Open Agenda

Health and Wellbeing Board

Thursday 29 January 2015
10.00 am
Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

Membership

Councillor Peter John (Chair)	Leader of the Council
Andrew Bland	NHS Southwark Clinical Commissioning Group
Councillor Dora Dixon-Fyle MBE	Cabinet Member for Adult Care, Arts and Culture
Aarti Gandesha	Healthwatch Southwark
Councillor Barrie Hargrove	Cabinet Member for Public Health, Parks and Leisure
Jonty Heaversedge (Vice-Chair)	NHS Southwark Clinical Commissioning Group
Eleanor Kelly	Chief Executive, Southwark Council
Gordon McCullough	Community Action Southwark
Professor John Moxham	King's Health Partners
David Quirke-Thornton	Strategic Director of Children's and Adults' Services
Dr Yvonneke Roe	NHS Southwark Clinical Commissioning Group
Dr Ruth Wallis	Director of Public Health
Metropolitan Police Service	Vacancy

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Contact

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

Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 21 January 2015

PRINTED ON RECYCLED PAPER

Health and Wellbeing Board

Thursday 29 January 2015
10.00 am
Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

Order of Business

Item No.	Title	Page No.
1.	**APOLOGIES** To receive any apologies for absence.	
2.	**CONFIRMATION OF VOTING MEMBERS** Voting members of the committee to be confirmed at this point in the meeting.	
3.	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT** In special circumstances, an item of business may be added to an agenda within five clear days of the meeting.	
4.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members of the committee to declare any interests and dispensation in respect of any item of business to be considered at this meeting.	
5.	**MINUTES** To agree as a correct record the open minutes of the meeting held on 2 October 2014.	1 - 4
6.	**THE NHS FIVE YEAR FORWARD VIEW AND NHS PLANNING GUIDANCE** To review the paper on the NHS Forward View and the associated planning guidance for 2015/16 and to note the nationally determined requirements of the clinical commissioning group included in the planning guidance and the proposed approach to meet the requirements.	5 - 22

Item No.	Title	Page No.

15. CROSS BOROUGH SEXUAL HEALTH STRATEGY

16. LONDON HEALTH COMMISSION REPORT

Date: 21 January 2015

Agenda Item 5

Health and Wellbeing Board

MINUTES of the OPEN section of the Health and Wellbeing Board held on Thursday 2 October 2014 at 10.00 am held at 160 Tooley Street, London SE1 2QH

PRESENT:	Councillor Peter John (Chair) Andrew Bland Councillor Dora Dixon-Fyle MBE Councillor Barrie Hargrove Eleanor Kelly Gordon McCullough Professor John Moxham Dr Yvonneke Roe Dr Ruth Wallis
OBSERVERS:	Sec-Chan Hoong, Healthwatch Southwark
OFFICER SUPPORT:	Kerry Crichlow, Director of Strategy and Commissioning

1. APOLOGIES

Apologies for absence were received from Jim Crook, Dr Jonty Heaversedge, Councillor Rebecca Lury, Chair of Healthy Communities Scrutiny Sub-Committee and Metropolitan Police Service.

2. CONFIRMATION OF VOTING MEMBERS

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

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

There were no late items.

4. DISCLOSURE OF INTERESTS AND DISPENSATIONS

There were no disclosures of interests or dispensations.

5. MINUTES

RESOLVED:

That the minutes of the meeting held on 28 July 2014 be approved as a correct record and signed by the Chair.

Matters Arising

Item 9 – Early Action Commission

Gordon McCullough gave a brief update on early action commission. He reported that Margaret Hodge MP would be chairing the commission. The commission would start on 12 November and would continue through to March 2015.

6. HEALTH AND WELLBEING BOARD GOVERNANCE REVIEW

Kerry Crichlow, Director of Strategy and Commissioning introduced the report.

RESOLVED:

1. That the recommendations of the Health and Wellbeing Board Governance review attached at Appendix 2 to the report be accepted.

2. That Dr Jonty Heaversedge be appointed vice-chair of the Health and Wellbeing Board.

3. That a planning sub-group be established as set out at paragraph 6(ii) of the report, made up of those Board members who currently form part of the agenda planning arrangements with the addition of Gordon McCullough, Community Action Southwark as the voluntary sector representative.

4. That the priority work areas for the board listed in paragraph 7 of the report and detailed below be agreed:

   - Sexual health
   - Mental wellbeing
   - Alcohol/substance misuse
   - Smoking
   - Obesity, diabetes and other long-term conditions
   - Early Years and children's health and wellbeing

5. That the protocol between the Health and Wellbeing Board, the Southwark Safeguarding Children Board and the Southwark Safeguarding Adults Board attached at Appendix 3 to the report be noted.

7. HEALTH IN SOUTHWARK - IMPROVING SEXUAL HEALTH PRESENTATION

The board received a presentation from Dr Gillian Holdsworth, Consultant in Public Health on sexual health in Southwark.

Dr Holdsworth highlighted the identified rates of sexual diseases in Southwark, the risk factors, demand for sexual health services, cost and cost pressures, the strategies and delivery mechanisms for addressing the issue including the need for increased focus on prevention.

In terms of sexual health clinics, due to the tariff system in place, it was requested that a breakdown of information of the people who were getting seen and what they were being seen for be provided in order to establish cost effectiveness.

8. HEALTH AND WELLBEING STRATEGY UPDATE PRESENTATION

The board received a presentation from Jin Lim, Assistant Director of Public Health on the Health and Wellbeing Strategy.

The board noted the presentation.

9. DIRECTOR OF PUBLIC HEALTH REPORT - LAMBETH & SOUTHWARK

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

RESOLVED:

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

10. INTEGRATION UPDATE - BETTER CARE FUND (BCF)

Adrian Ward, Programme Manager – Integration and Better Care Fund introduced the report.

RESOLVED:

That the Better Care Fund plan re-submission of 19 September 2014 and next steps as set out in paragraphs 13 – 18 of the report be noted.

11. ACCESS TO HEALTH SERVICES IN SOUTHWARK (HEALTH, ADULT SOCIAL CARE, COMMUNITIES & CITIZENSHIP SCRUTINY SUB-COMMITTEE)

RESOLVED:

That the contents of the review report, 'Access to Health Services in Southwark' be noted and a response to the relevant recommendations be provided at the board meeting scheduled for 20 November 2014 and the response be conveyed to the Healthy Communities scrutiny sub-committee.

The meeting ended at 11.55am

CHAIR:

DATED:

Agenda Item 6

Item No. 6.	Classification: Open	Date: 29 January 2015	Meeting Name: Health and Wellbeing Board
Report title:		The NHS Five Year Forward View and NHS Planning Guidance	
Ward(s) or groups affected:		All wards	
From:		Andrew Bland, Chief Officer, NHS Southwark CCG	

RECOMMENDATIONS

1. The board is requested to:

   - Review the attached briefing paper on the *NHS Forward View* and the associated planning guidance for 2015/16.
   - Note the nationally determined requirements of the CCG included in the planning guidance and also the current CCG's proposed approach to meeting these requirements.
   - Note the CCG's locally-determined approach to delivering improved outcomes for the people of Southwark.
   - Note that the Health & Wellbeing Board will receive a final draft of the CCG's Operating Plan at its March 2015 meeting. The Board will be asked to take to assurance that the CCG's plan sufficiently constitutes a credible plan, which ensures Southwark patients receive the services they are entitled to; that we are planning appropriate interventions to improve the outcomes of Southwark's residents; and that our plans are aligned with the objectives of the Health & Wellbeing Strategy and Better Care Fund in Southwark.

EXECUTIVE SUMMARY

2. The *NHS Five Year Forward View* was published on 23 October 2014 and sets out a vision for the future of the NHS. It has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority.

3. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

4. The purpose of the *Five Year Forward View* is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Everyone will need to play their part – system leaders, NHS staff, patients and the public – to realise the potential benefits for us all.

5. The *Forward View* covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

6. The *Five Year Forward View* starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England.

7. The document defines the framework for further detailed planning about how the NHS needs to evolve over the next five years. A summary of the specific requirements of planning guidance for 2015/16 are included in the briefing as well as a summary of the CCG's local response to these challenges.

BACKGROUND INFORMATION

8. The CCG presented its two year Operating Plan to the Health and Wellbeing Board in March 2014. The refreshed version will be presented in March 2015.

KEY ISSUES FOR CONSIDERATION

Policy implications

9. The emphasis on a radical new approach to public health and prevention with CCG and local authorities asked to set and share quantifiable levels of ambition to reduce local health and healthcare inequalities and improve outcomes for health and wellbeing. Further guidance is anticipated.

10. The encouragement to all local areas to develop a shared vision of health and care for their populations in the context of the strategic choices outlined by the *Forward View*.

11. The ambition for the level of improvement agreed by CCGs and Councils in Better Care Fund (BCF) plans should be reviewed if there is a material change in their assessment of the risk to delivery, taking into account:

    1. actual performance in the year to date, particularly through the winter;
    2. the likely outturn for 2014/15;
    3. progress with contract negotiations with providers.

12. Any such review should be undertaken within the partnership underpinning local BCF planning and approved by the Health and Wellbeing Board.

13. The Health and Wellbeing Board will be asked to endorse a refreshed CCG operating plan. The updated plan will be made available at the March 2015 HWB meeting. The refreshed plan should reflect any updated Health and Wellbeing Strategy.

Community and equalities impact statement

14. The CCG will complete an equalities impact assessment as part of its planning in order to determine the extent of any differential impact of proposed strategic changes on various groups in Southwark.

Legal implications

15. None at this stage

Financial implications

16. The full financial implications of the NHS Forward View and associated planning guidance is currently being modelled and will be detailed in full to the HWB Board at its March 2015 meeting.

BACKGROUND PAPERS

Background Papers	Held At	Contact
Southwark JSNA Southwark CCG Operating Plan 2014/15 Southwark Health and Wellbeing Strategy	www.southwarkccg.nhs.uk	Kieran Swann Head of Planning & CCG Assurance 0207 525 0466
NHS Forward View	http://www.england.nhs.uk/ourwork/futurenhs/	

APPENDICES

No.	Title
Appendix 1	The NHS Five Year Forward View and NHS Planning Guidance Presentation

AUDIT TRAIL

Lead Officer	Andrew Bland, Chief Officer, NHS Southwark CCG	
Report Author	Kieran Swann, Head of Planning & CCG Assurance	
Version	Final	
Dated	19 January 2015	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Strategic Director of Children's and Adults' Services	No	No
Date final report sent to Constitutional Team		19 January 2015

NHS Southwark Clinical Commissioning Group

APPENDIX 1

The *NHS Five Year Forward View* and NHS Planning Guidance

Southwark Health & Wellbeing Board

January 2015

The NHS Five Year Forward View

NHS Southwark Clinical Commissioning Group

The NHS Five Year *Forward View* was published by NHS England in October 2014 and **sets out a vision for the future of the NHS**. - http://www.england.nhs.uk/ourwork/futurenhs/

The document makes clear that a lot has been achieved over the last fifteen years:

- Cancer outcomes are vastly better, with more people surviving cancer than ever before.
- Waiting times for A&E and for routine operations have been cut significantly.
- Stroke and cardiac services have been centralised leading to better outcomes.
- Patient satisfaction in the NHS has increased.

But over the next five years more work is needed to:

- Reduce variation in the quality of services and outcomes
- Tackle preventable illness and inequalities and put an emphasis on public health
- Adapt to an aging population by changing the way we deliver services
- Ensure financial stability in a climate of growing demand

An emphasis on prevention and public health

NHS Southwark Clinical Commissioning Group

The first argument made in the *Forward View* is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health**. The NHS will therefore need to:

- Back hard-hitting national action on obesity, smoking, alcohol and other major health risks.
- Help develop and support new ideas in the workplace to help employees' health and cut sickness-related unemployment.
- Advocate for stronger public health-related powers for local government/elected mayors.

When people do need health services, **patients will gain far greater control of their own care**. This will include:

- The option of shared budgets combining health and social care.
- New support for the 1.4 million full time unpaid carers in England
- The NHS will becoming a better partner with voluntary organisations and local communities.

Breaking down barriers: models of integration

NHS Southwark Clinical Commissioning Group

The second argument in the *Forward View* is that **the NHS will take decisive steps to break down the barriers in how care is provided** between family doctors and hospitals, between physical and mental health, between health and social care.

However, there will be no model for transformation imposed on local health economies. Different local health communities will instead be supported and resourced to choose from a small number of new care delivery options and then put them into action:

The *Five Year Forward View* suggests two models that local areas could adopt:

- **Multispecialty Community Providers (MCPs).**This model envisages groups of GPs combined with nurses, hospital specialists, mental health, social care and community services to create integrated out-of-hospital services. These groups would seek to harness the collective skills and knowledge of those within them, to work much more intensively and proactively with patients with complex and on-going needs.

- **Integrated Primary and Acute Care Systems (PACS)**. This model would allow a single organisation to provide GP and hospital services, together with mental health and community services. Hospitals would be able to open their own GP services and provide additional out-of-hospital services. By bringing together all parts of the health system, this could promote 'joined-up care' and allow for greater discretion over how money is spent.

Breaking down barriers

NHS Southwark Clinical Commissioning Group

Further steps will also be taken at national and local levels so that:

- Across the NHS, **urgent and emergency** care services will be redesigned to join together A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services.
- **Smaller hospitals** will have new options to help them stay workable, including making partnerships with other hospitals further away, and partnering with specialist hospitals to provide more local services.
- Midwives will have new options to take charge of the **maternity services** they offer.
- The NHS will provide more support for **frail older people** living in care homes.
- More money will be invested in **primary care** and the number of GPs in training will be increased as fast as possible, with new options to help GPs who want to stay on working.
- More money will be spent on developing the **workforce** and improving the use of health technology and will improve the NHS' ability to do research and use innovation.

Resources

NHS Southwark Clinical Commissioning Group

The **third argument** is about the **NHS using money well**. Analysis has shown that there will be a significant gap of nearly £30bn a year between resources and patient needs by 2020/21. So to provide the full and high quality care that people clearly want from the NHS, we will need to:

- Take action on prevention, to reduce the burden of disease and keep people healthy.
- Invest in new care models to deliver services.
- Become more efficient in everything we do, and embrace innovation and new technologies.

But The *Five Year Forward View* is also clear that **these alone will not be enough** to close the £30 billion gap. Additional funding from the government will be required for the NHS (as well as partners in social care) to maintain and improve services.

Responding to the *Forward View*

NHS Southwark Clinical Commissioning Group

Southwark CCG is well placed to meet the challenges posed by the *Five Year Forward View*. We have been working with our partners across health and social care to change the way care is delivered to patients to make it more personalised and responsive.

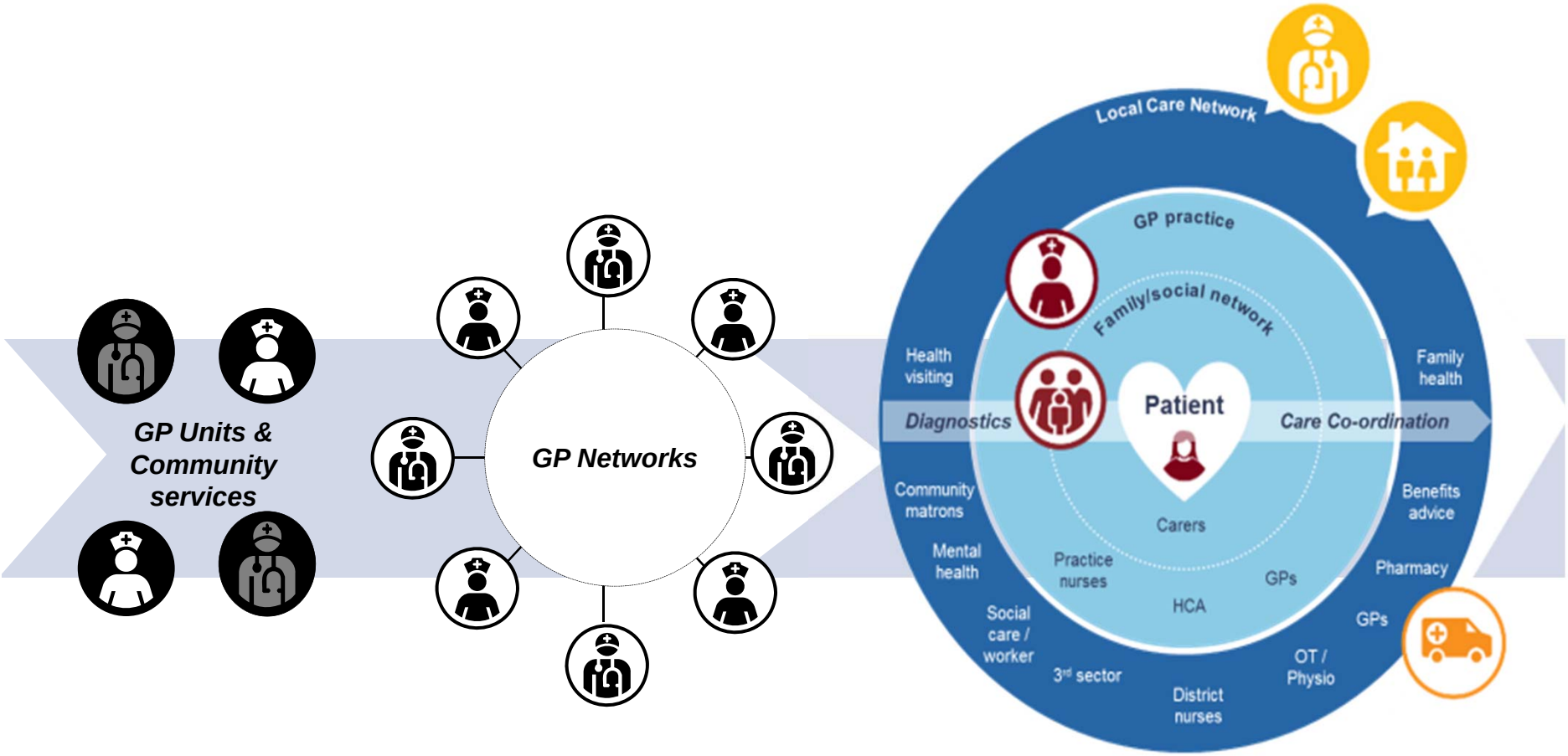
- GPs have now come together in **federations** to work together at scale and with greater resilience to reduce variation and improve quality, with an enhanced ability to work with others to provide a wider range of community based services.

- We rapidly moving towards agreement with partners to establish **Local Care Networks** which will bring together all health and social care organisations, the voluntary sector and patient groups and are founded on neighbourhoods of local populations.

- Local Care Networks will have the autonomy to act to improve health and wellbeing outcomes for their designated population with a strong emphasis on **prevention and early intervention**.

The Local Care Network model

NHS Southwark Clinical Commissioning Group



Primary care working within LCN's

NHS operating planning guidance

NHS Southwark Clinical Commissioning Group

- The *Forward View* into Action: Planning for 2015/16 guidance was published on 24th December 2014. This operating guidance for the NHS relays requirements and announcements included in the Five Year Forward View and the NHS financial allocations for 2015/16.

- The guidance sets out the first steps the NHS should take in 2015/16 towards implementation of the vision set out in the *Forward View* document.

- In response to the guidance, CCGs are required to complete a short 'Operating Plan', which should include:
  - A declaration of commitment to meeting national requirements;
  - A statement of ambition for the improvement of NHS performance indicators;
  - Demonstrate a credible financial plan;
  - Set a clear forecast of anticipated activity levels; and also
  - Describe some key programmes of service improvement.

- As CCG's current plans were written last year to cover the period until the end of 2016, the guidance requires CCGs only to review and refresh their plans for 2015/16 (these two year plans were endorsed by the HWB Board last year).

What's new in this year's planning guidance?

NHS Southwark Clinical Commissioning Group

- The specific national requirements set out in this year's guidance are very similar to those issued last year. The exception is additional performance targets, which establish maximum waiting times for psychosis and IAPT services:
  - By April 2016, it is expected that more than 50% of people experiencing a first episode of psychosis will receive treatment within two weeks.
  - At least 75% of adults should have had their first IAPT treatment session within six weeks of referral, with a minimum of 95% treated within 18 weeks.
- The CCG is currently working with providers to identify performance and activity trajectories in these areas.
- The operating planning guidance emphasises the requirement for CCG's to maintain an intense focus on ensuring performance and all NHS Constitution standards (e.g. A&E and RTT targets) are consistently delivered for their populations.

What's new in this year's planning guidance?

NHS Southwark Clinical Commissioning Group

- Planning guidance confirms an additional £1.83bn is to be allocated to the NHS as well as a further investment of £480m nationally to be used to support transformation in primary care, improved mental health and the transformation of local health economies. The guidance confirms winter pressures funds will be made available to trusts (via commissioners) upfront rather than in-year as had been the case previously.

- The guidance outlines a 'permissive' approach to local health economies developing and implementing new models of care transformation. The document describes an opportunity for "vanguard" areas to move at pace on the implementation of the models of change outlined in the *Forward View* (see previous slides).

- Local areas are also "strongly encouraged" to use 2014/15 units of planning (SPGs) to develop and progress transformation and whole system working is also strongly emphasised.

HWB implications of NHS planning guidance

NHS Southwark Clinical Commissioning Group

The *Forward View* into Action guidance is particularly relevant to the work of health and wellbeing boards in the following ways:

- The emphasis on a radical new approach to public health and prevention with CCG and local authorities asked to set and share quantifiable levels of ambition to reduce local health and healthcare inequalities and improve outcomes for health and wellbeing. These should be supported by agreed actions to achieve these, such as specifying behavioural interventions for patients and staff, in line with NICE guidance, with respect to smoking, alcohol and obesity, with appropriate metrics for monitoring progress. Further guidance is anticipated and the approach should be specified in the Health and Wellbeing Strategy.

- The encouragement to all local areas to develop a shared vision of health and care for their populations in the context of the strategic choices outlined by the *Forward View*. There is a call for partners to look afresh at their medium-term strategies so that the explore opportunities to create the conditions for rapid early adoption of the new models described in the *Forward View*.

HWB implications of NHS planning guidance

NHS Southwark Clinical Commissioning Group

- CCGs are to lead a major expansion in 2015/16 in the offer and delivery of personal health budgets to people, where evidence indicates they could benefit.

- The ambition for the level of improvement agreed by CCGs and Councils in Better Care Fund (BCF) plans should be reviewed if there is a material change in their assessment of the risk to delivery, taking into account:
  - actual performance in the year to date, particularly through the winter;
  - the likely outturn for 2014/15;
  - progress with contract negotiations with providers.

- Any such review should be undertaken within the partnership underpinning local BCF planning and approved by the Health and Wellbeing Board.

- The Health and Wellbeing Board will be asked to endorse a refreshed CCG operating plan. The updated plan will be made available at the March 2015 HWB meeting. The refreshed plan should reflect any updated Health and Wellbeing Strategy.

Example of local responses to the *Forward View*

NHS Southwark Clinical Commissioning Group

Prevention	Integration
Enhancing prevention and investing in smoking cessation. Strengthening early intervention **services to address obesity**. **Preventing and reducing the use of alcohol.** Developing approaches with our providers to influence employee behaviours and attitudes. Building **community resilience** by improving access to good information and advice on health & well-being.	Develop detailed commissioning ambitions for integrated locality care, testing new models of care and **Locality Care Networks.** Continued development and implementation of the service model for the **Dulwich** locality. Commission enhanced **homecare** services. Enable **independence and care at home** through the expansion of self management support and telecare.
Mental health and parity of esteem	**Primary and Community care**
An **enhanced mental health** offer across primary and community care including investing in dementia services and procuring extended talking therapies. Strengthen community based crisis management services. Re-commission community **drug and alcohol services** to improve patient recovery and outcomes. Provide assessment and treatment for people with **Autism/Asperger's** in line with Care Act (2014) requirements.	Implement and **embed extended primary care access** with GP Federations in North & South localities. Commission community pathways and outcome measures for patients with **common health conditions** (notably diabetes; respiratory illness; sickle cell for children; paediatric phlebotomy)

The above summarise the type of commissioning intentions likely to be included in the CCG's Operating Plan. A final draft of commissioning intentions will be presented to the HWB Board in March 2015.

Item No. 7.	Classification: Open	Date: 29 January 2015	Meeting Name: Health and Wellbeing Board
Report title:		Primary Care Co-commissioning	
Ward(s) or groups affected:		Southwark wide	
From:		Andrew Bland, Chief Officer, NHS Southwark CCG	

RECOMMENDATIONS

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

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

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

BACKGROUND INFORMATION

3. In October 2014 the NHS Leadership in England published a Five Year Forward View that makes clear that co-commissioning of primary care services will exist in some form across England by 1 April 2015.

4. This followed an initial invitation from NHS England to all Clinical Commissioning Groups in summer 2014 to consider the potential benefits to the health and wellbeing of their residents of taking greater control or involvement in the commissioning of primary care services delivered to their population.

5. Between October 2014 and January 2015 the CCG has engaged with local residents, key partners and its member practices to explore the potential for co-commissioning in the borough and to determine the form that co-commissioning might take.

6. By the end of January 2015 the CCG wishes to make an expression of interest to NHS England to enter arrangements that allow for joint commissioning of primary care from 1 April 2015 and a commitment to a work programme to explore and potentially take full delegation of this responsibility from 1 April 2016

Co-commissioning of Primary Care Services

7. The overall aim of primary care co-commissioning is to harness the energy of CCGs to create a joined up, clinically-led commissioning system which delivers

seamless, integrated out-of-hospital services based around the needs of local populations.

8. Co-commissioning could potentially lead to a range of benefits locally and in line with our partnership priorities:

- Improved provision of out-of hospital services for the benefit of patients and local populations;
- A more integrated healthcare system that is affordable, high quality and which better meets local needs;
- More optimal decisions to be made about how primary care resources are deployed;
- Greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services; and
- A more collaborative approach to designing local solutions for workforce, premises and IM&T challenges.

9. Importantly the development of co-commissioning arrangements on a borough basis will allow for a population focus for the commissioning of these services rather than the single operating model for commissioning that currently exists and is exercised once for England irrespective of local circumstance by NHS England.

10. Although this development refers to the commissioning of primary care the opportunity for CCGs relates to general medical services or GP practices only. Community Pharmacy, Optical services and dentistry will remain under current commissioning arrangements.

Integrated Commissioning for local populations

11. Under current NHS commissioning arrangements the commissioning of primary care services for local people is fragmented with services commissioned by up to four local or national bodies (including CCGs, Local Authorities, Public Health England and NHS England). Whilst co-commissioning does not bring those arrangements under one commissioning body it does seek to ensure that commissioning intentions are developed and implemented in the local context - CCG's with greater influence over the commissioning of local services alongside their Local Authority and Health and Wellbeing Board partners.

12. Commissioning for health services more generally is equally fragmented at this point in time and this may not maximise the opportunity to commission along the entire pathway of care. The establishment of co-commissioning will seek to align commissioning to address this with local decision making established across 'upstream' preventative measures, through to primary, secondary and tertiary care services. In addition to the co-commissioning of primary care - CCGs will also have the opportunity to take a greater role in the commissioning of specialised services with NHS England in future.

13. In the context of financial constraint right across the public sector - the bringing together of these budgets, in what might be termed a 'Place based budget' also provides the opportunity to build upon local work in areas such as the Better Care Fund and create pooled or capitated budgets that reward improved population outcomes for those providers who can collaborate or integrate across health and social care to deliver them. These arrangements have the potential to allow a greater shift of resources toward community based care.

KEY ISSUES FOR CONSIDERATION

Involvement in the commissioning of primary care services

14. In any future arrangement the statutory responsibility for primary care commissioning remains with NHS England and co-commissioning arrangements describe the way in which different parts of the commissioning system will work together to provide greater local focus to drive high quality, best value and locally responsive care.

15. The form that co-commissioning takes is for local CCG determination, working with their partners and residents to determine this. National arrangements do however stipulate three potential levels of involvement in co-commissioning:

- Greater involvement in NHS England Decision making (Greater Involvement)
- Joint decision making by NHS England and CCGs (Joint Commissioning)
- CCGs taking on delegated responsibilities from NHS England (Delegated Commissioning)

16. Whilst CCGs are asked to determine their level of involvement in advance of the 1 April 2015 there is then an annual opportunity to enhance that involvement by moving to the next level (e.g. from Joint to Delegated Commissioning). Both Joint and Delegated commissioning arrangements will provide a local focus for commissioning decisions although the former will establish arrangements whereby CCGs will take those decisions with NHS England, rather than as individual decision makers acting with full delegated authority

Local consideration of these options

17. Over the last four months the CCG has engaged its members, partners and local residents in an exploration of the strengths, weaknesses, opportunities and threats (SWOT) offered by the options outlined above. The SWOT analysis is available along with the outcomes of those discussions. This has led to the recommendation to the CCG Governing Body meeting in January 2015 to pursue the two stage proposal outlined above moving to joint commissioning in the first instance with active work and a programme of due diligence to determine whether to enhance that role in April 2016. This was based upon the following considerations:

- That co-commissioning of primary care services offers significant opportunity to improve local outcomes for residents and reduce inequalities by adopting a more integrated and locally responsive approach to commissioning.

- That the ‘Greater Involvement’ option did not maximise the potential of this important opportunity and represented an ‘as is’ option for the borough, based on current working relationships with NHS England Commissioners

- That both forms of greater responsibility held significant opportunities but that Joint Commissioning rather than full Delegation should be adopted in the first instance taking in to the account the following:

    - A recognised need for due diligence over the available local budget and any pre-commitments or unforeseen future financial commitments and

upon the required governance arrangements for full Delegation – the CCG's proposed option would allow for that process over the next year

- That joint commissioning in the first year of this new arrangement would secure sufficient influence over local decision making whilst allowing the CCG to learn more about the implications and resource requirements of fully delegated responsibilities

- The clear opportunity to adopt full delegation in future years

Further considerations

18. In addition to the concept and forms of co-commissioning that might be adopted locally the CCG has also given and continues to give full consideration to a number of areas (making use of more recently available national guidance) listed below. Specific responses to each of these areas will be determined in the remainder of 2014/15 and will be outlined to the Board in March 2015 ahead of any implementation.

Management of conflicts of interest

19. It is clear that as a membership organisation of local general practices the perceived or actual conflicts of interest may be heighted by co-commissioning of primary care services. In response to this the CCG will adopt new national guidance once it has been reviewed to enhance our current arrangements. This will need to be worked through locally but will include decision making in public, with greater lay involvement and an invitation to representatives of the Health and Wellbeing Board and Healthwatch to such committees or arrangements. NHS Southwark CCG is also considering how it can collaborate with the other five CCGs in south east London to strengthen arrangements.

Governance

20. Any joint commissioning arrangement will require the ability to work and take decisions with NHS England, with the potential to develop pooled or aligned budgets. This will require new governance arrangements to be established with the requisite changes to the CCG's constitution to enact them.

Resources

21. Any changes to commissioning arrangements will not attract additional management resources or 'running costs' to the NHS commissioning infrastructure and as such the CCG will need to share resources with NHS England to ensure the robust delivery against these new responsibilities. In order to achieve economies of scale the CCG is again giving active consideration to the sharing of management resources with the other CCGs in south east London whilst ensuring a local borough focus to commissioning activities.

Collaboration across south east London

22. As outlined above the CCG is giving active consideration to the benefits to be derived from collaboration with other CCGs in the region where it makes sense to do so. However, the benefits of co-commissioning are firmly grounded in the local nature of this arrangement and collaboration would only be established

where:

- It allows the implementation of effective borough based commissioning at lower cost or with greater efficiency
- Where working together has the potential to facilitate stronger governance arrangements (potentially in terms of managing conflicts of interest) or
- Where boroughs are working together with a strategic alignment (e.g. where primary care commissioning sits in the context of Southwark and Lambeth Integrated Care or where there is a common commissioning intention as part of the South East London strategic plan development).

Next Steps

23. Following an expression of interest as described above the CCG would work to develop the governance and management arrangements to secure the delivery of these arrangements locally. These will be reviewed by NHS England through an assurance.

24. Provided the necessary assurance in secured the CCG would seek the approval of its Governing Body and the endorsement of the Board to enter those arrangements from 1 April 2015.

Policy implications

25. See sections above

Resource implications

26. See sections above

Consultation

27. Plans for the future form of co-commissioning of primary care services in Southwark have been the subject of an engagement process between October 2014 and January 2015 with all CCG member practices in the borough (all general practices), residents as members of the CCG's Engagement and Patient Experience Committee of the Governing Body, the Local Medical Committee, local NHS providers and NHS England (London Region).

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

28. Not applicable.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
'Next Steps Toward Primary Care Co-commissioning (NHS England, November 2014)	NHS England (Link below)	
Link: http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf		
'Managing Conflicts of Interest: Statutory Guide for CCGs (NHS England, December 2014)	NHS England (Link below)	
Link: http://www.england.nhs.uk/wp-content/uploads/2014/12/man-confl-int-guid-1214.pdf		

AUDIT TRAIL

Lead Officer	N/a
Report Author	Andrew Bland, Chief Officer, NHS Southwark CCG
Version	Final
Dated	19 January 2015
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team		19 January 2015

Agenda Item 8

SOUTHWARK HEALTH AND WELLBEING BOARD

29 January 2015

Title:	**Strategic Commissioning Framework for Primary Care Transformation in London**

Open Report	**For Information and Engagement**
Wards Affected: Pan-London	**Key Decision: No**
Report Author: Paul Roche	**Contact Details:** E-mail: paul.roche@nhs.net;

Sponsor:
NHS England (London Region)

Summary:

Strong primary care is important for a wide range of health and care ambitions across the capital and it is widely recognised that, despite some great examples, there is a significant transformation challenge to be faced. Responsibilities for shaping and delivering change in primary care sit primarily with providers and commissioners, but a wide range of other partners have close interests and/or potentially positive roles to play.

The Strategic Commissioning Framework for Primary Care Transformation provides a new vision for general practice, and an overview of the considerations required to achieve it. From December 2014 to April 2015, a period of engagement will be undertaken locally to fully understand the implications of the Framework, and how it fits into the context of wider plans.

Recommendation(s)

The Health and Wellbeing Board is recommended to agree:

(i) Confirmation that the *Framework* covers the correct areas

(ii) Are there other areas that should be considered in the *Framework* that currently aren't?

(iii) How could the *Framework* be strengthened?

APPENDIX 1

Strategic Commissioning Framework for Primary Care Transformation in London

Better Health for London: A New Deal for General Practice

Draft for engagement

Acknowledgement

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This *Strategic Commissioning Framework* is presented by the Transformation Board and Primary Care Clinical Board, and has been developed by clinicians, commissioners, patients and other partners across London.

Due to the number of individuals involved, it is not possible to name everyone individually. However without these people, production of this *Framework* would not be possible.

In particular, we would like to extend our appreciation to the:

- Clinical Expert Panels
- Primary Care Transformation Board
- Primary Care Patient Board
- Primary Care Clinical Board
- Primary Care Delivery Group
- Primary Care Transformation Team

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Dr Clare Gerada: Clinical Chair for London's Primary Care Transformation Programme

Dr Clare Gerada is a London based GP. She is the immediate past Chair of Council of the Royal College of General Practitioners – the first female Chair for over half a century – and was previously Chair of the Ethics Committee. She established the RCGP's groundbreaking Substance Misuse Unit and also led on the strategic and logistical delivery of the RCGP Annual National Conference. She has held a number of local and national leadership positions including Senior Medical Adviser to the Department of Health. She is Medical Director of the largest practitioner health programme in the country and she has published a number of academic papers, articles, books and chapters. Prior to general practice, she worked in psychiatry at the Maudsley Hospital in South London, specialising in substance misuse. She was awarded an MBE for services to medicine and substance misuse and was presented with the National Order of Merit award in Malta for distinguishing herself in the field of health.

The NHS is unique because of its system of general practice – a medical home for the patient – underpinned by a life-long medical record. General practice is the first point of access for many people, where a high proportion of care is delivered close to people's homes with the potential for a continuous relationship with the same clinical team from birth through to the end of life.

General practice has served patients, the public and the NHS well for over 60 years. It has delivered accessible, high quality, value for money care. However our patients are changing, both in the complexity of their conditions and in their expectations. This means that if the NHS is going to continue to provide the excellent standard of care to which we all aspire, we will have to be more innovative.

Tweaking at the edges is not an option. London needs solutions that will sustain primary care for the next 60 years. We must maintain the integrity and core purpose of general practice (to provide holistic, patient-centred continuous care to patients and their families). But at the same time we must address the need to improve coordination of care, access to services and take a more proactive approach to our patients' health and wellbeing.

I believe that this *Strategic Commissioning Framework for Primary Care Transformation* in London represents a platform where clinicians, commissioners, and other stakeholders can build on the work done to date and find solutions to the challenges for general practice; supporting the healthcare community to make care better for all Londoners.

With the scale of support which has been seen for this developing work, and the opportunity of additional focus on primary care provided by the *NHS Five Year Forward View* and *Better Health for London* from the London Health Commission, now is the time to make these changes together.

Dr Clare Gerada, Chair of the Primary Care Clinical Board

Foreword

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We are pleased to present this developing *Strategic Commissioning Framework for Primary Care Transformation* (the *Strategic Commissioning Framework* or *Framework*) on behalf of the London Primary Care Clinical Board[1] and Transformation Board[2]. This document provides both a new vision for general practice, and an overview of the considerations required to achieve it. From December 2014 to April 2015, London's clinical commissioning groups (CCGs) together with NHS England (London) and working with other partners (such as the Care Quality Commission (CQC), Health Education England (HEE), Academic Health Science Networks (AHSN)) will engage locally to fully understand the implications of this *Framework*, and how it fits into the context of wider local plans. During this period, further work will also be undertaken to understand the implications of implementation, and this document will be updated to reflect this.

Transforming primary care is a concept that is rapidly gaining momentum as a key priority area in the NHS – both nationally and across London. Two important pieces of work have recently been published which set the platform for building on this energy and achieving the ambitions that are developing.

1. *NHS Five Year Forward View*[3]

In October 2014, Simon Stevens published the *NHS Five Year Forward View*, developed by NHS England, Public Health England (PHE), Monitor, HEE, CQC and the NHS Trust Development Authority (TDA). This sets out 'a new deal for general practice' recognising the central importance of the registered list and everyone having access to a family doctor. It also confirms the need for greater investment.

2. *Better Health for London*, The London Health Commission[4]

In October 2014, the London Health Commission published *Better Health for London*. The *Framework* closely aligns to, and is supportive of this report, which contained a number of recommendations specific to general practice.

1 See Appendix 1: Governance board membership
2 See Appendix 1: Governance board membership
3 http://www.england.nhs.uk/ourwork/futurenhs/
4 http://www.londonhealthcommission.org.uk/better-health-for-london/

This developing *Framework* provides a response from commissioners across London to these important pieces of work.

Since April 2014, around 1,500 key stakeholders have been engaged as part of a 'pre-engagement' phase. These activities have strengthened our ambitions for describing a new patient offer for all of London.

Throughout the co-development of this *Framework* it has been excellent to see the level of clinical leadership, public and patient contribution and significant commitment from commissioners across London, together with their partners. We have received support from all 32 CCGs across London to enter into the next stages of engagement, which will take place at a local level with GPs, the public and other key stakeholders. There has also been positive support from the London-wide Local Medical Committee, the Clinical Challenge Panel (which was set up for independent clinicians to review the specification (also known as the patient offer) on behalf of the London Clinical Senate) and the CQC, for the aspirations we wish to achieve.

The *NHS Five Year Forward View* and *Better Health for London* provide a new impetus to seize the moment and bring about sustainable transformation of the bedrock of healthcare in London. There are no easy solutions to the challenges we all face in the transformation of primary care but there is a strong belief that by working together and building on the focus and commitment to date, success can be achieved and we can develop services that Londoners deserve.

Dr Marc Rowland

Co-Chair of the Primary Care Transformation Board

Dr Anne Rainsberry

Co-Chair of the Primary Care Transformation Board

Dr Clare Gerada

Chair of the Primary Care Clinical Board

Context 7

This document, developed by commissioners across London, is both a new vision, and in effect a response to the *Five Year Forward View* and London Health Commission publications. It details a specification for Londoners in the future, and begins to articulate how these changes fit within the wider out-of-hospital context. The document also includes considerations for how this specification might be delivered, as well as sections on current estimations of cost, changes required to primary care workforce, contracts, and other key enablers.

Background: responding to *A Call to Action*

In November 2013, NHS England (London) published *Transforming Primary Care in London: General Practice A Call to Action*[5], which examines the challenges facing general practice in London today. It has been used by NHS England (London) and London organisations to obtain a consensus view on the need for changes to the way general practice is provided.

A ***Call to Action*** showed that London contains world-class examples of general practice but that urgent action is needed to tackle significant variations in quality. The report identified challenges including an increasing workload; an expanding population; people living longer and with increased care needs; all of which have occured whilst investment in general practice has fallen significantly as a proportion of total health spend. The pending workforce crisis was also highlighted, as a large swathe of GPs in the capital are near retirement and practice nurses are becoming increasingly difficult to recruit. The report was a call for bold action to develop solutions that will better meet the future needs of Londoners and provide a sustainable model of general practice for the next 50 years.

During 2014 clinicians, patients and commissioners from across the capital have been developing an ambitious strategy for service improvement in three key areas – proactive care, accessible care, and coordinated care.

In March 2014, NHS England (London) released a pre-engagement draft document entitled *The London GP Development Standards: A Framework for Service Improvement*. The document was developed by a clinical board and three expert panels working in partnership with CCG leads and patients.

Over the summer London CCGs and NHS England (London) worked in partnership with others to ensure that the service changes described in the initial draft would meet the needs of Londoners, address current and future challenges and develop a strong mandate for the overall direction of general practice development across the capital. In addition, there has been further development on answering 'how' this specification could be delivered. It is clear that changes are needed to support primary care in delivering a new vision.

The initial view on the enabling work required is included in this document. This includes, for example, the fact that changes to the numbers, skills and roles in the workforce are needed. There is also reference to the importance of suitable estates, and the fact that this change will need to be underpinned by investment.

