Open Agenda

Health and Wellbeing Board

Thursday 28 January 2016
10.00 am
Ground Floor Meeting Room G02B - 160 Tooley Street, London
SE1 2QH

Membership

Councillor Peter John OBE (Chair)	Leader of the Council
Andrew Bland	NHS Southwark Clinical Commissioning Group
Councillor Stephanie Cryan	Cabinet Member for Adult Care and Financial Inclusion
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

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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: 19 January 2016

PRINTED ON RECYCLED PAPER

Health and Wellbeing Board

Thursday 28 January 2016
10.00 am
Ground Floor Meeting Room G02B - 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 21 October 2015.	1 - 4
6.	**HEALTH AND WELLBEING STRATEGY: ALCOHOL, DRUGS & SEXUAL HEALTH** To note the update on alcohol, drugs and sexual health and proposed actions for 2016.	5 - 24

Item No.	Title	Page No.

14. PRIMARY CARE JOINT COMMISSIONING COMMITTEE - HEALTH AND WELLBEING BOARD OBSERVER 161 - 163

To nominate a named member to attend the (NHS Southwark) Primary Care Joint Commissioning Committee and the South East London Primary Care Joint Commissioning Committee in the capacity as an observer from the health and wellbeing board.

OTHER ITEMS

The following item is also scheduled for consideration at this meeting.

15. POLICY AND RESOURCES STRATEGY 2016/17 - 2018/19: REVENUE BUDGET

To note the Council's policy and resources strategy 2016/17 – 2018/19 due to be considered by cabinet on 27 January 2016.

Date: 19 January 2016

Agenda Item 5

Health and Wellbeing Board

MINUTES of the OPEN section of the Health and Wellbeing Board held on Wednesday 21 October 2015 at 1.30 pm at Ground Floor Meeting Room G01A - 160 Tooley Street, London SE1 2QH

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

1. APOLOGIES

Apologies for lateness were received from Professor John Moxham.

1. CONFIRMATION OF VOTING MEMBERS

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

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

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

Item 15 – Transformation Plan for Mental Health of Children and Young People

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 18 June 2015 be approved as a correct record and signed by the Chair.

6. 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 2015, attached as Appendix 1 to the report be noted.

7. HEALTH AND WELLBEING STRATEGY - OBESITY AND TOBACCO UPDATE

Dr Ruth Wallis introduced the report. The board heard from officers Bimpe Oki, Consultant in Public Health and Nigel Smith from the NHS Clinical Commissioning Group.

RESOLVED:

1. That the obesity and tobacco update (Appendix 1 of the report) on the action plan received at the June 2015 Health and Wellbeing Board be noted.

2. That it be noted that the update for alcohol and sexual health is scheduled for the January 2016 health and wellbeing board.

3. That the establishment of an obesity strategy task & finish steering group be noted and that the health and wellbeing board leads across the partnership for this group be Councillor Barrie Hargrove, Dr Jonty Heaversedge and David Quirke-Thornton.

4. That the presentation on the progress of the adult weight management service be noted.

8. SOUTHWARK AND LAMBETH EARLY ACTION COMMISSION FINAL REPORT

Gordon McCullough, Community Action Southwark, introduced the report.

RESOLVED:

That the report be noted and a response to the Commission's recommendations be

prepared and submitted to the next meeting of the board for consideration and agreement.

9. HEALTHWATCH SOUTHWARK ENGAGEMENT UPDATE

Aarti Gandesha, Healthwatch Southwark introduced the report.

RESOLVED:

1. That Healthwatch Southwark's engagement since April 2015 and planned engagement activities as set out in Appendix 1 of the report be noted.

2. That Healthwatch Southwark submit an engagement update for each health and wellbeing board meeting.

10. SOUTHWARK SAFEGUARDING CHILDREN BOARD - SERIOUS CASE REVIEW

David Quirke-Thornton, Strategic Director of Children's and Adults' Services introduced the report in his capacity as vice-chair of the Southwark Safeguarding Children Board.

RESOLVED:

That the serious case review, Appendix 1 of the report be noted.

11. SOUTHWARK COUNCIL AND CLINICAL COMMISSIONING GROUP - JOINT FIVE YEAR STRATEGIC PLAN: KEY MESSAGES

Mark Kewley, Director of Transformation, NHS Southwark Clinical Commissioning Group and Dick Frak, Director of Commissioning introduced the report.

RESOLVED:

1. That the Council and CCG publish a joint strategic plan relating to a shared approach to transforming the commissioning of health and social care services.

2. That the general approach and key messages set out in the summary report be endorsed.

12. OUR HEALTHIER SOUTH EAST LONDON

Mark Easton, Programme Director for Our Healthier South East London introduced the report.

RESOLVED:

That the development of the five-year strategy to date and the progress made since the last report be noted.

13. PRIMARY CARE CO-COMMISSIONING - UPDATE

RESOLVED:

That the progress made on the development and operation of primary care co-commissioning in the borough be noted.

14. HEALTH AND WELLBEING BOARD WORK PROGRAMME

RESOLVED:

1. That the work plan for the health and wellbeing board 2015/16 be noted.

2. That any further items to be added be submitted to Rachel Flagg, Principal Strategy Officer, Children's and Adults' department.

15. TRANSFORMATION PLAN FOR MENTAL HEALTH OF CHILDREN AND YOUNG PEOPLE

This item had not been circulated 5 clear days in advance of the meeting. The chair agreed to accept the item as urgent as the deadline set nationally for submission of the transformation plan was 16 October 2015. The Southwark's Local Transformation Plan was still being developed and required sign-off within the coming weeks.

RESOLVED:

1. That the national requirement for the development of Local Transformation Plans for children & young people's mental health and wellbeing be noted.

2. That the proposed areas for development within the transformation plan be noted and agreed.

3. That as part of the requirement of the transformation plan, David Quirke-Thornton be nominated as the board's representative to sign off Southwark's local submission, following agreement by local partners.

The meeting ended at 3.30pm

CHAIR:

DATED:

Agenda Item 6

Item No. 6.	Classification: Open	Date: 28 January 2016	Meeting Name: Health and Wellbeing Board
Report title:		Health and wellbeing strategy: alcohol, drugs & sexual health	
Wards or groups affected:		All	
From:		Ruth Wallis, Director of Public Health Aarti Gandesha, Healthwatch Southwark	

RECOMMENDATIONS

1. The board is requested:

   a) To note the update on alcohol, drugs and sexual health (Appendices 1 & 2)
   b) To note the proposed actions for 2016 as summarised in Tables 1 of the appendices for alcohol, drugs and sexual health
   c) To consider the menu of potential outcome and performance indicators being proposed in Tables 2 of the appendices and agree the selection of indicators for target setting and monitoring
   d) To note the summary of the findings from Healthwatch Southwark's engagement on sexual health.

EXECUTIVE SUMMARY

2. The Health and Wellbeing Board received the refreshed Health and Wellbeing Strategic framework in 2015 and has requested regular thematic updates. This update is on the alcohol, drugs and sexual health themes of the Health and Wellbeing Strategy.

3. The Health and Wellbeing Board has also requested that a range of indicators are proposed from which a selection would be made for target setting and monitoring purposes.

4. The refresh of the Health and Wellbeing Strategy was informed by the 1,000 Lives engagement exercise which was chaired by Southwark Healthwatch. Appendix 3 is a summary of further Healthwatch engagement on sexual health which will feed into the redesign of sexual and reproductive health services.

Policy implications

5. 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

6. The health and wellbeing strategy and associated action plans seek to improve

the health of the population and to reduce health inequalities. It is acknowledged that some communities and individuals are less likely to access or make use of the services offered and targeted support or initiatives are expected to address this.

