot food takeaways opening on Southwark High Streets and in close proximity to secondary schools.
6. Southwark Parks are safe and clean, and provide opportunities for residents to be physically active including active travel and play.	Lead: Parks and Leisure Services Partners: Public	6.1 Outcomes outlined in the Council plan are achieved for Parks Satisfaction, Green Flags and the delivery of top quality children's play target. Nine Specific Children's Play areas are developed as part of the parks investment programme.
7. All workplaces are supported to develop an environment that supports a healthy weight through the Healthy Workplace charter, resources and advice.	Lead: Public Health Partners: Transport, Local Economy team	7.1 A healthy workplace webpage is developed as part of the existing Southwark business portal. This will promote the London Workplace Health Charter, the Healthy Catering commitment, Active Travel and further local and national resources. 7.2 Website visits are monitored and workplace feedback assessed. 7.3 50% increase in the number of Southwark businesses signed up to the London Workplace Health Charter. 7.4 25% increase in the number of Southwark businesses signed up to the London Healthy Workplace Health Charter achieving accreditation

8. Residents and key stakeholders know about the services available to them.	Lead: Public Health Partners: Campaign Manager	8.1 A Southwark Healthy Weight communication engagement project is initiated, with scoping and mapping of existing communications.
--	---	--

Appendix 1

Local Qualitative Findings

The Southwark Child Obesity joint review (9) took place between September 2011 and March 2012. The children and young people partnership board requested that a joint review be carried out using a community lens to better understand the complex picture facing Southwark communities. A joint review group was established to steer the review comprising members of local communities, parents and representatives from local organisations. Multi-disciplinary events were held for our local communities, the voluntary sector and local professionals. There were focus groups in children's centres, schools, with parent groups, youth councils and other community settings. Thirty Community Researchers were recruited to carry out interviews with their own communities.

The aim of the review was to better understand from a community perspective how these complex factors operate in Southwark in order to formulate recommendations that would help tackle the increase in child obesity in Southwark.

We know that in Southwark child obesity is more prevalent in our more deprived communities with the highest rates being in Walworth, Rotherhithe and Peckham. We also know that Black African, Black Caribbean and mixed race children are more likely to be obese. Rates of obesity rise as children get older and there is a slightly higher prevalence in boys than girls.

From their experience, frontline staff felt that children from low income families, from some BME groups particularly African and Caribbean families, children in families with complex needs, and children of overweight parents were more likely to be overweight or obese.

Awareness of the problem of child obesity in the borough was high amongst the frontline staff who attended the Joint Review events but lower amongst parents/carers and family members a proportion of whom were unsure if there was a problem with child obesity in Southwark. However, it is difficult to know from survey responses what people perceive as obesity and overweight in children and if some people only recognise obesity in a child when it is quite severe.

Parents/carers and family members understand that child obesity could have an impact on physical health but were less likely to know the range of impacts or specific conditions. Many parents/carers and family members however thought that there was likely to be an emotional and social effect on children with many specifying bullying, low self-esteem and not 'fitting in'.

Both frontline staff and parents/carers and family members thought the problem was caused by too much unhealthy food availability in Southwark and children and young people eating too much of it. Many people talked particularly about chicken and chip shops and other fast food outlets where food was cheap and accessible. Children and young people themselves viewed fast food and unhealthy food as desirable. For older children with their own money they talked about how cheap, convenient and accessible it was. A risk time for unhealthy eating seemed to be after school and weekends.

Parents wanted school meals and other food provided in schools to be healthy. Low income and lack of time due to long working hours was seen as a reason for families making unhealthy food choices. The provision of Free Healthy School Meals is an important part of the jigsaw to promoting healthier eating.

Both parents/carers, family members and frontline staff felt that many families were not motivated or interested in making changes to their lifestyle or taking more control over their child's eating or exercise habits. They felt that this could be because they did not think there was a problem or because there were other more pressing priorities such as their family's financial situation and their children's immediate happiness, behaviour and safety.