Over the summer, two new important pieces of work have been published – from the NHS England Chief Executive, and the result of a piece of work commissioned by the Mayor of London.

These publications provide added impetus for the ideas developed in the *Framework* and will provide a platform for building on these proposals, ensuring that London gets the investment required in order to drive these commitments forward.

5 http://www.england.nhs.uk/london/ldn-call-to-action/gp-cta/

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The *NHS Five Year Forward View*

In October 2014 Simon Stevens, the Chief Executive of NHS England, published the *NHS Five Year Forward View* developed in collaboration with PHE, Monitor, HEE, CQC and TDA. This also referred to funding in general practice – mentioning both "Stabilis[ation]" and "new funding". The commitments included are listed below.

In addition to emerging GP federations, networks and super partnerships across London the *NHS Five Year Forward View* identifies two further models which may be applied.

These have been described as Multispecialty Community Providers (MCPs) or Primary and Acute Care Systems (PACs).

A new deal for general practice

Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.

Give GP-led clinical commissioning groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.

Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.

Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.

Expand funding to upgrade primary care infrastructure and scope of services.

Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.

Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.

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The London Health Commission

Also in October 2014, the London Health Commission launched its report *Better Health for London*. This report makes several recommendations for general practice, and the *Framework* aligns very well with these recommendations:

- increase the proportion of NHS spending on primary and community services.
- invest £1billion in developing GP premises
- set ambitious service and quality standards for general practice.
- promote and support general practices to work in networks.
- allow patients to access services from other practices in the same network.
- allow existing or new providers to set up services in areas of persistent poor provision.

Additionally, the vision of this *Framework* supports several of the broader recommendations, such as:

- engage with Londoners on their health and care. Share as much information as possible and involve people in the future of services.
- commission holistic services with clearly defined outcomes developed by listening to people who use services.

A Strategic Commissioning Framework for Primary Care Transformation in London

This document builds on work already undertaken and aims to support further development of local plans and other responses that London is making to the challenges currently faced in general practice as well as the two key publications referenced above. The *Framework* aims to complement and enhance other service requirements and standards, such as those published by the Care Quality Commission (CQC) in the *Provider Handbook for Primary Medical Services* (October 2014). Going forward, London's primary care transformation programme and the CQC will collaborate closely to ensure that there is true alignment between the vision set out in this *Framework* and standards articulated by the CQC. This also aligns with the National Institute for Health and Care Excellence (NICE) in their regularly updated guidelines. In summary, the specification outlines a new service design, but this must also be delivered to, for example, the level of safety and quality described by these other standards.

Executive summary

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The *Strategic Commissioning Framework* is a developing document which aims to support primary care transformation across the capital. A high-level overview of the content of the *Framework* is included below, however more detail may be found in the full sections of the document.

Future of general practice

General practices in London are under strain and are bearing the brunt of pressures to meet increasing and changing health needs.

This developing *Framework* sets out an ambitious and attractive vision of general practice that operates without borders, and in partnership with the wider health and care system. A patient and their GP should be at the heart of a multidisciplinary effort to deliver patient-centred coordinated care in general practices which are recognised as centres in each neighbourhood, developing community resilience and supporting Londoners to stay as well and as healthy as they can.

The *Framework* focuses on 'function' not 'form' and sets out a new patient offer for all Londoners that can only be delivered by primary care teams working in new ways and by practices forming larger primary care organisations. These organisations will be aligned to a shared geography in support of a population health model with other health, social, mental health, community and voluntary organisations. How this looks will differ from area to area and will be designed and owned locally. It will require an environment which supports innovation; shares best practices and new technologies; and is an attractive place to work for a variety of healthcare professionals.

The service specification (patient offer)

At the core of the *Framework* is a specification for general practice that sets out the new patient offer. This specification is arranged around the three aspects of care that matter most to patients:

- **Proactive care** – supporting and improving the health and wellbeing of the population, self-care, health literacy, and keeping people healthy
- **Accessible care** – providing a personalised, responsive, timely and accessible service
- **Coordinated care** – providing patient-centred, coordinated care and GP-patient continuity

Some elements of the specification have already been achieved and implemented in some parts of London. General practice will be transformed when all patients in London are able to access the care described in this document and when that care is of a sufficiently consistent high quality.

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Local planning

This *Framework* is not intended to be a static document but will form the basis of wider engagement over the coming months in each local area, on the changes that are needed. London CCGs with NHS England (London), will lead this engagement as part of developing local plans. It is anticipated that different areas will deliver this patient offer in different ways, at different paces. In order for local populations to be able to take part in discussions to decide what is best for their local community, it is essential that plans are locally designed based on different starting points.

Co-commissioning

NHS England (London), CCGs and local authorities recognise that the vision in this *Framework* will require significant collaboration across all parts of the commissioning system; co-commissioning will be a key enabler. *The NHS Five Year Forward View* sets out the aim to provide CCGs more control over NHS budgets, with the objective of supporting more investment in primary care, and CCGs across London have expressed an interest in becoming more involved in the commissioning of primary care services.

Co-commissioning will allow for a varying level of increased involvement. The options and considerations are described in detail in *Next Steps Towards Primary Care Co-commissioning*, published in November 2014. Currently the possible arrangements include:

- **allow CCGs greater involvement in commissioning decisions**, including actively participating in discussions about all areas of primary care
- **joint commissioning** model that enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their area team, either through a joint committee or "committees in common"
- **delegated commissioning** offers an opportunity for CCGs to assume full responsibility for commissioning some aspects of general practice services. The exact models for delegated commissioning will need to be worked up in local areas.

Financial implications

The new patient offer and the changes to, for example, the workforce and estates required to deliver it, cannot be made without significant investment.

Further work is required to understand all of the financial implications of this *Framework*, but high level financial analysis has been completed to estimate the cost of providing the new patient offer.

The required additional investment is currently estimated to be in the region of **£310-810 million per year**, which represents a **2% – 5.36% shift in the overall health care budget**. This will need to be phased, and can be achieved, for example, over five years with an average shift of 0.4 – 1.07% per year.

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Contracting approach

The specification described here can only be delivered in full by general practice working together at scale and with other parts of the health and care system. The *Framework* proposes new funding, not at an individual practice level but delivered through a wider population-based contract. The exact nature of these arrangements will vary by nature of the provider landscape but the principle of at-scale providers increasingly sharing pooled incentives with shared responsibility and risk for delivery will be a key marker against which investment will be made. Local approaches will be determined through co-commissioning arrangements and in discussions within each CCG area.

It is likely that the contracting vehicle will need to 'wrap around' existing national contracts (unless constituent practices are opting for a full merger/ super partnerships and therefore may voluntarily relinquish their current contract). It may also need to be flexible to wider collaborations and partnerships with other types of providers, for example where the strategic intent locally is for accountable care organisations that can hold capitated budgets and shared risk for whole populations. Although current legislation does not allow it, co-commissioners may also want to consider a future in which the accountability for constituent General Medical Services, Personal Medical Services and Alternative Provider Medical Services might sit with the lead provider/at-scale primary care organisation.

The full contracting approach section outlines example contractual forms and potential initial changes. Many areas already have a strong ambition towards bringing general practice and community services together over the next two years. It is however anticipated that most areas will be looking to contract networks/ federations of general practice as a starting point.

Workforce

A workforce of appropriate number, skills and roles is imperative for transforming care. Bolstering the primary care workforce has been identified as a core objective of Health Education England (HEE) and its Local Education and Training Boards (LETBs).

This document describes a future of more person-centred systems of care and less division between primary, secondary, community, voluntary and social care organisations .Although the way that roles and teams fit together will evolve in local areas, it is anticipated that the roles required will be as shown in the table below.

Within each practice	Aligned to each practice but working across a wider geography / at-scale primary care organisations
GPs, practice nurses, GP nurse practitioners / nurse prescribers, volunteers, receptionists, managers, health care assistants and may also include physician associates	Prescribing advisors, GPs with a special interest (GPSIs), care coordinators, wellbeing teams, and 'super practice managers/directors' with sufficient skills to lead the development and operational management of at scale primary care organisations. **As part of, for example, a wider Multispeciality Community Provider (MCP):** Secondary care specialists, social care, mental health and community services teams, community pharmacy

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The full workforce section outlines these in more detail, as well as some of the programmes being taken forward to support workforce development, however it also highlights that there is a great opportunity for partners associated with workforce development in London to collaborate. Ensuring the workforce is appropriate to deliver the specification will be crucial in improving outcomes across the capital.

Technology

This *Framework* does not aim to provide a technology blueprint for London, however it recognises that technology is a key enabler for delivering the specification. This is complemented by the recent publication by The National Information Board, *Personalised Health and Care 2020* which describes the need to better use technology to improve health, transform quality and reduce the cost of health and care services. Technology usage should support organisations working together – allowing less focus on co-location, and a smoother patient journey through the healthcare system. People should also be empowered with information about their care in order to participate in their care planning, set health goals, and better manage their health.

The technology section of this *Framework* identifies ways in which technology can support:

- **Proactive care**, for example through online wellbeing assessments, health improvement resources or support communities
- **Better access**, for example with online service portals, telephone triage and email appointment systems
- **Care coordination**, for example with interoperable systems for information exchange across a multidisciplinary team and with patients through integrated patient-held records
- **Modernising care**, for example, remote monitoring and diagnostic devices.

Estates

The recent London Health Commission (LHC) report, *Better Health for London* presented evidence that the quality of general practice estate in London is highly variable. This results in a poor patient experience and poor working conditions in some London practices and lost opportunities to improve health and healthcare. The specification in this *Framework* does not rely on estate changes, but there are a number of practices in London for which premises solutions are now urgently needed. The estates section of this document outlines some of the findings of the LHC report, and its recommendation for approximately £1 billion to be invested in general practice estates over the next five years.

Provider development

None of the changes set out in this *Framework* will be delivered unless there is significant investment in organisational development and capability building. The real change cannot be delivered by commissioning levers alone but will require providers to grab the development challenge and find successful ways to adapt it in their local area. The provider development section outlines some requirements for example, leadership for change, strategic planning, business development, legal guidance. It recommends a

forum for London's emerging providers and system leaders to share innovation and learning. It identifies the need for a strategic and comprehensive approach to building system capacity and capability for delivering change; an approach that is mapped to a development journey for emerging organisations and which can respond to their evolving needs over time.

Monitoring and evaluation

The purpose of this *Framework* is to improve outcomes, patient experience and working lives. Monitoring and evaluation will be designed to support practice teams working together on quality improvement at a population level. This *Framework* outlines the principles that monitoring and evaluation should build on systems already in place, and also focus on supporting provider development (through best practice sharing and peer learning), as well as commissioner assurance.

Next steps

This developing ***Strategic Commissioning Framework for Primary Care Transformation*** is being shared more widely in each local area of London as part of continuing engagement on the changes needed and to ensure each area can develop robust delivery plans in advance of implementation from April 2015.

Equality impact assessment

Commissioners (CCGs and NHS England) of general practice are required to give specific consideration to addressing health inequalities as stated in the Health and Social Care Act 2012 and requirements relating to people with protected characteristics as outlined in the Equality Act 2010. An equalities impact assessment has been completed to accompany this framework at its current stage, and is available as a separate supplement.

The equalities impact assessment concludes that the *Framework* provides a structure within which a consistent general practice patient offer can be delivered to all Londoners. The delivery and implementation of the specification outlined in the *Framework* has the potential to address health inequalities in London as commissioners work with general practices to secure services that are responsive to different needs and appropriate to all.

The *Framework* particularly notes the requirement for commissioners to give due regard to the reduction of health inequalities and to the statutory requirements of the Equality Act 2010 to consider the impact for people with protected characteristics. It is therefore recommended that local equality impact assessments are conducted to reflect local plans when these are sufficiently advanced. The proactive care specification also outlines the need to give consideration to additional vulnerable groups that have been identified such as travellers, sex workers, people recently released from custody, homeless people, vulnerable migrants or people with learning disabilities.

Future general practice

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Patients tell us that they want better continuity of care ("my doctor, my nurse"). They also want better access to services when they need them, to contact a health professional when they need to; to have care closer to home, to stay healthier and more independent for longer, have fewer trips to hospital and more support to enable them to manage their own health more effectively. This latter point is particularly important. As demand for health services grow, patients will need a good understanding of the services and resources available to help them to stay well and look after themselves through minor illness. General practices will be recognised as centres within each neighbourhood that are supporting Londoners to stay as healthy and well as they can be. Local communities, voluntary groups, faith organisations, patients and volunteers are part of a network of support for wellbeing that can work both inside and outside general practice, supporting general practice to connect people to wider resources available in the community and extending its scope to deliver proactive health and wellbeing resources. Partnership working with these groups and with local authorities and health and wellbeing boards will be essential.

At the moment (and for a number of reasons) general practice is not able to deliver this level of care consistently across London. Probably the main reason for this is that funding for general practice has been declining in real terms over the last decade, now receiving just over 7% of the NHS England budget, compared with over 10% a decade ago. Yet primary care continues to deliver the majority of care to patients in the NHS. Increasing funding alone will not solve the problem, general practice still needs to change. Our patients' needs are different now, and keep changing. The systems that are in place to care for them have to evolve to keep pace with this change.

If London is going to meet the challenges we all face there will need to be additional resource, but money is not the only answer. We will also need to achieve significant economies of scale and be more innovative in the way we deliver primary care. There is no 'one size fits all' solution. One of the great strengths of general practice is its variety – reflecting the great diversity of the population we serve in London. How we achieve excellence will be largely dependent on each local area, supported by their providers, their commissioners and their patients. But there are ten common building blocks that we need to address to reach the desired state, which are set out below.

1. The **way we deliver care**: inside and outside of the practice; how we best use skill-mix; how we work in and out of hours; how we work with others – not confined by our individual consulting rooms, practices and organisations; and how we work best with the primary, secondary, community and voluntary and charity sector services.

2. The **way we organise ourselves**. This applies to normal working hours and out of hours; how we deliver unscheduled care and how we organise our physical environment – the buildings we work from. Individual practices may want to form part of something bigger. Across London, practices are already starting to work together.

3. **How we work together** to deliver personalised care for certain groups of patients across a wider population for example:

   a. finding creative ways of connecting with the vulnerable, isolated and socially marginalized who are at highest risk of becoming ill and least likely to seek out support to stay well.

b. developing services across groups of practices where the complexity of care and range of professionals involved is such that it requires a central focus for higher intensity care coordination and frequent specialist input (e.g. complex frail elderly, people living with learning disabilities, people in care homes and prisons).

c. creating alternative access points for high volume, low complexity care services for minor ailments in order to free-up additional capacity in each GP surgery for the patients who need us most.

d. developing expert generalists and arrangements for working with secondary care practitioners such that they become a resource for groups of practices, enhancing the level of care and support offered and providing additional training and development activities for GPs locally.

4. How we **meet the different access needs** by allowing patients to choose from a range of service options (length of appointment, rapid access, booking ahead, GP of choice); choose the way they access general practice (in person, online, by phone, email or video conference); and how we meet any personal accessibility requirements (e.g. physical or sensory disability, language, chaperone/advocacy).

5. **How we use data**. Not simply to identify different patient needs but also to inform us; to provide intelligence that will improve the quality of clinical care; to provide early warning for system failure; to enable us to see patients on different sites; and to help us deliver care in different ways, for example through remote care (e-health and telecare).

6. How we improve ourselves and become a **learning environment**.

7. How we **disseminate innovation**.

8. How we develop a **vibrant attractive workplace** with career prospects for clinical and non-clinical staff (recruitment and retention).

9. How general practice can support patients, families and communities to **stay well and cope with minor illness**.

10. How we create an organisation that **empowers health and wellbeing in our population**.

What will Londoners notice?

People living in London will be able to have the right length of consultation for them provided by the most appropriate health professional, in better premises, using up-to-date technology. There will be more responsive care, which will be delivered in a range of ways, for example online, email and telephone rather than just face-to-face consultations. People will only need to make one call or click to book their appointment and won't be told to call back the next day. There will be no need to take a day off work to see a GP as there will be the choice of early or late appointments or telephone consultations. Those who need to will be able to book appointments up to several weeks ahead at a time to suit them. Care will be centred around each person so they won't need to have multiple appointments about different long term conditions; they will be arranged around them.

Patients will experience better management and care: of long-term diseases; when they are frail and elderly; and at the end of life. Their general

practices will be encouraged to organise themselves so that all patients have a named GP accountable for their care. The need for continuity of care should be defined by the patient and has the potential to be regarded as important irrespective of age. This care might be delegated to other GPs or healthcare professionals in the practice team as appropriate. Continuity of the personal care relationship is especially important for those patients with complex and chronic health care needs. The future practice will provide improved continuity of care for these patients and for those that require more coordinated care.

Multidisciplinary teams will work together to deliver care in- and out-of-hours, and in- and out-of-hospital.

There will be safer, less (unwarranted) variability and better quality care delivered closer to home by highly trained GPs, nurses and other professionals. Patients will not necessarily see "their" healthcare professional for all care at "their practice". They may choose to access an extended range of services at convenient opening times either in their own practices or in those practices linked to it. There will be no gaps for patients who are unregistered to fall through.

Models of care

The health system needs to be primary care orientated so that it is focused on improving population health and wellbeing. In order to ensure that patients receive the maximum benefit from this, general practice needs to have a collaborative approach involving, for example: voluntary and community organisations; community health services; community pharmacies; mental health services; social care and other partners. Some elements of the specification can only be delivered by working with patients and other partners to deliver high quality care.

It is likely that general practice will need to work together to form larger primary care organisations if it is to improve sufficiently. This will give groups of practices the opportunity to focus on population health and provide extended opening hours whilst protecting the offer of local, personal continuity of care. What begins as a conversation about greater collaboration, will move towards formation of practice networks that increase joint working and will then go further towards shared teams and infrastructure requiring a single primary care organisation. The *Five Year Forward View* describes this as the development of a Multispecialty Community Provider (MCP) which could offer increased efficiencies through wider collaboration and integration. These organisations are likely to align to a single population catchment or locality with other health, social, community and voluntary organisations. The shared organisation will enable them to: provide a wider range of services including diagnostics; share infrastructure, expertise and specialists e.g. for mental health or children; create career paths; train and learn together.

Shared systems for peer review, developmental and supportive learning should improve patient safety, clinical quality and outcomes for all practices involved. The organisations will contain teams that support care coordination and will have arrangements in place for closer partnership with a wider range of practitioners and specialists beyond general practice.

How this all looks will vary from area to area – local communities and patients will need to be

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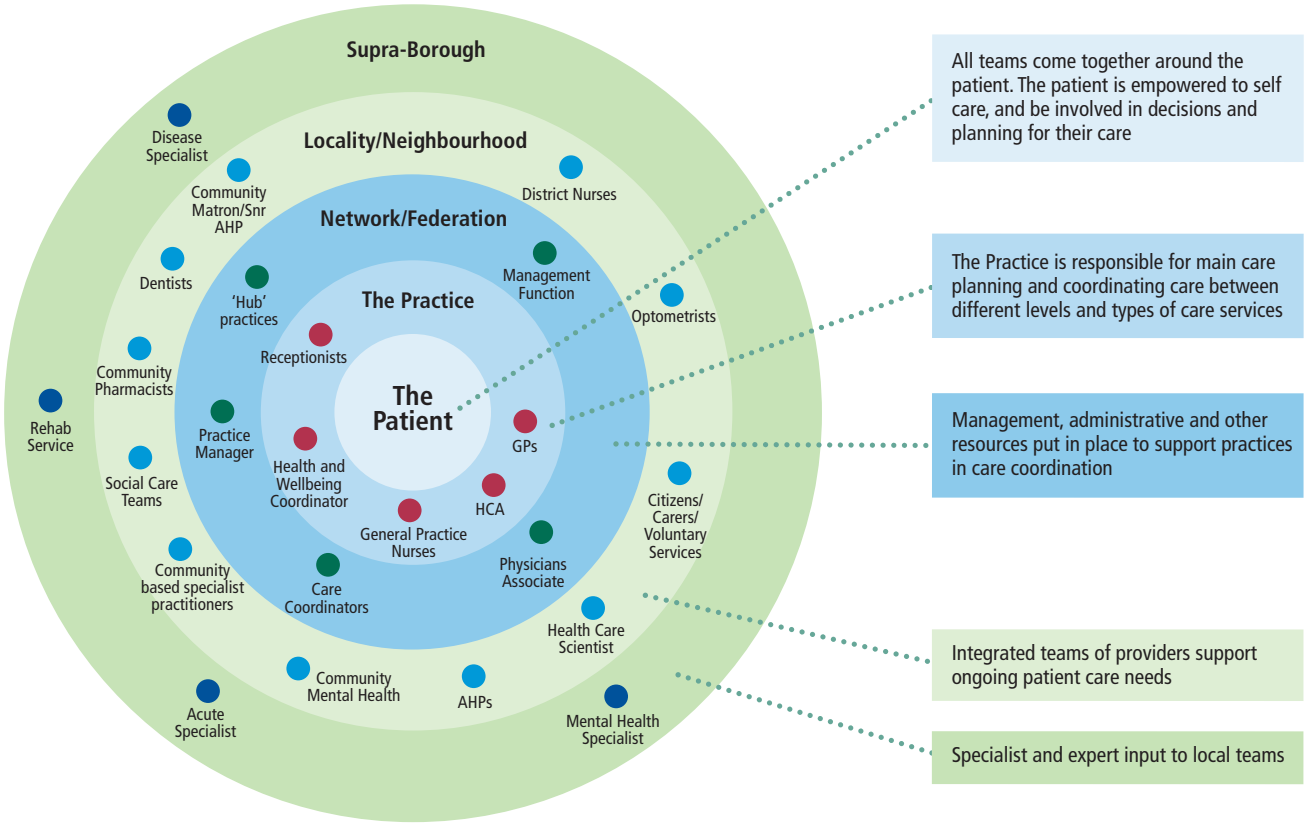
Illustrative model of care



involved in developing and agreeing these changes. In some boroughs there may be a review of the number and type of practices and other buildings. In areas of poor provision, existing and new providers may emerge and the opportunity described in the *NHS Five Year Forward View*, for acute, mental health and community services to also provide general practices services, may be taken.

The needs of an area will be met perhaps with fewer, smaller practices and some larger health and education hubs with diagnostics, day beds and leisure and exercise facilities for patients and the public. GPs will work together in a single system continuing to deliver first contact care but also providing continuity of care to those that wish to see the doctor of their choice. GPs will be linked together via a single electronic record with other practitioners such as elderly care doctors, paediatricians, palliative care and district nurses helping to deliver 24/7 care to those who most need it.

Patients will benefit through receiving care from a greater range of generalists, more specialist care and improved access to services in a better environment.

We need to work together to achieve this ambitious specification to ensure we can deliver the future requirements of our population.

Dr Clare Gerada
Chair of the Primary Care Clinical Board

The service specification 19

At the heart of this *Strategic Commissioning Framework for Primary Care Transformation* is a new service specification for general practice. This supports the need to define and commission a more consistent service for all Londoners, e.g. adults, children, young people, carers and families; reducing variations in access, patient experience and clinical outcomes. The specification provides a single definition of high quality care.

Three characteristics are needed for general practice to thrive and deliver the care that patients need and value.

1. **Proactive care** – supporting and improving the health and wellbeing of the population, self-care, health literacy, and keeping people healthy
2. **Accessible care** – providing a personalised, responsive, timely and accessible service
3. **Coordinated care** – providing patient-centred, coordinated care and GP-patient continuity.

The *Framework* covers these three aspects of care and contains a specification of the future patient offer covering 17 aspects of care. The document is informed by the London GP Innovation Challenge (2012) and Prime Minister's Challenge Fund (2013). Some elements have already been achieved and implemented in parts of London. Whilst the *Framework* describes a common patient offer, it is sufficiently flexible and adaptable for groups of practices to design how the service specification might be delivered consistently for all patients. Delivering the specification described in this document will require local planning and customisation in order to ensure that these are provided in the best possible way for the whole population, for example particular differences needed to deliver this for children as well as adults. London's general practice will be transformed when all patients are able to fully access the care described in this document and when it is of a sufficiently consistent high quality.

This *Framework* is about what is delivered and how it is delivered. From the moment a patient begins their interaction with general practice, they should feel they are treated with dignity and compassion. The Care Quality Commission assessment and inspection of general practices places great emphasis on whether patients are experiencing caring and empathetic services.

Evidence supplement

A supplement to this document is available on request (england.londonprimarycare transformation@nhs.net) and provides a compendium of the supporting evidence. This includes:

- detailed insight obtained through the pre-engagement activities that have taken place over the summer months and a record of the changes made as a result
- research and evidence gathered from analysis and piloting activities.

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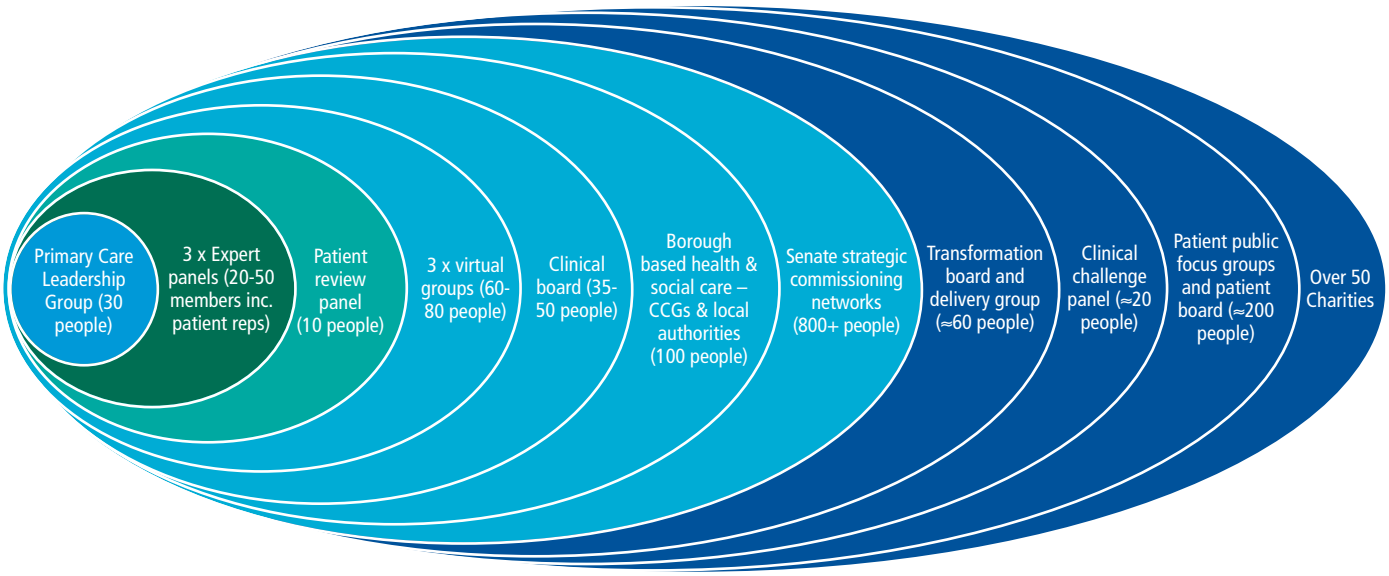
Service specification development process

NHS England (London) has worked with London's clinical commissioning groups to lead an open, transparent and collaborative conversation with key stakeholders to identify the primary care services which patients value, what they need to remain healthy and the services that will positively impact on the wider health economy. The service specification has been defined by patient voices, clinical leaders, current best practice, innovation and best evidence.

Around 1,500 people have contributed to drafting, testing and challenging the future service requirements to ensure that they are as robust, ambitious and innovative as possible.

Number of people and groups engaged to develop the service specification



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1. Proactive care specification

Proactive Care Expert Panel Chair: Dr Nav Chana

Dr Nav Chana is a GP and senior partner at the Cricket Green Medical Practice where he has been a GP for 22 years. He was previously the Postgraduate Dean for General Practice and Community Based Education at the London Deanery. He is now Chairman of the National Association of Primary Care (NAPC) where he has established collaborative networks to support primary care innovation. Nav's interests include improving the value of primary care through an enhanced focus on population-based healthcare.

Primary care is at the heart of every community, putting it in a unique position to empower patients to keep safe and well, and to lead healthier lives. This is the essence of proactive care. This includes activities and interventions which contribute to improving health and wellbeing by: increasing self-reliance; building greater capacity for health and health resilience in patients, the people who support their care (for instance friends and families); and through partnership with local communities. By supporting people to live well we avoid unnecessary care interventions, improve quality of life and reduce the overall cost of the system for taxpayers.

Proactive care can reduce health inequalities by providing a targeted response to those who are highly reliant on additional support to stay well. People who are at higher risk of deteriorating health due to social isolation, or a lack of personal capacity e.g. homeless people, 'looked after children' and isolated elderly people require a differential level of support to achieve positive health outcomes. This care might be delivered across a group of practices by a team comprising roles such as care navigators, peer advocates, health coaches, wellbeing support workers and community volunteers. Reducing health inequalities is not just about focusing on illness, but providing a holistic response to social issues like debt, housing, employment and substance misuse to improve health and wellbeing.

Proactive care requires moving assets across multiple agencies and community organisations to re-balance the current focus on illness and a clinical agenda aimed at enabling people to live well.

General practice is well placed to improve population health because:

- it is the most accessed part of the health system
- it holds a registered list for a defined population in an immediate locality
- generalists deliver care to people with a full understanding of their social context.

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proactive care

Delivering the proactive care specification will require practices to co-design new approaches to improving health with individuals, families, other health agencies and local community partners. Londoners will recognise general practice as caring about their wellbeing and providing holistic support to enable them to stay well. But delivering proactive primary care will go beyond general practice and will draw on the whole family of primary care services and professionals including those within the voluntary and third sectors.

The nature of consultations will change, to better combine clinical expertise with patients' aspirations for wellbeing. Patients will notice that they are being asked more frequently about their wellbeing, capacity for improving their own health and their health improvement goals. They may be reminded of signs of early disease such as cancer, or be offered support to manage conditions themselves (e.g. health information, advice and equipment) or social prescribing (e.g. debt advice).

Patients will be offered additional services such as coaching, mentoring and buddying from professionals or peers offering support to help build patient knowledge, skills and confidence for self care.

These types of services are already offered by some London practices. Practices in Lewisham have been piloting a service to support patients reach their care plan targets including regular motivational callers (people who phone patients – helping and encouraging them to meet their health goals), self-management demonstrations and role play; and the Well Centre in Streatham has helped 650 young people with complex needs to manage their conditions better, reducing the need for further referrals.

The service specification covering proactive care identifies opportunities for general practice to take a population based approach to improving health and wellness in partnership with local communities. This creates the required social capacity and resources in communities, improves health literacy, and increases the capacity and resilience of individuals for maintaining their health and wellbeing.

Dr Nav Chana

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proactive care

P1: Co-design

Primary care teams will work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve the health and wellbeing of the local population.

Involving individuals and communities in designing services will ensure that approaches are relevant locally; that they do not duplicate (and are integrated with) existing services in the community; and that they are more likely to be successful.

The process of co-design in itself will support improved understanding of health and wellbeing for those involved, support the identification of community advocates and volunteers and further build community resilience.

An example would be engaging young people, schools and youth workers locally in designing new ways of communicating with young people living with a long term condition.

P2: Developing assets and resources for improving health and wellbeing

Primary care teams will work with others to develop and map the local social capital and resources that could empower people to remain healthy, and to feel connected to others and to support in their local community.

Practices will work with local voluntary and community organisations; health, third sector and other organisations; and local authorities to:

- provide additional capacity for improving health and wellbeing (e.g. Citizen's Advice, community pharmacy services and the probation services)
- protect community resources for future generations (e.g. with the Environment Agency)
- test new ways to build and improve relationships with local communities
- build a map of local community assets that can be harnessed for health and wellbeing
- identify and develop local community health and wellbeing champions, advocates and volunteers.

Establishing and maintaining an up to date map of community assets will assist a range of organisations involved in an individual's care. The map will support other 'first contact' providers such as NHS 111 and community pharmacies to offer patients a range of options.

P3: Personal conversations focused on an individual's health goals

Where appropriate, people will be asked about their wellbeing, capacity for improving their own health and their health improvement goals.

Practices will co-ordinate plans of care, particularly for people who regularly visit the practice and whose health is at risk of deteriorating. If relevant, patients will be offered self-management support and/or social prescribing – directing them onto other information, resources and services available in their local communities e.g. debt advice.

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proactive care

P4: Health and wellbeing liaison and information

Primary care teams will enable and assist people to access information, advice and connections that will allow them to achieve better health and wellbeing. This health and wellbeing liaison function will extend into schools, workplaces and other community settings.

These services would offer a range of interventions from brief focused information to more extensive advice and support. Interventions could include group support, 1:1 coaching, signposting and improving health literacy. The service would also build partnerships to build on the contribution to health and wellbeing already made by leisure centres, gyms and voluntary groups.

P5: Patients not currently accessing primary care services

Primary care teams will design ways to reach people who do not routinely access services and who may be at higher risk of ill health

This specification focuses on two key areas:

1. People on the registered list (but not attending the practice)

- Practices will design ways to reach vulnerable patients who may live in circumstances which make it harder for them to access general practice. This includes patients whose language and culture form barriers to receiving care, for instance gypsies, travellers, sex workers, homeless people, vulnerable migrants, people in care homes, and people with learning disabilities or severe mental illness.

  Practices will identify the patients on their registered list who have not been attending and are therefore at higher risk of ill health. These may be people who have declined invitations for services, are reaching crisis, suffering social isolation or stigma.

  These patients will require a more personalised service offer, care coordination and care planning. Using peer advocates who have direct personal experience and can empathise with patients has been shown to be an effective way of engaging with these groups of patients.

- Primary care teams will also design approaches to follow up those patients who might be attending the practices from time to time but are not taking up invitations for services such as screening and vaccinations. Understanding the root causes for non-attendance will be crucial to ensuring maximum take-up of these services in the future; for example, understanding religious or cultural reasons for non-attendance.

2. The unregistered population

- Working collaboratively across a population and across multiple agencies, primary care teams will also design, with the support of their CCG, ways to reach and care for the unregistered population, for example homeless patients and people released from custody or places of detention.

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2. Accessible care specification

Accessible Care Expert Panel Chair: Dr Tom Coffey OBE

Tom has been working as a GP in Wandsworth since 1994. He started as a chemical engineer then transferred to medicine at Charing Cross and Westminster medical school. He is a GP partner at Brocklebank Group Practice; a medical advisor to Tooting Walk-in Centre; Clinical Assistant in A&E at Charing Cross Hospital and a tutor at St George's, University of London. Dr Coffey was awarded an OBE for services to healthcare in south west London in June 2009.

Good access to general practice is important to everyone. It's important to patients who may be distressed or who may suffer if diagnosis and treatment is delayed; those who value a continuous relationship with their clinician in order to remain healthy and independent; and people who find it hard to see a GP within current opening times. It's important to practices whose workloads can become inefficient if access is not managed systematically. It's important to the NHS as good access to primary care has the potential to reduce unnecessary emergency admissions and reduce the number of patients attending A&E.

Although there are examples of excellent services at some practices, many London patients report that access to general practice does not always meet their needs. On average, patients in London are less satisfied than those in other parts of England with: contacting the practice; seeing a GP quickly; their ability to book ahead; opening hours; and seeing a GP of choice when they want to.

Patients who cannot access their practice because it is closed or they are unable to get an appointment are more likely to attend A&E with issues that their GP could have resolved. Less than half of patients wanting an appointment in London are seen by the next working day. Phone lines are busy first thing in the morning and same day appointments run out quickly. Many patients are asked to call back the following day. For many patients, access to weekend and evening appointments is limited and many practices still close on a Wednesday or Thursday afternoon.

More London patients report that it is hard to see a preferred GP in London than anywhere else in England. Consequently patients who need regular contact and a continuous relationship with a clinician may not receive the best support to manage their health effectively in the community.

Our proposals

Good access means different things to different people. In developing these specifications we have tried to consider the various needs of different patient groups – whether that is accessing continuity of care, rapid access, out of hours care or online services.

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accessible care

Often patients concerned about a new health problem want to be seen as quickly as possible but are less concerned about who they see. There is also evidence that some patients go to A&E with minor issues because they can't get a same day appointment with a GP – especially at weekends when many practices are closed. So we've proposed that all patients should be able to access a consultation with a GP or senior nurse from their own practice on the same day in routine opening hours and on Saturday mornings. We've also suggested that patients should be able to access a primary care health professional seven days a week, 12 hours a day in their local area.

Commuters with occasional health needs want advice and care quickly, conveniently and in a variety of ways. Patients should be required to only make one call or click to make an appointment, and practices should promote online services including appointment booking, prescription ordering, viewing medical records and email. Many systems make telephone consultations the normal starting point for most patients – linking the two people who need to talk, in the shortest possible time.

Other patients, such as those with long term conditions, tend to need more frequent consultation and value continuity and familiarity – but are willing to wait a little longer to be able to do so. So this specification outlines that patients should be able to book at least four weeks ahead if they wish and see their GP of choice in an appointment with a flexible duration.

We know that patients will have different needs at different times. So we've suggested a specification that patients should be given a choice of access options to select the service that best meets their needs.

We also need patients to use the most appropriate service for their needs. For medical help or advice in a situation that is not life-threatening, patients can call 111 free from any phone. NHS advisers are on the line 24 hours a day, seven days a week and can give healthcare advice or signpost patients to local services.

Patients are often unaware of the range of services that their pharmacy can offer, so many people simply don't consider visiting. But pharmacies can provide medical advice on a range of conditions and can even provide prescription drugs under minor ailment schemes, without an appointment.

The fact that different dimensions of access are valued differently by different people (and by the same people at different times and in different circumstances) presents a real task to the formulation of concrete measures of good-quality access. Our challenge is to design and deliver a truly personalised service that responds to all patients, irrespective of their particular circumstances. We hope that this specification outlines a service which does just that.

Dr Tom Coffey OBE

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accessible care

A1: Patient choice

Patients will be given a choice of access options and should be able to decide on the consultation most appropriate to their needs.

Different patients, in different situations, have different access needs. Some patients value continuity of care over rapid access. Some people place more value on seeing a particular clinician. Others want a more convenient appointment time, or to book an appointment four or more weeks in advance.

General practice should make all these options available to the patient at the point of contact and allow the patient to select the service they want. Practices should also include reasonable adjustments to remove access barriers for patients, such as considerations for the homeless or non-English speakers, as well as adhering to the Equality Act (2010) for physical access needs (ramps, hearing loops etc).

A2: Contacting the practice

Patients will be required to only make one call, click or contact in order to make an appointment. Primary care teams will maximise the use of technology and actively promote online services to patients including appointment booking, prescription ordering, viewing medical records and email consultations.

Currently appointments are often allocated based on who gets through to the practice rather than by clinical need. Many practices hold back appointments so that a patient getting through may be told that there are no appointments left but that they should call back later or the following day when more are released. This increases the number of calls coming into the practice as patients have to call several times before securing an appointment and patients who do call back join the back of the queue.

In future patients would have multiple options for making an appointment, and would only need to make contact once in order to have a discussion with a clinician.

A3: Routine opening hours

Patients will be able to access pre-bookable routine appointments with a primary health care professional (see 'workforce implications' for the proposed primary care team) at all practices 8am – 6.30pm Monday to Friday and 8am to 12 noon on Saturdays. An alternative equivalent patient offer may be provided where there is a clear, evidenced local need.

There is significant variation in opening hours across London. This specification will create an equitable offer to patients across London. During the specified hours, all practices will be open to allow patients to access all services, including attending an appointment, speaking to a receptionist, and collecting or ordering a prescription.

A4: Extended opening hours

Patients will be able to access a GP or other primary care health professional seven days per week, 12 hours per day (8am to 8pm or an alternative equivalent offer based on local need) in their local area, for pre-bookable and unscheduled care appointments.

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accessible care

This service will be delivered by networks of practices working together at scale. In most cases a larger practice in the local community will take the lead to provide this service on behalf of other practices. A suggested offer of 8am to 8pm is described here, however there could be a suitable alternative equivalent offer based on local population needs, for which the totality of the offer (seven days, 12 hours) is not reduced.

A5: Same day access

Patients who want to be seen the same day will be able to have a consultation with a GP or appropriately skilled nurse on the same day within routine surgery hours at the practice at which they are registered (see Specification A3: Routine opening hours).

Patients with new health conditions often want to see or speak to a GP as soon as possible. It's important for patients who may be distressed or suffer if diagnosis and treatment is delayed. Consultations could be face-to-face or on the phone (or video phone) but will be provided by a GP or an appropriately skilled nurse on the same day.

Practices would be encouraged to use a demand-led telephone triage system. These approaches provide a phone conversation with an appropriate clinician throughout the day, often within 30 minutes of the patient contacting the practice. The patient can then discuss their needs with the clinician and between them they can then decide the most appropriate course of action (e.g. face-to-face consultation of appropriate length according to need; referral to community pharmacist, nurse, healthcare assistant or other service; booking for diagnostic tests; and self care).

A6: Urgent and emergency care

Patients with urgent or emergency needs will need to be clinically assessed rapidly. Practices should have systems in place and skilled staff to ensure these patients are effectively identified and responded to appropriately.

In the event that a patient accesses general practice with emergency care needs, there should be sufficient processes and procedures in place to enable all members of the practice to respond to that patient's needs appropriately.

A7: Continuity of care

All patients will be registered with a named GP who is responsible for providing an ongoing relationship for care coordination and care continuity. Practices will provide flexible appointment lengths as appropriate.

All patients should have a named GP for care continuity and coordination. Other GPs or healthcare professionals within the practice team may provide care as appropriate but the named GP will effectively still oversee delivery of the care plan.

General practice will routinely improve continuity of care through a range of mechanisms such as buddying; job sharing; forming 'teams within teams'; developing organised handover systems; enhanced use of communication and record-keeping technology; and increased involvement of patients and carers in care planning. These measures are of particular importance where personal continuity is not possible.