Legal implications

7. 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

8. 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
Link: www.southwark.gov.uk/jsna		
Southwark Health & Wellbeing Strategy 2015/20	http://www.southwark.gov.uk/downloads/download/3570/southwark_health_and_wellbeing_strategy_2015-2020	Public Health 020 7525 0280
Link: http://www.southwark.gov.uk/downloads/download/3570/southwark_health_and_wellbeing_strategy_2015-2020		

APPENDICES

No.	Title
Appendix 1.	Southwark Health and Wellbeing Strategy: alcohol & drugs thematic update
Appendix 2.	Southwark Health and Wellbeing Strategy: sexual health thematic update
Appendix 3.	Southwark Healthwatch summary of engagement on sexual health

AUDIT TRAIL

Lead officer	Ruth Wallis, Director of Public Health for Lambeth & Southwark	
Report Authors	Richard Pinder, Consultant in Public Health Kirsten Watters, Consultant in Public Health Aarti Gandesha, Healthwatch Southwark	
Version	Final	
Dated	7th January 2016	
Key decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer title	Comments sought	Comments included
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Strategic Director of Children's and Adults Services	No	No
Date final report sent to Constitutional Team		15 January 2016

APPENDIX 1

Health and Wellbeing Board Update
Alcohol in Southwark

Last updated 29 December 2015
Prepared for meeting 28 January 2016

SUMMARY

Like much of the country, alcohol and drugs continue to drive inequality in life opportunities and health in Southwark. Alcohol and substance misuse are identified as priority lifestyle risk factors in the Southwark Health and Wellbeing Strategy 2015-2020. Locally, we are taking a system-wide approach that seeks to manage the supply of alcohol, identify and prevent harm where possible, and mitigate and treat those chronically afflicted by alcohol. Drugs too, continue to affect the lives of many of our residents. New so-called 'legal highs', prescription medications and high-strength cannabis present new challenges for services.

On 4 January 2016, the drugs and alcohol treatment service was transferred to a single integrated provider following an extensive procurement exercise in 2015. This year, and following the release of HM Government's national alcohol strategy, we will seek to collaborate more closely with partners across the Council, law enforcement, and our nearby centres of academic and clinical excellence to develop an action plan.

WHERE ARE WE?

1. Alcohol and drug-related substance misuse continue to present challenges to health and other municipal services in Southwark and south-east London. While the national picture suggests a gradual reduction in alcohol consumption at population-level, the advent of so-called 'legal highs' and the ageing cohort of people whose lives have been chronically disadvantaged by substance misuse of all types, pose further hurdles to overcome.

2. Southwark continues to suffer significantly higher chronic morbidity relating to alcohol: alcohol-specific and rates of alcohol-related hospital admission are higher than the London average. Conversely, the rates of people attending hospital with 'intentional self-poisoning with alcohol' – the acute effects – are lower than the London average.

3. Yet children and young people are still adversely affected by the damaging effects of substance misuse in families. Social services estimate that 30% of care proceedings involving children involve alcohol. Young people are continuing to place themselves at risk from high-strength cannabis and novel psychoactive substances (NPS, so-called 'legal highs').

4. Ambulance attendances for the financial year 2014/15 show a reduction of approximately 10% on the previous year. The pressure remains however from the Night Time Economy (1800-0600hrs) with more than 60% of calls occurring within this time; more than 20% of all alcohol-related callouts occur between 2200hrs and 0100hrs.

5. There is evidence that street-drinking and antisocial behaviour related to alcohol in Southwark has markedly reduced across the borough over the last two years. Precisely quantifying this is difficult due to changing patterns of data collection and coverage.

POLICY LANDSCAPE

6. Public Health is now reviewing all alcohol licensing applications. Since 2011, the Director of Public Health has held 'responsible authority' status that grants powers to make representation to any alcohol licensing application (under the Licensing Act 2003). Between March 2015 and December 2015, the public health team received and reviewed 88 applications. We made representations against 23 (26%). Quantifying 'success' is methodologically challenging; however, additional conditions and restrictions upon retail hours are now being regularly achieved.

7. We are working to foster relationships across the Council and beyond including with trading standards, environmental protection and the Metropolitan Police. The advantages to taking a collaborative approach include better intelligence sharing, capacity to enforce decision and the potential to align the ambition of public health more comprehensively across the organisation and wider.

8. Public Health has contributed to the Council's newly published statement of licensing policy for 2015-2020 (effective 1 January 2016) and is working with other stakeholders to establish what effect "saturation zones" (formally termed cumulative impact zones, CIZ) have had thus far, and whether additional CIZ may be introduced.

9. LB Southwark is exploring the potential of a Public Spaces Protection Order (PSPO) that would take over from the existing Designated Public Places Order (DPPO) due to expire in 2017. The PSPO would offer additional powers to Police and wardens to prohibit and respond to antisocial behaviour caused related to alcohol and / or drugs.

10. Southwark is working with crime and disorder partners. Alcohol Abstinence Monitoring Requirements (AMMR, referred to as compulsory sobriety orders) are being piloted with The Mayor's office. Operating across several boroughs, an overall compliance rate of 93% has been observed for offenders enrolled in the programme.

HEALTH SERVICES

11. A range of services have been provided to Southwark's residents in 2015. Tier I activity includes Identification and Brief Advice (IBA) spanning the community and hospitals (with a CQUIN at King's College Hospital operated by the CCG). So-called Tier II self-referral and outreach work is also on-going with drop in visits to schools and cross-disciplinary working with sexual health; for 2015 Q2, there were 1064 contacts recorded.

12. Southwark's substance misuse treatment services have, until recently, been provided by a number of different providers including South London and Maudsley NHS Foundation Trust. In 2014, the proportion of patients successfully completing drug treatment have been similar to the London and national averages. Data for 2015 are not yet available.

13. From 4 January 2016, LifeLine Project has become the single integrated provider of substance misuse services (spanning alcohol and drugs) across Southwark. LifeLine takes over from a multiplicity of substance misuse provision that has organically arisen over past years.

14. Careful transition planning has taken place to mitigate the inherent risks of transferring clients to the new provider; the results of this transition will become apparent over the next several weeks.

PLANS FOR 2016/17

15. We are appraising the wide range of epidemiological and treatment-centric indicators to determine a more coherent and streamlined approach to measuring progress and performance. At present we are appraising the comparative benefits of the following five indicators:

Progress (Outcomes)

i. Alcohol-specific mortality (persons); *24-monthly data; Source, Public Health England and ONS.*

ii. Percentage of successful treatment completions (opiates and non-opiates); *12-monthly data; Source, National Drug Treatment Monitoring System, Public Health England*.

Performance (Process)

iii. Tier I and Tier II activity; *quarterly-reported; locally sourced.*

iv. Admission episodes for alcohol related conditions (narrow); *12-monthly data; Source, Public Health England and HES.*

v. People entering prison with substance misuse dependence issues not previously known to treatment; *12-monthly data; Source, National Drug Treatment Monitoring System, Public Health England*.

16. A national strategy on alcohol is to be published by HM Government in 2016, and this will form a starting point for a local action plan to be created over the course of the next year.

17. Drugs and alcohol are identified as priority lifestyle factors for improvement within the current Health and Wellbeing Strategy 2015-2020. Alcohol (with tobacco) are identified as ‘deep-dive’ topics. Both drugs and alcohol will be specifically appraised as part of the Joint Strategic Needs Assessment process in 2016.

18. In respect of local licensing policy, public health faces a level of uncertainty regarding resource as the shared specialist team is split into two borough specific teams. However, resources-allowing, we have an ambition to create a licensing environment that prevents the retail of high strength beers, lagers, ciders and similar alcohol beverages for newly licensed premises.

19. We aim to collaborate more closely with a range of partners across the Council, law enforcement, and our nearby centres of academic and clinical excellence.