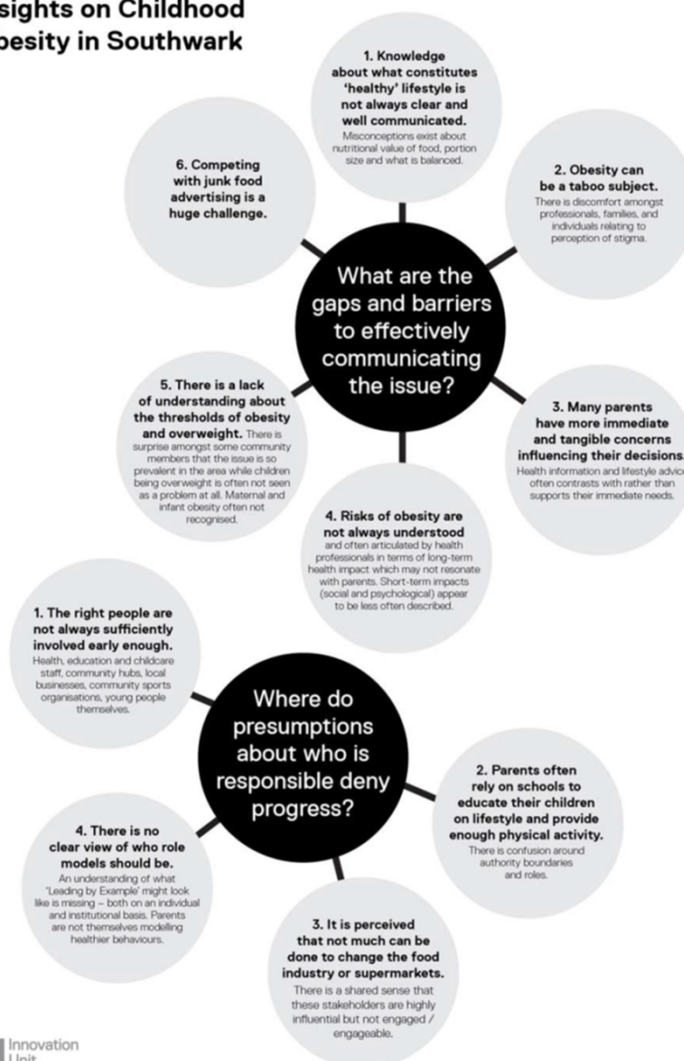
Parents/carers and children and young people themselves talked about the attraction of sedentary activities such as video games, TV, computers and social networking. Parents/carers and family members and young people felt that there were not enough affordable, attractive and age appropriate physical activity options in the borough.

People felt that educating and raising awareness with parents about risks of obesity, good nutrition and exercise was important. It was felt that parents often did not understand how much fat; salt and sugar were in foods. Frontline health staff felt some frustration that they did not always have the capacity to do this or that messages they delivered were sometimes not received well or that parents were not willing to make changes.

Many parents/carers and family members felt that schools, the NHS and Southwark Council could do more to educate parents in an interactive and appealing way. People also felt that community networks, faith groups and sport and leisure providers could do more.

Many frontline staff mentioned that there are a number of cultural norms and beliefs about weight, healthy eating and physical activity which are an on-going challenge when tackling child obesity. The review heard that there were many misconceptions about the relative healthiness of foods amongst some families. Inappropriate infant feeding was highlighted as being a problem especially in some communities. Frontline workers also felt that some African and Caribbean families may see a bigger body size as desirable in babies and children and were therefore less likely to be concerned.