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3. Coordinated care specification

Coordinated Care Expert Panel Chair: Dr Rebecca Rosen

Rebecca is a Senior Fellow in Health Policy at the Nuffield Trust, a GP in Greenwich and an accredited public health specialist. Her current policy interests include integrated care, primary care, new organisational models for general practice and NHS commissioning. Rebecca is a clinical commissioner with Greenwich CCG – where she leads on long-term conditions and quality. At her GP practice, Rebecca leads work to improve continuity and quality of care for people with chronic complex ill health. In the past, Rebecca has worked as a Medical Director of Humana Europe; as a Senior Fellow at the King's Fund; and in NHS academic public health departments. Past research interests include the diffusion of new medical technologies, patient choice and primary care policy.

For people with complex health and social care needs, coordinated care is essential to support their health and wellbeing.

One in five Londoners are living with one or more complex conditions. Other people go through periods of severe, complicated, health problems which may last months or years before they are resolved. Changes to the GP contract focus on the over-75s, but in London it is often younger people who live with complex health problems which may be harder to manage because of drug or alcohol dependence, mental health problems or financial and social pressures. Many Londoners, young and old, will be receiving care from several different services, which can become confusing and frustrating if the services don't work in close collaboration.

The National Voices report ***Integrated care: what do patients, service users and carers want?*** provides a powerful narrative which highlights clearly and effectively the kind of relationship people want with their health professionals. It stresses that coordination and care are the two 'top lines' in what people expect and need.

The statement "My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes" summarises the service which we want to outline in this specification. We know this type of service would result in significantly improved health outcomes and patient experience.

In the National Voices document, patients tell us they want a service: where their needs as a person are taken into account; where they are involved in discussions and decisions about their care; where they have regular reviews of their care, treatment and care plan; and where they have the information and support they need in order to remain as independent as possible. We also know patients want a first point of contact from someone who understands them and their condition and who they can go to ask questions at any time.

These are significant challenges for all health and care professionals, including GPs, which will require a fundamental change in the culture of general practice and communications between service users and professionals. New approaches to delivering care are needed, informing patients and their carers about their condition(s) and enabling them to participate effectively in decisions about their health and care.

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coordinated care

Our proposals

We want to move away from a reactive system which treats people when they become ill, to one which coordinates care and supports people to stay well.

Firstly we need to identify the patients who would benefit from this approach. Many will be elderly and suffer from multiple chronic conditions while others may suffer from mental health issues or have a set of social circumstances and lifestyle issues which are best addressed though coordinated care.

Secondly patients need a named clinician who will routinely provide the patient's care or act as an advocate, guide and contact for the extended practice team and to the wider multidisciplinary team in line with their needs.

Thirdly we want all such patients to have a personalised care plan and to have played an active role in determining its aims and content – agreeing goals and the support they need to achieve them.

Fourthly we want to create an environment in which patients can maximise the potential of their self-care, lifestyle changes and knowledge to contribute to their own health and wellbeing.

Finally, patients who require coordinated care will need frequent reviews and input from a range of members of a wider team ranging from a micro-team of practice staff, pharmacy and community nursing to a macro-team of health and social care providers. Their provider network needs to be well-connected and their services seamless.

While these challenges sound daunting, a great deal of work has been done on how to deliver high quality services tailored to individual and population health needs and examples continue to be developed across London. The chronic care model introduced the idea of 'informed, activated patients' and a 'prepared, proactive' clinical team. The recently launched *Delivering Better Services for People with Long Term Conditions – Building the House of Care* adapts this model for the NHS, highlighting the four key components of coordinated care: informed, engaged individuals and carers; organisational and clinical processes; health and care professionals committed to partnership working; and effective commissioning.

The ambitions of National Voices' patient-centred coordinated care and the organisational model of the *House of Care* feature heavily in the following specification. They create a framework around which practices can organise themselves to deliver high quality care with a relational continuity (seamless care), focused on the goals and preferences of individual patients and tailored to meet individual needs.

The specification is rightly ambitious and will not be achieved overnight. It requires a new culture for general practice in which the co-creation of health by patients, doctors, nurses and others becomes the norm. The specification addresses what individuals can do to keep themselves well; the ways in which professionals consult with patients; the ways in which practices are organised to support coordinated care; and the ways in which GPs work with other providers to deliver coordinated care. Practices may need additional resources to deliver the specification and these will have to be negotiated and put in place, but we believe achievement of the specification will result in better care for people with long term, complex health and care needs.

Dr Rebecca Rosen

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coordinated care

C1: Case finding and review

Practices will identify patients who would benefit from coordinated care and continuity with a named clinician, and will proactively review those that are identified on a regular basis.

Patients with complex conditions who need care from more than one professional or team will be added to a coordinated care register and will be provided with an enhanced level of service.

These patients may have long term conditions but may also be patients with a range of other health conditions and social support needs such as children and families with complex problems; people with mental health conditions; people in nursing homes; people at the end of life; or vulnerable people who find it hard to access services (for example homeless patients; those with learning difficulties or members of the traveller community).

Patients will be identified using a combination of clinical alerts, risk profiling and clinical judgment. Every practice, or network of practices where appropriate, will run a regular risk profiling / risk stratification process in order to identify patients who should be on their care coordination register.

The intensity of care, frequency and duration of contact with patients should be scaled up or stepped down as a result of reviews and patient progress. This should enable practices to identify those who may be, or are at risk of, experiencing an exacerbation of their condition but who have not reached a crisis point to seek treatment.

C2: Named professional

Patients identified as needing coordinated care will have a named professional who oversees their care and ensures continuity.

All patients identified as needing coordinated care should have a named professional from whom they routinely receive their care. The lead GP will provide continuity of care, either personally or in collaboration with a 'micro team' of clinicians and professionals in and around the practice, for example members of the wellbeing team or community pharmacists.

Patients may also be allocated an additional member of the practice team or an additional health or social care professional as a care coordinator to act as their first point of contact if they have questions, concerns or problems.

The person who coordinates their care should work with the patient to achieve their goals. For some patients, this will require extended consultations, for others it will mean regular contact with an extended primary care team. Patients with more complex needs would ideally be able to contact their care coordinator 24/7 for certain periods of very acute clinical risk or towards the end of their life.

The intensity of contact and amount of time spent with the named GP and extended team will fluctuate in accordance with need, as assessed by risk profiling and regular communication with patients and their family and carers.

The GP should act as an advocate and guide and should coordinate care with the extended practice team and a wider multidisciplinary team

as appropriate. If patients go into hospital or transition to other services, general practice should continue to be proactively informed about the patient as they move between services, continuing to coordinate their care if appropriate.

C3: Care planning

Each individual identified for coordinated care will be invited to participate in a holistic care planning process in order to develop a single care plan that can be shared with teams and professionals involved in their care.

Development of the care plan should follow the approach described in *Delivering Better Services for People with Long Term Conditions – Building the House of Care*. This represents a departure from the current focus on individual diseases towards a generic approach in which patients' goals drive care delivery and greater attention is paid to the contribution that people make towards managing their own health.

Care planning should be based on a philosophy of co-created goals for maintaining and improving health. It should be an iterative process that continues for as long as an individual has complex needs.

Patients identified for coordinated care, and their carers, should be encouraged to play an active part in determining their own care and support needs as part of a collaborative care planning process. This should involve discussing care and support options, agreeing goals the patient can achieve themselves, and co-producing a single holistic care plan that includes the needs of family and carers.

C4: Patients supported to manage their health and well-being

Primary care teams will create an environment in which patients have the tools, motivation and confidence to take responsibility for their health and wellbeing.

A culture of self-management support will underpin care coordination, recognising that the personal information that patients, their carers and families bring to the development of care plans can be as important as the clinical information in medical records.

Practices will develop an infrastructure to provide self-management support for patients with ongoing complex problems and support for their carers.

Following a new diagnosis of a long term condition (or identification of a need for coordinated care such as recovery from cancer), all patients will have at least one encounter dedicated to enhancing their ability to self-care, and then frequently according to need thereafter.

Support for patients could be provided by individual practices or across a number of practices and could for example include internet resources; advice from staff skilled in lifestyle training and/or motivational support; information packs; services provided by volunteers or voluntary organisations and access to patient groups in which patients support each other.

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coordinated care

C5: Multidisciplinary working

Patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs. The frequency and range of disciplines involved will vary according to the complexity and stability of the patient and as agreed with the patient/carer.

Patients on the coordinated care register will have a review by a multidisciplinary team involving clinicians from within the practice and from linked services. GPs should be regular, active participants in multidisciplinary reviews of their registered patients who have been identified for coordinated care. The frequency of multidisciplinary reviews will vary according to changing needs.

Multidisciplinary reviews should ideally include professionals from both health and social care. This might include acute care specialists, social services, housing and finance advisors, community matrons, mental health specialists and district nurses depending on the needs of the patient.

General practice should fully participate in multidisciplinary work across the health and care system and use reflective learning to improve patient care and for system enhancement.

The enablers

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This *Strategic Commissioning Framework for Primary Care Transformation* represents a significant ambition for service improvement. Delivering this ambition will require strong collaboration from all parts of the NHS, the CQC, local education and training boards (LETBs), academic health science networks (AHSNs), local authorities, charities and voluntary organisations and health and wellbeing boards (HWBs) in London. This section of the *Framework* provides a strategic London-wide case of the underpinning enablers that will need to be utilised in order to meet the scale of that challenge.

Local plans to deliver the changes

CCGs across the capital will continue to develop (in partnership with NHS England (London)) local plans for delivering these changes. These plans will focus on how to improve general practice and the wider primary care system from April 2015 onwards. The changes required to the system will take a long time to achieve, however some changes and some practices may be quicker to implement than others. In order for local populations to be able to take part in discussions to decide what is best for their local community, it is essential that plans are locally designed based on different starting points.

The *Framework* is not intended to be a static document but will form the basis of wider engagement over the coming months in each local area. There is an expectation that different areas will work at different paces and NHS England (London) will work closely with those areas that are ready, and will share the learning across London. Commissioners across London aim to ensure that in the future, all Londoners will receive the primary care services described in this document.

Co-commissioning

The current commissioning landscape for primary care is complex, with up to three different commissioners (CCGs, NHS England and local authorities) and several different funding streams for some pathways of care. To achieve the transformation of out-of-hospital care and thus improve health outcomes and deliver more care closer to home, commissioners have recognised the need to make it easier for them to work together and to better integrate services. Co-commissioning is a first step on this journey to empower CCGs to have greater influence over the development of primary care services. This will help to ensure local primary care developments are better aligned with CCGs' commissioning plans for hospital-based care and community services and better meet the needs of diverse local populations. Co-commissioning could potentially lead to a range of benefits for the public and patients including:

- improved access to primary care and out-of-hospital services, with more services available closer to home
- high quality out-of-hospital care
- improved health outcomes, equity of access, reduced inequalities
- a better patient experience through more joined up services.

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Options for models of co-commissioning

Proposals for co-commissioning arrangements across London, based on local requirements and plans, are being developed and their formulation is supported by national guidance. This national documentation, *Next Steps Towards Primary Care Co-Commissioning* describes several types of co-commissioning model. The exact nature of the arrangements will depend on local preferences but it is anticipated that co-commissioning arrangements with CCGs could be one of the following types:

- allow CCGs greater involvement in commissioning decisions, including actively participating in discussions about all areas of primary care, in order to make better decisions about how resources are allocated across primary care, community services and hospital services and with local authorities.
- joint commissioning model that enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their area team, either through a joint committee or "committees in common". This would allow CCGs and area teams to pool funding and give them an opportunity to more effectively plan and improve the provision of out-of-hospital services for the benefit of patients and local populations. Together, CCGs and area teams would be able to make better decisions about how primary care resources are deployed, for example by designing local solutions for workforce, premises and technology challenges.
- delegated commissioning model, offering an opportunity for CCGs to assume full responsibility for commissioning some aspects of general practice services. The exact models for delegated commissioning will need to be worked up in local areas.

Commissioners across London have set up a co-commissioning collaborative to develop thinking on some of the key elements required. Areas under consideration include finance, workforce, governance, benefits and contracting.

Financial implications

The changes described in this *Framework* cannot be delivered without significant investment. A high-level financial case has been completed at a London-wide level to estimate the cost of providing the new patient offer.

The financial modelling work has so far focused on the recurrent revenue investment required to provide the service specification for whole populations with differing degrees of care complexity. The modelling has focused on two main areas:

1. **Delivering a new service model.** Supporting clinicians to deliver more person-centred care by analysing the cost of new activities and the potential increase and diversification of the primary care team needed
2. **Increasing patient access to primary care.** By creating additional appointment slots, allowing extended practice opening hours in each area including evening and weekend working.

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Financial context

General practice undertakes 90% of first patient contacts, and in London this is done for 7.3% of the capitals's healthcare budget of £15.1bn – based on the combined CCG and NHS England commissioning budgets. Expenditure on general practice services has fallen in real terms between 2010/11 – 2011/12 in comparison to an increased spend in acute and community services.

The new service specification needs to be affordable within current NHS financial constraints, and NHS England and CCG budgets. There is a £2.4bn saving requirement for London by 2021/22, which means that finding ways to use existing resources more effectively is urgently needed.

Within this context there is a strong rationale for re-balancing the NHS investment profile towards primary care:

- **Improving services for patients and creating a sustainable general practice service**
- **Supporting sustainability across the wider health system.** For example there have been estimates that 10-30% of A&E attendances have the potential to be managed as part of a primary care offer
- **Securing better value for money.** Investing in general practice capacity and capability to deliver a higher proportion of activity closer to home would enable acute reconfigurations.

Estimate of the required investment

It is estimated that in order to reverse this trend, meet future population growth and deliver a modern, high quality service for all, £310 – £810 million (representing 2% – 5.36% of total health spend today) will need to be invested annually. This is expected to begin with a gradual shift in total health spend of 0.4% – 1.07% each year over five years. This shift in total health spend has the potential to deliver a significant increase in general practice capacity in the medium term. This will require changes at a local and regional level, both in terms of redirecting funding and supporting the process for doing this (e.g. with co-commissioning).

Caution: This estimate is a very high level calculation for the purpose of assessing the feasibility of the service changes, the methodology used is outlined below.

Financial modelling methodology

In developing the above hypothesis for the funding needed to deliver the envisaged primary care, a methodology was used to estimate the additional cost of delivery of the total specification as compared to current spend.

a) Calculating the additional cost of delivering the **coordinated and proactive** specification. The methodology is based on a differentiation of patients at different levels of need (i.e. some patients will require high frequency and longer appointments because they have more complex care needs, some may only require a quick consultation) and the requirements for involvement of

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different members of the practice team. Clinicians then provided estimates based on clinical complexity categories and the complexity bandings associated with patients on different disease registers of the frequency, amount of time and member of the clinical team which would be required to treat each type. These figures were then adjusted to account for their relative proportion of the population (e.g. approximately 80.3% of the population are 'mostly healthy' and not on the disease registers).[6] This allowed an overall cost to be estimated.

b) Calculating the additional cost of increasing **patient access** to general practice. There is a direct cost increase relating to additional opening hours. Extending the opening hours will result in additional workforce and non-pay costs. Two methods of estimating this additional cost are described below:

- Methodology A: calculating the cost of increased demand based on redirection of existing A&E minors
- Methodology B: The cost of increased access based on theoretical current estates capacity.

Summing these methodologies demonstrates that a range of between £310 – £810 million potential investment will be needed in primary care in London depending on the approach.

Cost Type	Annual Cost (£m)
Cost of delivering a new patient offer (excluding access)	250 – 300
Cost of delivering better access. (Methodology A, low end of range)	60[7]
Cost of delivering better access. (Methodology B, high end of range)	510
Total Cost Estimate	**310 – 810**

In addition to this, transitional funding will be required in the first few years to invest in the infrastructure and transition of organisations to these new ways of working.

Current funding opportunities

Current funding opportunities for improving general practice that are already identified include the Better Care Fund (£3.2 billion nationally) and the Prime Minister's Challenge Fund (£50 million 2014/15 expected to rise to £100 million in 2015/16). The *NHS Five Year Forward View* and London Health Commission have identified investment in general practice as a key priority for the health system with additional national transformation funds anticipated. In a survey of 24 CCGs in London, only two areas did not have resources already invested towards supporting

6 As per the Quality and Outcomes Framework database
7 Includes a +20% optimism bias

general practice improvement, and one area had already confirmed a recurrent £4.9 million investment across a number of CCGs to support general practice improvements and wider out-of-hospital changes.

Next step financial modelling

The next phase of financial analysis would involve local scenario testing and detailed work up of CCG area-specific, operational-level financial models. This would include:

- adjusting the financial and activity model to take into account: local factors to underpin the additional access changes and other patient offer changes; the workforce change requirements – consulting with workforce experts; additional clinicians; and local analysis of need
- local (CCG area) estimation of the building, IT and other infrastructure costs, including any additional 'pump prime' or upfront investment in order to implement the specification
- local (CCG area) analysis of cost efficiencies, including what, when and how much effect these would have
- adjusting the modelling to local population demographics, in order to account for local variations in 'healthy' populations, and co-morbidity (multiple disease) duplications across the disease registers
- further analysis of the sources of capital and revenue funding required and potential to release these locally (by strategic planning group area)
- understanding the impact on non-primary care finances (for example adult social care, and the cost of prescribing).

Contracting approach

The service specification for general practice can only be delivered by general practices working together at scale and with other parts of the health and care system. With that in mind the proposal in this *Framework* is that the specification will not be funded at individual practice level but will be delivered through a new contract at a wider population level, offered to groupings of geographically aligned general practices or Multispecialty Community Providers (MCPs) (alternative options might be considered for individual practices that have a significant geographical footprint and alignment with other health and social care providers).

The exact contracting approach used in each place will be determined through co-commissioning arrangements in consultation with each CCG, taking into account local arrangements for delivering against the new service specification.

Potential contractual forms

Contracts will be developed that incorporate the service specification as a distinct, scheduled and incentivised service innovation and general practice collaboration.

Broadly speaking, the following contractual forms are likely to be reviewed and considered for use in commissioning the new service specification for general practice:

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- Alternative Provider Medical Services (APMS)
- NHS standard contract
- hybrid of the APMS and NHS Standard Contract (note – this would represent a new form of contracting that would require legislative change).

Whatever contract form is used, it will typically include a phased transition for the primary care organisation/provider. For example, this could include a year on year increase to the contract value as well as greater degree of risk share and pooling of current incentives from constituent practices that might include:

i) complete or phased incentive sharing across constituent practices with regards to Quality and Outcomes Framework (QOF), Local Enhanced Service (LES) and other enhanced payments

ii) increasing the level of shared decision-making across constituent practices with regards to the specification for how current Personal Medical Services (PMS) investment contributes to delivery of the new service specification and specific local needs.

iii) increasing the level of pooled funding across constituent practices with regards to APMS, PMS and General Medical Services (GMS) for example £x per patient is pooled to represent the efficiencies that will be gained from working collaboratively or by delivering current services in different ways.

The contracting vehicle will need to 'wrap around' the existing national contracts unless constituent practices are opting for a full merger/super partnership in which case they may voluntarily relinquish their current contract. Whatever the approach, it will need to provide sufficient new financial incentive to increase the level of collaboration and joint ownership. The exact nature of these arrangements will vary by nature of the provider landscape but the principle of at-scale providers increasingly sharing pooled incentives with shared responsibility and risk for delivery will be a key marker against which additional investment will be made.

Consideration will be given as to whether the accountability for delivering the constituent GMS, PMS and APMS can be attributed to a lead provider within a scale primary care organisation. That type of change would require new permissions and a shift in national policy. It could only be undertaken on the basis that systems for assuring quality and patient safety continue to have sufficient probity and it would require changes in the approach to regulation. There is however some evidence, from Tower Hamlets networks for example, that clinical governance systems that are owned and reviewed across a number of general practices by peers and local training leaders have greater potential to secure improved quality and patient safety.

The contractual form chosen will need to be flexible to allow for wider collaborations and partnerships with other types of providers, for example community services and the voluntary sector. This may be in the form of governance arrangements that reflect the wider partnership. In some local areas the strategic intent may be to take a single step towards a merged contract between general practices and the wider system to form an accountable care organisation that can hold capitated budgets and shared risk for a whole population.

Many areas already have a strong ambition towards bringing general practice and community services together over the next two

years. It is however anticipated that most areas will be looking to contract networks/federations of general practices as a starting point.

Workforce implications

Implementation of the service specification in this *Framework* is set in the context of growing demand for primary and community care, increasing expectation, and the changing patterns of needs of patients with more complex and long-term conditions. These demands, coupled with technological advances and the adoption of best practice across care settings, have important implications for how to develop and train primary and community clinicians and the wider workforce of the future.

General practices are typically small organisations, working in relative isolation from one another, with the exception of some networking for the purposes of out-of-hours cover and involvement in clinical commissioning. Increasingly however this is changing with the rapid formation of at-scale general practice organisations involving closer working and in some areas changes to legal structures to enable practices to come together. However the general practice workforce (including GPs and GP nurses) is under significant workload pressure and many are now considering early retirement[8]. The number of mid-career doctors (under the age of 50 years) considering leaving the profession is also rapidly rising[9]. Nationally the growth in GP numbers has not kept pace with that of hospital consultant numbers (per WTE)[10] and boosting numbers entering GP training is proving difficult. GPs in London are a lower proportion of the total workforce compared to national figures.

Ongoing planning of the future workforce requirements will be at the heart of transforming care. Bolstering the primary care workforce has been identified as a core objective in the Health Education England (HEE) mandate and is also recognised as a key priority for HEE and its Local Education and Training Boards (LETBs). Implementing the general practice specification and planning the future workforce requirements will require alignment of resources to:

- manage immediate and forecasted workforce supply shortages
- reshape existing roles through ongoing training, education and development
- modify core training programmes to align with new service needs
- develop and pilot new roles
- evaluate and research the effectiveness of new roles and workforce configurations
- manage expectations around the pace of workforce change
- develop new primary care learning environments that build on multidisciplinary approaches such as Community Education Provider Networks (CEPNs)[11].

8 BMA quarterly tracker survey: Current views from across the medical profession. Health Policy and Economic Research Unit, 2014
9 Securing the Future GP Workforce. Delivering the Mandate on GP Expansion. GP taskforce final report. March 2014
10 Centre for Workforce Intelligence; In-depth review of general practitioner workforce. June 2014
11 CEPNs: collectives or networks of primary and community organisations working collaboratively to enhance educational delivery in local geographical contexts

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Implementation of the service specification in this *Framework* will require practices to offer an extended scope of services; more convenient opening times; personalised care; and an ongoing development of access options to match the needs of the population. Practices of all sizes will be faced with the challenge of how to:

- configure the workforce to ensure safe practice, on-going training and development whilst maintaining continuity of care; and harness the potential of temporary and locum staffing
- expand flexible working arrangements
- prevent professional isolation
- ensure staff are up to date on evidence-based practices, treatment developments, changes in medicines use, technological advances etc.
- efficiently manage workforce demands while ensuring the team has time for organisational development, service redesign and quality improvement.

The future health service will see more person-centred systems of care and less division between primary, secondary, community, voluntary and social care organisations. The developments to commission the future workforce for general practice will be undertaken in the context of overall professional clinical training and increasing multidisciplinary working across organisational boundaries.

Governance arrangements will need to be developed to support the increasing numbers of staff that will be in training, on placement and working independently outside hospital, and in community settings. Delivering integrated primary care using multidisciplinary models of working in community settings will require new approaches to safeguarding, to support safe clinical practice whilst ensuring staff are supported to continually learn and develop.

How roles and teams fit together in delivering future care still needs to be determined and different roles and responsibilities are likely to evolve in each local area as the specification is implemented. Broadly it is anticipated that the roles detailed below will be required:

Within each practice	**Aligned to each practice but working across a wider geography / at scale primary care organisations**
GPs, practice nurses, GP nurse practitioners / nurse prescribers, volunteers, receptionists, managers, health care assistants and may also include physician associates	Prescribing advisors, GPs with a special interest (GPSIs), care coordinators, wellbeing teams, and 'super practice managers/directors' with sufficient skills to lead the development and operational management of at-scale primary care organisations. **As part of, for example, a wider Multispeciality Community Provider (MCP):** Secondary care specialists, social care, mental health and community services teams, community pharmacy.

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A number of new roles are appearing in the general practice setting enabling the delivery of high quality care, improved patient experience and improved clinical outcomes. These are additional to what is now considered a core team of GPs, practice nurses and GP nurse practitioners, managers and reception staff. A few examples are provided below to illustrate the functions these new roles are performing and how they are supporting new ways of working both within general practice and across a wider care team.

- **Healthcare assistants (HCA) / clinical assistants**: provide clinical support for GPs to enable them to allocate more time for patients with complex problems.
- **Health and wellbeing coordinators**: enable patients to maintain their health and wellbeing and improve self-management of their condition.
- **Physician associates**: work to the medical model in the diagnosis and management of conditions in general practice and hospital settings, with the supervision of medical practitioners.
- **Care coordinators / navigators**: provide a central coordination role on behalf of the patient, working with their wider care team covering health, social care, voluntary and other local services.

For example, the National Association of Primary Care has joined forces with Health Education England to create a training programme for new Primary Care Navigators (PCN) to support patients with dementia, their carers and families. It is intended that this training will eventually be adapted and used for other long-term conditions.

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The table below examines some of these roles and the functions they perform.

Function	Role			
	HCA/ clinical assistant	Health and wellbeing Coordinator	Physician associates	Care coordinator /navigator
Basic clinical checks and tests incl updating clinical records	✔		✔	
Input to diagnosis and treatment planning			✔	
Refer to secondary care (incl A&E)			✔	
Focuses on acute conditions	✔		✔	
Supports patients with long term conditions	✔	✔	✔	✔
Broader assessment of patients' own health goals	✔	✔	✔	✔
Care plan facilitation	✔		✔	✔
Self-management support	✔	✔		✔
Health coaching	✔	✔	✔	✔
Establishing referral pathways to preventative and wellbeing services and activities		✔		
Multi-agency working		✔		✔
Directs patients to additional sources of support and care – health, social care, voluntary sector	✔	✔	✔	✔
Reports primarily to the named GP – largely practice employed	✔		✔	
Reports to the named GP and a wider MDT – largely non practice-based / employed		✔		✔

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Planning the future workforce requirement is always challenging and many organisations, institutions and professional bodies are attempting to do this as they develop their long-term plans. Especially important are HEE and the LETBs who are working with patients, carers and other key stakeholders to explore the workforce challenges and find ways of meeting these challenges[12,13,14,15] Sharing and utilising existing learning will be pivotal as prototype delivery and education models are being developed and tested across the capital as part of:

- integration pioneer sites
- Prime Minister's Challenge Fund sites
- LETB development programmes
- Academic Health Science Network (AHSN) primary care development work streams
- Community Education Provider Networks (CEPNs).

In addition, specific LETBs are taking forward programmes to support and enable the workforce.

Health Education North West London (HENWL)

Health Education North West London has invested funds to support all staff working in general practice to access continuous professional development courses which are block commissioned from Higher Education Institutes (HEI). £100,000 has been invested so far for 2014-15 and further funds will be added if demand exceeds this figure. The HENWL board has also funded £1.1 million workforce development activity for primary care for 2014-15, distributed via the CCGs to support the workforce transformation and development activity required to enable GP teams to cope with greater levels of demand and complexity as part of the wider system reconfiguration.

A further £1 million has been invested through the *Shaping A Healthier Future* programme to support the development of community learning networks which will be aligned to the whole systems programme in north west London (beginning with initiatives relating to the over 75s population).

As part of the planning work to inform the *Shaping a Healthier Future* service transformation programme, north west London's (NWL) CCGs commissioned a piece of work called *From Good to Great*, *a workforce strategy to support out-of-hospital care in north west London* which was published in January 2013. The document explores the need for innovative new roles and has been used to shape some of the thinking about demand for new roles in the future NWL health system.

Following the 2014 workforce and education planning activity, it has been recognised that whilst overall demand for staff groups is reflective of the overall transformation programme, the detailed analysis of specific new roles and changes to skill mix are not clear. HENWL has initiated a series of task and finish

12 Skills For Care. Principles for Workforce Integration. 2013
13 Health Education England: consultation on the role of bands 1-4. April – March 2014
14 The Cavendish Report. An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings. 2013
15 Greenaway D. Shape of Training: Securing the future of excellent patient care. An independent review of the way we educate and train our doctors. 2013

groups in 2014 to focus on the requirement for new and different roles to inform workforce development investment and future education commissioning decisions. Primary care will be a key focus of this activity.

Health Education South London (HESL)

Health Education South London's approach to the on-going development of the primary care workforce is twofold, encompassing a short- and long-term view. In the short term, HESL has made a direct Continuing Personal and Professional Development (CPPD) allocation of £1.2 million available for staff working in primary care in both 2013/14 and 2014/15 (a total of £2.4 million over two years). This money has been distributed to CCGs based on weighted capitation. HESL's Primary Care Forum (PCF) which acts as the advisory group to the HESL Board on matters relating to primary care, recommended that CCGs focus the CPPD money on bands 1-4, practice reception staff, HCAs working in primary care, practice managers and practice nurses. The PCF also noted that the funding could be used for clinical staff where no other allocation was available. In addition to the direct allocation made to CCGs, an indirect allocation of £400,000 was lodged with south London HEIs for practice staff to access. In 2014/15 this indirect allocation was overspent for the first time. In the future, the intention is for the CPPD budget for primary care staff to be allocated to the CEPNs rather than the CCGs and for the CEPNs to coordinate the on-going development needs of their local workforce. The above funding allocations were made in addition to funding for general practice nurse training and mentorship training for nurses working in primary care.

Health Education North Central and East London (HE NCEL)

A key priority for Health Education North Central and East London is to support the development of integrated care, especially across organisational boundaries. Local health economies have been invited to bid for up to £250,000 per borough to support education and training interventions that support integrated care based education. This has resulted in significant conversations and partnership arrangements that have previously not been possible. HE NCEL has engaged primary, community, secondary and social care providers in working together on workforce development opportunities. By the end of 2014, there will be a multi professional educator-led CEPN with cross-boundary engagement in every borough across HE NCEL. It is anticipated that as these CEPNs mature they will support local workforce planning, programme coordination, faculty development, support local workforce continuing professional development, and achievement of relevant HEE mandates. It is hoped they will be able to support both future and current workforce development.

The development of CEPNs is being supported through infrastructure funds and peer group support and is linked to a broader movement taking place across all three LETBs in London and Kent, Surrey and Sussex[16].

- Additional funding is likely to be provided to support apprenticeships in primary care (including both general practice and community pharmacy).
- A number of projects cross organisational boundaries and have a general practice element. For example, the mental health programme, which has included a successful

16 www.radcliffehealth.com/community-based-education-providers-network-opportunity-unleash-potential-innovation-primary-care

project to train practice nurses in the foundations of mental health; and the dementia project, which trained over 13,000 staff last year in dementia awareness (including many in primary care) and will achieve the same in 2014/15.

- Leadership development programmes have been commissioned for the broad primary care workforce from the London Leadership Delivery Partnership as well as the Florence Nightingale Nursing Programme. The programmes have been offered to the network of general practice nurses and nurses sitting on governing bodies in north central London.

A number of initiatives are already in place to deliver prototype education and delivery models; for example CEPNs, which are being developed and tested as collectives or networks of primary and community organisations working collaboratively to enhance educational delivery in local geographical contexts. The LETBs believe that the CEPNs offer an unprecedented opportunity for the development of the primary care workforce including the development of new roles where appropriate. By understanding both the local population and the existing workforce within their geographic areas CEPNs will be able to ascertain the development needs of existing staff and be able to identify the future workforce required to deliver on CCG commissioning intentions. This may include new roles such as care navigators or the use of physician associates in general practice depending on local need.

CEPNs are being used as the mechanism to bring workstreams together within a defined geography. Their work currently includes:

- developing testing and evaluating new roles – with higher education provider involvement
- drawing together feedback from engagement with local stakeholders. Understanding future requirements in relation to preparation, supply and development of the primary care workforce
- exploring how to increase undergraduate and foundation placements for doctors to promote positive experiences of primary care and encourage choice of general practice as a career
- explore ways to provide inter-professional learning opportunities in community settings.

CEPN development must include the fostering of learning organisations in primary and community care. Currently LETBs accredit GP practices for training, and HEIs accredit practices and community providers for nurse and undergraduate medical teaching. Other AHPs are trained in a variety of community placements. However the transformation of primary care service delivery requires a transformation in primary care education and training facilities. In the same way that hospitals educate multidisciplinary teams, all primary care and community care providers could become education providers. CEPNs will be well placed to drive this necessary development as both education managers and education providers to their local professionals, commissioned by LETBs.

It is now important for partners associated with workforce development in London to collaborate to ensure a coordinated approach. This will include:

- working together to analyse future workforce requirements in London

- working to improve the recruitment and retention of clinical staff
- developing working practices to support the delivery of person-centred integrated care
- representing London's priorities on national workforce initiatives.

Technology implications

Whilst this *Framework* does not aim to provide a technology blueprint for London, technology and digital health care provision will play an increasingly significant role in general practice service delivery. Technology will be a key enabler to delivering the service specification for proactive, accessible and coordinated care. There is already a considerable spectrum of useful technologies implemented or being implemented across the capital such as those outlined in the National Information Board publication *Personalised Health and Care 2020*. However uptake of the available technology is varied and existing arrangements for information sharing are currently limited.

In order to best address the needs described in this document, there should be a focus on maximising the use of the technology available; empowering the patient, and ensuring that there is interoperability between systems and across providers.

Primary care teams in the future will need to rely less on co-location, but instead will be able to come together virtually around a patient to design services. This does not need to be using the same type of technology, but ensuring that communication can occur seamlessly across systems will improve teamwork and the patient experience.

People should be empowered with information about their care that: supports them to participate in care planning; helps set personal health goals; and enables them to better manage their own health independently.

New advances in digital healthcare will provide patients with more choice about how they access services and what they access. This will require active promotion of the new access approaches available.

Technology to enable proactive care

Proactive care services will be best enabled by the integration of general practice systems with other systems and applications sitting outside of general practice:

- Online wellbeing assessments that identify lifestyle risks and enable people to establish personal goals for staying healthy
- Online resources to support health improvement e.g. apps and information services
- Online communities that enable people to learn and care for each other based on similar experiences of living with, and managing physical, social and psychological challenges.

Existing systems can be used to identify people not making best use of healthcare resources and to reach out to those people not accessing care. Systems can also be enhanced to track patient reported symptoms and investigations, highlighting those at greater risk of, for example, cancer.

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Technology to enable access

Providing improved access will require all practices in London to make use of the systems in place for online appointment booking, ordering of repeat prescriptions and giving people access to their care records. These will be provided through a single place for all Londoners via 'Patients Online'. The evidence on the effectiveness of phone and email appointments is still relatively limited. However in this digital age, they are expected to become the norm and are already provided in many practices in London. Video conferencing may also become more commonplace. Other new systems already in operation in some parts of London, that are likely to become more widespread include:

- telephone triage and email appointment systems
- summary care records
- electronic prescribing service
- e-referral service.

Technology to enable care coordination

Coordinating care requires timely information exchange, across a multidisciplinary team, with patients and their carers. This will require general practice to have interoperable systems with other providers to enable shared management of patient information through an integrated patient-held care record.

Technology to modernise care

In addition to the technologies that will enable delivery of the service specification, there are many other examples of new technologies that are modernising care in general practice settings. Just a few examples include:

- online communities of practitioners, building relationships and sharing knowledge to deliver improved care
- remote monitoring and diagnostic devices, enabling patients to be cared for in the comfort of their own home; and new devices bringing hospital-based diagnostics into the general practitioner's consulting room
- hand-held care record devices that allow practitioners to bring care away from the computer and alongside the patient and other practitioners.

Technology strategies

The technology available in each part of London varies and future development strategies for technology will need to be arranged in each local area. However there is a need to work together to:

- ensure wider strategic technology objectives relating to primary care are being met (such as those referenced in *Personalised Health and Care 2020*)
- identify where there may be advantages in implementing some technologies at a greater scale e.g. moving a range of different health, community, mental health and social care providers to a common interoperable system

- agree, across commissioners and providers, key design principles for future technology to enable patient-centred coordinated care and information exchange across organisational boundaries
- encourage the uptake of best practice. These groups will also encourage the uptake of best practice in the use of technologies and this is also reflected in the new approach of the CQC.

Achieving the vision outlined relies on general practice teams across London embracing new technology and ensuring it is used and promoted to patients. A baseline assessment of the current infrastructure in general practice and the extent to which it is used will underpin the development of technology strategies for primary care transformation in London.

The technology changes required to deliver this specification are well supported by the ambitious plans of the National Information Board in their publication *Personalised Health and Care 2020*, which lays out a timeline of technology improvements from now to 2020.

Estates

As evidenced in the recent London Health Commission report *Better Health for London*, the quality of the general practice estate is highly variable and there is a real challenge to improve it. This means poor patient experiences, poor working conditions for London GPs and lost opportunities to improve health and healthcare. In order to deliver the *Framework*, it is expected that modern, state of the art facilities will be required. It is likely that general practice will need to transition out of the existing estate gradually as investment is made in more modern buildings.

Overview Timeline of NIB Framework Milestones

By March 2015 proposals will have been set out to extend and enhance the MyNHS service on NHS Choices.

From March 2015 all citizens to have access to their GP records online.

From April 2015 mandatory use of NHS number as primary identifier in clinical correspondence and for identifying all patient activity.

By June 2015 the HSCIC will develop proposals with industry for personal data usage reporting.

By September 2015 proposals to be published for linking 111 with NHS Choices.

By October 2015 HSCIC, CQC, Monitor and NHS TDA to publish data quality standards for all NHS care providers.

By April 2016 HEE will introduce a new knowledge and skills framework for all levels of the health, care and social care workforce.

By 2018 clinicians in primary care and other key transitions will be operating without the use of paper records.

From March 2018 all individuals will be able to record their own comments and preferences on their care record.

By 2020 all care records will be digital real-time and interoperable.

London's GP practices are largely found in converted residential buildings – many are in poor condition. Many parts of the estate are not fit for the purpose and are underutilised. *Better Health for London* reported that 34% of premises need to be rebuilt and 44% are in need of repair. Often, even the most basic disabled access requirements are not in place. There are two main causes for this state of affairs: insufficient investment and fragmented decision-making on primary and out-of-hospital estate; and a lack of incentives for GPs to move from existing residential conversions to modern purpose-built facilities.

The NHS does not have any new funding to spend on fixing these problems and therefore must look to address the issues within the system. There are huge opportunities in the current (high value, even if it is in poor condition) estate. The estate could be used for health and care but also for public / social sector use, with the possibility of 550,000 new homes by 2021 and 118,000 new school places by 2016/17.

Investment required

Better Health for London set out that approximately £1 billion needs to be invested in the GP estate in London. The commission calculated that this investment, over five years, would secure modern general practice that is accessible to all Londoners.

This scale of investment would represent just 4% of the national NHS capital budget over the next five years, and 26% of London's share of the national NHS capital budget (assuming it is equally distributed across the country based on population).

It is vital that these investments are led through a partnership of CCGs, NHS England, and local authorities. The opportunity to include wider public services – such as leisure facilities, citizen's advice, libraries and education – should be explored.

Better Health for London also recommended that NHS England should reform the rent reimbursement system for GP premises, increasing incentives for GPs to move to more appropriate premises.

Commissioners across London have welcomed the *Better Health for London* recommendation on estates and are currently formulating their response.

Provider development requirements

GP provider development is fundamental to the success of primary care transformation in London and the implementation of the *Framework*. The strategic direction is ambitious, and the operational changes, working routines and learning needs are significant.

General practice teams and their health and care partners need to be supported in owning the new vision for primary care and be clear about the benefits it will deliver. This will require focused support and interventions so that general practice teams can co-develop solutions to the new operational requirements. There will be many attributes and behaviours to nurture in general practice, but the roles of effective leadership and collaboration are fundamental. Development and support programmes and activities should be flexible, tailored and provide practical support to a range of professionals across general practices. The intra- and inter-organisational development needs should not be underestimated, to ensure change happens.

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The following diagram, provided by South West London Collaborative Commissioning partnership, identifies GP provider development requirements.

There is not a natural forum in London to bring together and support system change leaders to transform primary care. London would greatly benefit from an agreed forum for commissioners, providers and lead partners such as local authorities and the voluntary sector to share innovation and learning about transforming primary care.

London's NHS should set out a strategic and comprehensive approach to building system capacity and capability for change in partnership with London and national partners. This should include a phased plan mapped to a development journey of emerging organisations which can respond to their evolving development needs over time.

Potential GP provider development requirements

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Monitoring and evaluation

Providers and commissioners will be able to consider progress across the capital through a monitoring and evaluation framework. This will have a dual purpose:

A: Information to enable provider development

- To provide tools that support continuous improvement of general practice in both service delivery and health outcomes
- To enable peer learning and development across a wider geographical population

Self-Assessment	Impact	Monitoring	Learning
1. Practices complete an **individual** assessment (how am I doing?) then a **collective** assessment (how are we doing when we consider the network/group together). This can be used for best practice sharing and development discussions	**2.** This can be triangulated with other evaluations and outcome data (CQC, GP outcome standards, high level indicators, GPES, staff survey)	**3.** Additional process measures may be agreed and monitored locally as required for improvement	**4.** Practices across London will be encouraged to share innovative and successful approaches to improvement via learning networks

B: Information to provide commissioning assurance

- To demonstrate value for money from new investments
- To provide information on delivery, learning and impact; evidencing change and improvement

Self-Assessment	Impact	Monitoring	Learning
1. The collective assessment will require the support of local HealthWatch and H&WBB.	**2.** These will be triangulated with CQC evidence and inspection output, GP outcomes standards, high level indicators, and GPES to evaluate impact	**3.** A small number of 'proxy markers' will signal that things are improving. Sample visited or asked to share more detail on improvement work underway.	**4.** Practices across London will be encouraged to share approaches to leverage improvements at pace

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The approach will encourage progression towards at-scale primary care organisations (in their various forms). The *Framework* will monitor improvements at both individual practice and at grouped practice/wider population levels. This approach to monitoring and evaluation work supports integrated care and practices working together on quality improvement at a population level. The direct impact that general practice developments have on population health and wider system activity are difficult to isolate from wider system changes. It is therefore important, in developing co-commissioning arrangements, to look towards monitoring the impact of whole systems on population health outcomes (this will be complemented by the work of the CQC in this area) as well as patient enablement and person-centred care and changes in overall activity.