Briefing Author

Richard Pinder, Consultant in Public Health Medicine
London Borough of Southwark
richard.pinder@southwark.gov.uk

29 December 2015

TABLE 1: ACTIONS SUMMARY

	PROGRESS IN 2015	ACTIONS FOR 2016
POLICY	• Review of Statement of Licensing (Licensing Team led) completed. Best practice approaches incorporated including defined saturation zones, closing times and model conditions.	• Substance misuse (including alcohol) will be included in the next round of the Joint Strategic Needs Assessment • Public health will be appraising the potential of new saturation zones for alcohol licensing in Southwark • Work will be taking place to refresh the alcohol strategy (2013 – 16)
REGULATORY (LICENSING)	▪ A toolkit has been developed which supports the identification of alcohol license applications where there may be concerns. The use of this tool has supported the review of applications and representations on 23 new applications, variations and reviews of licensed premises in Southwark. Conditions imposed include for example earlier closing times, minimum unit pricing and sales of single cans of high strength beers.	• With licensing colleagues, public health will continue to review licensing applications. • Further work will take place to reduce the supply of high strength beers, lagers and ciders from off-licenses, the effectiveness of minimum unit pricing and to learn from the London prevention devolution pilot.
PREVENTION	• A wide range of outreach activities have been undertaken on behalf of Southwark by the services commissioned by the drugs and alcohol commissioning team (DAT)	• With DAT, public health look to extract maximum value from the new integrated service (provided by LifeLine Project) which went-live 4 January 2016 • Public health be fostering links with CCG, acute and academic partners so that we can prevent, identify, treat and mitigate the effects of alcohol across Southwark
TREATMENT	▪ DAT have led the re-procurement of a new integrated prevention and treatment service taking over from the numerous services (including those provided by Foundation 66 and South London and Maudsley NHS Foundation Trust)	

TABLE 2: INDICATOR OVERVIEW

	Indicator	Southwark (most recent value)	London comparator	Comment
i.	**Alcohol-specific mortality (persons)**	**12.1** DSR per 100k people Data from 2011-13	**9.0** DSR per 100k people Data from 2011-13	Southwark mortality is 34% higher, but not significantly* different from the London average.
ii.	**Percentage of successful treatment completions (opiates and non-opiates)**	Opiates: **6%** Non-opiates: **34%** Data from 2013	Opiates: **9%** Non-opiates: **37%** Data from 2013	Southwark's treatment success for opiate-users is significantly* below London's average; success for non-opiate users is lower but not significantly* different.
iii.	**Tier I and Tier II alcohol activity**	*To be discussed in light of new provider contract; data reported quarterly.*		
iv.	**Admission episodes for alcohol-related conditions (narrow)**	**601** DSR per 100k people Data from 2013/14	**541** DSR per 100k people Data from 2013/14	Southwark's admission rate is 12% higher than the London average – a statistically significant* difference. These data are collected annually.
v.	**People entering prison with substance misuse dependence issues not previously known to treatment**	**58.6%** *equivalent to 242 people per year* Data from 2012/13	**57.1%** *equivalent to 4966 people per year* Data from 2012/13	A marginally higher (but statistically insignificant) proportion of Southwark residents entering prison with dependence were not known to treatment services previously. Nationally, 46.7% of offenders are not known to services prior to prison enrolment. We are currently investigating how these indicators (or proxy thereof) may be accessed in a more timely fashion.

DSR – directly standardised rate; interpretation – the calculation adjusts for age differences between populations enabling comparisons to be drawn between Southwark, other boroughs and the region.

* – a statistically significant difference implies that there is a 95% chance that the difference is real; put another way, the difference cannot be attributed to chance alone.

APPENDIX 2

Health and Wellbeing Board Update
Sexual Health Southwark

Prepared for meeting of 28 January 2016

SUMMARY

There remain a number of challenges for sexual health and sexual health services within Southwark attributable to:

- **The continued high rates of sexually transmitted infections.**
- **The diversity of population need and the range of services required to meet them.**
- **The requirement to make significant savings to the public health sexual health budget over the next two years amounting to a minimum of 25% by the end of 17/18.**
- **The risks to population health if access to testing and treatment is not maintained.**

WHERE ARE WE?

1. Responsibility for commissioning open access sexual health services – Genito-urinary Medicine (GUM) and Reproductive and Sexual Health (RSH) transferred from the NHS to Local Authorities in April 2013. By statute, a patient can attend any GUM clinic and the local authority where the patient is resident is responsible for the cost.

2. Southwark and Lambeth have joint commissioning arrangements for GUM and RSH services as there is a high degree of interdependencies between services. Lambeth and Southwark councils are host commissioners to two large providers of integrated sexual health services (integrated GUM and RSH services) at Kings College Hospital (KCH) and Guy's and St Thomas's Hospital (GSTT).

3. Activity data indicates that both sexual health services are operating at full capacity. Lambeth and Southwark residents also attend out-of-borough services in considerable numbers – especially the Chelsea and Westminster Hospital site at Dean Street which is a very popular choice for men who have sex with men (MSM).

4. The London Sexual Health Transformation Programme (LSHTP), which consists of 31 boroughs, is currently driving change across the sexual health system in London, working towards a new home sampling, online and partner notification service being in place by April 2017. A concurrent local, Lambeth, Southwark and Lewisham Transformation Programme is also underway, which aims to refocus activity away from clinics towards home sampling, online and primary care and pharmacy.

<u>Sexual health within Southwark</u>

5. During 2014 27, 359 Southwark residents used a sexual health service. A third of these did so via a Southwark clinic (GSTT) and further third via Kings College

Hospital. The remainder used an out of borough clinic, with Dean Street (Chelsea and Westminster) being the most popular. The average number of attendances per patient is 1.7 which is in line with national average although this varies with clinic.

6. Sexual health remains poor, and Southwark has the 4th highest rate of sexually transmitted infections nationally.

Rates of Sexually Transmitted Infections 2013 – 2014

		Southwark			
	England rate 2014	**2013 rate per 100,000**	**2014 rate per 100,00**	**% Change 2013-14**	**Rank**
New STIs (excl. those with Chlamydia aged 15-24)	828.7	2393.8	2464.9	3.0	4
Gonorrhoea	64.3	401.1	433.9	8.2	3
Syphilis	7.9	79.7	98.2	23.2	3
Genital Warts	129.3	228.2	211.8	-7.2	12

7. Southwark has the second highest prevalence of HIV nationally: In 2014, the diagnosed HIV prevalence rate was 13.0 per 1,000 population aged 15-59 years, compared to 2.2 per 1,000 in England. All medium super output areas in the borough have a prevalence rate higher than 2 per 1,000.

8. Southwark has high levels of risky sexual behaviour shown by high reinfection rates amongst men and the high incidence of syphilis and gonorrhoea.

9. Reducing late HIV diagnosis by 50% by 2020 is a key priority for Southwark through the 'Halve it Campaign' and Lambeth and Southwark have commissioned a new sexual health promotion programme from 1st April 2016 to replace the current HIV prevention programme (formally known as the Safer Partnership). The new contract has been awarded to the RISE Partnership, which consists of Naz Project London (lead contractor), GMFA, London Friend/Antidote and Race Equality Foundation. The contract for the Condom Distribution service has been awarded to Brook London.

HIV rates, testing and late diagnosis

	HIV per 1,000 population 15-59 2014	**% of eligible GUM patients tested for HIV**	**% of late diagnosis[i]**	**% late diagnosis MSM**	**% late diagnosis heterosexual**
Southwark	13	74.2%	37.8%	27.9%	53.7%
England	2.1	68.9%	42%	16%	31%

* Late diagnosis data 2012-14

[i] CD4 count <350 cells/mm³ within 3 months of diagnosis

Reproductive Health

10. Southwark continues to have high rates of abortion and repeat abortions reflecting unmet contraception needs. There is also significant variation in abortion and repeat abortion rates by ethnic groups and ward which may reflect barriers of access to contraceptive services.

Abortion rates 2014

	Abortion rate per 1,000 females 15-44 years	Previous abortion (under 25s)	Previous abortion (over 25s)	Proportion under 10 weeks (NHS funded only)
England	16.5	27%	45.6%	80.4%
Southwark	24.7	33.5%	50.6%	83.8%

11. Teenage conceptions have reduced significantly although they remain higher than the national average.

12. Increasing access to long acting reversible contraception remains a local priority as Southwark currently has low uptake.