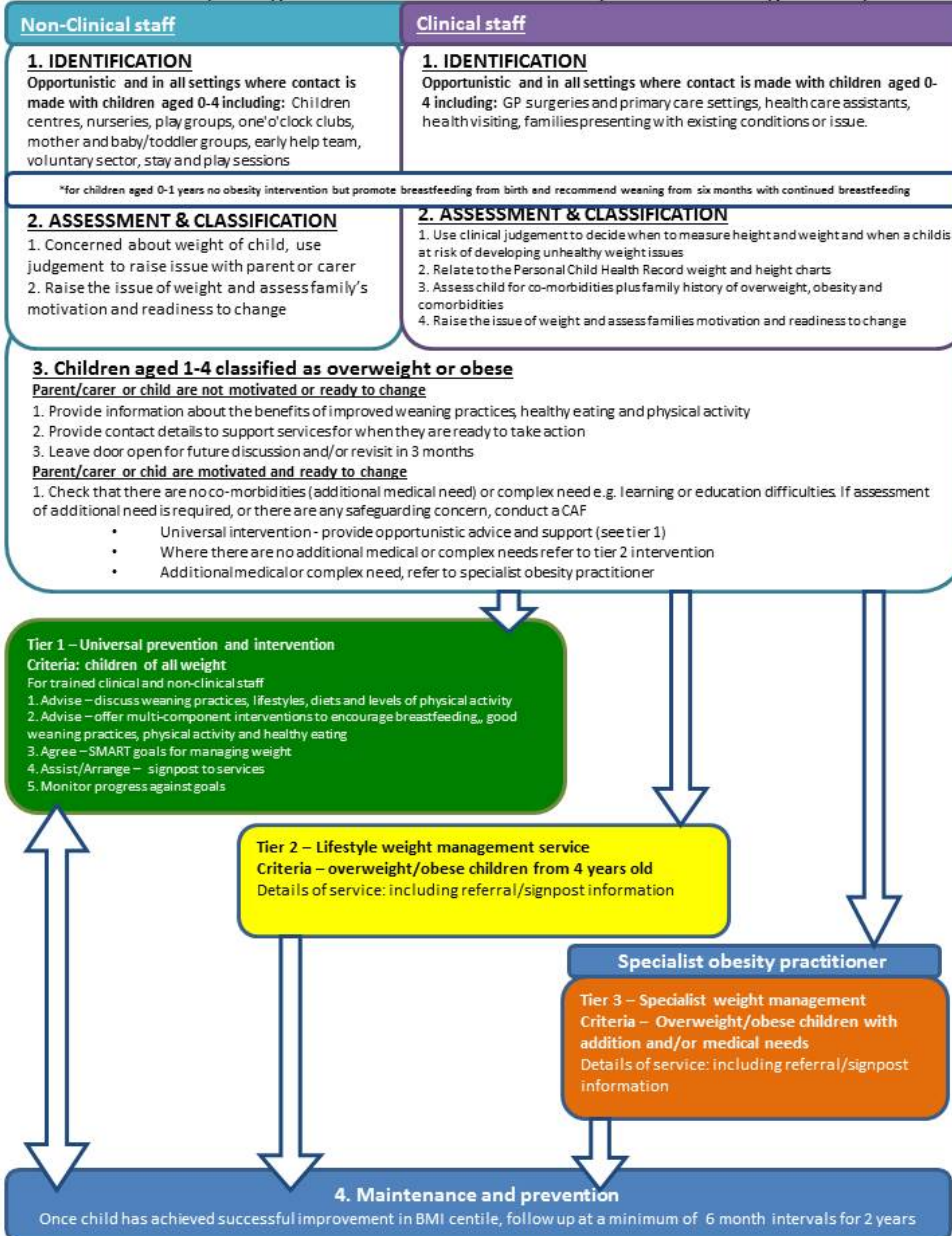
Insights on Childhood Obesity in Southwark