Sources of information

General practices in London are already subject to considerable monitoring and assurance controls. The approach taken will use existing datasets and collection processes in order to minimise additional administrative burden on practices. Information will be drawn from CQC assessments, GP outcome standards, high level indicators, QOF and the national GP patient experience survey; forming a picture of progress to deliver the new service specification. In addition the following will be considered:

- An **extension of the annual self – declaration used by practices to provide assurance of contractual delivery**. This would include an appraisal of progress to deliver the new service specification (unless a suitable alternative approach is available through CQC).
- A small number of '**proxy markers**' identified from existing data sets that provide additional assurance that improvements are having an impact. These act as a signal to undertake further enquiry and evaluation where measures are inconsistent with information provided through self-declarations.
- **Refreshed national GP Patient Experience Survey** to reflect changes in the patient offer (the national team is considering ways in which the survey can reflect different models of care across the country).
- A **new survey of working lives** to monitor the impact of these changes on staff.

The self-assessment tool

As described above, the annual self-declaration could be extended to include an online self-assessment tool. This would form the basis of a self-appraisal that can be undertaken by general practice teams, assured by people working with each practice and shared as a tool for enhanced development. The self-assessment tool will be designed in collaboration with various stakeholders in order to ensure this provides an appropriate reflection of progress and outcomes. The business intelligence team at NHS England (London) will establish a monitoring and evaluation reference group in order to ensure this work continues to align with, and not duplicate, the approach being undertaken by the CQC. An updated CQC assessment framework was published in October 2014. The design group will review this and may conclude that the

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CQC evaluation is sufficiently comprehensive and that a new self-assessment tool is not required. The reference group will finalise an approach with the aim to have monitoring tools and processes in place as implementation begins.

Keeping Londoners informed of service changes

NHS Choices provides patients with a single online portal through which they can access information about services provided through general practice. Patients will be keen to know whether services are improving in their local area and what service changes are being planned, including any changes to access arrangements. NHS England (London) and CCGs working with local providers will need to ensure any service changes are well communicated and explained through both NHS Choices and other methods.

Next steps

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This *Framework* outlines a specification for general practice which aims to transform primary care. It also provides an analysis of the supporting work required to do this.

It is by definition a framework, as its purpose is to provide guidance for commissioners when making strategic plans and decisions on primary care, and outlines how the vision of a transformed service can be achieved. It represents a new consistent patient offer for all Londoners. However this document is not intended to provide the solution for how these changes are delivered throughout London as local plans are expected to be built on top of this foundation.

In November 2014 this document will be shared with CCGs in London prior to a period of local engagement (expected to be December 2014 – April 2015). This engagement will be conducted with health and wellbeing boards, local authorities and the CQC, as well as the public and member practices. This will help to develop deeper understanding of how the vision and specification can and should be delivered in local areas, including consideration of the fit with wider local plans. During the engagement period, consideration of how the specification will be delivered over a five year period will be discussed and agreed for each local area.

The ambitions outlined in this document will continue to be developed by CCGs and NHS England based on the findings of the engagement and continued consideration of key areas such as finance and workforce. An update outlining progress made on delivery plans in each local area is expected to be released in April 2015.

Investment and development of primary care transformation as described in this document is expected to start from April 2015. Although elements of the specification are already being delivered in some parts of London, in order to realise the vision of high quality general practice for everyone, it is expected to require a long term commitment from all commissioners of health and care in London.

Appendix 1: Governance board members

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The below list indicates the membership of the transformation, clinical and delivery group boards as of November 2014. Please note – the patient board members are not included here to protect identities.

Our thanks go out to all board members, past and present.

Primary Care Transformation Board:

Co-Chairs:

- Dr Anne Rainsberry, Regional Director, NHS England (London Region)
- Dr Marc Rowland, Chair of the London Clinical Commissioning Council; Chair, Lewisham Clinical Commissioning Group

Members:

- Dr Sanjiv Ahluwalia, Primary Care Lead, Health Education North Central and East London
- Shahed Ahmed, Director of Public Health, London Borough of Enfield
- Ronke Akerele, Director of Programmes, Change & Performance Management, Imperial College Health Partners
- Caroline Alexander, Chief Nurse, Nursing Directorate, NHS England (London Region)
- Jane Barnacle, Director of Patients & Information, NHS England (London Region)
- Paul Bennett, Area Director for North Central and East London, NHS England (London Region)
- Alison Blair, Chief Officer, NHS Islington Clinical Commissioning Group
- Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group
- Eleanor Brown, Chief Officer, NHS Merton Clinical Commissioning Group
- Dr Charles Bruce, Managing Director, Health Education North West London
- Prof Adrian Bull, Managing Director, Academic Health Science Network, Imperial College Health Partners
- Helen Bullers, Director of HR & OD, NHS England (London Region)
- Conor Burke, Chief Officer, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups
- Helen Cameron, Director of Transformation, NHS England (London Region)
- Jane Clegg, Director of Nursing, NHS England (London Region); Co-Chair, Primary Care Transformation Patient Board
- Karen Clinton, Head of Primary Care Commissioning (NW London), NHS England (London Region)
- Dr Nav Chana, Chair of the Proactive Care Expert Panel; Chairman NAPC; Joint Director of Education Quality for Health Education South London
- Sir Cyril Chantler, Board Member, London Health Board
- Dr Tom Coffey, Chair of the Accessible Care Expert Panel; Co-Clinical Lead for Urgent & Emergency Care, London Region
- Ged Curran, Chief Executive Merton Council; London Chief Executive Lead on Adult Services
- Dr Charlie Davie, Director of the Academic Health Science Network, UCL Partners
- Dr Michelle Drage, Chief Executive, Londonwide Local Medical Committee
- Dr Sam Everington, GP; Chair, NHS Tower Hamlets Clinical Commissioning Group
- Dr Clare Etherington, Head of Primary Care Education and Training, Health Education North West London
- Andrew Eyres, Chair of London Chief Officers Group; Chief Officer, NHS Lambeth Clinical Commissioning Group
- Prof Sir David Fish, Academic Health Science Network, UCL Partners
- Prof Chris Fowler, Managing Director, Health Education North Central and East London
- Professor Howard Freeman, previous Chair, London Clinical Commissioning Council
- Dr Clare Gerada, Clinical Chair, Primary Care Transformation, NHS England (London)
- Jemma Gilbert, Head of Primary Care Transformation, NHS England (London Region)
- Steve Gilvin, Chief Officer, NHS Newham Clinical Commissioning Group
- Claire Goodchild, Chief Officer, London Health Board
- Terry Huff, Chief Officer, NHS Waltham Forest Clinical Commissioning Group
- Aurea Jones, Director of Workforce, Health Education South London
- Zoe Lelliott, Director of Strategy and Performance, Health Innovation Network, South London
- Paula Lloyd-Knight, Head of Patient and Public Voice, NHS England (London Region)
- Dr Andy Mitchell, Medical Director, Medical Directorate, NHS England (London Region)

- Neil Roberts, Head of Primary Care Commissioning (North Central and East London) NHS England (London Region)
- Paul Roche, Programme Director, Primary Care Transformation, NHS England (London Region)
- Dr Rebecca Rosen, Chair of the Co-ordinated Care Expert Panel; GP Board Member, NHS Greenwich Clinical Commissioning Group; Senior Fellow Nuffield Trust
- Thirza Sawtell, Director of Strategy and Transformation, NHS North West London Collaboration of Clinical Commissioning Groups
- Dr Kanesh Rajani, London GP; Governing Body Member, NHS Harrow Clinical Commissioning Group
- Stuart Saw, Head of Financial Strategy, NHS England (London Region)
- Grainne Siggins, Director, Adults Social Care, London Borough of Newham
- David Slegg, Director of Finance, NHS England (London Region)
- Dr Chris Streather, Managing Director, Academic Health Science Network, South London
- David Sturgeon, Head of Primary Care Commissioning (South London), NHS England (London Region)
- Dawn Wakeling, Director, Adults and Community, London Borough of Barnet
- Simon Weldon, Director of Operations and Delivery, NHS England (London Region)
- 3 x patient representatives

Primary Care Transformation Patient Board:

Co-Chairs:

- Jane Clegg, Director of Nursing, NHS England (London Region)
- 1 x patient representative

Members:

- 24 x patient representatives

Primary Care Transformation Clinical Board:

Chair:

- Dr Clare Gerada, Clinical Chair, Primary Care Transformation, NHS England (London)

Members:

- Sheila Adam, Chief Nurse and Director of Governance, Honorary Professor of Nursing Leadership, Homerton University Hospital NHS Foundation Trust
- Eileen Bryant, Nursing Advisor, NHS England (London Region)
- Tony Carson, Pharmacy Advisor, NHS England (London Region)
- Dr Nav Chana, Chair of the Proactive Care Expert Panel; Chairman NAPC; Joint Director of Education Quality for Health Education South London
- Jane Clegg, Director of Nursing, NHS England (London Region); Co-Chair, Primary Care Transformation Patient Board
- Dr Tom Coffey, Chair of the Accessible Care Expert Panel; Co-Clinical Lead for Urgent and Emergency Care, London Region
- Sarah Didymus, Independent Nurse Practitioner; Darzi Fellow in Community Nursing
- Dr Murray Ellender, Liberty Bridge Road Practice, Newham
- Dr Angelo Fernandes, Assistant Clinical Chair, NHS Croydon Clinical Commissioning Group
- David Finch, Medical Director (NW), NHS England (London Region)
- Dr Jane Fryer, Medical Director (South), NHS England (London Region)
- Jemma Gilbert, Head of Primary Care Transformation, NHS England (London Region)
- Dr Jonty Heaversedge, Clinical Chair, NHS Southwark Clinical Commissioning Group
- Dr Isobel Hodkinson, Principal Clinical Lead, NHS Tower Hamlets Clinical Commissioning Group; RCGP Clinical Champion for Person-centred Care and Support Planning
- Dr Sian Howell, PM Challenge Pilot representative; NHS Southwark Clinical Commissioning Group and Bermondsey and Landsdowne Medical Centre

- Dr Jagan John, PM Challenge Pilot representative; NHS Barking and Dagenham Clinical Commissioning Group
- Dr Nicola Jones, Clinical Chair, NHS Wandsworth Clinical Commissioning Group
- Dr Alex Lewis, Medical Director and Director of Quality (Mental Health), Central and North West London NHS Foundation Trust
- Dr Steven Mowle, Board Member, RCGP South London, NHS Lambeth Clinical Commissioning Group
- Maria O'Brien, Divisional Director, Central and North West London NHS Foundation Trust
- Dr Tony O'Sullivan, Community Paediatrician, Lewisham and Greenwich NHS Trust
- Terry Parkin, Director of Children's Services, London Borough of Bromley
- Dr Mohini Parmar, PM Challenge Pilot representative; Clinical Chair, NHS Ealing Clinical Commissioning Group
- Virginia Patania, Practice Manager, Jubilee Street Practice, East London
- Dr Niraj Patel, GP partner, Thamesmead Medical Associates; Visiting Fellow in Health Policy, The Nuffield Trust; Executive Member, NAPC
- Dr Arup Paul, Locum GP, Medical Director at HCML
- Dr Julian Redhead, Consultant in Emergency Medicine and Clinical Programme, Director for Medicine, Imperial College Healthcare NHS Trust
- Paul Roche, Programme Director, Primary Care Transformation, NHS England (London Region)
- Dr Rebecca Rosen, Chair of the Co-ordinated Care Expert Panel; GP Board Member, NHS Greenwich Clinical Commissioning Group; Senior Fellow Nuffield Trust
- Dr Tina Sajjanhar, Consultant Paediatrician, Lewisham and Greenwich NHS Trust
- Dr John Sanfey, Appraisal & Revalidation Lead, North West London Area Team, NHS England (London Region); Freelance Chambers GP
- Grainne Siggins, Director of Adult Services, London Borough of Newham
- Ashi Soni, NHS Lambeth Clinical Commissioning Group; Royal Pharmaceutical Society Board Member
- Dr Mark Spencer, Deputy Regional Medical Director, NHS England (London Region)
- Karen Stubbs, Project Director, First4Health Federation
- Fiona White, NHS Merton Clinical Commissioning Group
- Dawn Wakeling, Adults and Communities Director, London Borough of Barnet
- Jane Wells, Adult Community Services Director, Oxleas NHS Foundation Trust
- 1 x patient representative

Primary Care Transformation Delivery Group:

Chair:

- Paul Roche, Programme Director, Primary Care Transformation, NHS England (London Region)

Members (those not included in Transformation Board):

- Carl Edmonds, Deputy Director of Delivery, NHS Waltham Forest Clinical Commissioning Groups
- Olivia Farnesy, Communications Manager, NHS England (London Region)
- Delvir Mehet, Deputy Head of Commissioning and System Development – OD, NHS England (London Region)
- Ginny Morley, Assistant Director, South West London Collaborative Commissioning Group
- Andrew Parker, Director of Primary Care Development, NHS Southwark Clinical Commissioning Group
- Mike Part, Head of Strategic Systems and Technology, NHS England (London Region)
- Paul Price-Whelan, Senior Financial Strategy Accountant, NHS England (London Region)
- Katie Robinson, Head of Analytical Services, NHS England (London Region)
- Sarah See, Programme Director, Primary Care Improvement, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups
- Philip Spivey, Regional Head of HR, NHS England (London Region)
- Matthew Walker, Programme OfficeLead, NHS North West London Collaboration of Clinical Commissioning Groups
- Gary Williams, Senior Manager, Analytical Services, NHS England (London Region)

Glossary

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A&E	Accident & Emergency
AHP	Allied Health Professional
AHSCs	Academic Health Science Centres
AHSNs	Academic Health Science Networks
APMS	Alternative Provider Medical Services Contract
BCF	Better Care Fund
CCGs	Clinical Commissioning Groups
CCP	Clinical Challenge Panel
CEPNs	Community Education Provider Networks
CQC	Care Quality Commission
CSUs	Commissioning Support Units
DH	Department of Health
GLA	Greater London Authority
GMS Contract	General Medical Services Contract
GP	General Practitioner
GPOS	General Practice Outcome Standards
HCA	Health Care Assistant
HEE	Health Education England
HEI	Higher Education Institutes
HENCEL	Health Education North Central and East London
HENWL	Health Education North West London
HESL	Health Education South London
HSCIC	Health and Social Care Information Centre
HWB	Health and Wellbeing Board
IPC	Integrated Personal Commissioning
KSS	Kent, Surrey and Sussex
LES	Local Enhanced Services
LETB	Local Education and Training Board
LHC	London Health Commission
LMC	Local Medical Committee
London-wide LMC	Londonwide Local Medical Committee
LTCs	Long term conditions
MCP	Multispecialty Community Provider
MDT	Multi-Disciplinary Team
Monitor	NHS regulator
NAPC	National Association of Primary Care
NHS	National Health Service
NHS IQ	NHS Improving Quality
NHS TDA	NHS Trust Development Authority
NIB	National Information Board
NICE	National Institute for Health and Care Excellence
NIHR	National Institute of Health Research
PACs	Primary and Acute Care Systems
PCN	Primary Care Navigator
PHE	Public Health England
PMS	Personal Medical Services Contract
PPEG	Patient and Public Engagement Group
PPG	Patient Participation Group
QIPP	Quality, Innovation, Productivity and Prevention Scheme
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
SCN	Strategic Clinical Network
SPG	Strategic Planning Group
SWLCC	South West London Collaborative Commissioning partnership
WTE	Whole Time Equivalent

Agenda Item 9

Item No. 9.	Classification: Open	Date: 29 January 2015	Meeting Name: Health and Wellbeing Board
Report title:		Southwark Safeguarding Children Board Annual report 2013-14	
Wards or groups affected:		All	
From:		Michael O' Connor Independent Chair, Southwark Safeguarding Children Board	

RECOMMENDATIONS

1. The board is requested to:

   a) Note the Annual Southwark Safeguarding Children Board Report at appendix 1.

BACKGROUND INFORMATION

2. This report relates to the work of the Board and its partner agencies in the financial year 2013-14 and all agencies represented on the Board have contributed to the writing of this report and had an opportunity for comment on the final draft.

3. The Annual Report was agreed by the SSCB in September 2014. The report has been formally presented to the Leader and Chief Executive of the Council, Chief Executives of the Health Trusts providing services to Southwark residents and the Police Commissioner. *Working Together to Safeguard Children* (2013) advises that the annual report is presented to the Chair of the Health and Well Being Board as advised by

4. Statutory guidance in Working Together to Safeguard Children (2013) requires that the Local Safeguarding Children Board (LSCB) be independent and not subordinate to other local structures. As such, LSCBs are required to have an independent chair which can hold all agencies to account. The current chair has been in post since May 2013 and this is his first Annual report to the Board.

5. Section 14A of the Children Act 2004 and paragraph 16 of Chapter 3, *Working Together* require that the Independent Chair of the LSCB publishes an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area.

6. The report is one of the ways in which the LSCB enables challenge and transparency across the multi-agency partnership for protecting children in Southwark.

7. The Chairs of the Safeguarding Boards and the Chair of the Health and Wellbeing Board have agreed a protocol by which to ensure effective co-ordination and coherence in the work of the three Boards. This was noted by the Health and Wellbeing Board on 2nd October. The protocol includes an agreement

that the Chairs of the Safeguarding Boards should present their annual reports to the Health and Wellbeing Board.

KEY ISSUES FOR CONSIDERATION

8. The report provides information on the effectiveness of partnership working in Southwark and evidence of a busy and productive year.

9. The revised Working Together to Safeguard Children (2013) guidance issued by the government late in the financial year enabled a refresh of many areas of partnership working including single assessment, threshold document and a learning and improvement framework

10. The 2014/15 priorities of the Board have included the prevention and response to neglect, early help, and child sexual exploitation.

11. There have also been significant changes within the partnership including the development of the Multi Agency Safeguarding Hub (MASH) and implementation of Social Work Matters which has transformed the service and implemented systemic approaches to working with children and families. There is emerging evidence to suggest these developments are improving services for vulnerable children and families through a strong multi agency approach.

12. Alongside these changes there is positive feedback within the report on the work of Early Help Locality teams and the continued embedding of Signs of Safety as a framework and strengths based approach to child protection practice. The report also positively highlights reduction in the number of children subject to Child Protection Plans for more than two years. Quality Assurance Audits indicate that his is due to more effective interventions with families and a clearer pathway to step-down services provide by Early Help locality teams.

13. The Board has taken its responsibility to reflect and learn seriously. The learning and improvement framework developed sets out a clear methodology for formal Serious Case reviews and other management reviews it may need to consider. In March 2014 the Board considered a serious incident affecting a young person and this is currently subject to a Serious Case Review. The review is using the locally agreed systems methodology from the Welsh guidance for arrangements for multiagency child practice reviews. The review is due to be completed in April 2015. This is the first Serious Case Review the Board has commissioned since 2011.

14. The Board held a well received conference focusing on neglect. The event was attended by 200 partners with strong engagement from health, children social care and education and supported the strategic and operational conversations about Southwark's response to neglect

15. The Lambeth and Southwark Child Death Overview Panel (CDOP) was reviewed and new processes to improve communication and learning are in place. Meetings are now more focussed and strategies for disseminating learning have been sharpened, with notable successes, for example in the provision of defibrillators in schools

16. For the remainder of this financial year, the SSCB will maintain its focus on the key areas of Family Matters as a response to early help and neglect help and

child sexual exploitation. This is in addition to the continued focus on the core business of the Board - child protection and the safety of looked after children

17. During 2013/14 The Board has also reviewed governance arrangements to ensure closer and more direct attention is paid to the voices of children and young people in the work of the Board. The plan to develop a child and young peoples engagement group with the Board has been taken forward in the 2014/14 work programme

18. Arrangements have been put in place to ensure that the 2014/5 Annual Report will be produced and circulated earlier.

19. The annual report report offers development areas for improvement for the Board to take forward in the 2014/15 work plan. These include:

    a) Improving timeliness of assessments and effectiveness of multi-agency interventions.
    b) Understanding the reasons for the rate of children looked after (CLA) remaining high and developing new approaches to supporting children within their families and communities.
    c) Improve placement stability to ensure better outcomes for children in care.
    d) Developing and implementing a multi agency Child Sexual Exploitation Strategy.
    e) Implementing and embedding a multi agency approach to single assessment to ensure that children get the right help at the right time.
    f) Building on early help enhancing multi agency engagement and pathways to reduce the high rate of unnecessary contacts and referrals to social care.
    g) Continuing to raise awareness on private fostering and increase the rate of notification and support to children in these arrangements.

BACKGROUND PAPERS

Background Papers	Held At	Contact
Working together to safeguard children: A guide to interagency working to safeguard and promote the welfare of children	https://www.gov.uk/government/publications/working-together-to-safeguard-children	Ann Flynn SSCB Development Manager
Protecting children in Wales: Guidance for arrangements for multi agency child practice reviews	http://www.nspcc.org.uk/preventing-abuse/child-protection-system/wales/child-practice-reviews/	Ann Flynn SSCB Development Manager

APPENDICES

No.	Title
Appendix 1	Southwark Safeguarding Children Board Annual Report 2013/4

AUDIT TRAIL

Lead Officer	Michael O'Connor, Chair of the Safeguarding Board
Report Author	Ann Flynn, Development Manager Safeguarding Board
Version	Final report
Dated	September 2014
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments included**
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No

APPENDIX 1

Southwark Safeguarding Children Board

Annual Report
2013 - 2014

'Preventative services can do more to reduce abuse and neglect than reactive services'
Munro review of child protection services

Any comments on this report can made to the independent chair Michael O'Connor on SSCB@southwark.gov.uk

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1. Foreword from the independent chair

Introduction

This is my first Annual Report as the Chair of Southwark Safeguarding Children Board. (SSCB). It has been a busy and productive year and this is reflected in this annual report for 2013/4. My introduction provides a summary and gives me an opportunity to highlight particular achievements and future priorities.

Working Together sets out the responsibilities of Safeguarding Children Boards and outlines the content of annual reports. The 2013/4 annual report provides an overview of the effectiveness of safeguarding children and young people in Southwark including highlighting key achievements and identifying areas for development.

Overview of Safeguarding Practice

Southwark has a diverse population of children and young people with comparatively high levels of deprivation and this impacts on needs and outcomes. Section 4 assesses the effectiveness of the help being provided starting with a summary of positives and areas for development. In 2013/14 the number of repeat referrals to social care and the number of children who were found to be at risk of harm or had been harmed for a second or subsequent time reduced. There was also a reduction in the number of child protection plans in place for over two years. These are indications of improvements in early help and safeguarding practice. In Southwark, we are keen to triangulate findings which means we do not rely on one evidence source to assess impact. We use a range of different methods. Early Help audits and robust case tracking also indicate some good early help practice. The annual report also highlights positive feedback from parents on their experience of Children's Centres and from schools on their experience of the Council's Early Help Service.

Significant changes took place in 2013/14 in social care under the auspices of the borough's *Social Work Matters* transformation programme. The SSCB scrutinised the plans for implementing Social Work Matters and will continue to monitor the impact on vulnerable children and families. This is a whole system transformation programme which is changing the way social work is delivered in practice. The SSCB is pleased that Southwark is responding to the recommendations of the Munro review.

The Southwark Multi-Agency Safeguarding Hub (MASH) became operational in September. The MASH reflects both the complexity and commitment of the safeguarding landscape in Southwark with 14 agencies actively involved in assessing the needs of vulnerable families. In Southwark we are also keen to use external and independent assessors to monitor and evaluate practice and impact. An external review of the MASH took place in March 2014. This found evidence of effective case tracking, good management oversight of Section 47 child protection investigations and evidence of child centred practice. Improvements identified included better analysis of performance information. The SSCB will continue to scrutinise the MASH.

Against this backdrop of changes to process and organisational structure, there has been a drive to improve practice through the development of systematically trained social work practice groups and the implementation of Signs of Safety. This is a strengths-based approach to working with families. Audits undertaken in 2013/14 illustrated that Signs of Safety is proving to be a useful tool for engaging parents and supporting change.

Performance with regard to outcomes for Looked After Children (LAC) and care leavers were also strong and I am pleased to note that partners' ambitions and aspirations for these cohorts continue to rise.

During 2013/14 the SSCB focussed on the issue of child neglect. Neglect was the subject of the Board's annual conference and multi-agency audits on neglect also look place. This work will continue in 2014/5, with greater scrutiny of data and local intelligence. There is firm agreement to develop and implement a new model of early intervention and prevention which brings together a range of services from social care to youth and health services to create a co-ordinated model of intervention. The work to achieve this has started and this is a priority for the Board given the significant impact of neglect on Southwark's children and young people .

2013/14 was also a year in which the Board intensified its focus on understanding and tackling Child Sexual Exploitation (CSE) in Southwark. The establishment of a multi-agency subgroup as part of the SSCB to develop a strong local strategy is an important step forward, and as Chair I will be keen to ensure during 2014/15 local arrangements and protocols are making a positive impact. Ensuring that Southwark embeds pan-London protocols for tackling CSE will also be imperative.

Priorities going forward

Neglect and CSE will continue to be priority areas for the Board in this forthcoming year, alongside early help. During the year I called upon partners to improve local arrangements for early help through the realignment of services, to ensure that the right services are provided promptly as soon as needed by children, young people and their families. The Board will continue to scrutinise the impact of early help services.

Along with a continued focus on core child protection the Board will also be focusing on placement stability, private fostering and referral and assessment.

Identifying and embedding learning is a key responsibility of the Safeguarding Board and I look forward in 2014/15 to strengthening our approach to the delivery, implementation and evaluation of learning. This applies not just to Serious Case Reviews and Management Reviews, but also to the multi-agency audits co-ordinated by the Board.

As ever, the good governance of the Board is critical to enabling its success, and governance arrangements are periodically reviewed. In particular, I note processes in place to improve the Board's oversight and management of performance across agencies, and efforts to pay much closer and more direct attention to the voices of children and young people in our work.

I commend this report to all partner members on the Board and look forward to a busy, successful year in 2014/15.

Michael O'Connor
Independent Chair

Vision

We believe all children living in or visiting the borough have the right to safety and being protected from harm.. We will strive to work together across all agencies to protect children and young people by providing the highest quality services and encourage children to grow and develop to their full potential achieving the best possible outcomes.

Responsibilities

The SSCB will ensure that all agencies are aware of and undertake their key safeguarding responsibilities:

- All those who work with children and young people know what to do if they are concerns about possible harm
- When concerns about a child's welfare or concerns about harm are reported action is taken quickly and the right support is provided at the right time. This covers the spectrum from early help when issues first arise through to emergency action needed to keep children and young people safe.
- Agencies who provide services for children and young people ensure they are safe and monitor service quality and impact.

Key Strategic Questions for LSCBs

NB. This Annual Report responds to these key questions

- **Is the help provided effective?** How do we know our interventions are making a positive difference? How do we know all agencies are doing everything they can to make sure and children and young people are safe? This includes early help.
- **Are all partner agencies meeting their statutory responsibilities** (as set out in Working Together chapter 2)?
- **Do all partner agencies quality assure practice** and is there evidence of learning and improving practice? This includes learning from joint multi-agency audits.
- **Is training on early help and safeguarding monitored and evaluated** and is there evidence of training impacting on practice? This includes multi-agency training.

2014-15 SSCB Priorities:

Thematic priorities

- Families Matter
- CSE
- Neglect

Operational priorities

- MASH, access & assessment
- Core CP Work
- LAC
- Private fostering

Quality assurance and Performance Management Priorities

Governance priorities

SSCB Priorities 2014/15: Please note a separate business plan is available which provides detail on plans for implementing the priorities noted below.

Thematic priorities

1. **Families Matter** – (Southwark's response on early help)
   - Better co-ordination of all prevention and early intervention services including streamline pathways.
   - Further work will be taking place in 2014/5 on neglect including analysing the impact of the action taken in 2013/4 and a specific JSNA on neglect being led by Public Health
2. **Child Sexual Exploitation**
   - Development of multi-agency CSE strategy with action plan and clear success criteria
3. **Neglect**
   - Build on 2013/14 work on neglect, interrogate neglect data and develop approach to tackling neglect in families

Operational priorities

4. **MASH, initial access and assessment**
   - Improve timeliness including timeliness of assessments and initial child protection conferences
   - Implement and embed a multi-agency approach to single assessment including finalising the Single Assessment protocol
   - Review of the multi-agency thresholds document to further reduce inappropriate referrals to the MASH.
5. **Child Protection**
   - Effective child protection processes
   - Outcome focused child protection plans
6. **Looked After Children**
   - Further analysis on current high LAC rate
   - Improve LAC placements: stability and distance from home
   - More effective oversight of safeguarding of LAC
7. **Private Fostering**
   - Continue to increase awareness of Private Fostering and monitor impact of actions being taken on Private Fostering

Quality Assurance and Performance Management priorities

8. **Quality assurance**
   - Improvement in SSCB engagement with CYP
   - Continue to monitor roll-out of changes associated with Social Work Matters and develop plans for monitoring impact in 2014/15
   - Ensure there is a programme of multi-agency audits
   - Continue to monitor LADO activity
   - Maintain and develop Learning & Improvement Framework in relation to audits and QA with strengthened 'learning loop'
9. **Performance Management**
   - Embed rigorous performance and QA reporting to the Board including further development of the performance dashboard, with greater data input from all agencies
   - Ensure shared multi-agency understanding of strengths and weakness of frontline safeguarding practice through more critical analysis of practice and data
   - Build network of designated safeguarding lead persons within agencies

Governance Priorities

- Plan dates and schedule for 2013/4 and 2014/5 Annual Reports
- Plan and deliver 2014/5 Section 11 Audit
- Agree financial contributions for 2015/6
- Monitor delivery of 2014/5 work plan and develop 2015/6 work plan
- Plan succession with and for lay members in 2015
- Organise and run Annual Safeguarding Conference
- Hold 3 Safeguarding Partnership Group meetings
- Hold 6 SSCB meetings
- Develop and monitor delivery of sub-group work plans.

2. Purpose of the Southwark Safeguarding Children Board

Working Together 2013 sets out the statutory responsibility of Local Safeguarding Children Boards (LSCB) and of partner agencies.

As a minimum LSCBs are required to:

- Assess the effectiveness of the help being provided to children and families, including early help. This is covered in Section 4.
- Assess whether LSCB partners are fulfilling their statutory obligations as set out in Working Together chapter 2. The Annual Section 11 audit is used to provide an overall assessment on compliance with statutory responsibilities. Information on the 2013/4 Section 11 audit is provided in section 5.6
- Quality assure practice, including through joint audits of case files involving practitioners and identifying lessons learned. Section 4.9 covers learning from reviews and case audits.
- Monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children. Section 4.9 also covers training.

Working Together also sets out requirements regarding Annual Reports.

3. Local profile

Southwark is a London borough bordering the City of London and the London borough of Tower Hamlets to the north with the River Thames forming the boundary. To the west Southwark is bordered by the London Borough of Lambeth and to the south by the London Borough of Lewisham.

According to the 2001 census Southwark had a population of 288,283

29% of households are owner–occupiers, 44% are social rented (including a significant proportion of council rented properties). Significant redevelopment is taking place particularly in older estates, for example. Aylesbury and Heygate. Deprivation is concentrated in the northern and central parts of the borough and large health inequalities exist between different geographical wards, as evidenced in the Joint Strategic Needs Assessment (JSNA).

Some key facts about children and young people who live in Southwark are included below.

Children and Young People in Southwark – Some Key Facts

- The 0 to 18 years population comprise a fifth (21%) of all residents in Southwark. This is in line with the GLA 2013 inner London average.
- The latest figures for children living in low-income families, published by HMRC in 2014, show that Southwark has the 18th highest proportion of children in low income families in England
- 30% of resident school-aged children in Southwark are White British, 24% Black African, 19% Black Other, 13% Asian, 8% Mixed and 6% Black Caribbean (GLA custom age range creator).
- 54% of Southwark's children and young people identify their faith as Christian, 13% as Muslim, 1% Buddhist, 1% Hindu and 21% identify themselves as agnostic (Census 2011)
- 45% of primary school pupils in Southwark are known or believed to have a first language that isn't English.
- Children from state schools in Southwark speak at least 53 different languages when at home. (2008 data, GLA).
- 64% of all 0-24 year olds resident in Southwark were born in the UK. This compares with 80% in London and 91% nationally. Southwark has high numbers of residents aged 0-24 born in Europe (11%), Africa (10%), Middle East and Asia (10%) and the Americas and the Caribbean (5%) (Census 2011).
- 29.9% of state secondary pupils in Southwark were eligible for and claiming free school meals in January 2014, the 12th highest proportion in England.
- Southwark also had a higher proportion of state primary school pupils eligible for and claiming free school meals than the English average. 21.9% compared to 17%.

4. Assessing the effectiveness of help being provided

4.1 Overall assessment of effectiveness

This section provides information on the effectiveness of help being provided. It includes the following sections:

A summary of 2013/4 overall positives and areas for development is included in the table below:

Positives	**Priority areas for improvement**
• A reduction in the percentage of cases where there was a repeat referral to social care. • A reduction in the number of children who were found to be at risk of harm or had been harmed for a second or subsequent time. • A reduction in the percentage of child protection plans in place for 2 years or more. • Multi-agency deep-dive analysis of need, performance and local intelligence on neglect. • Multi-agency safeguarding hub (MASH) going live. • Positive feedback on work of the Early Help Locality Teams. • The development of Social Work Matters change programme. • Continued embedding of Signs of Safety as a framework for social work practice. • Revised Working Together leading to a refresh of many areas of partnership working e.g. single assessment, learning and improvement framework, threshold document • Work undertaken to develop a group of young people linked to the SSCB for engagement and consultation	• Improve the timeliness of assessments. • Improve the percentage of initial child protection conferences which take place within 15 days. • Further analysis on number of LAC as the LAC rate per 10,000 is high • Improve placement stability and reduce number of LAC living more than 20 miles away from Southwark. • Implement and embed a multi-agency approach to single assessment. • Build on the early help strengths to reconfigure local early help provision to enhance multi-agency working, streamline pathways and improve outcomes for all children. • Development of a multi-agency Child Sexual Exploitation Strategy with an action plan with clear success criteria. • To make sure there is a shared multi-agency understanding of the strengths and weaknesses of front-line safeguarding practice across all partner agencies. • Continue to raise awareness on Private Fostering and undertake further work to understand why notifications are reducing.

The table below summarises some key social care activity for 2013/4. It is interesting to note that in Southwark there is a comparatively high rate of children with a child protection plan and children who are looked after. This contrasts with a lower comparative rate of referrals and assessments. There could be many reasons for this. For example, it might be the case that Southwark is quickly and effectively assessing children's needs and acting where there is significant risk. Or it could be that social care thresholds for a children in need assessment and plan are high and children and young people wait too long for a social care responses. During 2013/4 the SSCB will monitor activity levels closely and will triangulate this data using other methods for example audits, peer challenge and observations.

Indicator	2011/12	2012/13	2013/14	Statistical neighbour average 2012/13	London average 2012/13	English average 2012/13
Rate of referrals completed in the year per 10,000 under 18	616.5	580.2	518.0	577.8	458.5	520.7
Rate of children in need at end of period	509.8	557.5	476.8	497.8	368.4	332.2
Rate of core assessments per 10,000 under 18	218.0	221.2	150.7	286.1	226	204.2
Rate per CPP plan at end of period	46.2	46.1	53.5	42.5	34.8	37.9
Children looked after rate per 10,000	93.5	95.7	90.0	72	55	60

4.2 Context

4.2.1 SSCB and the Children's Plan priorities.

Southwark's Children and Young People's Plan 2013 to 2016 sets out the framework for work with children and young people in Southwark. The Plan has 3 priorities as described below.

- Best Start - Children and young people getting the right services at the right time.
- Safety and Stability – Children and young people receiving purposeful support which brings safe, lasting and positive change.
- Choice and Control for children and young people with a special educational need or disability and their families through access to a local offer of seamless personalised support.

The SSCB works closely with the Children's Trust. In 2013/14 the SSCB led work on neglect and early help which linked to the Children's Trust priorities noted above.

4.2.2 Social Work Matters

In September 2013, after extensive consultation with social care staff and with partners agencies Southwark Social Care published *Social Work Matters* which set out a vision for social work in Southwark. Social Work Matters is a whole system transformation programme. It builds on the good social work practice already taking in place in Southwark, developing a more reflective and systemic approach through creating Practice Groups. A robust project management approach has been used to manage the change process incrementally.

During 2013/4 the SSCB scrutinised Social Work Matters plans and will continue to monitor the roll-out of the changes and develop plans for monitoring impact in 2014/5. It is intended that the impact of the changes will be externally evaluated.

4.2.3 Signs of Safety

Signs of Safety provides a framework for social work practice and for partner agencies. It is a strengths-based approach to working with families, understanding cases and planning for children's safety and welfare. It involves child and parent focused approach to understanding issues and working out what works well and what needs to change. This helps all agencies to be child and family centred.

Signs of Safety is used in Southwark in Child Protection Conferences but also in day to day practice by social workers assessing risk and in reflective supervision Audits undertaken in 2013/4 indicated that Signs of Safety is assisting with:

- Increased engagement and satisfaction from parents
- Better identification of risk
- More transparent and focused child protection planning.
- Increased confidence of social workers and other professionals

In 2014, Ofsted's Thematic Inspection found that the Signs of Safety approach had been widely embedded in practice. In 2014/5 Signs of Safety will be used to further develop outcome-focused care planning.

4.3 Early Help

Some key early help facts for 2013/4 are noted below:

Early Help Key Facts 2013/4

- The latest DfE figures of rates of pupil absence for Southwark schools (primary, secondary and special schools including academies and free schools) show that overall absence from schools in Southwark at 4.8% is now lower than the national average and on a par with the London average. Rates of persistent absence have also declined by 0.6%.
- Primary permanent exclusions remain at ZERO for the 7th consecutive year and fixed term exclusions are declining with over half of primary schools reporting ZERO fixed term exclusions.
- Secondary permanent exclusions are similarly low with an emphasis placed on managed moves as part of the In-Year Fair Access Strategy.
- There was an increase in the number of Common Assessments (CAFs) completed from 2,276 in 2012/3 to 2,830 in 2013/4
- There was an increase in referrals to Early Help – 2,144 during 2013/14 in comparison to 1,664 during 2012/13. There was, meanwhile, a decrease in referrals to Children's Social Care from 3,450 in 2012/3 to 3,165 in 2013/14. Work is being undertaken to understand these figures and the relationship between increased Early Help referrals and lower referrals into Social Care.
- 136 cases were logged as 'step downs' from children's social care to early help.
- Over 1,000 children have benefitted from a place in early years provision as part of the National 2 Year Old Offer.
- The take up of free early learning by 3 and 4 year olds has improved from 83% in 2012 to 88% in 2013 narrowing the gap with Inner London and national take up.
- The highest number of referrals for the Early Help Service were from schools (70%) with nearly half of referrals for children under 5 (45%), a further 43% in the primary school age range (5 to 11) and 12% in the secondary school age range(12 -19).
- A survey of parents using Children's Centres was undertaken in June 2013, with 2,500 respondents. Findings included:
  - 97% of parents judged their overall experience of Children's Centres as Good or Excellent.
  - 90% reported that contact with Children's Centre had made them a more confident parent.
  - 94% that it improved their understanding of how their children learn and develop.

The SSCB scrutinised early help during 2013/4 and the Independent Chair challenged all agencies to consider whether services needed to be re-modelled in order to further improve performance and outcomes. This work – now called Families Matter – is being progressed in 2014/5. Families Matter will build on the strengths of the Council's Early Help Service and of the work led by the Family Focus Team which is part of the local response to the national Troubled Families initiative. The aim is to develop a better co-ordinated response to the needs of vulnerable children and their families. Further information on Early Help and the Southwark response to Troubled Families can be found below.

Southwark Early Help Service

Comments from parents on the early helped received:

- *'I had postnatal depression.... this centre made me feel safe and welcomed and was the only real reason I left the house'*
- *'My eldest came here and had Autism and was mute. Staff here helped him to talk and communicate'*
- *'By coming here our very shy son learns how to interact with other children and feel more confident. A great place to play at weekends with other dads'.*

During 2013/14 the Early Help Service continued to develop and embed multi-professional and multi-agency practice to support vulnerable children and their families. An external mock inspection of the service resulted in a judgment of 'at least good' recognising that the service is well led and well regarded by service users who value the support of knowledgeable teams of professionals.

The Early Help Teams focus strongly on the impact that their work is having on children and families and a monitoring cycle has been developed which enables progress to be analysed. The quality of casework is audited on a regular basis taking into account responsiveness, how well delivery plans are matched to need and how drift, delay and avoidance are tackled. The analysis of case work impact is rated (red, amber, green) and a consistent pattern is emerging where there is swift movement from red to amber and then a slowing down as support is consolidated ultimately resulting in positive outcomes for the majority of cases. This approach to casework is a powerful management tool as the pattern of the progress of individual cases is visually very clear and enables appropriate questions to be asked and timely decisions to be made.

Further evidence of impact is captured through qualitative reports from service users.

Positive response from schools have included:

- *'I feel the Early Help model is working for us.....; not least because of the very clear structure and names and contact details for the various roles. The opportunity to meet with our early help team leader and our educational welfare officer on a face to face basis in school is invaluable. The history of attendance at our school has not been good but, with the rigorous support of our educational welfare officer we are finally turning the tide.....Furthermore, whenever we have phoned for advice or signposting, we have received the necessary information'*

- *'....we have been really pleased with the service, have met a large number of the team who have responded to our invites to come and support our work in school, and we feel pleased that all CAFs are now resulting in something happening. Well done you all for pulling this together it does feel much more connected and that there is a support net for those families who don't quite meet(social care) thresholds.'*

Southwark's response to the national Troubled Families initiative is also part of the early help offer as many of the families who meeting the national criteria do not meet social care thresholds for receiving and assessment and services. Information on Troubled Families can be found below.