Current Financial Challenge

13. Approximately 90% of Southwark council's 2015/16 budget for sexual health is spent on GUM/RSH services. 2% of the sexual health budget is on HIV and STI prevention/early intervention, 3% on young people's sexual health services, 2% on online sexual health services (SH24) with the remainder on Primary Care and Pharmacy services (Section 75 arrangement with CCG) and support costs.

14. Considerable savings are required to be delivered in the Public Health sexual health budget over the next two years. The level of savings required and the rising population demand necessitates a significant change in the way sexual and reproductive health services are delivered and this is being managed through the Lambeth, Southwark and Lewisham Sexual Health Transformation Programme.

LSL Sexual Health Transformation Programme

15. A key aim of the LSL Sexual Health Strategy 2014-17 is to refocus activity away from clinics towards home sampling, online services, and primary care and pharmacy to:
    - Better meet complex need by increasing capacity within clinics to deliver more complex work.
    - Reduce costs and produce cashable savings.
    - Improve access to testing and treatment.
    - Deliver services closer to home.

16. Lambeth and Southwark are working with providers to move to a new Sexual Health Integrated Tariff from April 2017. This is will be a more sensitive payment mechanism which will better reflect levels of complexity across services and enable better commissioning across the system. Modelling indicates this will financially benefit the Council.

17. Pharmacies will have an increased role within the new sexual health system and their offer expanded to include STI testing and treatment, referral to specialist services, LARC insertion and removal as well uncomplicated partner notification.

Key actions for 2016/17

18. Working with providers to manage demand for specialist services and redirect patients towards online and self testing.
19. Embedding and strengthening actions which contribute to reducing late diagnosis of HIV
20. Embedding the new primary care and pharmacy offer
21. Supporting the move to an Integrated Tariff.

Briefing Author

Kirsten Watters FFPH, Consultant in Public Health
London Borough of Southwark

TABLE 1 ACTIONS SUMMARY

	Progress in 2015	**Actions for 2016**
HIV Prevention and reducing late diagnosis	Review completed to inform commissioning of a new sexual health promotion programme to replace the current HIV prevention programme (formally known as the Safer Partnership). The new contract has been awarded to the RISE Partnership, which consists of Naz Project London (lead contractor), GMFA, London Friend/Antidote and Race Equality Foundation and will start 1st April 2016.	• Develop and implement an action plan with new provider to reduce late diagnosis. • Work with GPs and the CCG to promote and support detection and appropriate monitoring and management of HIV in primary care.
Young People	Condom Distribution service reviewed and retendered. The new contract has been awarded to Brook London.	• Increase appropriate condom accessibility and provision in community settings across the borough through Brook.
Primary care and Pharmacy	The review of sexual and reproductive health provision by primary care and pharmacies has been completed. Commissioning intentions have been developed.	• Commission new enhanced pharmacy services from April 2016.
Transformation programme	The Lambeth, Southwark & Lewisham transformation programme has been agreed by the three Councils. This is a major programme involving behavior change, contract and tariff re-negotiations and service re-design. Develop and launch SH 24 (online sexual health service).	• Work with Kings and GSTT to accelerate the work of the LSL transformation programme.

TABLE 2: INDICATOR OVERVIEW

Indicator	Southwark	London Region	England	Commentary
Under 18 Conceptions per 1000 (2013)	30.6	21.8	24.3	Southwark's under 18 conceptions are significantly* higher than both the London and England rates.
Rate of Chlamydia detection per 100,000 people aged 15-24	3241	2178	2012	Southwark's detection of chlamydia 56% higher than the London rate - a statistically significant* difference.
Proportion of adults (15 and above) with newly diagnosed HIV with CD4 count less than 350 mm^2 (2012-14)	37.8%	36.6%	42%	Southwark's proportion of late HIV diagnosis is marginally higher, but not significantly* different from the London average. There is a small statistically significant* difference between Southwark and England rates.
GUM & RSH activity	To be discussed in light of new provider contract			

* – a statistically significant difference implies that there is a 95% chance that the difference is real; put another way, the difference cannot be attributed to chance alone.

healthwatch Southwark

Southwark Health and Wellbeing Board

Summary of HWS's engagement on sexual health

Background

Sexual health was identified as a priority area for Healthwatch Southwark through public and stakeholder consultation. Within this area, we were keen to hear the views and experiences of young people.

The Lambeth, Southwark and Lewisham Sexual Health Strategy prioritised young people as a 'high risk group' and also recognised that people with mental health difficulties are vulnerable to poor sexual health.

We approached YoungMinds, a charity working to improve the emotional wellbeing and mental health of children and young people, and attended a meeting where we were given a 45 minutes slot to run a workshop.

At our public forum in March 2015, the discussions that took place at this workshop were presented by two young people. The presentation can be found on our website as well as the full public forum report where further discussions took place around sexual health.

The Healthwatch Southwark team also visited two sexual health clinics in Southwark to talk to people about their experiences of using these services.

This update provides a summary of the findings from each of these activities.

Workshop with young people on sexual health

What we did...

At the YoungMinds workshop we spoke with 14 young people - a mixture of male and female attendees of different ethnic backgrounds aged between 17 and 21. We spoke to the group about:

- Their views and experiences of using sexual health services
- What influences sexual behaviour
- What ideas they had for improving sexual health services

We put statements to the group on the theme of sexual and mental health amongst young people. Each participant was given a voting card which they used to indicate if they 'Agreed or Disagreed' with the statements.

What young people told us about access to services and information…

We wanted to understand how easy young people thought it was for them and their peers to access sexual health and mental health services. The group of 14 were asked if they agreed or disagreed with some statements:

- 12 agreed that they can access mental health services without fear or judgement (all attendees were involved with YoungMinds)
- 3 agreed that they can access sexual health services without fear or judgement
- 5 said that they know what sexual health services are
- 13 thought that young people know how to access information, support or services relating to sexual health
- 5 said that young people have a good understanding of sexual health (or sex education)
- 5 agreed that there are lots of services to help young people to have healthy relationships and safe sex

In relation to where to get information, the internet was high on the list, lower down was doctors, teachers, clinics and no one said they would would turn to parents. Some felt that teachers knew less than they did or were too embarrassed to talk freely which makes them feel unable to ask the questions they really wanted to. Comments were made around sex education in schools being more about biology of sex rather than the emotional side, which they would like to talk about more.

What young people told us about behaviour and influences…

We wanted to understand young people's perceptions of the behaviours of young people and to explore what is in their life that influences their behaviour and actions. The group of 14 were asked if they agreed or disagreed with some statements:

- 13 agreed that youth face a lot of peer pressure and this can affect their sexual behaviour
- 12 agreed that it is ok to be in a sexual relationship without emotional involvement

Discussions took place about attititudes towards sex, and it was generally felt that if you were having safe sex then it was ok – regardless of being in a relationship.

Who young people talk to…

We were interested in who young people talk to about sex and where they go to for information and support around sexual activity. The group of 14 were asked if they agreed or disagreed to some statements:

- 5 people said that youth are able to talk to their peers about their sexual health
- 5 said they are able to talk to adults about their sexual health
- 5 agreed that young people were free to be open about their sexuality
- 11 people agreed that it's taboo to talk about sex

Cultural barriers were discussed – some said that different cultures have different ideas about what is acceptable to talk about and do.

What's important to young people…

Consent was raised as being important, as well as getting information, getting free contraception and having better knowledge about sexual health. It was felt that education in schools could be improved and that there should be more focus on emotional relationships rather than just biological aspects of sexual health.

Sexual health services and professionals should feel able and confident to talk about sex with young people, as this can affect whether a young person will engage in future conversations and seek advice.

What young people recommended…

Improved services for young people:

- *"Waiting rooms should be more relaxed and have different spaces for privacy"*
- *"Separate guys and girls, as girls don't want to know what guys might think of them"*
- *"More places to get free contraception"*
- *"Free contraception with C Card from all pharmacies [not just local ones]"* – as they might be identified.