Appendix 2

Southwark healthy weight referral and care pathway for children aged 0-4 years

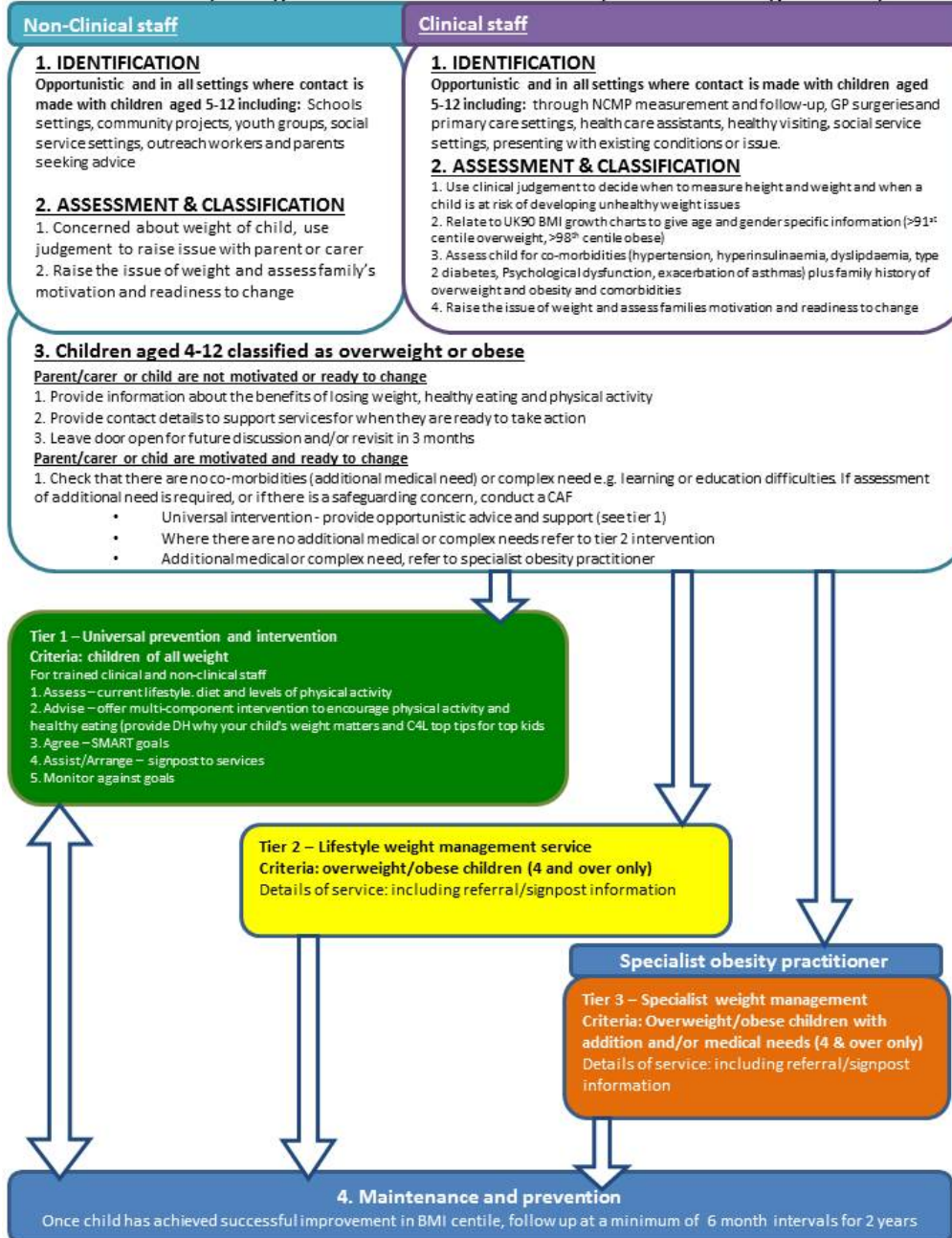
Southwark Healthy Weight Referral and Care Pathway for Children aged 0-4 years



Appendix 3

Southwark healthy weight referral and care pathway for children aged 4-12 years

Southwark Healthy Weight Referral and Care Pathway for Children aged 5-12 years



References

1. Obesity - Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children 2006' NICE clinical guidelines
2. Government Office for Science . (2007) Tackling obesity's future choices report. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/287937/07-1184x-tackling-obesity-future-choices-report.pdf
3. McPherson NO, Fullston T, Aitken RJ, Lane M. (2014) *Paternal Obesity, interventions and mechanistic pathways to impaired health in offspring*. *Ann Nutr Metab.* 7:1027-76
4. Reilly, J., Dorosty, A. and Emmett, P. (1999). Prevalence of Overweight and Obesity in British Children: Cohort Study. *British Medical Journal*, 319(7216):1039
5. http://www.unicef.org/nutrition/index_24824.html
6. Weng SF et al, (2012) Systematic review and meta-analyses of risk-factors for childhood overweight identifiable during infancy. *Arch Dis Child* 97 (12): 1019-26)
7. Kahn, B. E., & Wansink, B. (2004) The influence of assortment structure on perceived variety and consumption quantities. *Journal of Consumer Research.* 30:4, 519-533.
8. Kantar Worldpanel, sample of 27,000 households in England, January 2013/January 2014.
9. Lambert, K. G., Neal, T., Noyes, J., Parker, C., & Worrel, P. (1991) Food-related stimuli increase desire to eat in hungry and satiated human subjects. *Current Psychology.* 10:4, 297-303.
10. Public Health England (2014) Everybody Active, Everyday: A framework to embed physical activity into daily life
11. Lundahl, Kidwell and Nelson (2014) Parental underestimates of child weight: a meta-analysis. *Paediatrics.* 014: 133, e689–703. 12. https://www.noo.org.uk/NOO_about_obesity/maternal_obesity/maternalhealth
13. Baird, J., Fisher, D., Lucas, P., et al. (2005) Being big or growing fast: systematic review of size and growth in infancy and later obesity. *BMJ.* 331(7522):929.
14. https://www.noo.org.uk/NOO_about_obesity/child_obesity/Health_risks
15. http://www.noo.org.uk/NOO_about_obesity/adult_obesity/Health_risks
16. http://www.noo.org.uk/NOO_about_obesity/economics
17. Department for Health. (2008). Healthy Weight, Healthy Lives Toolkit for Developing Local Strategies. Available at: http://www.fph.org.uk/healthy_weight%2c_healthy_lives%3a_a_toolkit_for_developing_local_strategie
18. National Child Measurement Programme <http://www.hscic.gov.uk/ncmp>
19. Local Southwark Obesity NCMP results, available at: <http://fingertips.phe.org.uk/profile/national-child-measurement-programme/data#page/3/gid/8000011/pat/6/par/E12000007/ati/102/are/E09000028/iid/92033/age/201/sex/4>
20. Southwark Childhood Obesity Joint Review Bertoul (2012)
21. Department of Health. (2011) Start Active, Stay Active: A report on physical activity from the four home countries' Chief Medical Officers
22. Southwark Council. (2015) Free Swim and Gym report.