Troubled Families

In 2013/4 there was a coordinated offer of family focused support for families who met the national criteria. The Family Focus Plus team includes family therapy, adult mental health, education welfare and a nurse practitioner. The team also draws on a virtual professional network including youth offending, employment advisers and early help teams as well as bespoke provision commissioned from the local voluntary sector including Family Action and St Giles Trust.

Through the programme, agencies are building an infrastructure of effective support, which is actively reducing risk by providing an opportunity to work differently with families to ensure outcomes improve from the point at which they first engage with local services. An Ofsted thematic inspection of the Youth Offending Team's involvement found strong practice, a coordinated strategic approach, and highly positive service user feedback. Although recognising that further work is needed to ensure outcomes are always specific and focused, the inspector praised the flexible, comprehensive interventions and whole-family approach employed, as well as the high profile of health involvement and the strong working relationship between the youth offending and looked after children services.

4.4 The Multi-Agency Safeguarding Hub (MASH)

Southwark's MASH became fully operational on 23rd September 2013. The MASH involves 14 agencies/services. This will increase in 2014/5.

Five core agencies are involved in the MASH:

MASH core agencies
Social Care, Police, Education, Health and Housing.

In addition there is involvement from another 9 agencies/services:

Other agencies/services involved with the MASH
Probation, Early Help, Specialist Family Focus, Mental Health, YOS, Adult Social Care, Pre-Birth Service, DV Victim Support, Hidden Harm and Substance Misuse.

Many agencies are co-located in the MASH while others are virtual participants. A bespoke referral and information management system enables real-time tracking of individual contacts as they progress through the MASH according to their RAG status. A Duty Social Work Manager oversees the MASH process and makes decisions regarding next steps.

An external review of initial access arrangements including the MASH took place in March 2014. The table below summarises the positive findings and areas for development.

External review of initial access arrangements including the MASH	
Positives	**Areas for Development**
• Evidence of child centred practice • Morale good • Caseloads manageable • Supervision is regular • Pathways are clear • Good recording and decision making from managers on S47s. • MAISy is an effective tracking tool	• Improved performance management and analysis of data • More focus on outcomes • More analysis on reasons for re-referrals • Supervision policy to include frequency of supervision • More involvement of CAMHS in the MASH and improved participation of Housing

4.5 SSCB work on neglect

In 2013/4 the SSCB prioritised work on neglect. This work included initial exploration of key neglect issues by the Board, and neglect was the focus of the SSCB annual conference in January 2014. Multi-agency audits focussing on neglect were undertaken, as were thematic workshops and action learning sets. Further work will be taking place in 2014/5 including analysing the impact of the action taken in 2013/4 and a specific JSNA on neglect being led by Public Health. The work on neglect led to Families Matter which is Southwark's response to ensuring that the right children and young people get the right service as soon as they need it. This will lead to the integration of a range of services to create a whole systems approach to tackle neglect , building on the strengths of the Early Help service referred to above in section 4.3.

Information on the January 2014 SSCB conference on neglect is noted below.

January 2014 – SSCB Conference on Neglect

Southwark Safeguarding Children Board hosted their annual conference in January 2014. The focus was **Neglect Matters** - ***Working together to assess, prevent and remedy the impact of neglect*.**

Key speakers included Prof. David Shemmings (Kent University), Ruth Gardner (NSPCC & University of East Anglia); and Dr Hilary Cass (President of Royal College of paediatrics and child health). There was also a theatre production which illustrated what neglect means to children and young people.

Workshops at the conference covered aspects of assessment of neglect in the child's developmental age, dentistry, obesity, learning lessons from local audit and working with parents with personality disorder.

Two hundred delegates attended and the feedback was positive. The good representation from different agencies and the contributions by the speakers were highlighted in the feedback. Choosing neglect as the main theme was timely and relevant

Observations from delegates included:

> *...'great that a 'much neglected' topic is getting a higher profile. Highlights the need for better interagency communication…'*
>
> *' ….I was looking for answers and came away with questions……..'*

"Twitter" was used to collect live feedback from the audience and for a few weeks after this.

The conference acted as a catalyst for a number of changes which will improve the response to neglect issues in Southwark. These are summarised below.

Delegates called for:	The response
More training on working with parents who have a personality disorder	SSCB training commissioned for working with hard to reach families
More emphasis on how we support health needs of vulnerable young	Health have increased resources for looked after children's services.
Obesity task force to assess children in Southwark	Public health are leading a work stream and new initiatives have been planned.
Improved engagement with GPs	GPs held a protected learning event exploring neglect
Improvements in early intervention, including information regarding access, promotion as a supportive service including feedback	Families Matter programme initiated

4.6 Child Protection

4.6.1 Key facts child protection as at 31st March 2014

As at 31st March 2014 327 children and young people were the subject of a child protection plan. This represents a significant increase from 31st March 2013 when 272 children were the subject of a child protection plan. As was noted above in section 4.1 this equates to a comparatively high rate of children with a child protection plan.

However, during 2013/4 numbers involved in child protection processes for example Section 47 enquiries and initial child protection conferences were comparatively low. This is illustrated in the table below. There could be a number of reasons for this. For example it could indicate that children and young people are not necessarily involved in child protection processes. Or, when considered with the comparatively high child protection plan numbers it might mean child protection thresholds are too low and/or that multi-agency challenge is not as affective as it could be. There might be other reasons and this these issues will explored in 2014/5. Performance on the timeliness of ICPCs has improved and now exceeds averages for London and statistical neighbours.

CPP Plans ending	2011/12	2012/3	2013/4	Statistical neighbour average 2012/13	London average 2012/13	English average 2012/3
Rate per 10,000 S47s started	143.6	121.9	106.1	136.5	107	111.5
Rate per 10,000 ICPCs	53.7	56.2	56.1	57	46.7	52.7
% conferenced but no CPP	8%	13%	4%	15%	15%	12%
ICPCs within 15 days of start of S47 enq (working days)	35%	49%	73%	63%	65%	70%

The table below outlines the length of time children and young people are subject to a child protection plan as a percentage of all plans ending in that year. In 2011/2 and 2012/3 a significantly higher percentage of children and young people remained at risk of significant harm for over 2 years or more. In 2013/4 this figure reduced. This is positive. During the year, 282 children ceased to be subject to a Child Protection Plan – representing a rate of 46.2 per 10,000. This is a slight reduction compared to the previous year's figure (49.6) but remains broadly in line with the average for Southwark's statistical neighbours (48.3 per 10,000).

CPP Plans ending	**2011/12**	**2012/3**	**2013/4**	**Statistical neighbour average 2012/13**	**London average 2012/13**	**English average 2012/3**
% CP plans ending under 3 months	26%	17%	13%	16%	17%	19%
% CP plan ending 3 to 6 months	14%	6%	9%	11%	10%	10%
% CP plans ending 6 month to 1 year (cumulative year to date)	26%	34%	40%	37%	37%	39%
% CP plans ending 1 year to 2 years (cumulative year to date)	21%	27%	34%	27%	29%	26%
% CP plans ending over 2 years (cumulative year to date)	13%	16%	4%	9%	8%	5%
Number ceasing CPP (cumulative year to date)	309	293	282	n/a	n/a	n/a
Rate per 10,000 ceasing CPP during the year	52.3	49.6	46.2	48.3	39.8	46.2

In 2014/5 the SSCB will continue to monitor the length of time child protection plans are in place and in addition monitor the number and percentage of children who are the subject of a child protection plan for a second or subsequent time. In 2013/4 there were no (zero) children and young people were subject of a child protection plan within 2 years of a previous plan. 14 children and young people became subject of a plan for a second time. Further analysis will take place on the reasons for repeat child protection plans.

4.6.2 Female Genital Mutilation (FGM)

The incidence of FGM is higher in certain African, Middle Eastern and Asian populations, notably Somali, Kenyan, Sudanese, Sierra Leonean, Egyptian, Nigerian, Eritrean, Yemeni, Kurdish and Indonesian communities. Southwark is known to be home to a relatively large number of children and young people from some of these communities, as indicated in the 2011 Census. As a consequence FGM is a high priority issue for the SSCB. In 2013/4 initial work took place jointly between Southwark Council, with Lambeth Council and local hospitals. The initial work focused on exploring why there had been so few health and social care referrals relating to FGM. Findings were inconclusive as the work revealed difficulties in accessing data and information. Tackling FGM in the UK, the intercollegiate recommendations for identifying, recording and reporting published by the Royal College of Midwives provides useful guidance which will be considered by the SSCB in 2014/5.

4.6.3 Missing from home, care or school

Under the leadership of the SSCB, the local protocol on children and young people missing from home care or school was been updated and revised guidance was distributed early in 2014. Key performance indicators on missing from home, care or school have been added to the SSCB data dashboard.

Audits have found good joint working including risk assessments and increased use of return home interviews, which are commissioned from the voluntary sector. During 2013/4 the local Children in Care Council, Speakerbox, began a research project to explore the reasons young people run away, including interviewing those living in residential homes who have run away.

4.6.4 Private Fostering

During 2013/4 the SSCB received the Private Fostering Annual Report for 2012/3. This assisted the SSCB to assess whether all agencies were working well together to ensure that privately fostered children are being appropriately safeguarded. The Annual Report highlighted work which had taken place on raising awareness, assessing private foster carers and providing advice and support.

The SSCB noted that there had been an increase in private fostering notifications from 37 in 2010/11 to 45 in 2012/3. However ,the 2012/3 figure of 45 notifications was still well below the 77 notifications received in 2010/11. In response the SSCB decided to scrutinise private fostering more closely including ensuring all agencies were raising awareness about the need to notify the local authority about private fostering arrangements. A Private Fostering Panel was established in 2013/14. The reviews notifications of private fostering, and acts as a critical friend to the process. It has also had a quality assurance role and was responsible for ensuring statutory responsibilities were correctly discharged. In some cases, the panel identified neglectful care within PF arrangements.

The SSCB now receives regular Private Fostering reports. 2013/14 data shows a marked reduction in the number of private fostering notifications, dipping below the comparator figure for statistical neighbours. In previous years, Southwark had received considerably more private fostering notifications than averages for England, London and statistical neighbours, as illustrated in the table below.

During 2014/5 a multi-agency Private Fostering Action Plan is being developed. This is being managed by the Private Fostering Steering Group. Further work will be taking place to increase awareness of Private Fostering arrangements. It is anticipated that notifications will increase.

Indicator	2011/12	2012/13	2013/14	Stat neighbour average (2012/13)	London average (2012/13)	England average (2012/13)
Number of PF notifications	36	43	17	N/a	N/a	N/a
Rate of PF notifications per 10,000 age 0-17	6.1	7.6	2.7	3.9	2.3	2.6

4.7 Looked after children

4.7.1 Key facts on Children in Care in Southwark at 31st March 2014

- At 31st March 2014 there were 550 children looked after by Southwark, a slight decrease from 2013 when there were 565 children looked after. This equates to a 92.5 children looked after per 10,000 of population at 31st March 2014, significantly higher than the statistical neighbour (72) and national rates (60) from 31st March 2013. The rate of children who started to be looked after declined from 52.3 per 10,000 to 41.7 per 10,000.
- 23.1% (122 children) were placed more than 20 miles from home. This is higher than statistical neighbour and London average figures and represents an increasing compared to the previous year
- 66.4% (365 children) were placed outside of Southwark's boundaries.
- 10% - 55 young people were placed in residential settings (DfE definition).
- 70% - 386 children were placed with foster families who are not family or friends. 66% of these children were placed out of borough.
- In 2013/14 273 children ceased to be looked after, of these: 33 children were adopted and 21 children ceased being looked after due to Special Guardianship Orders
- 13% of children looked after had three or more placements during the year (short-term stability). This is in line with previous' years performance and very slightly above average.
- Indicators for long term stability continue to lag behind averages for England, London and statistical neighbours.
- 93% of CLA reviews were held on time (compared to 95.5% the previous year). 96.8% of CLA participated in their reviews.

CLA indicators	2011/12	2012/3	2013/4	Statistical neighbour average 2012/13	London average 2012/13	English average 2012/3
Number of children looked after	552	565	550	n/a	n/a	n/a
Children looked after rate per 10,000	93.5	95.7	90.0	72	55	60
Number of children starting to be looked after	274	309	255	n/a	n/a	n/a
Rate per 10,000 children who started to be looked after (at end of period)	46.4	52.3	41.7	n/a	n/a	n/a
Number of children who ceased to be looked after (cumulative year to date)	244	303	273	n/a	n/a	n/a
Rate per 10,000 of children who ceased to be looked after	41.0	50.9	44.7	n/a	n/a	n/a
% of CLA at end of the period placed more than 20 miles from home	17%	17%	23%	18%	13%	18%

4.7.2 Outcomes for looked after children and care leavers

Outcomes for looked after children have been sustained, with children and young people experiencing good health and education when compared with other local authorities as a result of concerted partnership prioritisation and action. For example, 42% of looked after children in the relevant year group cohort achieved 5 A*-C GCSE in 2013 which places Southwark in the top quartile nationally. Ambitions for looked after children locally are much higher than this, and efforts will continue for even better outcomes in forthcoming years.

There is also good performance on the proportion of young people in care and care leavers moving into education, employment and training (EET). Young people can access a wide range of support options, including apprenticeships, university support, coaching, drop-in services, Connexions, Southwark Works and training. Care leavers are also well supported to make a positive contribution and achieve independence, for example through a guaranteed secure tenancy, free leisure access locally and a wide range of arts and cultural activities.

The council's Corporate Parenting Committee provides active leadership and management. Priorities in 2013/4 included developing a life chances strategy and supporting the integration of council and partner services for looked after children and care leavers.

Audits found housing and care leaver support to be good. The rate of young people in suitable accommodation is on a par with statistical and London neighbours. Personal Advisers are seen as providing strong support, particularly around issues such as benefits. Keeping in touch rates are very high, at nearly double the England and London average.

4.7.3 Adoption

During 2013/14 the drive to improve permanency included significant improvement to the adoption service, processes and offer to families. In combination with enhanced marketing, outreach and support packages, performance locally has improved with more adopters, matches and adoptions and better timeliness as the impact of the additional service capacity and new processes has been realised. The number of placement orders granted, for example, is now above London and statistical neighbours and in line with the England average.

It is recognised, however, that more work is required to further improve timeliness in order to achieve DfE thresholds and to reduce the number of children awaiting adoption, which remains high. Priorities include addressing the barriers to adoption and investing in and implementing more robust case management. This includes the development of robust tracking to better monitor case progress, particularly harder-to-place cases, and the greater use of concurrent planning and fostering for adoption.

4.7.4 Stability of LAC Placements

Performance on LAC short and long term stability has declined over the last 2 years. In 2011/12 12.7% of children looked after experienced 3 or more moves in a year. This increased to 13.6% in 2012/13 and to 14.1% in 2013/4. Long term stability decreased from 66.1% in 2012/3, to 62.6% the next year and to 59.9% in 2013/4.

In 2013/4 the SSCB began some in-depth analysis which found that young people aged 11 to 13 years are more likely to have unstable placements. Short-term stability declines have also been driven by adolescents with multiple placement breakdown. Other white ethnic groups are also over-represented, with, conversely, white British, black African and black Caribbean children and young people more likely to be in a stable placement as are children with a disability.

Analysis of children and young people's circumstances where there is placement instability shows a high complexity of need, with significant levels of special educational needs and trauma particularly among the late teens. These children are more likely to need education or mental health interventions, and are more likely to be moved because of challenging, indeed often violent, sexualised and/or offending behaviour.

This work is continuing into 2014/5 and work is planned on exploring the impact of schooling on stability, including special educational needs, further audits and Speakerbox leading visits and interviews with young people placed out of borough to ensure their views and needs inform service planning and redesign proposals.

In 2013/4 work also took place on children placed out of borough. This included the Children's Rights officer visiting residential settings and producing a video of young people's views which was presented to the Corporate Parenting Committee.

CLA stability indicators	2011/12	2012/3	2013/4	Statistical neighbour average 2012/13	London average 2012/13	English average 2012/3
% CLA with 3+ placements during the year (short term stability)	12.7%	13.6%	13.0%	12%	11%	12%
% CLA at end of period who have been looked after continuously for 2.5+ years who were living in the same placement for 2+ years, or are placed for adoption at end of reporting period (long term stability)	66.1%	62.6%	59.9%	69%	69%	67%

4.8 Child Sexual Exploitation (CSE)

During 2013/4 there was considerable multi-agency action on understanding, raising awareness, preventing and dealing with Child Sexual Exploitation. This included the following:

- Strengthening activity on CSE perpetrators. A Southwark Detective Inspector will be joining the new pan-London CSE enforcement unit. The focus will include how local best practice 'anti-gangs' work can support improved intelligence gathering and sharing.
- A monthly multi-agency sexual exploitation (MASE) panel takes place. Future work includes ensuring the MASE process reflects changes in the local police protocol, which is based on the Metropolitan Police's pan-London protocol and which has multi-agency commitment.
- Step-B research highlighted the actions being taken by all partners and highlighted multi-agency buy-in and robust, timely early identification and response through the MASH
- The SSCB established a Child Sexual Exploitation sub-group which is leading on developing a multi-agency Child Sexual Exploitation strategy and operating model which encompass prevention through to rehabilitation with a tiered approach to intervention.

An intelligence gathering exercise took place, under the auspices of the CSE subgroup, to build a profile of children and young people who were identified as victims or at risk of sexual exploitation. This exercise, involving several agencies across the partnership, identified 98 children, who were then risk-assessed according to an agreed framework. Arrangements for the referral and recording of (suspected) CSE have also been tightened up, enabling the police and social care to maintain accurate data via the MASH.

4.9 Health Agencies and Safeguarding

NB: The health economy in Southwark comprises Kings College Hospital NHS Foundation Trust, Guy's and St Thomas NHS Foundation Trust,, South London and Maudsley NHS Foundation Trust, Southwark Clinical Commissioning Group and Public Health.

During 2013/4 the health economy in Southwark maintained safeguarding as a priority whilst successfully navigating the NHS structural changes which gave responsibility for elements of health commissioning to primary care clinicians. Southwark CCG has been authorised by NHS Commissioning Board and has been operating as a statutory body since April 2013.

Positive developments and impact during 2013/4 included:

- There was very strong engagement from health and GPs at the SSCB Neglect Conference in January 2014, including a keynote address by a clinician.
- Appointment of a Named GP for Safeguarding which led to a number of positive impacts including a very good (82%) response to GP safeguarding audits, consolidation of safeguarding information for GPs, improved data coding and gathering, and particularly successful Protected Learning led by the Named GP in partnership with social care.
- Safeguarding Children standards were updated and are now included in contracts with main providers
- The Lambeth and Southwark Child Death Overview Panel (CDOP) was reviewed and new processes to improve communication and learning are in place. The splitting of the CDOP – (which continues to operate on a bi-borough basis across the two hospital Trusts) into neonates and other children was embedded and the backlog of cases reduced. Meetings are now more focussed and strategies for disseminating learning have been sharpened, with notable successes, for example in the provision of defibrillators in schools. See 5.7.1 for further information.
- Progress has been made in ensuring the views of children and young people are heard and considered in the planning and development of health safeguarding services. This has included focus groups with Speakerbox and consulting care leavers' preferences about access to their health information. A process is now in place to include the views of young people and carers, through interviews and discussions, as part of multi-agency case audits
- Additional funding for a LAC nurse and administrative support.
- CCG commissioning advice has been provided to ensure the range of services commissioned by CCG takes account of the need to safeguard and promote the welfare of vulnerable children. There were specific instances of improved safeguarding practice within health services, such as the exemption of children from charging for anti-malarial medication.
- A Health and Safeguarding sub group of the SSCB was established.

Areas for Development in the health economy for 2013/14

- To develop safeguarding children links with accountability frameworks for safeguarding with NHS England in order to ensure that safeguarding remains joined up within the NHS and within our local area
- To ensure children, young people and families have their health needs met at the earliest possible stage and to engage closely on the multi-agency Families Matter agenda.
- To work with NHS England to promote best quality safeguarding practice within General Practice, including training, information sharing and promoting early help for families
- To ensure health service planning and developments consider the views of children and young people
- To continue to promote a multi-agency integration of safeguarding services utilising MASH and MARAC channels
- To strengthen the safeguarding of young people through transition into adult services by developing a safeguarding vulnerable people approach to working with families. This will involve a TAC approach in the Transition team.
- Continue to work collaboratively with health provider organisations to ensure a more joined up approach is achieved in caring for vulnerable groups within the community

- Continue to develop the work initiated with GP Practices in Southwark to support and advise on safeguarding children including safeguarding audit action plans and the key issues identified nationally on neglect, domestic abuse, serious youth violence, child sexual exploitation and the vulnerability of Looked After Children

4.10 Learning and development

4.10.1 Learning and Improvement Framework

During 2013/4 the SSCB agreed a Learning and Improvement Framework which outlines the approach to Serious Case reviews and other types of learning.

4.10.2 Serious Case Reviews

In March a serious case review panel was held and a decision taken to commission a Serious Case Review using the SCR methodology developed by the Welsh Government and outlined in "*Protecting Children in Wales: Guidance for arrangements for multi agency child practice reviews*." This was the first SCR undertaken since 2010.

Also in March the Department for Education asked Southwark to participate in an investigation into a historical allegation into one of the Council's children's homes. This work has been completed and the outcome will be published by the Department for Education.

4.10.3 Management Reviews

Management reviews are undertaken in cases where an incident of concern affects a child but the case does not fit the SCR criteria outlined in Working Together.

In 2013/4 a management review was completed in order to learn lessons from a case where a young person was seriously sexually assaulted.

The Board commissioned a thematic review of 7 cases where management reviews had been completed over the previous four years. The themes emerging informed the focus on private fostering, children missing from home and care and emphasised the potential vulnerability of some adolescents

4.10.4 Multi-agency audits

In 2013/4 multi-agency audits took place on:

- Agency responses to children exhibiting sexually harmful behaviour (SHB)
- Effectiveness of work undertaken by the Family Focus Team
- Understanding the experience of young people who go missing form care

Consolidating learning from these audits is a key task for 2014/15, to be overseen by the Audit & Learning subgroup.

4.10.5 Sharing learning from single agency audits

In future the Audit and Learning Sub-group will take an overview of the single agency audits programme in partner agencies. This approach will be strengthened by the appointment of an independent chair to the audit and learning sub group.

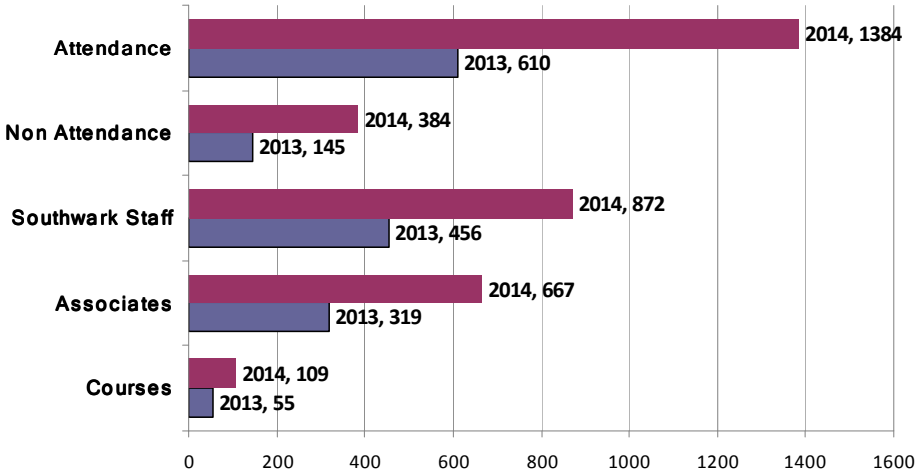
4.10.6 Training Programme

The training programme included at Appendix 3 sets out the safeguarding children's courses accessed through the on-line portal, 'My Learning Source'.

An evaluation, comparing the previous year with April 2013 - March 2014, identified significant improvements. Training highlights for the year included:

- Attendance improved by 56% in 2013/2014.
- There was a 50% increase in the number of courses available.
- Booking figures has increased by 49% from last year.
- There are 2,716 Associates now registered on My Learning Source
- The SSCB has continued to provide a wide programme of safeguarding training which includes basic safeguarding and other courses such as training on learning from serious case reviews and specialist courses such as "The art of difficult conversation in child protection."
- Participants report an 81% positive impact evaluation.

Comparing April to March – 2012/13 to 2013/14



However, non-attendance was also higher. The increase was proportional to the rise in attendance figures (62%). The Organisational Development team plan to address this issue in 2014/5. This will involve engagement with managers and considering more direct action to recover the cost of non-attendance.

A review of all training materials started in 2013/4. This is continuing into 2014/15. Feedback will be provided through the Practice Development and Training sub group.

Providers met with the SSCB development manager and the chair of the Practice Development and Training sub group in December 2013 in order to look at best practice examples of training courses and how providers could be supported to ensure they reflect local learning from audits and management reviews. Providers and the sub-group chair will meet annually to review and plan training.

The SSCB has arrangements in place for 2014/15 for the quality assurance of training providers, who will all be awarded an Ofsted-style judgement.

4.10.7 My Safeguarding Newsletter

My Safeguarding Newsletter was launched in October 2013. The newsletter is produced 3 times a year and is sent to all agencies. The newsletter will update partners on emerging local and national issues in safeguarding, learning opportunities and new developments in practice

4.10.8 Southwark Safeguarding Children Board: Lunch time learning

In March, the lunch time learning sessions reflected on lessons from an audit on children at risk of peer to peer sexual exploitation. These sessions are planned bi- monthly covering contemporary topics such as Female Genital Mutilation, neglect and dentistry in children.

5. SSCB Governance arrangements and activity

5.1 Summary of governance positives and areas for development

This section focuses on SSCB governance arrangements and activity during 2013/4. It includes information on the following:

5.2 Participation of children and young people in the work of the SSCB
5.3 SSCB governance and membership
5.4 SSCB Performance Dashboard
5.5 Links with other key strategic groups
5.6 SSCB Budget
5.7 Links with other key strategic groups
5.8 Work of the SSCB sub-groups

5.2 Participation of children and young people in with work of the SSCB

The best way to protect children and young people is to listen to them and engage positively with them so that they can help us improve our safeguarding work. The participation of children and young people has developed over this year and included the following initiatives:

- Key messages being shared with children and young people on keeping safe.
- Consulting with young people on their understanding of neglect and child sexual exploitation and what young people think will keep them safe. Children and young people's views were included in a DVD on CSE. This ensures that a wide range of leaders and practitioners can hear and understand children and young people's views on CSE.
- Involving young people in the SSCB annual conference.
- Speakerbox, the local children in care council, has long-established relationships with the SSCB. This includes meetings between Speakerbox members and the Independent Chair.
- In 2013/4 the SSCB heard concerns directly from children in care and care leavers about preparations for independence and the quality of their accommodation. As a result of SSCB scrutiny, a care leavers group within Speakerbox has been established
- As the reporting year ended the Board was planning a formal child engagement project to enable young people to meet with the SSCB.

5.3 SSCB governance and membership

The governance arrangements for the SSCB were reviewed following publication of Working Together (2013). The Board was strengthened over the year with a newly appointed independent chair who reviewed the overall structure and organisation of the Board. During 2013/4 there were 3 meetings of the Main SSCB partnership Board and 6 meetings of the Executive Board. The board has engagement from the required agencies. A full membership list can be found at Appendix 2.

The Independent Chair met regularly with the Council Chief Executive and Strategic Director of Children's and Adults' services and met with the Cabinet Member for children. The Lead Member attends Board meetings and the Education and Children's Scrutiny Subcommittee scrutinises the Annual Report.

Following a community safeguarding survey and forum last summer an initial community engagement meeting took place, as forerunner to a creating a Community Engagement sub group.

5.4 SSCB Performance Dashboard

In June 2013, the SSCB considered a report which noted improvements needed to SSCB performance reporting arrangements. This led to the development of an SSCB Performance Dashboard. This includes outcomes measures as well as key safeguarding and child protection performance indicators on activity, thresholds and quality. Further work is planned to ensure that the dashboard reflects key safeguarding performance indicators from all agencies.

5.5 Links with other key strategic groups

During the year a protocol was developed between the Heath and Wellbeing Board and the SSCB. The SSCB Independent Chair held meetings with the Independent Chair of the Adults Safeguarding Board. The Children's Trust includes a standing agenda item on the work of the SSCB. In 2013 there was an annual health executive meeting held jointly with Lambeth safeguarding children Board.

5.6 SSCB Budget

The SSCB receives financial contributions from a number of agencies and other forms of in-kind support. As at 2013/14, financial contributions were as follows:

London Borough of Southwark	50,000
Southwark Clinical Commissioning Group	20,000
South London and Maudsley NHS Foundation Trust	5,000
Probation Service	2,000
Metropolitan Police	5,000
CAFCASS	550
London Borough of Lambeth (CDOP Administration)	5,000
Total GBP	**87,550**

SSCB income and expenditure in 2013/4 is outlined in the following table. This includes the recruitment costs for the Independent Chair. Expenditure on training, on Child Death Reviews and Serious Case Reviews is not reflected in these figures. The SSCB has agreed to maintain a reserve which is carried forward.

Income and expenditure 2013/14

Income 2013/14	**£**	**Expenditure 2013/14**	**£**
Brought forward	107,474.00	Board administrator	39,538.97
Cafcass	550.00	Catering Board meetings	175.00
Inner London Probation	2,000.00	Hotel accommodation/travel for chair	1,774.00
London Council	5,000.00	Independent chair (1)	3,710.73
London Borough Lambeth	5,000.00	Hotel accommodation (Chair 1)	1,774.45
London Borough Southwark	50,000.00	Independent chair (2)	23,020.00
Slam	5,000.00	Independent author for management review	5,398.30
Southwark NHS	20,000.00	Independent author for management review	3,412.50
Training recoupment	1,400.00	Policy officer	47,285.85
		Printing	494.00
Total income	**196,424.00**	Room hire	503.00
		Recruitment costs	11,400.00
		Training	1,075.00
		IT	300.00
		Total expenditure	**138,087.80**
		Carried over 14/15	**58,336.20**

5.7 Work of the SSCB sub-groups

At the start of 2013/4 there were 7 subgroups:

- Audit and Learning
- Human Resources and Safeguarding
- Practice Development and Training
- Serious Case Review
- Child Sexual Exploitation
- Child Death Overview Panel
- Designated, Named and Lead Professionals Group

During the year, new subgroups were established for Education, Health and Community Engagement.

The chairs of each subgroup meet three times a year with the SSCB chair in order to report back on their activity and to facilitate open communication between the subgroups. The work of the subgroups is planned in these joint meetings with the Independent Chair.

In addition the Council's Head of Quality Assurance reports regularly on child protection, the local authority designated officer (LADO) activity and on children missing from home and care.

5.7.1 The Child Death Overview Process

Following a review and streamlining of its processes, the Child Death Overview panel has successfully reduced its backlog and continues to work together with Lambeth in this area of work.

1. ***Overview of CDOP Operation in Lambeth and Southwark***

Cases reviewed:

- 70 cases were reviewed by the Child & Neonatal Death Overview panels in 2013/2014 financial year:
  - 32 cases were reviewed by the Neonatal Death Overview Panel (NDOP) and 38 cases were reviewed by the Child Death Overview Panel (CDOP)
  - 27 cases involved deaths in 2013/14, the remaining 43 cases were in 2009 - 2013.
- 47 (67%) cases were <1 year old; 37 (53%) were males; 19 (27%) cases were Black African, then other Black Ethnicity, other White, and white British.
- There were 33 outstanding cases as of the end of the year (Southwark 14, Lambeth 19)

Deaths reported:

- 63 in the 2013/2014 financial year (42 neonatal deaths and 21 child deaths).

2. ***Southwark cases reviewed***

- 30 Southwark cases were reviewed in this financial year with 20 (67%) deaths occurring within an acute hospital setting.
- The most common classification of death was neonatal death (18; 60%) followed by life limiting conditions and fire & burns.
- 17 (57%) cases had modifiable factors.
- Deaths reported: 37 comprising 25 neonates and 12 children.

3. ***Recommendations from this Annual Report***

Youth Violence including Gang Activity – this remains a yearly theme. A public health approach is needed to include addressing norms and attitudes to violence amongst young people, parents and others, strengthening the role of schools, and reducing risks in the night time economy.

Road/Traffic Safety & Awareness – Better awareness of road safety for children and young people in schools and related settings, traffic calming, road speed and driver training is required.

Hospital Staffing – Hospitals should review capacity and availability of midwifery staff to meet the needs of the increased birth rate and increased complexity of cases.

4. **Progress on recommendations from 2012-2013 Annual Report**

- School health improvement: actions done include the school nurse review, the Southwark Schools' Healthy Lives programme, and the Evelina Child Health programme.
- Youth violence: Lambeth's public health approach to violence is informing its Serious Violence strategy and has been to the Health and Wellbeing Board.
- Housing (unintentional injuries prevention): work with both boroughs is underway and an awareness workshop for Housing staff commences this year.
- Sudden Infant Death Syndrome and co-sleeping: advice and awareness sessions to reduce the risk of SIDS and infant mortality are in place for a variety of CYP stakeholders.

5.8 2013/4 Section 11 Audit

The 2013/14 Section 11 process involved each agency completing an audit using an agreed template. A report analysing strengths and weaknesses was presented to the SSCB. A summary of strengths are areas for development can be found in the table below.

Going forwards the agreed methodology for 2014/5 is for a challenge panel to be developed. This panel of senior officers will scrutinise the single agency reports based and an overview report will be presented to the SSCB.

Strengths	**Areas for development**
• Safer recruitment is well established in all agencies and the changes brought in the Disclosure and Barring Service were effectively adopted • Agencies are ensuring lessons from SCRs and CDOP are disseminated. • Engagement with safeguarding training is good across the system • Health reports detailed a commitment to audit and showed a strong cycle of listening to critiques on the service and analysing issues. • Agencies showed strong leadership in ensuring safeguarding children remained a priority during significant organisational changes. • Agencies have a clear reporting framework for safeguarding with health providers demonstrating strong practice in this area. • Each agency has clear and updated policy for responding to allegations against staff or volunteers which has been updated to meet new Working Together requirements. • Strong evidence suggesting good governance arrangements in place across all organisations with clear reporting and interface with the SSCB.	• All agencies to continue to prioritise listening to the wishes and feelings of children, and then incorporate this into policy and practice development. • Effective supervision of workers is a challenge for some agencies given the level of staff turnover and pockets of high vacancy rates. • The standard of induction varied across agencies. • UKBA/Home office did not complete a Section 11 audit report due to the internal changes to management arrangements. The SSCB Chair met with the Board Member to discuss this going forward • There is a challenge for regional and national organisations in producing a Section 11 report that is both accountable as an agency and reflects local circumstances

Appendix 1: SSCB Organisation Chart as at March 2014

Chair: Michael O'Connor, Independent

Vice Chairs: Romi Bowen, Strategic Director of Children's & Adults Services, Southwark Council
Rory Patterson, Director of Children's Social Care, Southwark Children's Services

Membership of the Executive Board:

- Children's & Adults Services
- Metropolitan Police
- Southwark Clinical Commissioning Group
- SLAM NHS Foundation Trust
- Guy's & St Thomas' NHS Foundation Trust
- King's College Hospital NHS Foundation Trust, Community Action Southwark
- Lay Members

Meets 5 times per year or as required

Staff:

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SSCB Senior Administrator
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Subgroups of SSCB

SUBGROUP	CHAIR(S)	FREQUENCY OF MEETINGS
Serious Case Review Subgroup	Michael O'Connor Independent Chair, SSCB	Meets 4 times a year
Audit & Learning Subgroup	Jackie Cook Head Of Social Work Improvement And Quality Assurance Children's Services	Meets 5 times a year
Child Death Overview Panel (CDOP) and Neo-Nate Panel (joint with Lambeth)	Abdu Mohiddin Consultant in Public Health Lambeth CCG Gillian Holdsworth Consultant in Public Health Lambeth CCG	Meets monthly
Child Sexual Exploitation Subgroup	Rory Patterson Director of Children's Social Care Children's Services	Meets 4 times a year
Community Engagement Subgroup	Gordon McCulloch Chief Executive Officer Community Action Southwark	First meeting February 2014
Education Sub group	Merril Haeusler Director of Education Children's Services	Meets 3 times a year
Health Subgroup	Gwen Kennedy Director of Quality and Safety NHS Southwark CCG	Meets 6 times a year
Human Resources & safeguarding Sub group	Bernard Nawrat Head of Human Resources Southwark Council	Meets 4 times a year
Practice Development & Training Subgroup	John Howard/Mary Mason (JH) Organisational Development Manager, Children's Dervices (MM) Designated Nurse, Southwark CCG	Meets 4 times a year
Designated, Named and Lead Professionals Group	Ann Flynn SSCB Development Manager	Meets twice a year

Appendix 2: Southwark Safeguarding Children Executive Board Members as at March 2014

Note that during 2013/14, the work of the Executive Board was supplemented by further meetings of the Main Board, which had wider membership.

First Name	Last Name	Job Title	Agency
Elaine	Allegretti	Head of Strategy, Planning and Performance	Children's & Adults' Service
Justin	Armstrong	Detective Chief Inspector	Metropolitan Police
Andrew	Bland	Managing Director	Southwark BSU, NHS Southwark
Romi	Bowen	Strategic Director of Children's and Adults Services	Children's Services
Becky	Canning	Assistant Chief Officer, Southwark	London Probation Service
Dora	Dixon-Fyle	Councillor	Southwark Council
Eva	Edohen	Lay Member	
Ann	Flynn	SSCB Development Manager	Children's Services
Zander	Gibson	Borough Commander	Metropolitan Police
Merril	Haeusler	Deputy Director of Children's Services	Children's Services, Education
Dr Ros	Healy	Consultant Paediatrician/Designated Doctor	NHS Southwark
Ron	Kerr	Chief Executive	Guy's & St Thomas' NHS Foundation Trust
Alex	Laidler	Interim Director for Adults Social Care	Children's & Adults' Service
Mary	Mason	Designated Named Nurse	Southwark BSU, NHS Southwark
Chris	McCree	Acting AD of Nursing	SLaM NHS Trust
Gordon	McCullough	Chief Executive	Community Action Southwark
Michael	O'Connor	Independent Chair	SSCB
Deborah	Parker	Associate Chief Nurse	Guy's & St Thomas' NHS Foundation Trust
Rory	Patterson	Director, Children's Social Care	Children's & Adults' Service
Gerri	Scott	Strategic Director Housing & Community Services	Housing and Community Services
Tim	Smart	Chief Executive	King's College Hospital
Claudina	Tuitt	Lay Member	
Ruth	Wallis	Director of Public Health	Public Health
Geraldine	Walters	Executive Director of Nursing and Midwifery	King's College Hospital
Susi	Whittome	Head Teacher Representative	Keyworth Primary School

Appendix 3: Approved Safeguarding Children's Courses delivered through My Learning Source – 2013 - 2014

Course Name	No. held
Child Protection: Keeping children safe from harm - (Foster carers)	1
Common Assessment Framework (CAF)	5
Contacting victims of adolescent harmful sexual behaviour	1
Critical thinking and supervision of complex risk: for safeguarding managers and supervisors	2
Crossing bridges: implementing a think family approach	2
Developing critical thinking in working with risk and the child protection process	3
Domestic Abuse Awareness	9
Domestic Abuse Champions Programme	7
Drug awareness training for children's social workers	1
Effective recording and data sharing for the multi agency safeguarding hub	2
Facebook, Mobiles and MSN: Safeguarding Children online (Foster carers)	2
Multi-agency safeguarding hub members development day	4
'Neglect Matters' Working together to assess, prevent and remedy the impact of neglect	1
Risk assessment for the multi-agency safeguarding hub	2
Sexual exploitation of children	2
Signs of Safety Bespoke Training ASAF, YOS &0-12OS,SSFT & Adolescence & Aftercare (2 days)	2
Signs of Safety Refresher Training	1
Signs of Safety Training Bespoke Training for Children's Social Care Specialist Services	1
SSCB - Child protection update seminar	4
SSCB - Domestic violence risk assessment model - multi - agency awareness briefing	3
SSCB - Emotional Abuse: The impact for children and young people on attachments	5
SSCB - E-Safety - recognising the harms of new technologies	4
SSCB - FGM - Awareness course	1
SSCB - Honour Based Violence (HBV)	2
SSCB - Interagency working together in Assessment and Intervention with and C & F	3
SSCB - Neglect - An analytical approach	5
SSCB - Parental and perinatal mental health: impact on children and their families	2
SSCB - Race, culture and faith belief systems in safeguarding children	3
SSCB - Safeguarding children with disabilities	1
SSCB - Substance misuse by parents: impact on children and families	1
SSCB - The Art of Difficult Conversations in Child Protection	3
SSCB -Child Protection Level 2	3
SSCB - Child Protection Level 3	1
SSCB- Domestic violence risk assessment model - multi agency awareness briefing	3
SSCB-Attending child protection meetings, conferences, network, strategy and core groups	2
SSCB - Honour Based Violence (HBV) PM	2
SSCB - Working with children who have been sexually abused	4
The Mental Health Needs of Young People Involved in Street Gangs	3
Working with challenging and hard to help families: developing authoritative practice for safeguarding practitioners/managers	1

Agenda Item 10

Item No. 10.	Classification: Open	Date: 29 January 2015	Meeting Name: Health and Wellbeing Board
Report title:		Health and Wellbeing Strategy 2015-2020	
Wards or groups affected:		All	
From:		Ruth Wallis, Director of Public Health	

RECOMMENDATIONS

1. The board is requested to:

   a) Agree the health and wellbeing strategy, to note the 6 high level priorities for 2015-2020 and to note the iterative strategy process
   b) Note that the focus for the board will be on ensuring added value from partners and on health inequalities and to manage by outcomes.

EXECUTIVE SUMMARY

2. The health and wellbeing board is required by the 2011 Health and Social Care Act to publish a joint health and wellbeing strategy.