Better education in schools - more information:

- *"Better sex education in schools"*
- *"Sex education should start younger at primary school"*
- *"More focus on emotional relationships"*

Relationships with staff and communication

- *"Staff should not judge and [should] be supportive"*
- *"If staff are open it's easier to talk to them"*
- *"Age matters when it comes to the person you are talking to about sex"*

Discussions around sexual health at our public forum

At Healthwatch Southwark's public forum in March 2015, two young people who took part in the workshop about sexual health presented some of the key discussion points.

70 people attended the public forum and 19 people took part in a discussion around sexual health - 10 of these were young people. Below is a summary of the discussions about sexual health.

Getting advice about sexual health…

It was felt that sexual health is not seen as equal to other types of health. People should be able to go to their GP about all health-related issues, and this includes sexual health. It was felt that assumptions are sometimes made when you do access your GP for such an issue. For example, depending on whether you are male or whether you are married with children, an STI test may not be suggested. It was suggested that health professionals should not avoid asking questions about sexual health.

Young people felt it was important for them to be able to speak about their sexual health problems, and health professionals should feel comfortable to approach this. Young people said they would find it easier to access services if they felt they were not being judged.

Awareness of sexual health and services available…

Suggestions were made to improve awareness of sexual health and services available, such as: appropriate hours for younger people to access services, improved online information about available services, more places to access free contraception.

The need to reduce stigma surrounding sexual health to encourage people to access services was discussed. It was felt that better promotion of sexual health is needed – through TV, leafleting, in GP practices and across other health services.

Access to sexual health services…

The group agreed that there are enough sexual health services in Southwark, but that they could be made more accessible e.g. more flexible opening hours. Location was also discussed – people preferred not to go to a service near their work or where they live in case they were seen by someone they knew.

The group discussed barriers to going to a service for advice and support. Stigma and discrimination were mentioned, particularly relating to age and sexuality.

When we asked what more could be done to keep young people sexually healthy, these were some of the suggestions made:

- Stop sex being a taboo subject.Sexual health should be considered to be as important as other health issues.
- Improved sex education in schools. Ensure that it targets both males and females from an early age. It should include information about emotional needs and relationships, as well as the physical side of sexual health.
- Sexual health checks should be more widely available.
- Improve the way parents and health professionals talk to young people about sexual health.

Visits to sexual health clinics in Southwark

Healthwatch Southwark visited two sexual health clinics in June 2015 and August 2015, to speak to people about their experiences. We visited Burrell Street Sexual Health Clinic, Guys and St Thomas' NHS Foundation Trust, and Camberwell Sexual Health Clinic, King's College Hospital NHS Foundation Trust. In total, we spoke to 33 people.

Why were people there?

- (Routine) Check-Up: 23 people
- HIV check –up: 1 person
- Emergency Contraception : 3 people
- Advice & Free condoms : 2 people
- Coil or Implant fitting: 3 people

What did people think was the best thing about the experience?

- 10 people commented that the staff were friendly, and respectful.
- 7 people were pleased that they could be seen on the same day, and that they got results or contraception quickly.
- 2 people came away with more knowledge and reassurance about contraception.

Concerns about the service

- 10 people found the waiting times too long
- 5 people found the registration process confusing (1 person wanted clearer signposting or direction from their health centre to the sexual health clinic).

How people rated the service overall

- 11 found the service to be excellent
- 16 found the service to be good
- 5 found the service to be average
- 1 person did not comment

High rates of satisfaction with staff and facilities

- 31/33 people agreed that staff were friendly and helpful
- 27/33 people found the environment clean and comfortable
- 28/33 people felt that they were well listened to by staff

Some comments from the respondents

- *"The experience wasn't awkward at all. Thank you."*
- *"A nurse spoke to and gave me the necessary advice. So it made me feel great".*
- *"The nurse, they spoke to me about the injection and what side effects it may cause. They made me feel safe."*
- *The registration system is confusing and it takes the whole day to be seen. I have to take time off from work"*
- *"One time when I saw the doctor, he was so nice, talked to me, made jokes - it made me relaxed".*
- *"Came to the clinic at 6 pm and told that it was too late instead of saying we are fully booked today could you come another day. Otherwise find the rest of the services very good. Not sure what to do with the paper they give with the computer registration".*
- *"Along with the nurse who was with me, there was a man there too (which made me uncomfortable). Nurse was a bit aggressive when she found out I hadn't gone for a smear test!"*

Item No. 7.	Classification: Open	Date: 28 January 2016	Meeting Name: Health and Wellbeing Board
Report title:		Southwark Childhood Obesity Data and Options for 5 year Childhood Obesity Outcome Ambitions	
Wards or groups affected:		All	
From:		Ruth Wallis, Director of Public Health, Lambeth and Southwark	

RECOMMENDATIONS

1. The board is requested to:

   - Receive an update on the most up to date Southwark data for childhood obesity
   - Note the evidence based interventions required to effectively tackle childhood obesity in the borough
   - Note the scale of the challenge, consider and agree suitable 5 year outcomes for childhood obesity that Southwark should seek to work towards in its new Obesity Strategy.

EXECUTIVE SUMMARY

2. Childhood obesity is of major public health concern nationally and locally. Over the years, childhood obesity levels in Southwark, particularly at Year 6 have been some of the highest in the country. Southwark Health and Wellbeing Board has indicated that addressing childhood obesity locally is a priority with senior leaders being nominated to be part of the obesity strategy development senior leaders group. Latest National Childhood Measurement Programme results indicate that in Southwark13.0% of Reception and 27.9% Year 6 children are obese. The prevalence for excess weight (obesity and overweight) is 26.4% for Reception and 42.7% for Year 6 children. Tackling obesity requires sustained concerted action. The Children and Families Partnership Board agreed for a set of evidence based interventions to be put into place, to support the local children's healthy weight care pathway. A couple of these interventions are up and running whilst the others are currently still being procured. These prioritised interventions are:

   - Promoting sustained breastfeeding through the implementation of the UNICEF Baby Friendly Initiative
   - Capacity building of health and non-health practitioners in contact with children and their families (including early years)
   - Schools Healthy Weight Promotion programme
   - Community and Specialist children's weight management services
   - Specialist Healthy Weight School Nurse support for "high risk" children

3. An update on current action around childhood was presented at the last Health and Wellbeing Board meeting. The board requested that proposals for ambition outcomes for childhood obesity be presented at a future meeting. This report offers options for 5 year Southwark ambition childhood obesity outcomes..

4. Using the NCMP trends, Public Health has modelled different options for local 5 year childhood obesity and excess weight outcomes for Reception and Year 6 children. The different options are as follows:

- **Ambition Outcomes for Reception Year - Obesity**
  - ***Obesity Option 1***: Reduce the level to ***12% by 2019/20*****,** equivalent to approximately 15% reduction over five years
  - ***Obesity Option 2***: Reduce the level to ***11.3% by 2019/20***, equivalent to approximately 25% reduction over five years

- **Ambition Outcomes for Reception Year - Excess Weight**
  - ***Excess Weight Option 1***: Reduce the level to ***25.0% by 2019/20***, equivalent to approximately 10% reduction over five years
  - ***Excess Weight Option 2***: Reduce the level to ***23.6% by 2019/20***, equivalent to approximately 20% reduction over five years

- **Ambition Outcomes for Year 6 - Obesity**
  - ***Obesity Option 1***: Reduce the level to ***26.4% by 2019/20***, equivalent to approximately 10% reduction over five years. The ambition would seek to halt any further increase and bring it down to levels seen around 2009/10 and 2010/11
  - ***Obesity Option 2***: Reduce the level to ***24.9% by 2019/20***, equivalent to approximately 20% reduction over five years. The ambition would seek to bring down the Year 6 obesity level to the lowest ever seen since the introduction of the NCMP

- **Ambition Outcomes for Year 6 - Excess Weight**
  - ***Excess Weight Option 1***: Reduce the level to ***26.4% by 2019/20***, equivalent to approximately 10% reduction over five years. The ambition would seek to halt any further increase and bring it down to levels seen around 2009/10 and 2010/11
  - ***Excess Weight Option 2***: Reduce the level to ***24.9% by 2019/20***, equivalent to approximately 20% reduction over five years. The ambition would seek to bring down the Year 6 obesity level to the lowest ever seen since the introduction of the NCMP.