23. fingertips: <http://www.phoutcomes.info/search/obesity%20data#pat/6/ati/102/par/E12000007>
24. Southwark Joint Strategic Needs Assessment (2015)
25. Rimmer J, Wang E, Yamaki K, & Davis B. FOCUS Technical Brief No. 24. Documenting Disparities in Obesity and Disability, National Center for the Dissemination of Disability Research (NCDDR) 2010.
26. Child and Maternal Health Observatory (CHIMAT). Disability and obesity: the prevalence of obesity in disabled children, 21 July 2011
27. <https://nice.org.uk/guidance/ph42/evidence/review-1-identifying-the-key-elements-and-interactions-of-a-whole-system-approach-to-obesity-prevention2>
28. <http://www.who.int/end-childhood-obesity/en/>
29. http://www.london.gov.uk/sites/default/files/gla_migrate_files_destination/Early%20Years%20Briefing.pdf.
30. Department of Health. (2009) *Healthy Child Programme –Pregnancy and the first five years of life*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf
31. <http://www.unicef.org.uk/babyfriendly/>
32. <https://www.healthystart.nhs.uk/>
33. WHO.(2015) *Report of the Commission on ending Childhood Obesity*. Available at: http://apps.who.int/iris/bitstream/10665/204176/1/9789241510066_eng.pdf
34. All Party Parliamentary Group for Fit and Healthy Childhood. (2015) *The National Obesity Framework*. Available at: http://www.api-play.org/upload/public/news-stories/APPG%20Report_Early%20YearsFINAL%20with%20images.pdf
35. Childrens Food Trust. (2012) *Voluntary Food and Drink Guidelines for Early Years Settings in England – A practical guide*. Available at: http://cft-staging-cdn.core-clients.co.uk.s3-eu-west-1.amazonaws.com/2015/06/CFT_Early_Years_Guide_Interactive_Sept-12.pdf
36. Local uptake of FSM –taken from London Association of Directors of PH framework
37. Dimpleby, H & Vincent, J. (2013) *The School Food Plan*. Available at: http://www.schoolfoodplan.com/wp-content/uploads/2013/07/School_Food_Plan_2013.pdf
38. <http://www.healthyschools.london.gov.uk/resources/healthy-take-aways/whole-school-approach>
39. Public Health England. (2015) *What works in Schools to increase Physical Activity*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/469703/What_works_in_schools_and_colleges_to_increase_physical_activity.pdf
40. <http://www.southwark.gov.uk/healthcheck>
41. http://www.southwark.gov.uk/info/10096/physical_activity/892/southwarks_exercise_referral_programme
42. <https://www.london.gov.uk/what-we-do/health/priority-areas/healthy-workplace-charter>
43. https://www.noo.org.uk/NOO_about_obesity/causes

This page is intentionally blank

**HEALTH AND WELLBEING BOARD AGENDA APPENDICES DISTRIBUTION LIST (OPEN)
MUNICIPAL YEAR 2016/17**

NOTE: Amendments/queries to Everton Roberts, Constitutional Team, Tel: 020 7525 7221

Name	No of copies	Name	No of copies
Health and Wellbeing Board Members		Officers	
Andrew Bland	1	Eva Gomez	1
Councillor Stephanie Cryan	1	Everton Roberts, Constitutional Team	4
Aarti Gandesha	1		
Councillor Barrie Hargrove	1		
Dr Jonty Heaversedge	1		
Councillor Peter John	1		
Eleanor Kelly	1	Total:	18
Gordon McCullough	1		
Professor John Moxham	1		
Carole Pellicci	1		
David Quirke-Thornton	1		
Dr Yvonneke Roe	1		
Dr Ruth Wallis	1		
		Dated: July 2016	