BACKGROUND INFORMATION

3. This is a refresh of the Health and Wellbeing Strategy 2013/14. This refresh is informed by the joint strategic needs assessment (www.southwark.gov.uk/jsna), by what local people are telling us (Southwark Lives Engagement) and evidence of what works to improve the health of the population and to reduce health inequalities.

KEY ISSUES FOR CONSIDERATION

4. The health and wellbeing board is committed to working together to improve health and wellbeing outcomes, to reduce health inequalities and to promote integration. The health and wellbeing strategy is intended as an overarching strategic framework which sets the high level direction for health and wellbeing improvement for the whole system. The six priorities are:

   - Giving every child and young person the best start in life
   - Addressing the wider socio economic determinants of health which we know determine our life chances: to maximise opportunities for economic wellbeing, development, jobs & apprenticeships, and make homes warm, dry and safe
   - Preventing ill health by promoting and supporting positive lifestyle changes & responsibility for own health (smoking, physical activity, obesity, alcohol & substance misuse, sexual health & HIV) and improving people's wellbeing, resilience & connectedness
   - Helping people with existing long term health conditions to remain healthier and live longer lives by improving detection & management of health conditions

including self management & support

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

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

5. The six priorities are high level and complex and the intention is not for the strategy to provide the detail for the delivery of these priorities. The strategy identifies and sign posts to the associated strategies, action plans and relevant partnerships.

6. The health and wellbeing board will be assured that there is progress by developing and agreeing the outcomes that will be monitored. This will inform thematic deep dives by the board. A focus of the board is to draw out how individual partner organisations 'add value' through collaboration and how health inequalities is addressed.

7. Because the board vision is long term and far reaching, the strategy and associated documentation have to be a live process and should be viewed as iterative and not standing still. The iterative process is guided by a number of engagement questions which will inform the work of the health and wellbeing strategy steering group.

Policy implications

8. Southwark council and the Southwark CCG have a statutory duty under the 2012 Health and Social Care Act to produce a health and well being strategy for Southwark. The health and wellbeing board leads the production of the strategy. Local health and wellbeing commissioning and service plans have to pay due regard to the health and wellbeing strategy.

Community impact statement

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

Legal implications

10. The board is required to produce and publish a joint health and wellbeing strategy on behalf of the local authority and clinical commissioning group. The proposals and actions outlined in this report will assist the board in fulfilling this requirement and will support the strategy's implementation.

Financial implications

11. There are no financial implications contained within this report. However, the priorities identified in the health and wellbeing strategy will have implications for other key local strategies and action plans and the development of commissioning intentions to improve the health and wellbeing of Southwark's population.

BACKGROUND PAPERS

Background papers	Held at	Contact
Southwark Joint Strategic Needs Assessment	www.southwark.gov.uk/jsna	jsna@southwark.gov.uk
Southwark Health & Wellbeing Strategy 2013/14	www.southwark.gov.uk	Public Health 020 7525 0280

APPENDICES

No.	Title
Appendix 1	Southwark Health and Wellbeing Strategy 2015 – 2020

AUDIT TRAIL

Lead officer	Ruth Wallis, Director of Public Health for Lambeth & Southwark	
Report Author	Jin Lim, Assistant Director of Public Health	
Version	Final	
Dated	16 January 2015	
Key decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer title	**Comments Sought**	**Comments Included**
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Strategic Director of Children's and Adults Services	No	No
Date final report sent to Constitutional Team		18 January 2015

APPENDIX 1

DRAFT

Southwark Health and Wellbeing Strategy 2015 – 2020

Improving the health of our population and reducing health inequalities

Southwark Health and Wellbeing Board

Contents

APPENDICES

Foreword

I welcome the commitment of the health and wellbeing board and its partners to improving the health of Southwark's population and to reducing health inequalities.

Our vision sets a far reaching ambition. We fully recognise that to address the complex multi factorial determinants of health, we will need an approach that encompasses improving the social economic wellbeing of the borough, giving our children and young people the best start, supporting risk reduction and positive behaviour changes to reduce the risks for poorer health, improving the detection and management of people who have common health conditions, supporting our most vulnerable and to strengthen local approaches to integration so that seamless services are accessible, effective and efficient.

We believe we can achieve this by building upon the foundations of our first health and wellbeing strategy, by understanding the needs of our population and by building a fairer future for all. We know that only through partnership can we make our vision and ambitions a reality and overcome the biggest challenges facing our communities. This document does not seek to duplicate the actions already set out in major local plans. As a board, we will monitor using the agreed outcomes, conduct deep dives into areas of interest and to focus on areas where partners can add real value. We will also want assurance from partners that our actions reduce and do not widen health inequalities.

We intend to now make these ambitions a reality and to do this the strategy has to be an iterative live process. Over the coming months, the health and wellbeing board will be hosting stakeholder engagement events to which everyone across the borough is invited so that together we can make our borough a healthier place. Some questions to which I seek your views are highlighted in the document. Please feedback to PHadmin@southwark.gov.uk I look forward to hearing from you.

Peter John

Leader, Southwark Council

Chair of the Southwark Health and Wellbeing Board

1. Our strategic framework for improving health & wellbeing

Vision

Our vision builds on our existing strategy.

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

We are committed to working together to promote integration, to improve outcomes and to reduce health inequalities by:

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

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

3. Preventing ill health by promoting and supporting positive lifestyle changes & responsibility for own health and improving people's wellbeing, resilience & connectedness

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

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

6. Supporting integration for better health & wellbeing outcomes by integrating health and social care that is personalised & coordinated in collaboration with

individuals, carers & families and by shifting away from over reliance on acute care towards primary care & self care.

Engagement questions

1. How are you and your organisation adding value and contributing to the above health and wellbeing priorities?

2. How are you ensuring health inequalities are addressed?

Appendix 1 – Please use the priority template to let us know your views.

Appendix 2 – Here are some examples of how some health and wellbeing board members are contributing added value and ensuring that what they do reduce and not widen health inequalities.

Our approach

The health and wellbeing strategy**.....**

❶ Sets vision and direction

The focus of our approach is to develop the health and wellbeing strategy as an overarching strategic framework which sets the direction for health and wellbeing improvement for the whole system.

❷ Sign posts to detail in other documents and does not duplicate

Our strategy identifies the priority areas for work and the corresponding strategy or action plan. This document will be high level and will not duplicate or repeat the considerable detail that is available in other local documents.

❸ Ensures progress by monitoring outcomes and deep dives

The health and wellbeing board will ensure there is progress by developing and agreeing the outcomes that will be monitored. This will determine the thematic deep dives by the Board.

❹ Focuses on adding value and addressing health inequalities

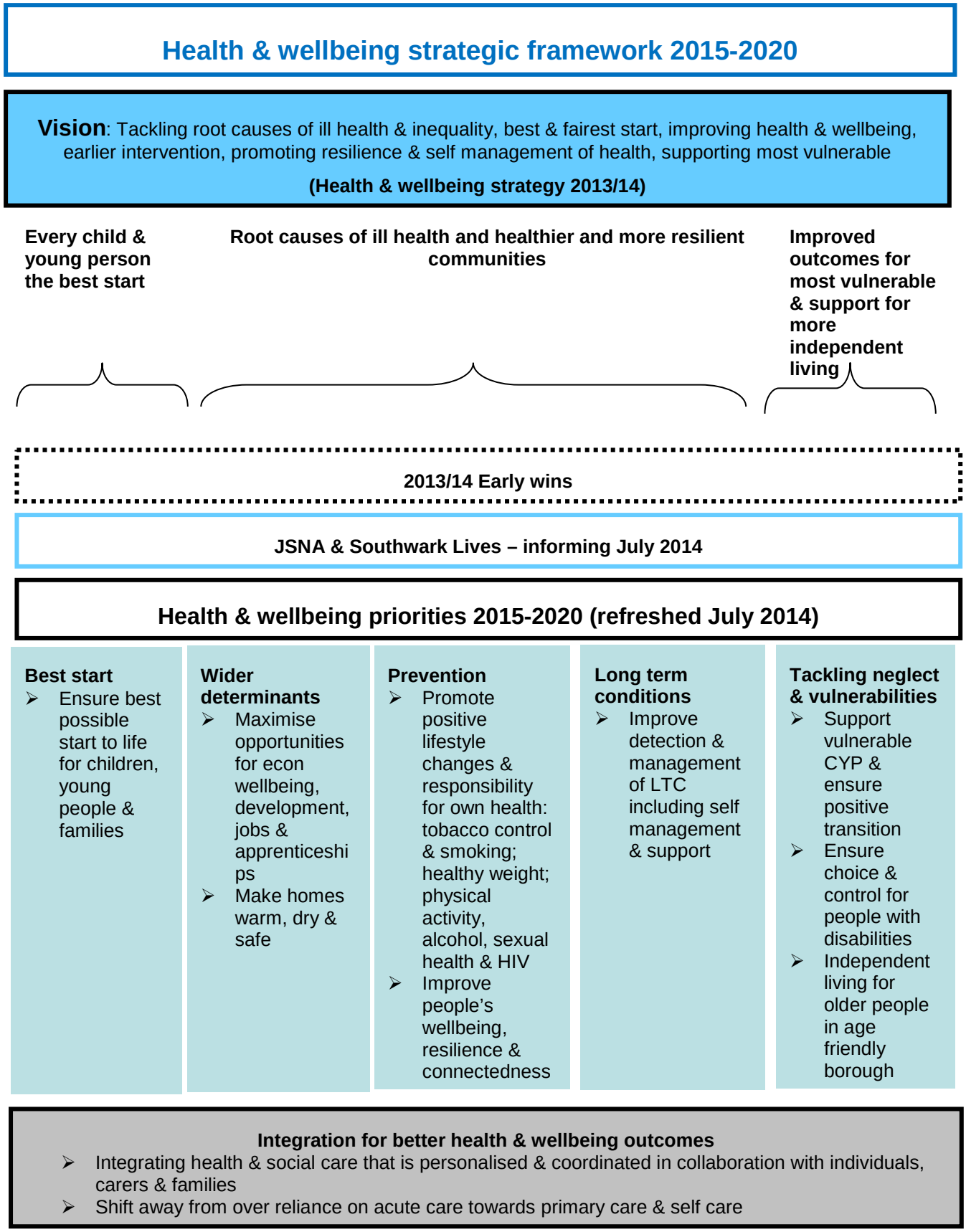
A focus of this document is to draw out how individual partner organisations ‘add value’ through collaboration and how health inequalities is addressed.

❺ Is a live process of engagement & further development

Our vision is long term and far reaching. The strategy itself has to be a live process which responds to the complex systems it operates within and seeks to change. As such, the strategic process and this document are iterative.

Our strategic approach is set out in the following diagram (Figure 1).

Figure 1


Health & wellbeing strategic framework 2015-2020
Vision: Tackling root causes of ill health & inequality, best & fairest start, improving health & wellbeing, earlier intervention, promoting resilience & self management of health, supporting most vulnerable
(Health & wellbeing strategy 2013/14)
Every child & young person the best start
Root causes of ill health and healthier and more resilient communities
Improved outcomes for most vulnerable & support for more independent living
2013/14 Early wins
JSNA & Southwark Lives – informing July 2014
Health & wellbeing priorities 2015-2020 (refreshed July 2014)
Best start
Ensure best possible start to life for children, young people & families
Wider determinants
Maximise opportunities for econ wellbeing, development, jobs & apprenticeships
Make homes warm, dry & safe
Prevention
Promote positive lifestyle changes & responsibility for own health: tobacco control & smoking; healthy weight; physical activity, alcohol, sexual health & HIV
Improve people's wellbeing, resilience & connectedness
Long term conditions
Improve detection & management of LTC including self management & support
Tackling neglect & vulnerabilities
Support vulnerable CYP & ensure positive transition
Ensure choice & control for people with disabilities
Independent living for older people in age friendly borough
Integration for better health & wellbeing outcomes
Integrating health & social care that is personalised & coordinated in collaboration with individuals, carers & families
Shift away from over reliance on acute care towards primary care & self care

2. Health & wellbeing in Southwark

What is the Joint Strategic Needs Assessment (JSNA) telling us?

The text box below summarises some key health facts. More detail is available in Southwark's JSNA at www.southwark.gov.uk/jsna

Key health facts for Southwark

- Male Life expectancy is 78.2 years compared to 78.5 years in England.
- Female Life expectancy is 83.4 years compared to 82.5 years in England.
- Infant mortality rate (death in babies under 1 year) has decreased year on year and but is 6.17 per 1000 live births compared to 4.29 in England.
- Lifestyle risk factors such as alcohol/substance misuse, smoking, unhealthy diet (e.g.child obesity) and unprotected sex continue to be major risks to good health in the population.
- As a consequence, there is higher incidence of emergency hospital admissions due to alcohol related conditions, high rates of teenage pregnancy and HIV, high rate of premature deaths from cancer and cardio-vascular diseases and high prevalence of mental illness in the local population.
- Coronary heart disease, malignant neoplasms (cancers) and respiratory diseases remain the top three causes of death in the population.
- Disease prevalence models have shown that there are high numbers of undetected cases of diabetes, hypertension and heart disease in Southwark population. Early detection and treatment is beneficial for patient's health outcomes as well as cost of treatment to the NHS.
- Socio-economic challenges such as unemployment and poor housing result in a relatively higher rate of child poverty and social exclusion which subsequently contribute to poor physical and mental health manifesting in health inequalities.

The health and wellbeing related issues for Southwark include:

1. **DEPRIVATION:** Index of Multiple Deprivation (2010) shows Southwark as the 12th most deprived borough in London with an average score of 29.7 compared to 19.8 in London which means there are approximately 97,000 individuals facing life challenges due to deprivation. [See Appendix 1 – Southwark Deprivation IMD 2010]

2. **BIRTHS:** In 2010, there were 5131 live births recorded in Southwark which is higher than in 2009 at 4873. The trends show a rise over the past few years although it is a bit unpredictable to state whether the rise in births will continue at that rate.

3. **TEENAGE PREGNANCY:** The teenage pregnancy rate in Southwark has reduced from 84.8 per 1000 females aged 15-17 in 1998-2000 to 53.3 in 2010.

4. **ALCOHOL:** 1 in 5 adults in Southwark are high risk alcohol drinkers. Hospital stays for alcohol related harm in Southwark account for 4330 admissions each year with a rate of 1809 per 100000 population compared to England average of 1895. Despite this lower rate, alcohol attributable mortality, alcohol specific hospital admission for males and Alcohol related crimes and sexual offences rate are worse in Southwark compared to England. The proportion of young people admitted for alcohol related illness as well as due to self-harm (mental health related) is lower in Southwark.

5. **SMOKING & OBESITY:** 1 in 5 adults (21.4%) in Southwark smoke based on findings from the health surveys. Similarly just over 1 in 5 adults (22.5%) are obese. The percentage of women smoking in pregnancy is lower in Southwark. The Active People Survey data suggests that about 50% of Southwark people are considered 'inactive' ie doing less than 30mins a week moderate activity.

6. **CHILD OBESITY:** 1 in 4 children (24%) are recorded as obese in year 6 (aged 10-11) through the National Child Measurement Programme (NCMP) which is higher than the England average of 19%.

7. **SEXUAL HEALTH:** Annually 5130 acute sexually transmitted infections are recorded with a crude rate of 1787 per 100000 population compared to England average of 775. Chlamydia diagnosis rates are highest at 6132 per 100000 15-24 year olds compared to 1979 in England.

8. **LONG TERM CONDITIONS (LTC):** The GP registers for long term conditions show the following as at March 2013: 5812 people with cardiovascular diseases, 32104 with hypertension, 11,975 with diabetes, 3899 with chronic obstructive pulmonary disease, 4708 with coronary heart disease, 2757 with stroke, 3209 with cancer and 5335 with chronic kidney disease. Please note a patient can be on multiple disease registers so the above figures should not be added to get a total number of individuals with LTCs. The prevalence models published by APHO have shown under detection of conditions such as diabetes, hypertension and kidney disease in Southwark.

9. **QUALITY & OUTCOME FRAMEWORK (QOF) SUMMARY:** The QOF summary for 2011-12 for Southwark shows underperformance in the following areas - hypertension control, diabetes control, BP control in patients with kidney disease, control in stroke patients.

10. **SCREENING:** Breast cancer screening uptake rates in Southwark were 61.3% compared to England average of 76.9% while cervical cancer screening uptake

rate was 68.4% compared to 75.3% in England (in 2012). Diabetic retinopathy screening uptake is 77% compared to 80.9% in England.

11. **IMMUNISATION:** Child immunisation rate is rising but lower than the England average especially MMR (82.3%) and immunisation in children in care (currently 72% compared to 83% in England). Flu immunisation rate in 65+ population was 68.9 in 2011-12 compared to 74% in England.

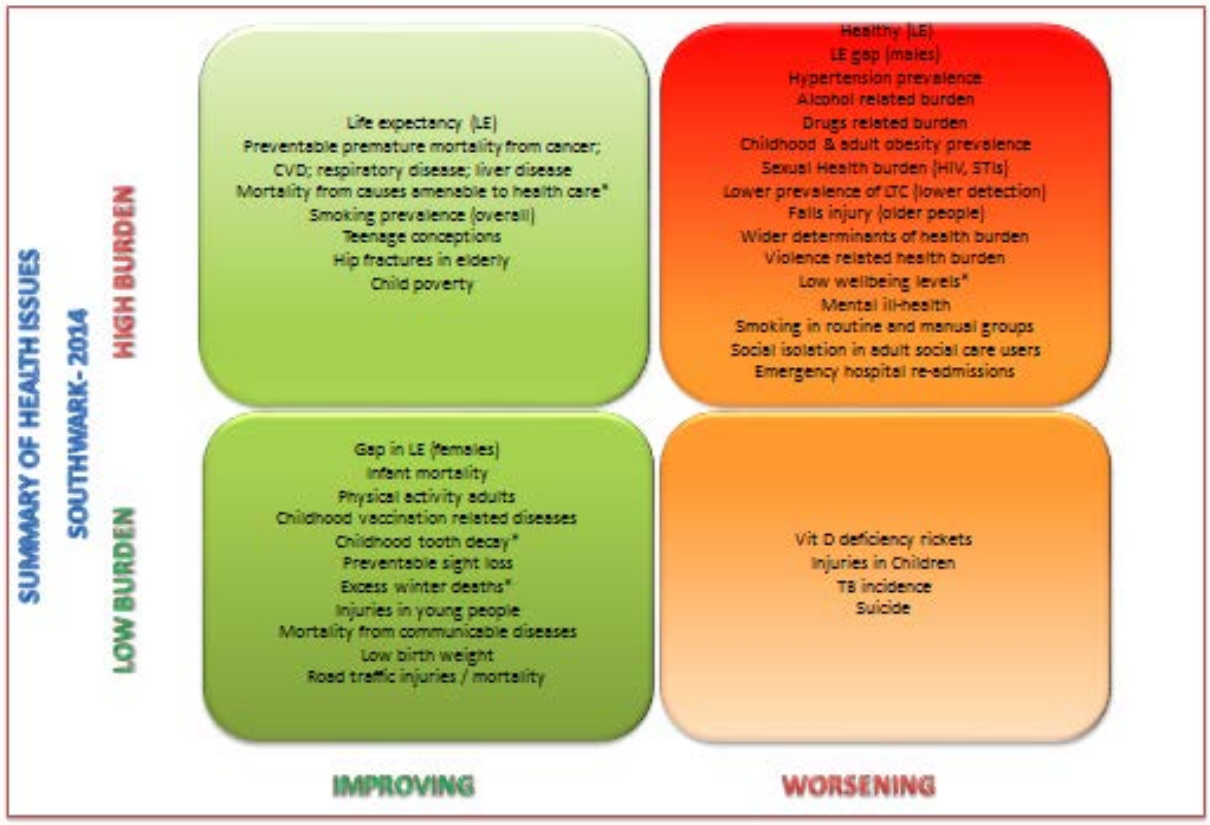
12. **BREAST FEEDING:** Breast feeding initiation, as well as maintenance at 6-8 weeks are higher in Southwark compared to England.

13. **FALLS:** Injuries due to falls in both males and females aged 65 and over is higher in Southwark compared to the England average. Age standardised emergency hospital admission rate due to hip fractures in 65+ is slightly higher than the England average with a scope to reduce further.

14. **MORTALITY:** Premature mortality rate (deaths in <75 year olds) due to circulatory diseases is higher at 74 per 100000 compared to England at 60. Similarly the death rate in <75s due to cancer is higher at 122 per 100000 compared to 108 in England. Mortality rate from liver disease, respiratory disease, communicable diseases was also higher in Southwark than the England average. Excess winter deaths index in 65+ population is slightly higher in Southwark (17.2) compared to England (15.6)

The prioritisation framework (Figure 2) has been used to inform the priorities for the health and wellbeing strategy.

Figure 2 Prioritisation framework



What are our residents telling us?

Over 2014/15, we carried out the Southwark Lives engagement exercise. With the help of Healthwatch Southwark and partners, we heard from hundreds of people across Southwark. Stories were collected from residents of all ages, giving us an insight into the ordinary and often extraordinary lives of Southwark people. The stories reflect the diverse needs and experiences of our communities, from staying fit and active, to preventing isolation, to dealing with long term conditions, disabilities and mental illness.

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

Their levels of personal resilience had an impact on how people felt about the experiences they described. Some people who talked about suffering traumatic events or being the victim of violence, for example, said that they had struggled to cope. Others seemed to feel confident that they were in control of their own wellbeing and were optimistic about the future. There were many stories from people who were born outside Southwark and the challenges they have faced.

Problems like domestic violence, poverty, unemployment and poor housing featured in many of the stories and had a negative impact on health. Many people described living with multiple health problems, and often, those with physical health problems were also suffering from mental health problems.

More detailed information is available from our accompanying document, ***Southwark Lives.***

Informed by the Southwark JSNA and what our residents are telling us, the high level priorities for the health and wellbeing strategy are set out in the next section. Potential outcomes against these priorities are also identified.

3. Improving our health & wellbeing

Evidence of what works and priorities for the health and wellbeing strategy

A number of important national reviews have highlighted what local health and wellbeing systems should be addressing to deliver improved population health and to reduce health inequalities in effective as well as cost effective ways. The key recommendations are summarised in Table 1.

Table 1

Reviews	Key recommended areas for action
King's Fund '*Improving the Public's Health – a Resource for Local Authorities'* This resource pulls together evidence from successful interventions across key local authority functions about 'what works' for improving health and reducing health inequalities.	• The best start in life • Healthy schools and pupils • Helping people find good jobs and stay in work • Active and safe travel • Warmer and safer homes • Access to green and open spaces and the role of leisure services • Strong communities, wellbeing and resilience • Public protection and regulatory services • Health and spatial planning
Source: http://www.kingsfund.org.uk/projects/improving-publics-health?gclid=CMjZ68nO7cICFUXKtAod5nwA_g	
National Institute for Clinical Excellence (NICE) '*Local Government Briefings'* They summarise the best available evidence-based information about effective and cost effective public health activity, which will help improve the health of their communities and to support the development of joint health and wellbeing strategies.	• Alcohol • Behaviour change • Contraception • Domestic violence • NHS health checks • Access to health & social care • Physical activity • Walking & cycling • Weight management • Drug misuse • Workplace health
Source: http://www.nice.org.uk/about/what-we-do/our-programmes/nice-advice/local-government-briefings	
NICE '*Judging whether public health interventions offer value for money'* This briefing summarises the economic and health benefits that can be gained from public health interventions and the	*Areas to intervene in to save money:* • Smoking • Alcohol • Weight • Physical inactivity • Stroke

methods that can be used to measure them and what could be gained by placing greater emphasis on 'prevention rather than cure'.	• Diabetes *Good value for money 'best buys':* • stop smoking services • healthy eating initiatives • physical activity programmes • alcohol interventions • mental health at work • safe sex initiatives
Source: http://www.nice.org.uk/advice/lgb10	
The Marmot Review Report *'Fair Society, Healthy Lives'* The report proposes an evidence based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities.	6 policy objectives: • Give every child the best start in life. • Enable all children, young people and adults to maximise their capabilities and have control over their lives. • Create fair employment and good work for all. • Ensure healthy standard of living for all. • Create and develop healthy and sustainable places and communities. • Strengthen the role and impact of ill health prevention.
Source: http://www.local.gov.uk/health/-/journal_content/56/10180/3510094/ARTICLE	

Informed by Southwark's JSNA, the Southwark Lives engagement exercise and the above reviews, the Health and Wellbeing Board has agreed the key priority areas for the health and wellbeing strategy as set out below.

A number of potential outcome indicators of success are also being proposed. They are a combination of high level longer term outcomes as well as some 'process' level outputs and actions. The intention is that these outcomes are further refined as part of the 'deep dives' so that there is health and wellbeing board ownership.

1. Every child & young person the best start

Priority areas	**Outcome indicators of success**
1.1 Ensure the best possible start to life for children, young people and their families	• Improved maternal & infant health • Increase in numbers of families receiving early help • Improved educational attainment / reduction in educational variation

2. Root causes of ill health & healthier & more resilient communities

Priority areas	Outcome indicators of success
2.1 Maximize opportunities for local economic wellbeing, development, jobs & apprenticeships	• Increased numbers of apprenticeships and local people in jobs
2.2 Make every home warm, dry and safe	• Implementation of improved housing standards
2.3 Promote positive lifestyle changes and encourage individuals to take responsibility for their own health: tobacco control & smoking; healthy weight; physical activity, alcohol, sexual health & HIV	• Promoting positive health and reducing negative health impacts of licensing and planning policy • Front line workers from a range of sectors and communities delivering Making Every Contact Counts (MECC) • Increased uptake of stop smoking services and implementation of range of tobacco control action • Range of evidence based healthy weight services commissioned; obesity prevalence • Increased physical activity, reduced inactivity • Reduced alcohol related / specific conditions, admissions • Improved sexual health, reduced HIV late detection
2.4 Enable people to effectively manage and maintain their physical health & mental health & wellbeing	• Increased uptake of screening, immunizations, health checks • Reduced variation in range of primary care (QOF) indicators
2.5 Increase the resilience and capacity of our communities	• Frontline workers from a range of sectors and communities supporting 5 ways to wellbeing • Strong social & community networks developed with more cohesive & connected communities

3. Improved outcomes for most vulnerable & support for more independent living

Priority areas	Outcome indicators of success
3.1 Support vulnerable young people and ensure their transition into adulthood is positive	• More vulnerable CYP helped to make positive life choices
3.2 Ensure that people with disabilities have the choice and control to live their lives they want and achieve their potential	• Better health outcomes for people with disabilities through implementation of personalization • More PWLD in paid employment • Adequate and appropriate housing for people with disabilities
3.3 Enable older people to live independently in an age friendly borough	• Increase in preventive interventions for older people to reduce unnecessary hospital and residential admissions • More older people supported to live at home longer • Communities that understand dementia issues and support people with dementia

4. Integration for better health & wellbeing outcomes

Priority areas	Outcome indicators of success
4.1 Integrated health & social care that is personalized and coordinated in collaboration with individuals, carers & their families	• Effective emergency response, care coordination, reablement, services appropriately redesigned • Improved data sharing, information systems infrastructure and IG
4.2 Shift away from over reliance on acute care towards primary care and self care	• Effective emergency response, care coordination, reablement, services appropriately redesigned

Engagement questions

3 Are the suggested outcome indicators of success the right ones?

4 Are there areas that you would like the health and wellbeing board to do a deep dive into?

Appendix 3 shows how Southwark compares to the rest of the country for some of these indicators.

4. Making it happen

Monitoring & progress

The health and wellbeing board recognises that improving health and wellbeing and reducing health inequalities is by its very nature complex and requires multi factorial actions by a wide range of agencies. The priorities identified by the board reflect this. The board acknowledges that for each of the priority areas, there already exist strategies with detailed action plans.

Table 2 below sets out the key strategies and various action plans associated with our health and wellbeing priorities as well as the relevant boards and partnerships which hold the detailed overview. The health and wellbeing board does not intend to duplicate the efforts of these other boards and partnerships. Instead, the health and wellbeing board will **'hold to account'** other board and partners: it will monitor biannually an agreed set of outcomes. Informed by outcome monitoring and feedback from engagement events, the board will hold deep dives into particular topics of interest. It is acknowledged that there will be potential room for improvement in some areas and the expected improvement will be highlighted and reinforced as part of the deep dives.

The board also wants to focus on what partners bring to the table, that is, what 'added value' partners can create. It additionally wants to be assured that health inequalities are being tackled. With this in mind, in developing our health and wellbeing strategy, we are asking partners and stakeholders:

- In implementing their action plan for a specific health and wellbeing priority, what are their 'big asks' of other partners (ie what is their added value)
- How are they ensuring that health inequalities are being reduced and not widened be their proposed contribution to the health and wellbeing priority?

The board has started identifying some of these actions and some examples are included in Appendix 2.

Appendix 3 has a spinal chart with some suggested indictors for inclusion in the monitoring framework. They will be further developed informed by feedback from stakeholder engagement.

Table 2

Priority	Associated implementation key strategies & action plans	Board / partnership	Health and wellbeing board member lead(s)
1. Every child & young person the best start			
1.1 Ensure the best possible start to life for children, young people and their families	Children & young people strategy & action plans	Children & young people board	Strategic Director of Children & Adult Services
2. Root causes of ill health & healthier & more resilient communities			
2.1 Maximize opportunities for local economic wellbeing, development, jobs & apprenticeships	Economic Wellbeing Strategy	Council plan	Leader, Southwark Council Chief Executive of Southwark Council
2.2 Make every home warm, dry and safe	Council Plan Housing Strategy	Council plan	Leader, Southwark Council Chief Executive of Southwark Council
2.3 Promote positive lifestyle changes and encourage individuals to take responsibility for their own health: tobacco control & smoking; healthy weight; physical activity, alcohol, sexual health & HIV	Council Plan Physical Activity & Sports Strategy Walking Strategy (in progress) Cycling strategy (in progress) CCG Prevention& Resilience Programme Action Plan Sexual health & HIV strategy Action plans for tobacco & smoking, healthy weight, substance misuse & alcohol Kings public health committee work programme	Proactive Southwark CCG Resilience & Prevention Board Sexual health board Tobacco Alliance Healthy Weight Network Alcohol Strategy Group King's Public Health Committee	Cabinet lead councillor for public health, parks & leisure Director for Public Health CCG clinical lead for resilience, wellbeing & prevention King Health Partners
2.4 Enable people to effectively manage and maintain their physical health & mental health & wellbeing	CCG Operating Plan Joint Carers Strategy SE London Strategic Plan CCG Prevention& Resilience Programme Action Plan Sexual health & HIV strategy Action plans for tobacco & smoking, healthy weight, substance misuse & alcohol Kings public health committee work programme	CCG Board CCG Resilience & Prevention Board Sexual health board Tobacco Alliance Healthy Weight Network Alcohol Strategy Group King's Public Health Committee	Chair of CCG Chief Executive – CCG CCG clinical lead for resilience, wellbeing & prevention Cabinet lead councillor for public health, parks & leisure Director of Public Health Kings Health Partners

2.5 Increase the resilience and capacity of our communities	CCG Mental wellbeing & parity of esteem Programme Action Plan Lambeth & Southwark Mental Wellbeing Programme Joint Mental Health Strategy Housing Strategy	CCG Mental wellbeing & parity of esteem board Mental health strategy group	CCG clinical lead for resilience, wellbeing & prevention Cabinet lead councillor for Adult care, arts & culture Chief Executive of Southwark Council
3. Improved outcomes for most vulnerable & support for more independent living			
3.1 Support young people who are vulnerable and ensure their transition into adulthood is positive	Children & young people strategy & action plans	Children & young people board	Strategic Director of Children & Adult Services
3.2 Ensure that people with disabilities have the choice and control to live their lives they want and achieve their potential *3.3 Enable older people to live independently in an age friendly borough*	Council Plan Adult social care strategies Joint Carers Strategy Better Care Fund CCG Operating Plan CCG Integration Programme Primary Care & Neighbourhood Development Programme End of Life Care Strategy Housing Strategy	Adult social care partnerships CCG Governing Board CCG Integration Programme Board Primary Care & Neighbourhood Development Programme Board End of Life Care Strategy Group	Cabinet lead councillor for Adult care, arts & culture Strategic Director of Children & Adult Services Chair of CCG Chief Executive – CCG Chief Executive of Southwark Council
4. **Integration for better health & wellbeing outcomes**			
4.1 Integrated health & social care that is personalized and coordinated in collaboration with individuals, carers & their families *4.2 Shift away from over reliance on acute care towards primary care and self care*	South London Integrated Care Programme CCG Integrated Plan Adult social care strategies Better Care Joint Carers Strategy	SLIC Board Adult social care partnerships CCG Governing Board CCG Integration Programme Board Primary Care & Neighbourhood Development Programme Board	Cabinet lead councillor for Adult care, arts & culture Strategic Director of Children & Adult Services Chair of CCG Chief Executive – CCG Chief Executive of Southwark Council

Engagement question

5 Are there other strategies and action plans that are relevant to the health and wellbeing strategy priorities? Are there specific aspects of these strategies or action plans that you would like to draw to the attention of the health and wellbeing board?

Deep dives

While primary prevention is effective and cost effective, bringing about sustained behaviour change at a population level is difficult. Additionally, the cost benefits may not be noticeable immediately. The board has expressed an interest in having deep dives to better understand the current programmes. The deep dives will provide the board with an opportunity to seek assurance and to drive forward strengthened partnership approaches. Topics of interest include:

- **Tobacco and smoking**
- **Sexual health and HIV**
- **Alcohol**
- **Obesity**
- **Physical activity**

The deep dives will form part of the work plan for the board. Other deep dive topics will be further indicated by the health and wellbeing board.

On-going engagement

The health and wellbeing board recognises that to be truly successful, the health and wellbeing strategy needs to be responsive to the changing environment and to engage with and be shaped by local stakeholders and Southwark people. The health and wellbeing strategic process is iterative (Figure 3). The board is working with Community Action Southwark, Healthwatch Southwark and other partners to involve stakeholders and local people in further shaping the strategy. A governance review was carried out earlier in the year with one of the recommendations being that the health and wellbeing board should strengthen its engagement processes.

To further shape our health and wellbeing strategy, we are seeking views on the engagement questions in this document. To summarise, the engagement questions are:

(please reply to PHadmin@southwark.gov.uk)

Engagement questions

1. How are you and your organisation adding value and contributing to the above health and wellbeing priorities?

2. How are you ensuring health inequalities are addressed?

Appendix 1 – Please use the priority template to let us know your views.

Appendix 2 – Here are some examples of how health and wellbeing board members are contributing added value and ensuring that what they do reduce and not widen health inequalities.

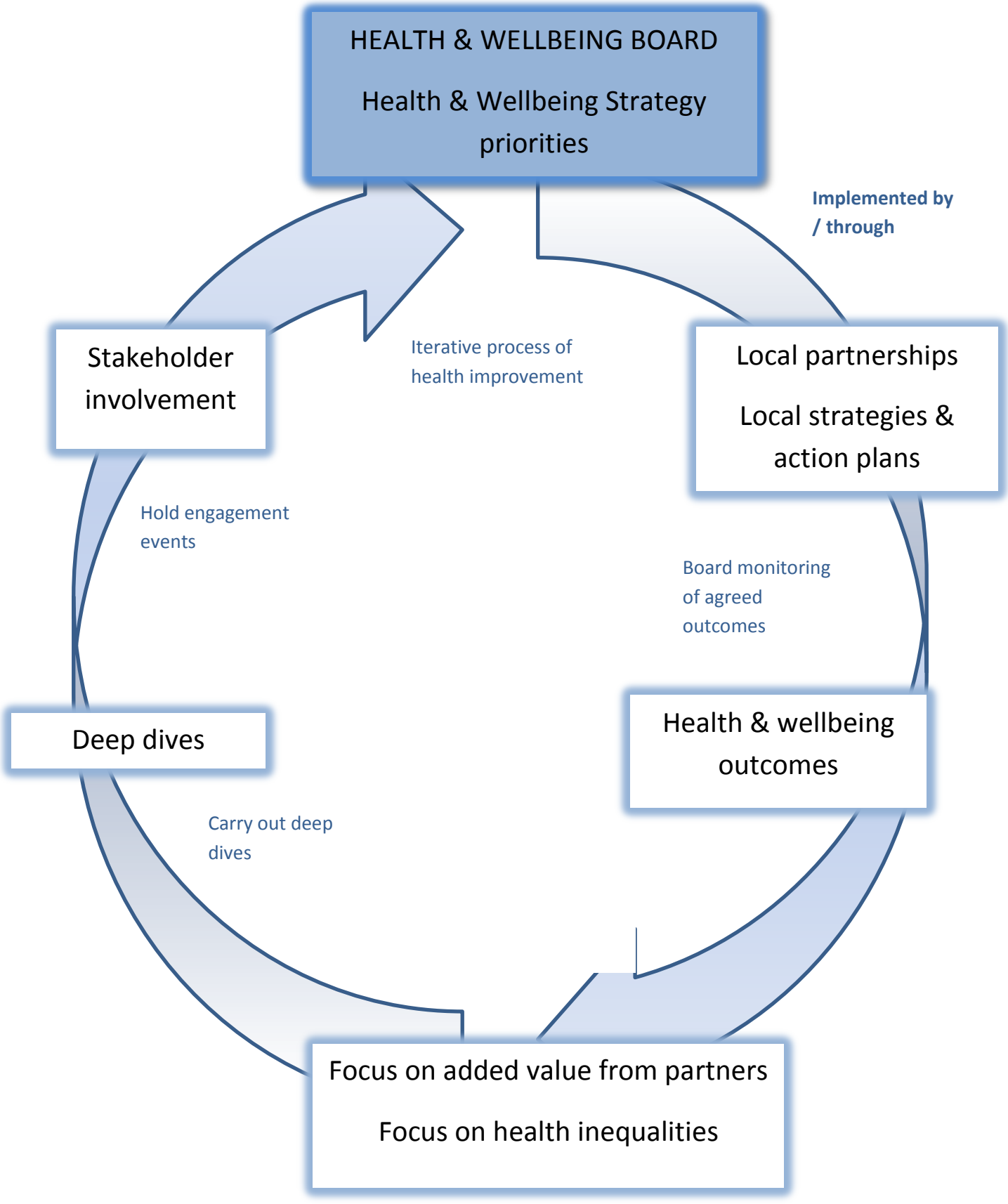
3. Are the suggested outcome indicators of success the right ones?

Appendix 3 shows how Southwark compares to the rest of the country for some of these indicators

4. Are there areas that you would like the health and wellbeing board to do a deep dive into?

5. Are there other strategies and action plans that are relevant to the health and wellbeing strategy priorities? Are there specific aspects of these strategies or action plans that you would like to draw to the attention of the health and wellbeing board?

Figure 3


HEALTH & WELLBEING BOARD
Health & Wellbeing Strategy priorities
Implemented by / through
Local partnerships
Local strategies & action plans
Board monitoring of agreed outcomes
Health & wellbeing outcomes
Focus on added value from partners
Focus on health inequalities
Carry out deep dives
Deep dives
Hold engagement events
Stakeholder involvement
Iterative process of health improvement

Appendices

Appendix 1 – Please use the priority template to let us know your views.

Appendix 2 – Here are some examples of how health and wellbeing board members are contributing added value and ensuring that what they do reduce and not widen health inequalities.

Appendix 3 shows how Southwark compares to the rest of the country for some selected outcome indicators

Please send comments and feedback to PHadmin@southwark.gov.uk

Appendix 1 – Please use the priority template to let us know your views.

Priority themes & work areas	My organization will contribute to the HWB priority by: We are asking HWB partners to collaborate on: Health inequalities is addressed by:
1. Every child & young person the best start	
1.1 Ensure the best possible start to life for children, young people and their families	
2. Root causes of ill health & healthier & more resilient communities	
2.1 Maximize opportunities for local economic wellbeing, development, jobs & apprenticeships	
2.2 Make every home warm, dry and safe	
2.3 Promote positive lifestyle changes and encourage individuals to take responsibility for their own health: tobacco control & smoking; healthy weight; physical activity, alcohol, sexual health & HIV	
2.4 Enable people to effectively manage and maintain their physical health & mental health & wellbeing	
2.5 Increase the resilience and capacity of our communities	
3. Improved outcomes for most vulnerable & support for more independent living	
3.1 Support young people who are vulnerable and ensure their transition into adulthood is positive	
3.2 Ensure that people with disabilities, LD & MH have the choice and control to live their lives they want and achieve their potential	
3.3 Enable older people to live independently in an age friendly borough	

4. Integration for better health & wellbeing outcomes

4.1 Integrated health & social care that is personalized and coordinated in collaboration with individuals, carers & their families	
4.2 Shift away from over reliance on acute care towards primary care and self care	

Appendix 2

Table 2 on page 19 identifies the key strategies and action plans underpinning the health and wellbeing strategy priorities. The health and wellbeing board has a focus on enhancing partnership working and the following tables begin to capture some of the **'big asks'** from partners. In addition to monitoring health inequalities outcomes, the board is also seeking assurance from partners that the 'asks' contribute toward reducing health inequalities.

This section will be developed and monitored in an iterative way informed by emerging programmes and strategic reviews such as Southwark CCG's Resilience and Prevention Programme Board, the Children and Young People and Adult Social Care Local Accounts and the Early Action Commission.