5. Although the point percentage reductions may appear small, these are very challenging ambitions. In order to meet these outcomes a sustained whole systems approach will need to be implemented for a minimum of five years. The currently agreed interventions that are being commissioned will need to be scaled up even further and concerted effort will be required by all key partners to ensure that their policies, strategies and practices positively promote healthy weight.

6. Public Health is recommending that at least one outcome relates to reducing excess weight at Reception Year. This would provide a focus on prevention and

early action. The Health and Wellbeing Board is asked to decide on which of the 5 year outcome(s) for childhood obesity that it would want to aspire towards and a commitment to seek relevant financial investment and input across the Partnership.

BACKGROUND INFORMATION

7. The latest National Child Measurement Programme results (2014-15 academic year) were published in November 2015. For Southwark Reception children, the obesity rate only slightly decreased from 13.2% in (2013-14) to 13.0% (2014-15). For Year 6, the obesity rate increased from 26.4% (2013-14) to 27.9% (2014-15). Southwark has the highest proportion of obese Year 6 children in the country and the second highest for Reception children. For excess weight, the proportion of Reception children has decreased from 28% (2013-14) to 26.4% (2014-15). For Year 6 children there has been a slight decrease from 43.8% (2013-14) to 42.7% (2014-15), however Southwark still has the highest proportion of Year 6 children with excess weight in the country. Tackling childhood obesity is challenging and requires a whole systems approach, no one single intervention or isolated interventions will be able to deliver sustained improvements. The Health and Wellbeing Board has requested potential outcome ambitions for childhood obesity reduction in Southwark.

KEY ISSUES FOR CONSIDERATION

8. The Health and Wellbeing Board will need to decide on the potential childhood obesity and/or excess weight outcome ambitions for Southwark. Agreeing the local ambitions for childhood obesity will also require commitments to complete the commissioning of the already agreed evidence based interventions, with a view to sustaining and scaling up the implementation of these, and securing the associated resources necessary. A commitment to a purposeful approach across the Partnership to promote healthy weight will also be required. In the current financial climate, the Health and Wellbeing Board will need to make tough decisions regarding any of the ambitions it seeks to work towards. Reducing childhood obesity is a long term ambition and a life course approach alongside co-ordinated evidenced based interventions will be required. This will need, at the very least, to channel existing resources towards co-ordinated evidence based interventions and approaches.

Policy implications

9. Addressing childhood obesity is incorporated within the priorities of the Southwark Health and Wellbeing Strategy. Key organisations represented within the Partnership should assess the health and wellbeing impact of their main strategies and policies to ensure opportunities to promote healthy weight are maximised.

Community impact statement

10. There is a strong association between childhood obesity and deprivation. Black African and Black Caribbean children are at greater risk of obesity compared to their white counterparts. However, childhood obesity is widespread across Southwark with most of the wards having prevalence levels that are higher than the national average. A whole population approach is therefore required, ensuring that those at greatest risk are benefiting the most from the interventions

in place.

Legal implications

11. There are no specific legal implications

Financial implications

12. There will be financial implications for working towards the 5 year outcomes that are to be agreed. If there is no significant change in the local approach to tackling obesity then trends for Year 6 indicate a continued rise in obesity levels. It is important that interventions to prevent and manage childhood obesity are evidence based, co-ordinated, sustained and well resourced to achieve optimal cost benefit. This means reassessing existing programmes intended to address obesity to ensure they are cost effective and form part of a comprehensive approach to tackling obesity. This may require current resources being allocated differently and/or additional resources being sought across the Partnership to support the comprehensive approach.

BACKGROUND PAPERS

Background papers	Held at	Contact
Rapid Assessment of the Impact after a Year of Introduction of Universal Free Healthy School Meals for Reception Year Children (2011-12) in Southwark (Oct 2013)	Public Health	Public Health 020 7525 0280
Addressing Childhood Obesity in Southwark (Dec 2013)	www.southwark.gov.uk	Public Health 020 7525 0280

APPENDICES

No.	Title
Appendix 1	Southwark Childhood Obesity Data and Options for 5 year Childhood Obesity Outcome Ambitions

AUDIT TRAIL

Lead officer	Ruth Wallis, Director of Public Health for Lambeth & Southwark	
Report Author	Bimpe Oki, Consultant in Public Health, Lambeth & Southwark	
Version	Final	
Dated	15 January 2016	
Key decision?	Yes	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Date final report sent to Constitutional Team		15 January 2016

APPENDIX 1

SOUTHWARK CHILDHOOD OBESITY DATA AND OPTIONS FOR 5 YEAR OBESITY AND EXCESS WEIGHT OUTCOME AMBITIONS

Author: Bimpe Oki, Consultant in Public Health, Lambeth and Southwark

January 2016

INTRODUCTION

1. Childhood obesity is of major public health concern nationally and locally. Over the years, childhood obesity levels in Southwark, particularly at Year 6 have been some of the highest in the country. Southwark Health and Wellbeing Board has indicated that addressing childhood obesity locally is a priority with senior leaders being nominated to be part of the obesity strategy development senior leaders group

2. The National Child Measurement Programme (NCMP) is an annual measure of height and weight of children in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) in state maintained primary schools across England. The data gathered as part of the programme enables local planning and delivery of services for children, population-level surveillance data to allow analysis of trends in growth patterns and obesity and an opportunity to increase public and professional understanding of weight issues in children. The NCMP provides robust data for the child excess weight indicators in the Public Health Outcomes Framework. The latest National Child Measurement Programme results (2014-15 academic year) were published in November 2015. For Southwark Reception children, the obesity rate only slightly decreased from 13.2% in (2013-14) to 13.0% (2014-15). For Year 6, the obesity rate increased from 26.4% (2013-14) to 27.9% (2014-15). Southwark has the highest proportion of obese Year 6 children in the country and the second highest for Reception children. For excess weight, the proportion of Reception children has decreased from 28% (2013-14) to 26.4% (2014-15). For Year 6 children there has been a slight decrease from 43.8% (2013-14) to 42.7% (2014-15), however Southwark still has the highest proportion of Year 6 children with excess weight in the country.

3. Tackling childhood obesity is challenging and requires a whole systems approach, no one single intervention or isolated interventions will be able to deliver sustained improvements. The Southwark Children and Families Partnership Board agreed for a set of evidence based interventions to be put into place, to support the local children's healthy weight care pathway. A couple of these interventions are up and running whilst the others are currently still being procured. These prioritised interventions are:

    - Promoting sustained breastfeeding through the implementation of the UNICEF Baby Friendly Initiative
    - Capacity building of health and non-health practitioners in contact with children and their families (including early years)
    - Schools Healthy Weight Promotion programme
    - Community and Specialist children's weight management services
    - Specialist Healthy Weight School Nurse support for "high risk" children

4. The Health and Wellbeing Board has requested potential outcome ambitions for childhood obesity reduction in Southwark. The Health and Wellbeing Board will need to decide on the childhood obesity and/or excess weight outcome ambitions for Southwark. Agreeing the local ambitions for childhood obesity will also require commitments to complete the commissioning of the already agreed evidence based interventions, with a view to sustaining and scaling up the implementation of these, and securing the additional resources required. A commitment to a purposeful approach across the Partnership to promote healthy weight will also be required. In the current financial climate, the Health and Wellbeing Board will need to make tough decisions regarding any of the ambitions it seeks to work towards. Reducing childhood obesity is a long term ambition and a life course approach alongside co-ordinated evidenced based interventions will be required. This will need, at the very least, to channel existing resources towards co-ordinated evidence based interventions and approaches.

5. This paper provides a brief explanation of how Public Health has come up with the 5 year ambition options for childhood obesity outcomes and what these are. It also highlights the importance of securing the associated resources and the commitment of the organisations across the Partnership in delivering on their potential roles and responsibilities towards tackling obesity. The intention is that the ambitions and commitments agreed by the Health and Wellbeing Board are taken forward through the obesity strategy development senior leaders group to work up the detail and for these to be reflected in the Southwark Obesity Strategy that is being developed.

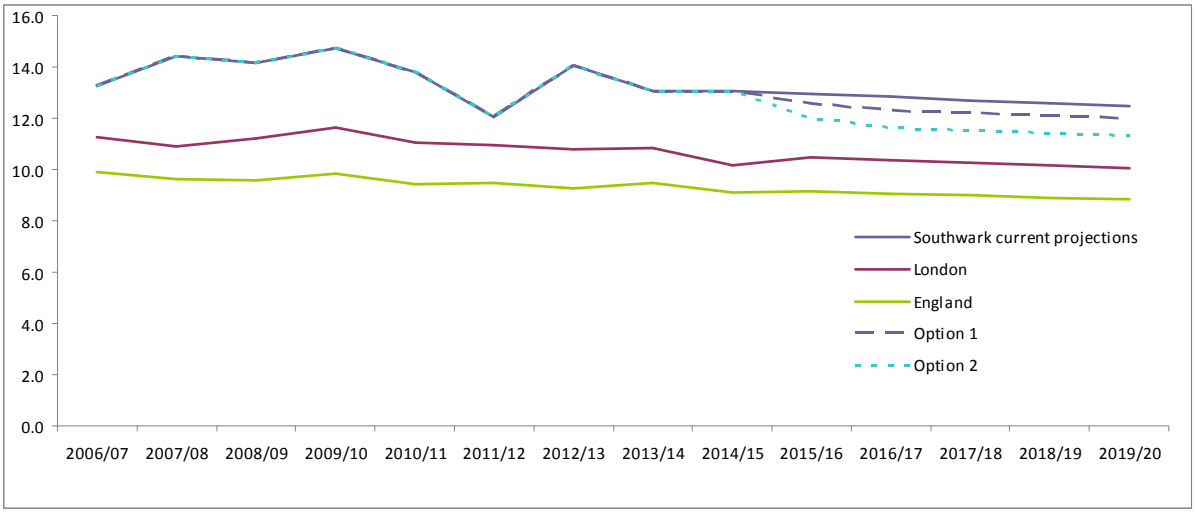
MODELLING APPROACH

6. The National Child measurement Programme (NCMP) was first conducted in 2006/07 academic year and has since been implemented on an annual basis. The NCMP therefore to date provides a rich source of 9 years worth of data. Public Health looked at historical patterns of the NCMP from the first results (2006/7) to the most recent (2014/5). Using the actual trends, projections were made for different scenarios; looking first at what the continued current trend would look like in 5 years time and then identified options to demonstrate how more positive achievements could be made over the same period of time. Five year outcomes were chosen as this would be the minimum amount of time that we would expect to see any significant impact of the interventions. Assumptions for the modelling have been made on the basis that the current regional and national interventions and trends continue.

AMBITION OUTCOMES FOR RECEPTION YEAR (OBESITY AND EXCESS WEIGHT)

7. Ambition Outcomes For Reception Year - Obesity

Chart 1: Reception Year actual Obesity Trajectories (2006/07 – 2014/15) and Projected Trajectories (2015/6 – 2019/20) for Southwark, London and England



8. Currently there appears to be a slight downward trend for obesity in Reception Year for Southwark, London and England. Modelling on the historical Reception obesity trends show that:

   a) If trends continue the Southwark Reception obesity levels will be an estimated 12.5% by 2019/20

   b) **Option 1 provides a Southwark ambition to reduce the level to 12% by 2019/20, equivalent to approximately 15% reduction over five years**

   c) **Option 2 provides a Southwark ambition to reduce the level to 11.3% by 2019/20, equivalent to approximately 25% reduction over five years**

9. Assuming the current Reception obesity trends for London and England continue, this would mean that for options 1 and 2 the reduction in Southwark would be greater and there would be a closing of the gap between the Southwark average and the regional and national averages.

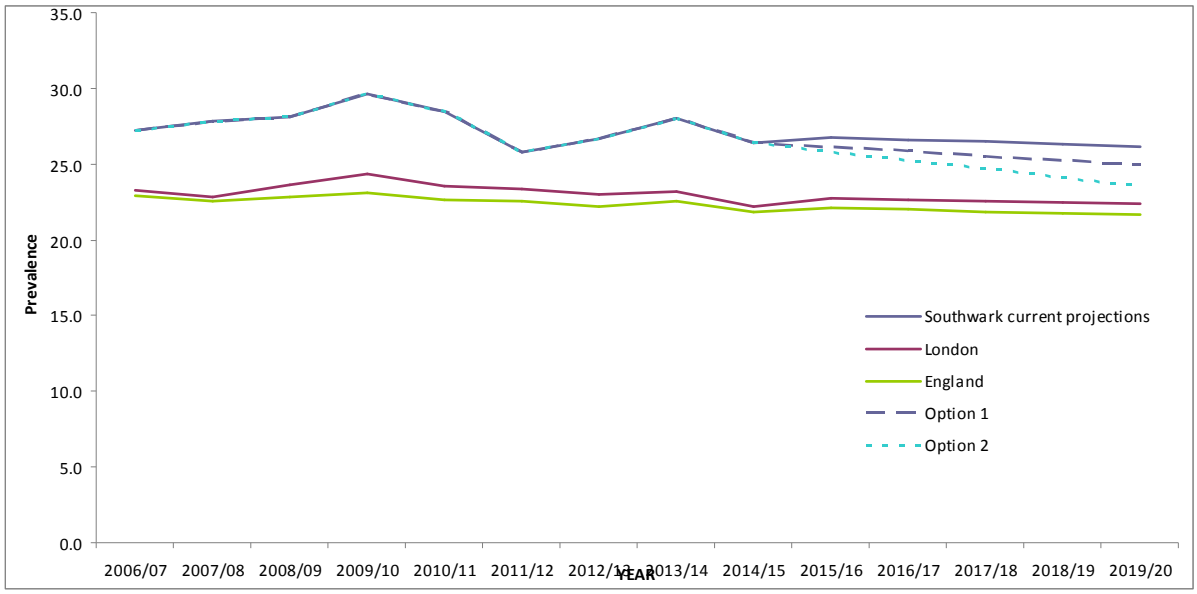
Table 1: Reception Year actual Obesity Prevalence figures (2012/13 – 2014/15) and Projected Figures (2015/16 – 2019/20) for Southwark, London and England

	2012/13*	2013/14*	2014/15*	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Southwark (%)	14.0	13.1	13.0	**12.9**	**12.8**	**12.7**	**12.6**	**12.5**
London (%)	10.8	10.8	10.1	**10.5**	**10.4**	**10.3**	**10.2**	**10.1**
England (%)	9.3	9.5	9.1	**9.1**	**9.1**	**9.0**	**8.9**	**7.3**
Southwark Option 1 (%)	**14.0**	**13.1**	**13.0**	**12.6**	**12.3**	**12.2**	**12.1**	**12.0**
Southwark Option 2 (%)	**14.0**	**13.1**	**13.0**	**12.0**	**11.6**	**11.5**	**11.4**	**11.3**

* Actual published figures

10. Ambition Outcomes For Reception Year - Excess Weight

Chart 2: Reception Year actual Excess Weight Trajectories (2012/3 – 2014/5) and Projected Trajectories (2015/6 – 2019/20) for Southwark, London and England



11. Current trends indicate a slight plateau for excess weight in Reception Year for Southwark, London and England. Modelling on the historical Reception excess weight trends show that:

a) If trends continue the Southwark Reception excess weight level will be an estimated 26.2% by 2019/20

b) **Option 1 provides an ambition to reduce the level to 25.0% by 2019/20, equivalent to approximately 10% reduction over five years**

c) **Option 2 provides an ambition to reduce the level to 23.6% by 2019/20, equivalent to approximately 20% reduction over five years**

12. Assuming the current trends for London and England continue, this would mean that for options 1 and 2 the reduction in Southwark would be greater and there would be a closing of the gap between the Southwark average and the regional and national averages.