ECONOMIC WELLBEING ASKS

Priority themes & work areas	My organization will contribute to the HWB priority by: We are asking HWB partners to collaborate on: Health inequalities is addressed by:
2. Root causes of ill health & healthier & more resilient communities	
2.1 Maximize opportunities for local economic wellbeing, development, jobs & apprenticeships	**Southwark Council will support 5,000 more local people into jobs and create 2,000 new apprenticeships by 2018.** *Collaboration asked of partners* Health and voluntary sector providers to help signpost residents to find the right advice, support and skills to overcome barriers to work, work with local employers to help encourage work experience and soft skills to help improve people's employment prospects and promote/contribute to delivering the Southwark Apprenticeship Standard. *Addressing health inequalities* People who are not in employment tend to have poorer physical and mental health compared to those in employment and people with poorer physical health and mental health tend to be more likely not to be in employment. Support people into employment, supporting those at risk of falling out of employment because of poor health & mental health and promoting best practice in healthier workplaces are one of Marmot's recommended policy drivers.
	Southwark Council will promote thriving town centres and high streets through initiatives such as the high street challenge to bring about a greater mix of shops, encourage people to shop locally and create a 'healthy' high street. *Collaboration asked of partners* Partners are asked to engage effectively in the promotion of local high streets and town centres and also encourage healthier high streets through stopping the spread of betting shops and encouraging a greater mix of shops and businesses in our centres. *Addressing health inequalities*

	'Unhealthier town centres' (a town centre that supports unhealthy choices) tend to be in more deprived areas and tend to 'normalise' unhealthy choices.
2.5 Increase the resilience and capacity of our communities	**Southwark Council will stop the spread of pawnbrokers, betting shops, gambling machines and pay day lenders and promote financial well-being and independence among residents.** *Collaboration asked of partners* Partners are asked to work together to support the provision of quality debt advice particularly for those affected by welfare reform. This includes working across borough boundaries to help the most vulnerable/those furthest from the labour market out of welfare and into work. *Addressing health inequalities* Very high interest loans and problem gambling tend to most affect those who are least able to afford them and have a inter-relationship with poorer mental health and wellbeing.

3. Improved outcomes for most vulnerable & support for more independent living	
3.1 Support young people who are vulnerable and ensure their transition into adulthood is positive	**Southwark Council will guarantee education, employment or training for every school leaver by 2015/16 and open a credit union account with a £10 opening deposit for every 11 year old** *Collaboration asked of partners* Partners are asked to contribute to securing opportunities for young people whether through work experience, signposting or advice and in particular to work with the local credit union to promote the benefits of sound money management. *Addressing health inequalities* Employment, income and debt are inextricably linked to impacts on health.

HOUSING ASKS

Priority themes & work areas	My organization will contribute to the HWB priority by: We are asking HWB partners to collaborate on: Health inequalities is addressed by:
2. Root causes of ill health & healthier & more resilient communities	
2.2 Make every home warm, dry and safe	**Southwark Council will have an improvement programme for Council homes and will also implement a licensing and accreditation scheme for private landlords to drive up standards in the private rented sector.** *Collaboration asked of partners* Health and Voluntary Sector professionals are asked to report rogue landlords and letting agencies so that tough enforcement action can be taken. *Addressing health inequalities* Over 25% of households in Southwark live in private rented sector and people who are on the lowest incomes in the private rented sector who are most vulnerable to unscrupulous landlords.

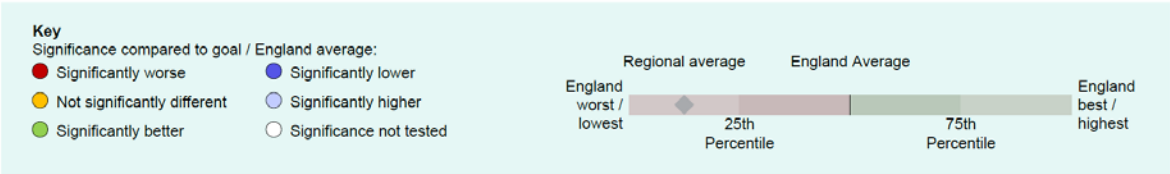
2.5 Increase the resilience and capacity of our communities	**Southwark Council's Housing Strategy will support and encourage residents to take pride and responsibility in their homes and local area** *Collaboration asked of partners* Southwark Council will promote resident involvement and provide advice to tenants on their rights and responsibilities. The voluntary sector and community groups are asked to help vulnerable tenants to understand their rights and responsibilities. Partner agencies are asked to report antisocial behaviour and vulnerability. *Addressing health inequalities* Vulnerable people (eg older people, people with disabilities) are less likely to understand their rights and less likely to report antisocial behaviour.
3. Improved outcomes for most vulnerable & support for more independent living	
3.1 Support young people who are vulnerable and ensure their transition into adulthood is positive	**Southwark Council will have a comprehensive programme to prevent homelessness by delivering specialist including tenancy support and advice to people who are at risk of becoming homeless** *Collaboration asked of partners* Partners are asked to work together to support the provision of quality debt advice particularly those affected by welfare reform. Partners are asked to undergo shared training on homeless protocols. *Addressing health inequalities* Homelessness and health are closely related: poor health is both a cause and a result of homelessness. People who are homeless are three to six times more likely to become ill than housed people.

FREE SWIMMING & GYM ASKS

Priority	My organization will contribute to the HWB priority by: We are asking HWB partners to collaborate on: Health inequalities is addressed by:
2. Root causes of ill health & healthier & more resilient communities	
2.3 Promote positive lifestyle changes and encourage individuals to take responsibility for their own health	**Southwark Council will deliver free swimming and gyms for local residents.** *Collaboration asked of partners* All health & wellbeing board partners are asked to promote the Council's offer of free swimming and gyms to those who should be benefiting from it the most, particularly low income residents and those suffering from or at risk of developing through physical inactivity, ill health. NHS partners are asked to provide brief advice on the benefits of physical activity and to make physical activity referrals though the Kickstart, exercise on referral and the Health Checks Passport schemes. *Addressing health inequalities* People with additional needs have poorer health and will be supported through targeted programmes (eg Exercise on referral, health checks activity passport, KickStart)

Appendix 4 Public Health Outcome Framework

To be further shaped in consultation



Overarching indicators

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
0.1i - Healthy life expectancy at birth (Male)	2010 - 12	60.3	63.4	52.5		70.0
0.1i - Healthy life expectancy at birth (Female)	2010 - 12	62.5	64.1	55.5		71.0
0.1ii - Life Expectancy at birth (Male)	2010 - 12	78.0	79.2	74.0		82.1
0.1ii - Life Expectancy at birth (Female)	2010 - 12	83.1	83.0	79.5		85.9
0.1ii - Life Expectancy at 65 (Male)	2010 - 12	17.9	18.6	15.8		20.9
0.1ii - Life Expectancy at 65 (Female)	2010 - 12	21.4	21.1	18.8		23.8
0.2i - Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (Male)	2010 - 12		9.2			
0.2i - Slope index of inequality in life expectancy at birth based on national deprivation deciles within England (Female)	2010 - 12		6.8			
0.2ii - Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Male)	2010 - 12		73			
0.2ii - Number of upper tier local authorities for which the local slope index of inequality in life expectancy (as defined in 0.2iii) has decreased (Female)	2010 - 12		73			
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Male)	2010 - 12	7.1	-	3.9		16.0
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area (Female)	2010 - 12	7.3	-	1.3		11.4
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Male)	2010 - 12	-1.2	0.0	-5.2		2.9
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole (Female)	2010 - 12	0.1	0.0	-3.5		2.9
0.2v - Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Male)	2010 - 12		19.4			
0.2v - Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (Female)	2010 - 12		19.8			

Wider determinants of health

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
1.01i - Children in poverty (all dependent children under 20)	2011	30.8	20.1	46.1		6.6
1.01ii - Children in poverty (under 16s)	2011	30.7	20.6	43.6		6.9
1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception	2012/13	59.6	51.7	27.7		69.0
1.02i - School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2012/13	51.6	36.2	17.8		60.0

Wider determinants of health continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
1.02ii - School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	2012/13	72.0	69.1	58.8		79.0
1.02iii - School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2012/13	67.8	55.8	37.2		70.9
1.03 - Pupil absence	2012/13	4.74	5.26	6.31		4.36
1.04 - First time entrants to the youth justice system	2013	707	441	847		171
1.05 - 16-18 year olds not in education employment or training	2013	2.9	5.3	9.8		1.8
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Persons)	2012/13	73.1	73.5	32.6		96.6
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Male)	2012/13	71.5	73.2	32.2		97.9
1.06i - Adults with a learning disability who live in stable and appropriate accommodation (Female)	2012/13	75.8	74.0	33.3		97.9
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons)	2012/13	70.0	58.5	5.5		94.1
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Male)	2012/13	69.4	57.3	5.2		92.7
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation (Female)	2012/13	70.9	59.8	5.5		96.2
1.07 - People in prison who have a mental illness or a significant mental illness	2012/13		4.35			
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	2012	12.4	7.1	-5.3		21.7
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	2013/14	62.3	65.1	46.7		79.1
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	2012/13	65.0	62.3	53.1		75.1
1.09i - Sickness absence - The percentage of employees who had at least one day off in the previous week	2010 - 12	1.9	2.5	4.6		0.8
1.09ii - Sickness absence - The percent of working days lost due to sickness absence	2010 - 12	0.7	1.6	3.1		0.4
1.10 - Killed and seriously injured (KSI) casualties on England's roads	2011 - 13	37.5	39.7	78.9		16.6
1.11 - Domestic Abuse	2012/13	18.6	18.8	5.6		30.2
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	2010/11 - 12/13	81.0	57.6	167.8		9.3
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population	2013/14	18.3	11.1	4.6		27.8
1.12iii- Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population	2013/14	1.53	1.01	0.38		2.43
1.13i - Re-offending levels - percentage of offenders who re-offend	2011	26.2	26.9	14.4		36.3
1.13ii - Re-offending levels - average number of re-offences per offender	2011	0.67	0.78	0.31		1.27
1.14i - The rate of complaints about noise	2012/13	23.7	7.5	80.4		2.5
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	2011	14.3	5.2	0.8		20.8
1.14iii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	2011	17.2	8.0	1.2		42.4
1.15i - Statutory homelessness - homelessness acceptances	2013/14	4.3	2.3	0.1		12.5
1.15ii - Statutory homelessness - households in temporary accommodation	2013/14	6.1	2.6	29.7		0.0
1.16 - Utilisation of outdoor space for exercise/health reasons	Mar 2013 - Feb 2014	9.6	17.1	0.3		30.8
1.17 - Fuel Poverty	2012	6.4	10.4	21.3		4.9
1.18i - Social isolation: % of adult social care users who have as much social contact as they would like	2012/13	40.1	43.2	31.9		53.5

Wider determinants of health continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
1.18ii - Social isolation: % of adult carers who have as much social contact as they would like	2012/13	28.6 $	41.3	23.9		58.5
1.19i - Older people's perception of community safety - safe in local area during the day	2012/13		97.5			
1.19ii - Older people's perception of community safety - safe in local area after dark	2012/13		61.9			
1.19iii - Older people's perception of community safety - safe in own home at night	2012/13		94.3			

Health improvement

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
2.01 - Low birth weight of term babies	2012	2.7	2.8	5.0		1.5
2.02i - Breastfeeding - Breastfeeding initiation	2013/14	88.1	73.9	36.6		93.0
2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	2013/14	- x	-	19.4		77.4
2.03 - Smoking status at time of delivery	2013/14	3.8	12.0	27.5		1.9
2.04 - Under 18 conceptions	2012	31.8	27.7	52.0		14.2
2.04 - Under 18 conceptions: conceptions in those aged under 16	2012	4.7	5.6	15.8		2.0
2.06i - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2012/13	26.7	22.2	32.2		16.1
2.06ii - Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2012/13	44.2	33.3	44.2		24.1
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2012/13	108.6	103.8	191.3		61.7
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	2012/13	122.5	134.7	282.4		76.0
2.07iii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2012/13	104.4	130.7	277.3		63.8
2.08 - Emotional well-being of looked after children	2012/13	11.0	14.0	9.4		21.5
2.09ii - Smoking prevalence age 15 years - regular smokers	2013		8			
2.09iii - Smoking prevalence age 15 years - occasional smokers	2013		10			
2.12 - Excess Weight in Adults	2012	56.3	63.8	74.4		45.9
2.13i - Percentage of physically active and inactive adults - active adults	2013	56.5	55.6	43.4		66.3
2.13ii - Percentage of active and inactive adults - inactive adults	2013	27.0	28.9	39.2		16.3
2.14 - Smoking Prevalence	2013	20.7	18.4	29.4		10.5
2.14 - Smoking prevalence - routine & manual	2013	29.3	28.6	47.5		16.5
2.15i - Successful completion of drug treatment - opiate users	2013	6.0	7.8	3.5		15.8
2.15ii - Successful completion of drug treatment - non-opiate users	2013	34.2	37.7	7.6		60.2
2.16 - People entering prison with substance dependence issues who are previously not known to community treatment	2012/13	58.6	46.9	69.8		19.7
2.17 - Recorded diabetes	2012/13	4.94 ^	6.01	3.69		8.42
2.18 - Alcohol related admissions to hospital (Persons)	2012/13	641	637	1121		365
2.18 - Alcohol related admissions to hospital (Male)	2012/13	945	829	1425		454
2.18 - Alcohol related admissions to hospital (Female)	2012/13	374	465	839		269
2.19 - Cancer diagnosed at early stage (Experimental Statistics)	2012	39.1	41.6	34.4		60.3
2.20i - Cancer screening coverage - breast cancer	2014	64.1	75.9	57.4		83.7
2.20ii - Cancer screening coverage - cervical cancer	2014	72.5	74.2	59.5		79.7
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy	2012/13	79.1 ^	79.1	66.0		94.8

Health improvement continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
2.22iii - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check	2013/14	33.1	18.4	0.8		44.4
2.22iv - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	2013/14	33.0	49.0	14.6		100
2.22v - Cumulative % of the eligible population aged 40-74 who received an NHS Health check	2013/14	10.9	9.0	0.9		29.1
2.23i - Self-reported well-being - people with a low satisfaction score	2012/13	6.7 ^	5.8	10.1		3.4
2.23ii - Self-reported well-being - people with a low worthwhile score	2012/13	4.4 ^	4.4	8.2		2.9
2.23iii - Self-reported well-being - people with a low happiness score	2012/13	9.7	10.4	15.8		5.5
2.23iv - Self-reported well-being - people with a high anxiety score	2012/13	21.9	21.0	29.0		10.9
2.23v - Average Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) score	2010 - 12		37.7			
2.24i - Injuries due to falls in people aged 65 and over (Persons)	2012/13	2941	2011	3508		1178
2.24i - Injuries due to falls in people aged 65 and over (males/females) (Male)	2012/13	2665	1602	2975		903
2.24i - Injuries due to falls in people aged 65 and over (males/females) (Female)	2012/13	3217	2420	4041		1452
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79	2012/13	1446	975	1826		544
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+	2012/13	7276	5015	9119		2876

Health protection

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
3.01 - Fraction of mortality attributable to particulate air pollution	2012	7.1	5.1	3.0		7.7
3.02i - Chlamydia screening detection rate (15-24 year olds) - Old NCSP data < 2000 2000 to 2400 ≥ 2400	2011	4383	2092	948		4911
3.02ii - Chlamydia detection rate (15-24 year olds) - CTAD (Persons) < 1900 1900 to 2300 ≥ 2300	2013	3218	2016	840		5758
3.02ii - Chlamydia detection rate (15-24 year olds) - CTAD (Male) < 1900 1900 to 2300 ≥ 2300	2013	2334	1387	599		4262
3.02ii - Chlamydia detection rate (15-24 year olds) - CTAD (Female) < 1900 1900 to 2300 ≥ 2300	2013	3554	2634	1094		6358
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	2012/13	97.8 ^	-	40.0		100
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2012/13	91.4 ^	-	9.1		100
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old) < 90 ≥ 90	2012/13	91.1 ^	94.7	79.0		99.0
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old) < 90 ≥ 90	2012/13	93.1 ^	96.3	81.9		99.4
3.03iv - Population vaccination coverage - MenC < 90 ≥ 90	2012/13	90.3 ^	93.9	75.9		98.8
3.03v - Population vaccination coverage - PCV < 90 ≥ 90	2012/13	90.6 ^	94.4	78.7		99.0
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old) < 90 ≥ 90	2012/13	84.8 ^	92.7	77.0		98.3
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years) < 90 ≥ 90	2012/13	86.2 ^	91.5	75.7		98.1
3.03vii - Population vaccination coverage - PCV booster < 90 ≥ 90	2012/13	85.3 ^	92.5	75.1		97.5
3.03viii - Population vaccination coverage - MMR for one dose (2 years old) < 90 ≥ 90	2012/13	85.7 ^	92.3	77.4		98.4

Note: ^ - Value estimated

Health protection continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
3.03ix - Population vaccination coverage - MMR for one dose (5 years old) < 90 ≥ 90	2012/13	89.0 ^	93.9	82.1		98.3
3.03x - Population vaccination coverage - MMR for two doses (5 years old) < 90 ≥ 90	2012/13	78.9 ^	87.7	68.9		97.0
3.03xii - Population vaccination coverage - HPV < previous years England average ≥ previous years England average	2012/13	66.9 ^	86.1	62.1		96.2
3.03xiii - Population vaccination coverage - PPV < previous years England average ≥ previous years England average	2012/13	55.5 ^	69.1	55.3		77.0
3.03xiv - Population vaccination coverage - Flu (aged 65+) < 75 ≥ 75	2012/13	70.4 ^	73.4	65.5		80.8
3.03xv - Population vaccination coverage - Flu (at risk individuals) < 75 ≥ 75	2012/13	49.0 ^	51.3	44.2		68.8
3.04 - People presenting with HIV at a late stage of infection < 25 25 to 50 ≥ 50	2010 - 12	42.9	48.3	80.0		0.0
3.05i - Treatment completion for TB < 85 ≥ 85	2012	83.1	82.8	22.6		100
3.05ii - Incidence of TB	2010 - 12	37.8	15.1	112.3		0.0
3.06 - NHS organisations with a board approved sustainable development management plan	2013/14	33.3	41.6	0.0		83.3

Healthcare and premature mortality

	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
4.01 - Infant mortality	2010 - 12	4.2	4.1	7.5		1.1
4.02 - Tooth decay in children aged 5	2011/12	0.79	0.94	2.10		0.35
4.03 - Mortality rate from causes considered preventable (Persons)	2011 - 13	212.1	183.9	319.7		130.3
4.03 - Mortality rate from causes considered preventable (Male)	2011 - 13	291.9	233.1	409.1		166.5
4.03 - Mortality rate from causes considered preventable (Female)	2011 - 13	140.6	138.0	235.2		93.7
4.04i - Under 75 mortality rate from all cardiovascular diseases (Persons)	2011 - 13	94.4	78.2	137.0		52.1
4.04i - Under 75 mortality rate from all cardiovascular diseases (Male)	2011 - 13	138.9	109.5	184.9		75.0
4.04i - Under 75 mortality rate from all cardiovascular diseases (Female)	2011 - 13	53.2	48.6	91.2		29.9
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2011 - 13	60.9	50.9	89.0		30.7
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2011 - 13	94.8	76.7	130.9		46.2
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2011 - 13	29.4	26.5	57.1		14.5
4.05i - Under 75 mortality rate from cancer (Persons)	2011 - 13	153.8	144.4	198.9		104.0
4.05i - Under 75 mortality rate from cancer (Male)	2011 - 13	168.8	160.9	230.7		113.8
4.05i - Under 75 mortality rate from cancer (Female)	2011 - 13	140.7	129.2	182.3		95.5
4.05ii - Under 75 mortality rate from cancer considered preventable (Persons)	2011 - 13	97.4	83.8	126.9		52.7
4.05ii - Under 75 mortality rate from cancer considered preventable (Male)	2011 - 13	110.2	91.3	148.1		46.9
4.05ii - Under 75 mortality rate from cancer considered preventable (Female)	2011 - 13	86.2	76.9	118.2		55.6
4.06i - Under 75 mortality rate from liver disease (Persons)	2011 - 13	27.9	17.9	43.4		11.3
4.06i - Under 75 mortality rate from liver disease (Male)	2011 - 13	42.7	23.6	58.9		14.3

Healthcare and premature mortality continued	Period	Local value	Eng. value	Eng. worst	Range	Eng. best
4.06i - Under 75 mortality rate from liver disease (Female)	2011 - 13	13.9	12.5	27.7		7.4
4.06ii - Under 75 mortality rate from liver disease considered preventable (Persons)	2011 - 13	26.7	15.7	39.5		9.6
4.06ii - Under 75 mortality rate from liver disease considered preventable (Male)	2011 - 13	41.6	21.1	54.4		12.4
4.06ii - Under 75 mortality rate from liver disease considered preventable (Female)	2011 - 13	12.7	10.5	24.5		6.4
4.07i - Under 75 mortality rate from respiratory disease (Persons)	2011 - 13	40.1	33.2	78.1		19.5
4.07i - Under 75 mortality rate from respiratory disease (Male)	2011 - 13	52.9	39.1	94.6		23.0
4.07i - Under 75 mortality rate from respiratory disease (Female)	2011 - 13	28.2	27.6	67.1		14.2
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Persons)	2011 - 13	25.8	17.9	46.6		7.6
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Male)	2011 - 13	34.0	20.4	52.9		10.6
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (Female)	2011 - 13	18.3	15.5	41.4		7.6
4.08 - Mortality from communicable diseases (Persons)	2011 - 13	66.6	62.2	93.8		36.0
4.08 - Mortality from communicable diseases (Male)	2011 - 13	86.8	72.1	117.0		45.9
4.08 - Mortality from communicable diseases (Female)	2011 - 13	54.1	56.2	91.4		30.9
4.09 - Excess under 75 mortality rate in adults with serious mental illness	2011/12	313.8	337.4	510.4		124.7
4.10 - Suicide rate (Persons)	2011 - 13	7.5	8.8	13.6		4.5
4.10 - Suicide rate (Male)	2011 - 13	14.4	13.8	21.9		8.0
4.10 - Suicide rate (Female)	2011 - 13	- x	4.0	6.6		2.2
4.11 - Emergency readmissions within 30 days of discharge from hospital (Persons)	2011/12	13.0	11.8	14.5		8.8
4.11 - Emergency readmissions within 30 days of discharge from hospital (Male)	2011/12	14.2	12.1	14.9		8.7
4.11 - Emergency readmissions within 30 days of discharge from hospital (Female)	2011/12	11.8	11.5	14.7		8.3
4.12i - Preventable sight loss - age related macular degeneration (AMD)	2012/13	65.3	104.4	31.7		221.3
4.12ii - Preventable sight loss - glaucoma	2012/13	9.6	12.5	2.8		29.3
4.12iii - Preventable sight loss - diabetic eye disease	2012/13	3.6	3.5	1.1		14.0
4.12iv - Preventable sight loss - sight loss certifications	2012/13	19.8	42.3	13.5		79.8
4.13 - Health related quality of life for older people	2012/13	0.693	0.726	0.636		0.793
4.14i - Hip fractures in people aged 65 and over	2012/13	653.7	568.1	808.4		403.1
4.14ii - Hip fractures in people aged 65 and over - aged 65-79	2012/13	330.2	237.3	401.7		121.8
4.14iii - Hip fractures in people aged 65 and over - aged 80+	2012/13	1592	1528	2150		1108
4.15i - Excess Winter Deaths Index (Single year, all ages)	Aug 2011 - Jul 2012	13.8	16.1	30.7		2.1
4.15ii - Excess Winter Deaths Index (single year, ages 85+)	Aug 2011 - Jul 2012	31.2	22.9	53.1		-7.6
4.15iii - Excess Winter Deaths Index (3 years, all ages)	Aug 2009 - Jul 2012	17.7	16.5	27.4		6.4
4.15iv - Excess Winter Deaths Index (3 years, ages 85+)	Aug 2009 - Jul 2012	31.8	22.6	38.5		11.3
4.16 - Estimated diagnosis rate for people with dementia	2012/13		48.7			

Improving health in Southwark

APPENDIX 2

THIS IS HOW WE'LL DO IT

Best start

Ensure best possible start to life for children, young people & families

Tackling neglect & vulnerabilities

Support vulnerable children & young people & ensure positive transition to adulthood

Ensure choice & personalisation for people with disabilities

Independent living for older people in an age friendly borough

Wider socio - economic determinants

Maximise opportunities for economic wellbeing, development, jobs & apprenticeships

Make homes safe, warm & dry

Prevention

Promote positive lifestyle changes & responsibility for own health: tobacco control & smoking; healthy weight; physical activity, alcohol, sexual health & HIV

Improve people's wellbeing, resilience & connectedness

Integration for better health & wellbeing outcomes

A more joined up service that is personalised

Shift away from over reliance on acute care towards primary care & self care

Long term health conditions

Improve detection & management of common health conditions including self management & support

Southwark Health & Wellbeing Board

Health & Wellbeing Strategy 2015 - 2020

Agenda Item 11

Item No. 11.	Classification: Open	Date: 29 January 2015	Meeting Name: Health and Wellbeing Board
Report title:		Tobacco Control in Southwark	
Wards or groups affected:		All	
From:		Ruth Wallis, Director of Public Health, Lambeth and Southwark	

RECOMMENDATIONS

1. The board is requested to:

   a) Receive the update of Tobacco Control In Southwark
   b) Endorse the evidence based multi-pronged tobacco control approach, ensuring tobacco control is a significant element to improve health and tackle health inequalities
   c) Agree and align tobacco control priorities across the Partnership. Partnership priorities for Tobacco Control should Include:
      - Prevention: Incorporating preventing tobacco use (including shisha) within a whole school health and wellbeing approach
      - Promoting access to evidence based commissioned stop smoking services, that have a more targeted approach to supporting priority groups (pregnant women, unemployed, LTC including mental health)
      - More systematic approach and better resourcing to effectively tackle illicit tobacco sales
   d) Encourage partners to be exemplars through more "explicit" workforce / workplace polices
   e) Encourage the signing of the NHS Statement of Support for Tobacco Control by the Southwark CCG and local acute trusts

EXECUTIVE SUMMARY

2. A Health and Wellbeing Partnership Board informal seminar focusing on tobacco control was held in December 2014. This paper summarises the update provided at the seminar.

   Tobacco Control is a range of supply, demand and reducing harm strategies that aim to improve the health of the population by eliminating or reducing their consumption of tobacco products and exposure to tobacco smoke. There is clear evidence that the most effective tobacco control strategies involve taking a multi-faceted and comprehensive approach at both national and local levels.

   Tobacco Control requires a structure that supports clear accountability and strategic decision making as well as allowing for a wide range of partners (local authority, health, police, fire brigade, HMRC, voluntary sector, prison service) with different fields of expertise and interests to engage at different levels. This structure locally is in the form of the Lambeth and Southwark Tobacco Control Alliance in which the core functions of advocacy, communications, planning, monitoring and evaluation occurs. The Alliance advises and oversees the development of activities relating to tobacco control in Lambeth and Southwark.

The Alliance champions tobacco control at a local level and ensures a coordinated approach to the different strands of work and that work is based on best practice.

Tobacco Control should be central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups.

BACKGROUND INFORMATION

3. Addressing tobacco in Southwark is a priority because:

- Smoking is the major single cause of preventable ill health and premature death in Southwark.
- It is a main contributor of Health Inequalities
- Harms others through Secondhand smoke
- Harms families & communities
- Spending on tobacco contributes to Child Poverty
- Illicit tobacco fuels Crime and disrupts Community Safety

Key Southwark Facts

- 20.7% of adults smoke (estimated 46,761 people)
- 29.3% from routine and manual groups smoke.
- 3.8% women are smoking at the time of giving birth
- 73% of smokers were offered illegal tobacco in the last year
- 56.4% smokers bought illegal tobacco in the last year
- 22% of adults had smoked shisha
- 46% of secondary school pupils stated they had smoked shisha

KEY ISSUES FOR CONSIDERATION

4. Compared to the rest of the country, Southwark has similar figures for

- Smoking prevalence
- Smoking prevalence of routine and manual workers

Compared to the rest of the country Southwark is statistically significantly higher in:

- Lung Cancer Registrations
- Deaths from lung cancer (2011- 13)
- Deaths from COPD (2011- 13)
- Smoking attributable mortality) /100,000 (2011-13)

Smoking prevalence has reduced over the last 10 years due to:

- less young people taking up smoking
- national smoke free bans in public places enforced in 2007
- more education in regards to the harm of smoking
- encouraging people to quit with more suitable services now available
- national government commitment to a comprehensive tobacco control approach

Reasons for why the health outcomes for smoking related diseases are relatively poor in Southwark when prevalence is dropping are complex. Smoking related health outcomes relate to the level and duration of tobacco addiction of smokers and ex-smokers; exposure to secondhand smoke; the stage at which the condition was detected: and provision of appropriate primary, secondary and tertiary care.

Policy implications

5. A range of interventions working in synergy is required to reduce tobacco use. An evidence based multi-pronged approach should consist of interventions to:

- Stop the promotion of tobacco, thereby reducing uptake
- Make tobacco less affordable
- Effectively regulate tobacco products
- Reducing exposure to second hand smoke
- Help tobacco users to quit

There are elements of these interventions being implemented in Southwark but often not at the quality and scale to make significant impact. Currently peer education programmes are delivered in only three Southwark schools each a year. Last year Southwark trading standards seized 146,800 illegal cigarettes, 1.6kg counterfeit and 23kg smuggled hand rolled tobacco and 26kg shisha. However, local intelligence indicates that more resources are required to effectively tackle illegal sales.

32% of 453 Southwark pupils interviewed indicated that they lived in homes where smoking occurred. The implementation of a smokefree homes programme is adhoc. A smokefree playground policy is currently being considered.

The number of smokers that accessed the local stop smoking service and set a quit date in 2013-14 was 1,320 (per 100,000 population) similar to the national average. Of these, 563 (per 100,000 population) quit at 4 weeks, this is 125 (per 100,000 population) less than the national average. This equates to 43% quit rate compared to 51% nationally. A poor quit rate is defined below 35% of quitters accessing a particular stop smoking service. The stop smoking service overall in Southwark has achieved over 39% for the last 3 years.

Low quit rates can be caused by poor administrative and quality issues.

- Administrative issues
    - Errors in the recording of data and coding
    - Inconsistent use of templates
    - High lost to follow up (some lost to follow up are unrecorded quitters)

- Quality issues
    - Stop smoking advisors skills and competences vary – all are encouraged to have annual training. Clients need to be seen on a weekly basis due to the need for behavioural support. Many practices do not always adhere to this regime and behavioural support is limited.
    - Medication – there is a lack of routinely offering Varenicline (Champix), the most effective treatment. The majority of patients received Nicotine replacement therapy (51%) and only 17%

received “Champix”

Community and equalities impact statement

6. The smoking prevalence in routine and manual workers has reduced minimally over the last 10 years. There is a strong link between tobacco use and those from lower socio-economic groups and mental health users. Death rates from tobacco are two to three times higher among disadvantaged social groups than among the better off.

Evidence suggests that the following groups are more likely to be smokers:

- Those in routine and manual occupations
- Those with a mental disorder (which includes those with mental illness or alcohol problems or substance misuse problems)
- Those living in unstable circumstances e.g. low income, homeless
- Young adults
- Those from certain ethnic groups

Lambeth and Southwark Public Health is in the process of conducting a health equity audit of the Southwark stop smoking service. An initial analysis of the profile of users has been done, but the quality of the available service data is poor. For instance 57.8% of patients had no socio-economic status recorded compared to the national average of 13.8%. Of those who had been coded, the majority of smokers accessing the service were not working and had never worked or been unemployed for over a year (24%), were retired (16%), or were sick and unable to work (14%). Those in managerial and professional occupations, as well as those in intermediate occupations were more likely to report a successful quit than other groups (60%). Older smokers were more likely to report successfully quitting than younger smokers. There was little difference in successful quit rates between males and females. Black (39%) and mixed (35%) ethnic groups were slightly less likely to self report a successful quit than others.

The Health Equity Audit once completed, will provide more understanding of whether those with greatest need have the same opportunity of stop smoking service access and successful quitting as the rest of the population.

Legal implications

7. N/A

Financial implications

8. Reducing smoking prevalence is one of the Public Health outcomes; financial implications will depend on the locally agreed level of ambition to reduce smoking in Southwark. Resources will be required for all the evidenced based interventions, in addition to smoking cessation service which has been proven to save £10 in future health care costs for every £1 invested.

BACKGROUND PAPERS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
None	

AUDIT TRAIL

Lead Officer	Ruth Wallis, Director of Public Health, Lambeth and Southwark
Report Author	Bimpe Oki, Consultant in Public Health, Lambeth and Southwark
Version	Final
Dated	21 January 2015
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Strategic Director of Children's and Adults' Services	No	No
Date final report sent to Constitutional Team		21 January 2015

Agenda Item 12

Item No. 12.	Classification: Open	Date: 29 January 2015	Meeting Name: Health and Wellbeing Board
Report title:		Southwark Pharmaceutical Needs Assessment (PNA) Consultation	
Wards or groups affected:		All	
From:		Dr Ruth Wallis, Director of Public Health	

RECOMMENDATIONS

1. The board is requested to note that:

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

EXECUTIVE SUMMARY

2. Southwark's Health and Wellbeing Board (HWB) has a statutory responsibility for developing a Pharmaceutical Needs Assessment (PNA) as set out under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (SI 2013 No. 349). A PNA is a document which records the assessment of the need for pharmaceutical services within a specific area.v The same Regulations require NHS England to use the PNA to consider applications to open a new pharmacy, move an existing pharmacy or to commission additional services from pharmacy.

BACKGROUND INFORMATION

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

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

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

As part of the development process, the Regulations require that the HWB undertakes a formal consultation on a draft of its PNA. This is running from 19 December 2014 until midnight on 28 February 2015. The draft PNA for consultation and associated appendices can be found on our website via the following link: www.southwark.gov.uk/pna A paper version of the PNA can be obtained by contacting Claudia Craig via email Claudia.Craig@southwark.gov.uk who will arrange to provide this within 14 days of your request.

All responses to the consultation have been requested in writing, using the standard questionnaire which has been developed to facilitate comment and feedback. The feedback consultation questionnaire can be downloaded on our website www.southwark.gov.uk/pna. A return email and address has been provided.

KEY ISSUES FOR CONSIDERATION

4. As part of the consultation we are asking respondents to consider whether:

- the purpose, scope and local context of the PNA been explained sufficiently within the draft PNA document
- there is a reasonable description of what is currently provided by pharmacies currently and if anything is missing from the document that is currently provided
- the accuracy of understanding of the pharmaceutical needs of the population clearly reflected in the draft PNA
- respondents agree with the conclusions reached and any additional information required
- sufficient information has been provided for market entry and how service commissioners may wish to commission services from pharmacies in the future.

Policy implications

5. Not applicable

Community and equalities impact statement

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

Legal implications

7. From the 1st April 2013 the Health and Wellbeing Board has a statutory responsibility to assess the needs for pharmaceutical services in Southwark. There is a legal requirement for Southwark's Health & Wellbeing Board to publish a new PNA by the 1st April 2015. The PNA report will assist the board in fulfilling this requirement.

Financial implications

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

BACKGROUND PAPERS

Background Papers	Held At	Contact
Draft PNA	www.southwark.gov.uk/pna	Claudia Graig 020 7525 0280

APPENDICES

No.	Title
None	

AUDIT TRAIL

Lead Officer	Dr Ruth Walls, Director of Public Health
Report Author	Dr Hiten Dodhia, Consultant in Public Health
Version	Final
Dated	16 January 2015
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Strategic Director of Children's and Adults' Services	No	No
Date final report sent to Constitutional Team		21 January 2015

Agenda Item 13

Item No. 13.	Classification: Open	Date: 29 January 2015	Meeting Name: Health & Wellbeing Board
Report title:		Director of Public Health Report – Lambeth & Southwark	
Ward(s) or groups affected:		All wards	
From:		Director of Public Health	

RECOMMENDATION(S)

1. That the Board note the Director of Public Health Report covering the period October to December 2014 attached as Appendix 1 to the report.

BACKGROUND INFORMATION

2. Director of Public Health reports periodically on health issues in the borough.

KEY ISSUES FOR CONSIDERATION

3. This report is a quarterly report of the Joint Director of Public Health to the Lambeth & Southwark Health and Wellbeing Boards and the Lambeth & Southwark clinical commissioning groups. This report covers the current health intelligence work streams:

- Update on the annual public health reports for Lambeth and Southwark
- Public Health Outcomes Framework – update on Health Care Public Health domain
- Update on Marmot indicators
- Joint Strategic Needs Assessment (JSNA)
  - Web site development
  - New factsheets on suicides
  - Development of primary care profiles
  - Shisha survey in South East London
- Alcohol Licensing

Policy implications

4. This is an overview document and any implications for policy will be subject to a more detailed report

Resource implications

5. Any resource implications are set out in the Appendix attached.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	Director of Public Health Report – Lambeth & Southwark

AUDIT TRAIL

Lead Officer	Dr Ruth Wallis, Director of Public Health – Lambeth & Southwark	
Report Author	Dr Ruth Wallis, Director of Public Health – Lambeth & Southwark	
Version	Final	
Dated	21 January 2015	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team		21 January 2015

Working together for the public's health

Lambeth

Southwark Council

APPENDIX 1

Public Health in Lambeth and Southwark

Director of Public Health Report

October - December 2014

Lambeth and Southwark Public Health

Director of Public Health: Dr Ruth Wallis

Introduction

This is the quarterly report of the Director of Public Health for Lambeth and Southwark for the third quarter of 2014-15. The report is for the London boroughs of Lambeth and Southwark and Lambeth and Southwark Clinical Commissioning Groups as well as for all Health and Wellbeing Boards partners.

The aim of the quarterly reports is to update partners on the activities of the Lambeth and Southwark specialist public health team and work being done in partnership; and to provide information about current public health issues relevant to Lambeth and Southwark, including alerting people to areas of concern or risk.

This quarter summaries are from the health intelligence work streams, including an update on the annual public health reports for Lambeth and Southwark, Public Health Outcomes Framework – update on Health Care Public Health domain, update on Marmot indicators, Joint Strategic Needs Assessment – including web site development, new factsheet on suicides; summary of data section of; development of primary care profiles; key findings from the Shisha survey in South East London and alcohol licensing.

Comments and ideas for future topics are welcome. Please contact PHadmin@southwark.gov.uk

2. Annual Public Health Reports (APHR) – data section

The APHR data section is a supplemental indicator profile supporting the APHR. Indicators cover geography, population, life expectancy, infant mortality, teenage conceptions, mortality, long term condition prevalence and vital statistics.

Lambeth

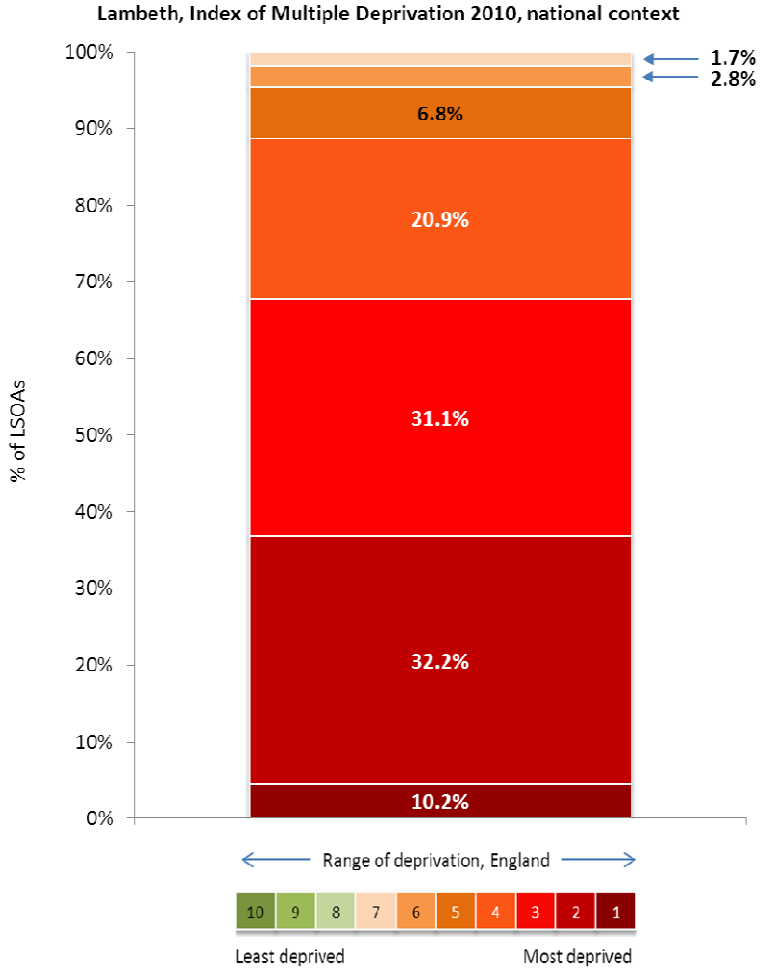
Lambeth is a densely populated, young ethnically diverse population with over 150 languages spoken. The resident population, 314,242, is estimated to increase by 9% over the next 10 years. Lambeth will remain a young borough in 2024 with 21% of the population aged under 20 and 50% of the population aged 20-44.

Lambeth records comparatively high levels of internal migration, migrant national insurance number registrations, estimates of non-UK born residents and migrant GP registrations. Lambeth has an ethnically diverse population with the Black, Asian and Minority Ethnic (BAME) community accounting for around 43% of the total population. Approximately 30% of people are classified as Black with almost equal proportions of Black African (12%) and Black Caribbean (9%). Projections estimate the

Black Caribbean population is likely to decrease by 6% in the next 10 years, compared to increase in the Black African population by 9%. The Chinese & Pakistani population will experience a population increase by 19% and 5% respectively. The projections suggest BAME overall will increase by 14%.

The 2010 Index of Multiple Deprivation (IMD) places Lambeth as the 9th most deprived borough in London and 29th most deprived in England. Variation of deprivation can be seen across the borough, 37% of Lower Super Output Areas (LSOAs) are in the 20% most deprived areas in England and 89% of LSOAs are in the 40% most deprived areas in England. Fig 1 shows the proportion of Lambeth LSOAs assigned to each deprivation range

Fig 1



Source: Index of Multiple Deprivation 2010 (IMD) [1]

The 2012 under-18 conception rate for Lambeth is 33.2 per 1,000 girls aged 15-17, representing an overall decline of 61.1% since 1998, the baseline, and a 65.4% reduction since 2003, when under 18

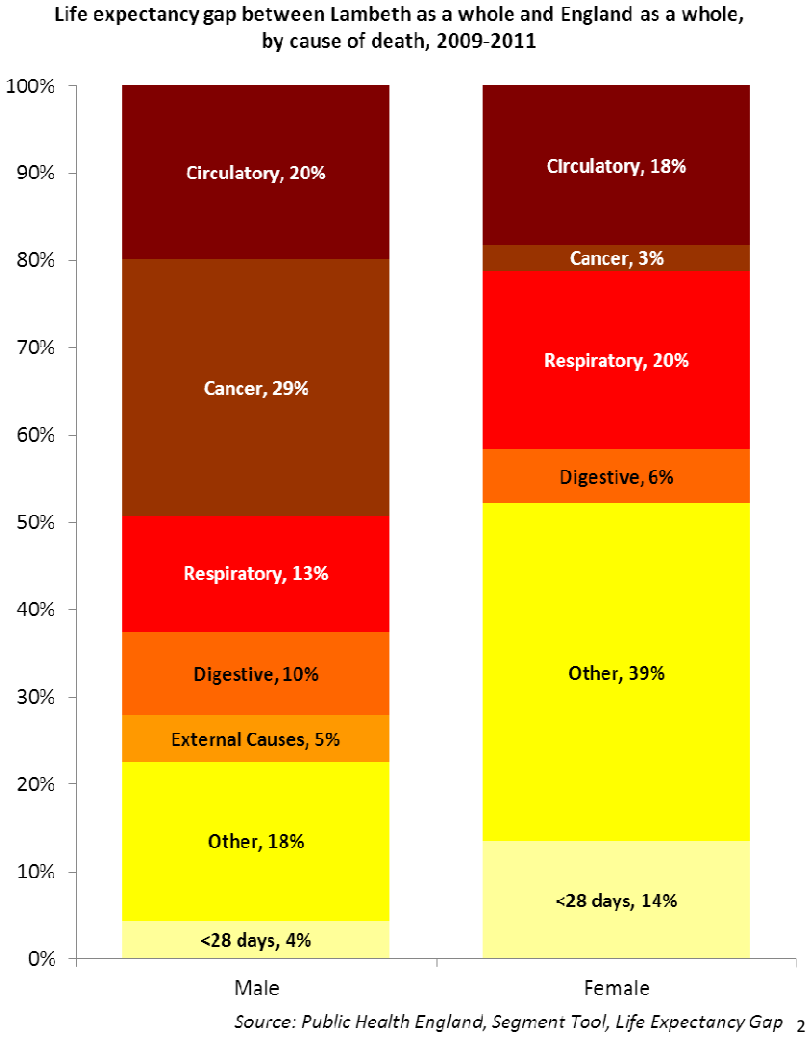
[1] Index of Multiple Deprivation 2010 (IMD)

conceptions rate was highest. That is a reduction from 415 in 2003 conceptions to 142 conceptions in 2012.

Infant mortality (deaths of infants aged under 1 year) has dropped from 8.8 per 1,000 live births in 1995-97 to 6.0 per 1,000 live births in 2010/12, which is a reduction of over 33%; however, there is still a gap when compared to the London and England rate.

At national level, Fig 2 shows life expectancy (LE) gap between Lambeth and England. For males and females, circulatory and respiratory conditions are key contributors to the LE gap. For males, cancer related deaths are also key, 2/3 of which were due to lung cancer. Chronic obstructive pulmonary disease explained 100% of male and 60% of female respiratory disease gap.

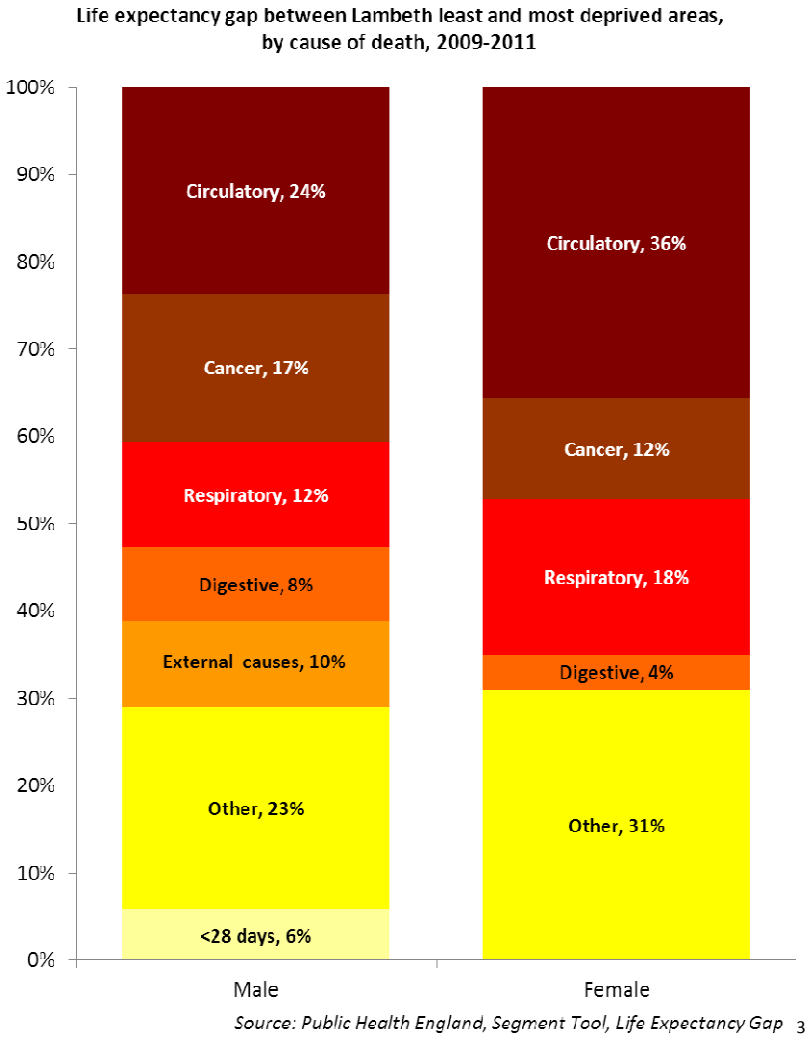
Fig 2



[2] Public Health England, Segment Tool, Life Expectancy Gap

At local level, Fig 3 shows LE gap between Lambeth's least and most deprived areas. For males and females, circulatory and respiratory conditions are key contributors to the LE gap. Heart disease explains 1/3 of male and 2/3 of female circulatory disease. Chronic obstructive pulmonary disease explained 100% of male and 50% of female respiratory disease gap.

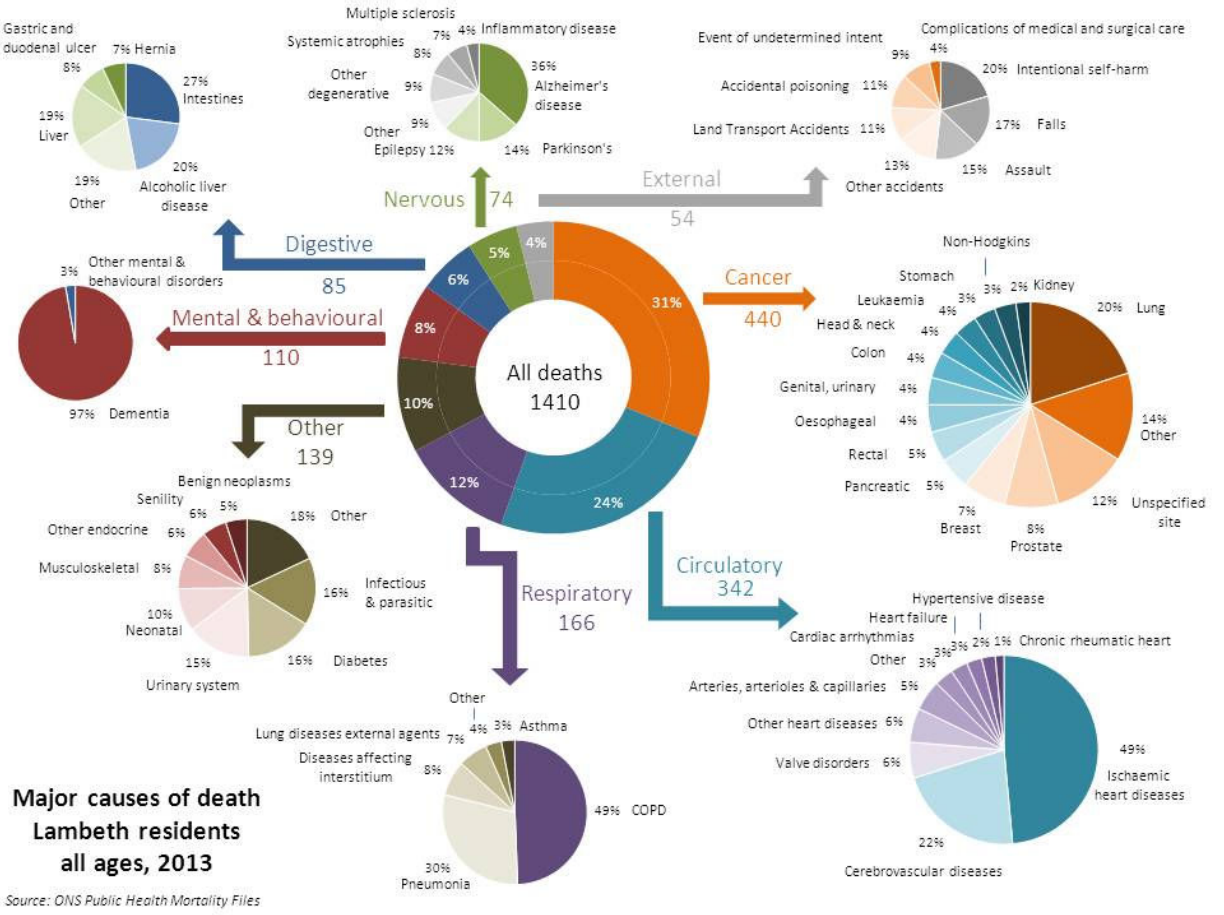
Fig 3



[3] Public Health England, Segment Tool, Life Expectancy Gap

The pie charts in Fig 4 show the proportion each cause of death contributes to total deaths. In 2013 there were 1,410 deaths to Lambeth residents. Cancer is the largest cause of death (31%) followed by circulatory disease (24%).

Fig 4



4

Southwark

Southwark is a densely populated, young ethnically diverse population with over 300 languages spoken. The resident population of 299,304 is estimated to increase by 16% over the next 10 years. Southwark will remain a young borough in 2024 with 23% of the population aged under 20 and 48% of the population aged 20-44.

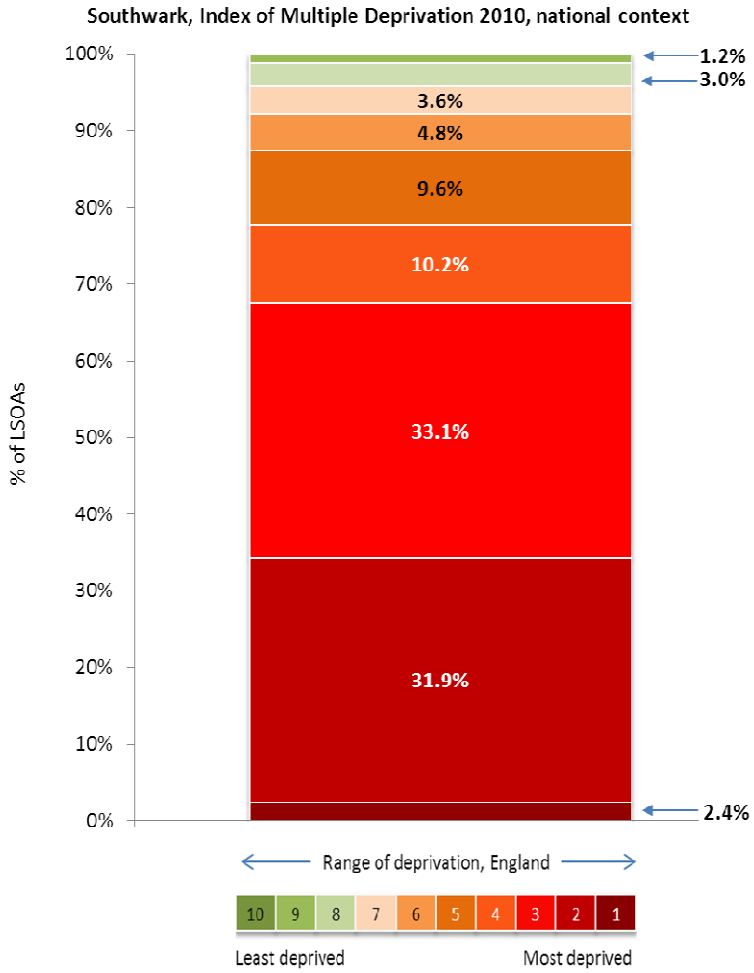
Southwark records comparatively high levels of internal migration, migrant national insurance number registrations, estimates of non-UK born residents and migrant GP registrations. Southwark has an ethnically diverse population with the Black, Asian and Minority Ethnic (BAME) community accounting

[4] ONS Public Health Mortality Files

for around 47% of the total population. Approximately 30% of people are classified as Black with a larger proportion of Black African (16%) and Black Caribbean (6%). Projections estimate the Black Caribbean population is likely to decrease by 1% in the next 10 years, compared to increase in the Black African population by 15%. The Asian (Chinese 30%, Pakistani 22% and Indian 20%) population will experience a population increase. The projections suggest BAME overall will increase by 23%.

The 2010 Index of Multiple Deprivation (IMD) places Southwark as the 12th most deprived borough in London and 41st most deprived in England. Variation of deprivation can be seen across the borough, 35% of LSOAs are in the 20% most deprived areas in England and 79% of LSOAs are in the 40% most deprived areas in England. Fig 5 shows the proportion of Southwark LSOAs assigned to each deprivation range

Fig 5



Source: Index of Multiple Deprivation 2010 (IMD) [5]

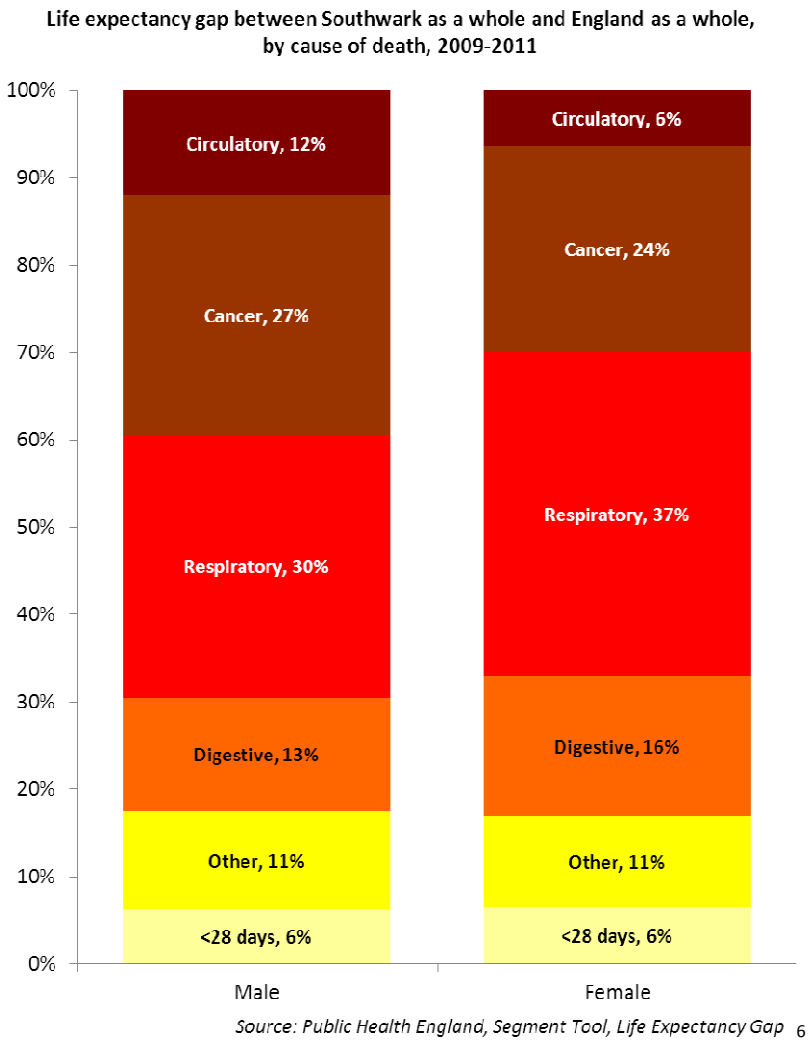
[5] Index of Multiple Deprivation 2010 (IMD)

The 2012 under-18 conception rate for Southwark is 31.8 per 1,000 girls aged 15-17, representing an overall decline of 63.5% since 1998, the baseline, and a 25.5% reduction since 2011. This accounts for a reduction of 46 conceptions between 2011 and 2012.

Infant mortality (deaths of infants aged under 1 year) has dropped from 8.2 per 1,000 live births in 1995-97 to 4.3 per 1,000 live births in 2010/12, which is a reduction of 48%. Southwark's rate is similar when compared to the London and England rate.

At national level the following Fig 6 shows life expectancy (LE) gap between Southwark and England. For males and females, respiratory disease and cancer were key contributors to the LE Gap. Chronic obstructive pulmonary disease accounts for 90% of all respiratory diseases for males, and 100% for females. 2/3 cancer deaths contributing to the gap were due to lung cancer.

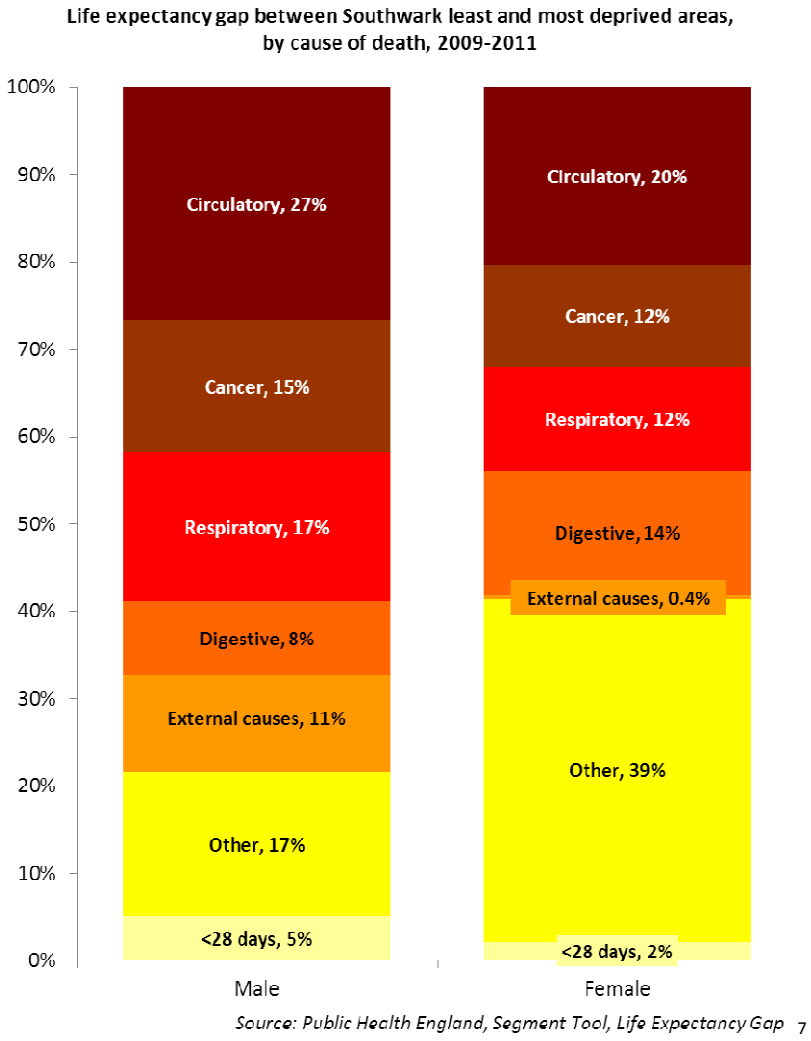
Fig 6



[6] Public Health England, Segment Tool, Life Expectancy Gap

At local level, Fig 7 shows the life expectancy gap between Southwark's least and most deprived areas. For males and females, circulatory diseases were a key contributor to the LE gap, as were respiratory diseases and cancer. For females, mental and behavioural disorders contributed to the LE gap. Heart disease explained 40% of male and 65% of the female gap. Other conditions not specified for females contributed to 22% of the gap. COPD accounted for most of the gap for respiratory disease.

Fig 7

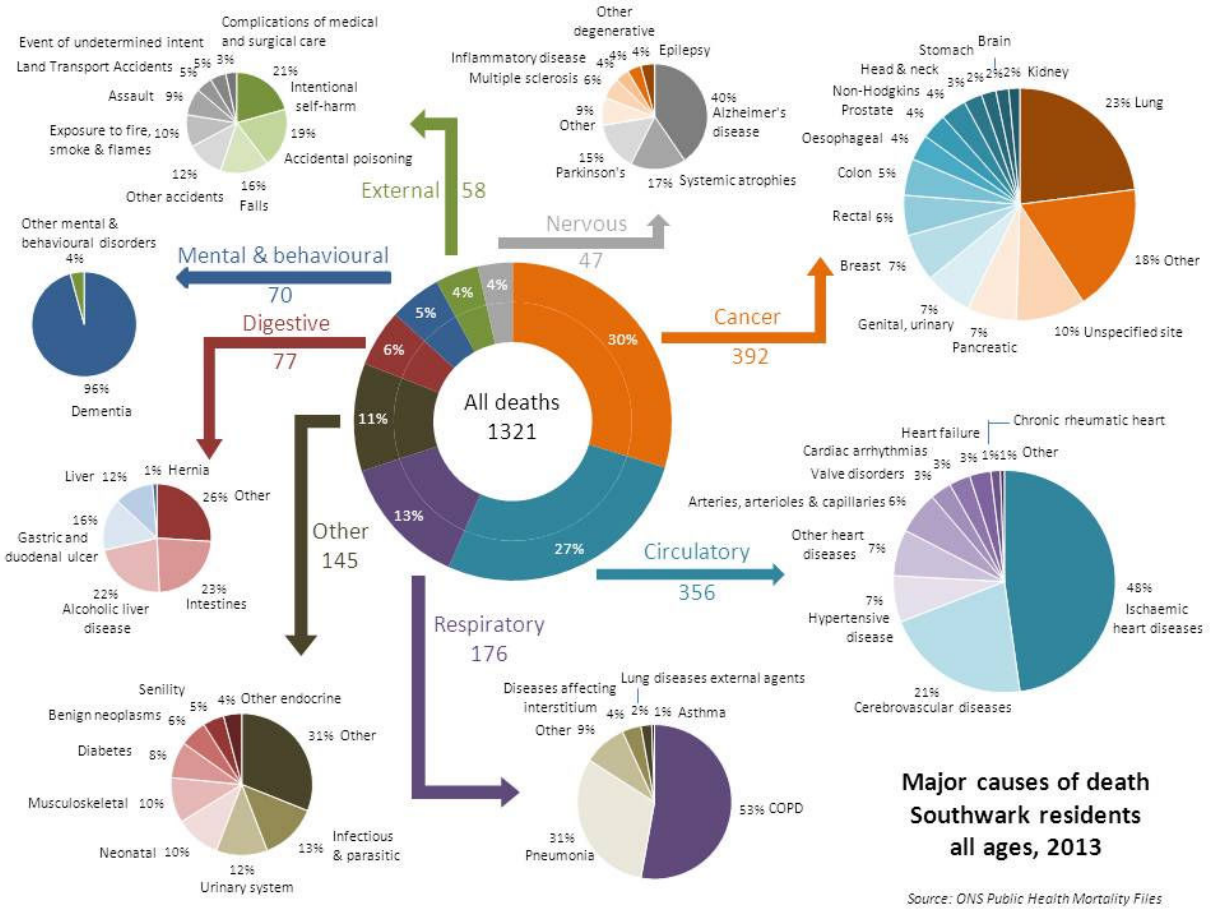


[7]

[7] Public Health England, Segment Tool, Life Expectancy Gap

The pie charts in Fig 8 show the proportion each cause of death contributes to total deaths. In 2013 there were 1,321 deaths to Southwark residents. Cancer is the largest cause of death (30%) followed by circulatory disease (27%).

Fig 8



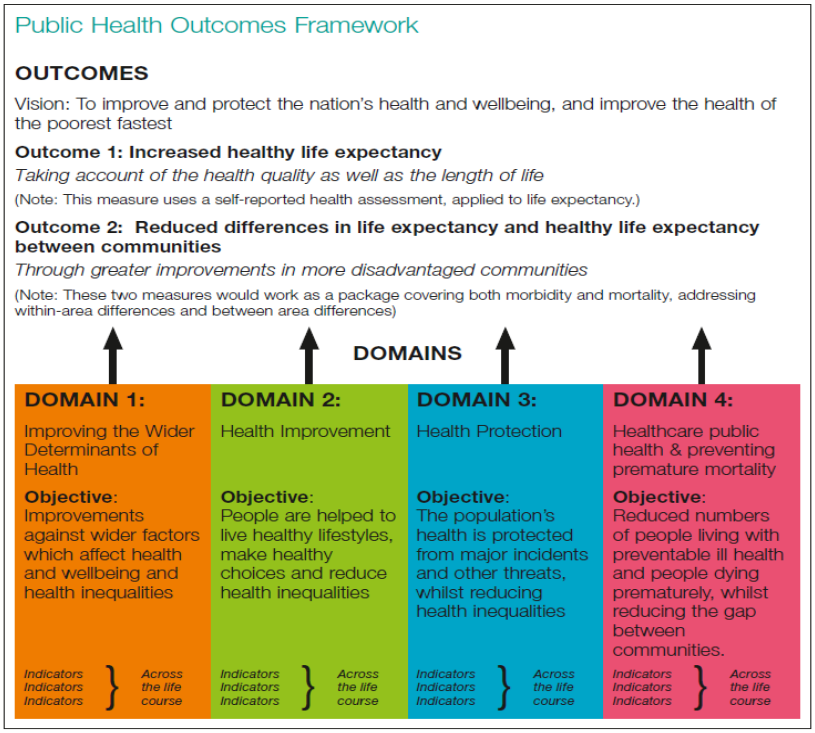
8

[8] ONS Public Health Mortality Files

3. Public Health Outcomes Framework – update on Health Care Public Health domain

The PHOF "Healthy lives, healthy people: Improving outcomes and supporting transparency" sets out a vision for public health, desired outcomes and the indicators that help us to understand how well public health is being improved and protected.

The framework concentrates on two high-level outcomes to be achieved across the public health system, and groups further indicators into four 'domains' that cover the full spectrum of public health as illustrated in the figure on the left. The outcomes reflect a focus not only on how long people live, but on how well they live at all stages of life. Data are published as part of a quarterly update cycle in August, November, February and May.



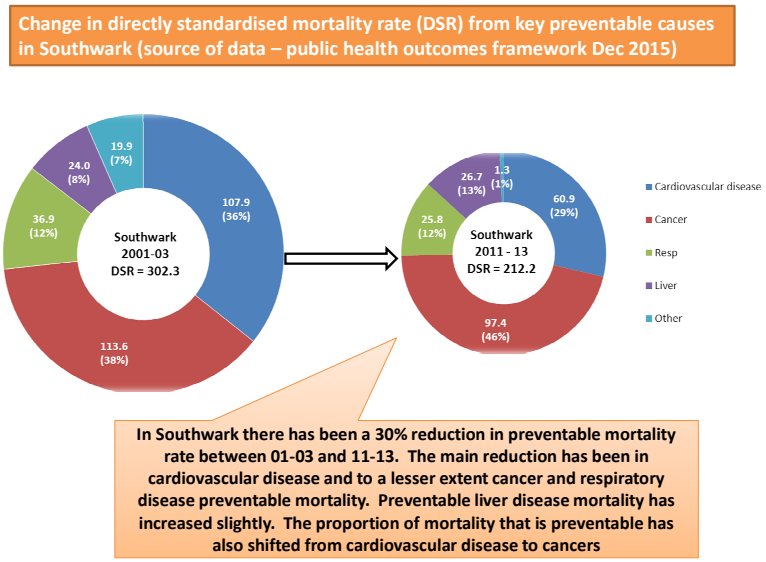
More details on the overarching outcomes and life expectancy can be found in the JSNA web pages (www.southwark.gov.uk/jsna[9] and www.lambeth.gov.uk/jsna[10]). In this report, we are updating local boards on the fourth domain (Health Care Public Health and Preventing Premature Mortality), with a focus on premature/preventable mortality.

The figures on the next page summarise the changes in the four main causes of preventable mortality in Southwark and Lambeth. These are heart disease/strokes, cancers, respiratory disease and liver disease. There has been a significant reduction in preventable deaths from heart disease and strokes – this is as a result of reduced smoking levels, better dietary measures and blood pressure controls as well as the availability of effective treatments. However, as the population ages, more people are developing cancers and this is reflected in the shift in the proportion of people dying from preventable cardiovascular diseases to cancers over time. There has been significant change in the preventable respiratory disease mortality in Southwark, with a slight worsening in Lambeth. Lambeth has seen a slight improvement in preventable liver mortality, with Southwark seeing a slight worsening. The

[9] www.southwark.gov.uk/jsna
[10] www.lambeth.gov.uk/jsna

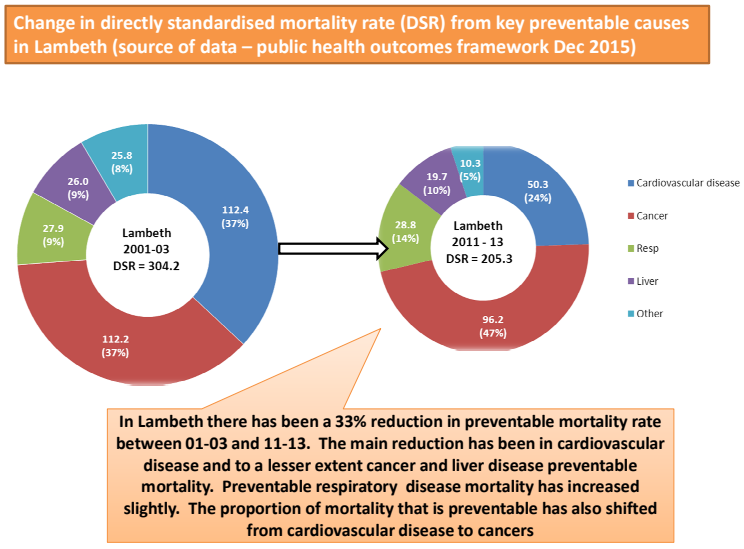
relative percentage of preventable mortality from these two areas has also increased over time. Continuing effort needs to be put into prevention of risk factors related to these four conditions – smoking, blood pressure control, alcohol, obesity (diet and physical activity), and lipid control. These require both the implementation of healthy policy as well as targeted individual behaviour.

Fig 9



Source: Public Health Outcomes Framework (PHOF)[11]

Fig 10



Source: Public Health Outcomes Framework(PHOF)[12]

[11] Public Health Outcomes Framework (PHOF)

4. Marmot indicators update

The Marmot Indicators are a specific set of indicators that form part of the Public Health Outcomes Framework (PHOF). The Marmot indicators specifically address wider determinants of health, health outcomes and health inequality. The data presented here shows an update of these indicators, and progress since last year. In addition, some new indicators were introduced that seek to reflect educational attainment, wellbeing and income. Unless otherwise stated, indicators cover the period from 2010-12 and compare to the period of 2009-2011.

Overall, the indicators show that the situation has not changed much compared to the previous reporting period. In summary:

- In **Southwark**, healthy life expectancy for women has improved from 60.2 to 62.5 years, but with no change for men, and is significantly worse than the England average. Healthy life expectancy in **Lambeth** has improved from 61.1 to 63.1 years for men and with no change in women 62.3 to 62.2 years, both of which do not differ significantly from the England average.
- Life expectancy at birth in **Southwark** has slightly improved for men (78 years) and women (83.1), but male life expectancy is still significantly lower than for the whole of England. Life expectancy at birth in Lambeth is similar men (78.2 years) and women (83 years), again with male life expectancy significantly lower than for the whole of England.
- **Southwark's** inequality in life expectancy at birth within the borough is 7.1 years for men and 7.3 for women, meaning that people in the poorer parts of Southwark die seven years earlier than those in the wealthier parts. In **Lambeth**, this gap is lower with 5 years for men and 2.8 years for women.
- 7.8 per cent of **Lambeth** residents report a low life satisfaction, which is not significantly different to England's value of 5.8%. [13]

On development and educational attainment, key predictors for later income and health and wellbeing, Lambeth and Southwark achieve different outcomes:

- In **Lambeth** in 2012/13, 46 per cent of children at the age of five have a good level of development, which is significantly worse than England's average of 51.7 per cent. Children at age 5 with free school meals perform close to the English average: 36.5 per cent have a good level of development, compared to England's average of 36.2 per cent. In **Southwark**, more children

[12] Public Health Outcomes Framework (PHOF)
[13] This indicator is not available at Southwark level

achieve these outcomes: 59.6 per cent of children at the age of five have a good level of development, and 51.6 per cent on free school meals.

- In both boroughs, the percentage of young people who have obtained 5 A*-C GCSEs including English and Maths is higher than the English average (60.8%) for all pupils (Lambeth: 65.9%, Southwark 65.2%), and also for those on free school meals (Lambeth: 59.9%, Southwark: 60.1%, England: 38.1%)
- The percentage of 19-24 year olds not in education, employment or training isn't broken down to borough level, but for **London**, the value is 13.7.

Employment, long-term employment and income in Southwark and Lambeth also reveal some differences to the England average:

- Employment levels in **Southwark** (10.4%) are worse than the England average of 7.4%, but similar in **Lambeth** (8.3%). In **Southwark**, 15.4 per 1000 population are long-term unemployed, and in Lambeth 16.8 per 100,000 (England: 9.9%). In 2012, 7.5 % of **Lambeth** and 6.4% of Southwark households were in fuel poverty, both significantly fewer than the 10.4 % average in England.
- In 2011/12, 2920 per 100,000 Londoners had a work-related illness, and income levels in for 29.4% of Londoners in 2011/12 did not reach minimum income standards. [14]

What are we doing locally?

The Public Health Directorate is working with both councils and the CCGs to improve on these indicators, and to reduce inner-borough inequalities, for example in life expectancy for men and women. Current work includes an analysis of existing PHOF indicators to determine inner-borough inequalities and to include an inequality dimension in an assessment of the impact of certain indicators on the boroughs' populations, such as number of people affected, the severity of the impact, and the financial impact on the person, the council and the NHS. We provide CCGs and the council with expert input and data analysis on departmental strategies (e.g. housing, air quality) and work towards building capacity in recognising the wider determinants of health and ways that organisations can mitigate against them in all their work.

The public health team has worked with the councils on integrating public health outcomes framework with the council plans. For example, we have completed with Southwark CCG an in-depth analysis of inequalities in the borough and are planning to do the same for Lambeth CCG. Public Health is represented on the housing and air quality steering groups to highlight the impact of poor

[14] Both of these indicators are not available on borough levels

housing and air quality on public health, and to inform what can be done to prevent ill health. Further projects are in development.

5. JSNA

Background

As part of the JSNA, the Public Health Team produces a series of factsheets to bring together local data for Lambeth and Southwark to provide a snapshot profile of current or local issues to a broad audience using standard statistics. Factsheets on *Wellbeing*, *Life Expectancy* and *Demography* have been completed and uploaded to the respective Southwark (www.southwark.gov.uk/jsna) and Lambeth (www.lambeth.gov.uk/jsna) JSNA websites.

5.1 Suicide Factsheet

The *Suicide* factsheet is the first to cover both Lambeth and Southwark as a single report. It provides a summary of the national context and how Lambeth and Southwark fare compared to national indicators, in addition to a comprehensive list of '*What works*' in terms of suicide prevention strategies.

Suicide rates in England are historically low and lower than in most other European countries. Rates have remained stable over time. The highest suicide rates overall are in the 45-49 year age group. Men are three times more likely to take their own life. Suicides have substantially decreased since a national target of 20% reduction was set in 1995-97 (see fig 8). Number of deaths from suicide in Lambeth and Southwark remain low in men and very low in women. Suicide rates in Lambeth and Southwark are similar to the England average.

Admissions to hospital after an episode of self-harm or self-poisoning tend to suggest severe harm or a 'near miss'. This group of people are at higher risk of taking their own lives in the future and are an important group to review alongside deaths due to suicide as they represent a level of severe distress. There has been an increase in admissions in men and women in the last 5 years. Admissions for women remains higher than that for men and rates are highest in young women aged 15-19 (338 per 100,000). Admission rates for intentional self-harm and injury of undetermined intent are lower in Lambeth and Southwark compared to England.

Fig 11

Source: IC Indicators (HSCIC) Health and Social Care Information Centre[15]

5.2 Primary Care Locality Profiles

The Health Intelligence team has been working with both Southwark and Lambeth CCGs to develop the Primary Care Locality profiles. The final drafts have been presented to the CCGs and further work is on-going to present to localities within the CCGs. The profiles includes a map of the localities with practice locations, key health priorities, demographic information on populations relevant to both primary care and community services, vital statistics, deprivation, variation in Quality and Outcomes related prevalence of specific conditions, and variation in hospital admissions for selected causes. The profiles will be available on the JSNA web pages in January 2015.

[15] IC Indicators (HSCIC) Health and Social Care Information Centre

5.3 Shisha: An Emerging Public Health Issue in South East London

The rapidly rising popularity of shisha tobacco is a new and unwelcome development in public health. A shisha smoker inhales large volumes of tar, carcinogens and carbon monoxide deep into their lungs which exposes them to all of the diseases associated with smoking cigarettes. [16] Smoking shisha products that do not contain tobacco is not necessarily less damaging in terms of the effect of the smoke inhaled, as it will still expose users to carcinogens and carbon monoxide.

In response to this emerging problem the South East London Illegal Tobacco Network (SELITN)[17] commissioned an adult and young people survey during 2013-14 and drew together available information on shisha use in South East London.

Shisha use in South East London is endemic. The survey of adults revealed that 31% of those adults surveyed had smoked shisha at least once and that 16% had smoked it in the year prior to the interview. This compares to an adult smoking rate for cigarettes of 17.3% for London.[18] Approximately 70% of the adults interviewed indicated that they were aware of shisha before the interview, and 96% of those aware of it had seen it being smoked in the UK. The majority of people who smoked shisha last year were from ethnic groups identifying as 'white', and Arabic or Asian users now represent less than 25% of users in South East London.

Shisha use is particularly prevalent among younger people. Amongst the 18-34 age group in South East London, 45% have tried shisha and 25% have smoked it at least once in the last year. By the age of sixteen more than 40% of young people in South East London will have tried shisha. The most common place for young people to report first trying shisha is either at a shisha café or a friend's house.

The dangers of shisha smoking are poorly understood by the public. Although the use of shishas is widespread, understanding of what shisha is and its potential impact on health remains poor.

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[16] In smoking shisha using a water pipe the user draws air over a charcoal briquette to create the hot gas that vaporises the shisha molasses, this means that significant quantities of carbon monoxide are inhaled. In addition as the smoke has been cooled more is inhaled and it is inhaled deeper into the lungs.

[17] SELITN is a collaborative network of Trading Standards and Public heath teams in the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.

[18] Data from London Heath Observatory over 18 smoking rates, London 2014 data. http://www.tobaccoprofiles.info/

Action Being Taken in South East London

While an over-arching strategy for dealing with shisha has yet to be agreed these boroughs are taking the following actions to limit its impact on their communities.

- Trading Standards and Environmental Health teams are working to ensure that shisha café type businesses operate in accordance with the laws on under age sales of tobacco products and smoke free legislation (smoking indoors).
- Trading Standards teams are working jointly and individually with HM Revenue and Customs to prevent illegal shisha being sold in in South East London.
- Public Health teams are looking at ways of ensuring that residents of their boroughs can make informed choices regarding shisha use and that parents better understand the risks that shisha poses to their children.
- The SELITN is also working with Public Health England, Action on Smoking and Health (Public Health charity) and the London Trading Standards Association to help develop more effective shisha policies for London as a whole.

6. Alcohol licensing

Public Health is increasing its role in local licensing decisions. Lambeth and Southwark both have large numbers of people who are drinking at unsafe levels. It is estimated that over 100,000 people (in both boroughs combined) are drinking at increasing or higher risk levels. This means drinking more than 3-4 units a day for a man or 2-3 units for a woman; one pint of lager or one large glass of wine can be over three units.

The licensing process is one way Public Health Teams can contribute to reducing alcohol-related harm. Under the Police Reform and Social Responsibility Act (2011), the Government amended licensing legislation to give health authorities a statutory role in the licensing process. This means the Director of Public Health can submit evidence to inform local licensing decisions.

The Lambeth Alcohol Prevention Group (APG) commissioned Safe Sociable London Partnership (SSLP) to develop a Lambeth Public Health Licensing Process Tool and pilot it for five months (Jan – May 2014). The Lambeth & Southwark Public Health Directorate has also funded SSLP to develop a similar Licensing Tool for Southwark, which is now available.

Within the 5-month pilot in Lambeth, 53 applications were received. After putting each application through the Lambeth Public Health Licensing Process Tool, it was decided that for just over a quarter of applications (14 in total), health representations should be made to the licensing sub-committee. Of the 12 representation which have been heard by the sub-committee, 9 (75%) resulted in the license being revoked/refused, withdrawn or granted based on conditions that reduce alcohol-related harm. Verbal feedback indicates that the Lambeth licensing sub-committee and the other responsible authorities welcomed the collaboration with, and representations from Public Health.

The process developed for the Lambeth pilot is being used by Public Health England as an example of best practice for national guidance.

A business case, based on the results of the Lambeth pilot, was put forward to Lambeth and Southwark Councils to jointly fund a 2-day per week post to lead on the delivery of public health input into local licensing decisions. The Lambeth Joint Commissioning Group has recently allocated money to fund half of this post for one year. The post was successfully recruited to in December and work will be evaluated.

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