Table 2: Reception Year actual Excess Weight Figures (2012/13 – 2014/15) and Projected Figures (2015/16 – 2019/20) for Southwark, London and England

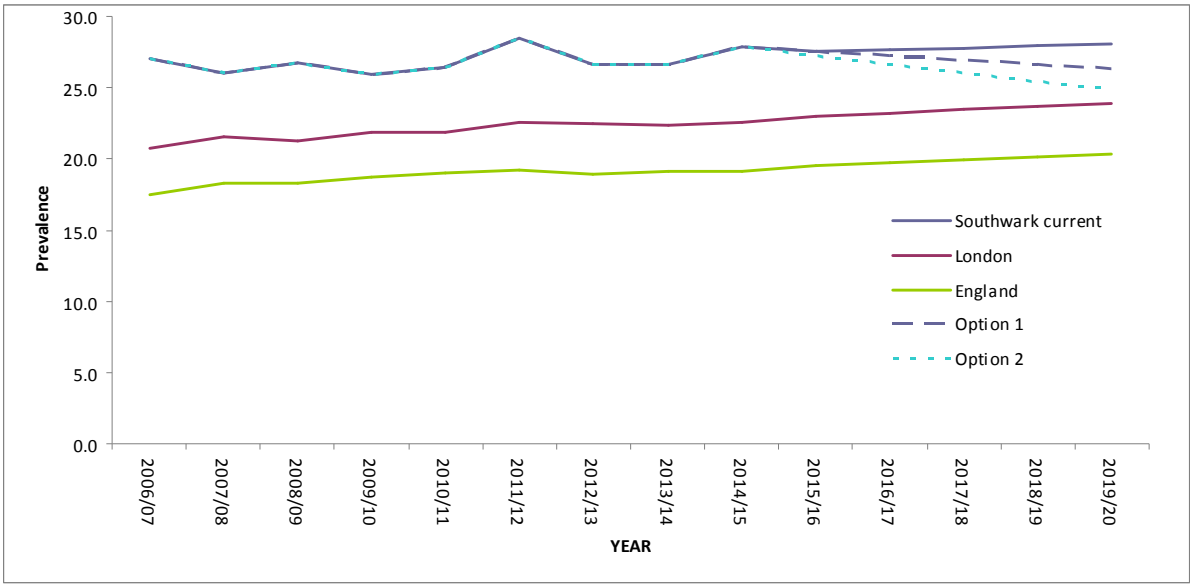
	2012/13*	2013/14*	2014/15*	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Southwark (%)	26.7	28.0	26.4	**26.8**	**26.6**	**26.5**	**26.3**	**26.2**
London (%)	23.0	23.1	22.2	**22.8**	**22.7**	**22.6**	**22.5**	**22.4**
England (%)	22.2	22.5	21.9	**22.1**	**22.0**	**21.9**	**21.8**	**21.7**
Southwark Option 1 (%)	**26.7**	**28.0**	**26.4**	**26.1**	**25.8**	**25.5**	**25.3**	**25.0**
Southwark Option 2 (%)	**26.7**	**28.0**	**26.4**	**25.8**	**25.2**	**24.7**	**24.1**	**23.6**

* Actual published figures

AMBITION OUTCOMES FOR YEAR 6 (OBESITY AND EXCESS WEIGHT)

13. Ambition Outcomes For Year 6 - Obesity

Chart 3: Year 6 actual Obesity Prevalence Trajectories (2012/13 – 2014/15) and Projected Trajectories (2015/6 – 2019/20) for Southwark, London and England



14. Currently there appears to be a slight upward trend for obesity in Year 6 for Southwark, London and England. Modelling based on the historical Year 6 obesity levels trends show that:

- If trends continue the Southwark Reception obesity levels will increase to an estimated 28.1% by 2019/20
- **Option 1 provides a Southwark ambition to reduce the level to 26.4% by 2019/20, equivalent to approximately 10% reduction over five years. The ambition would seek to halt any further increase and bring it down to levels seen around 2009/10 and 2010/11**
- **Option 2 provides a Southwark ambition to reduce the level to 24.9% by 2019/20, equivalent to approximately 20% reduction over five years. The ambition would seek to bring down the Year 6 obesity level to the lowest ever seen since the introduction of the NCMP.**

15. Assuming the current Year 6 obesity trends for London and England continue with increasing obesity levels, this would mean that for options 1 and 2, Southwark would buck the regional and national trends leading to the closing of the gap between the Southwark and London as well as Southwark and England.

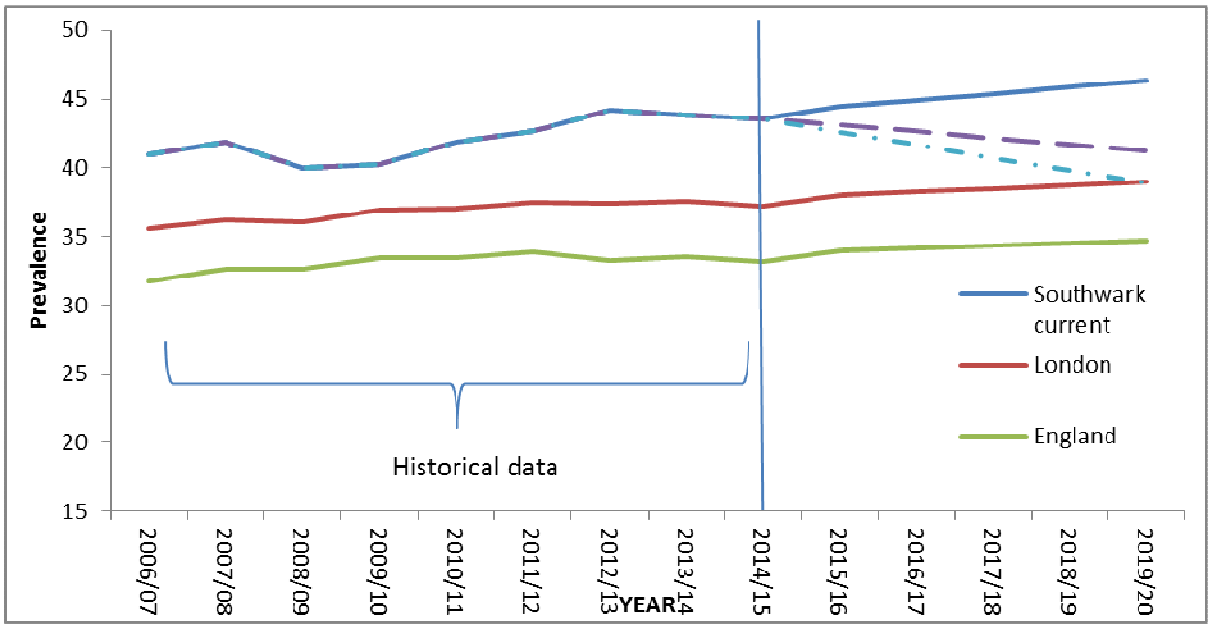
Table 3: Year 6 actual Obesity Prevalence Figures (2012/13 – 2014/15) and Projected Figures (2015/16 – 2019/20) for Southwark, London and England

	2012/13*	2013/14*	2014/15*	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Southwark (%)	26.7	26.7	27.9	**27.5**	**27.7**	**27.8**	**27.9**	**28.1**
London (%)	22.4	22.4	22.6	**23.0**	**23.2**	**23.6**	**23.7**	**23.9**
England (%)	18.9	19.1	19.1	**19.6**	**19.8**	**19.9**	**20.1**	**20.3**
Southwark Option 1 (%)	**26.7**	**26.7**	**27.9**	**27.6**	**27.3**	**27.0**	**26.7**	**26.4**
Southwark Option 2 (%)	**26.7**	**26.7**	**27.9**	**27.3**	**26.6**	**26.0**	**25.5**	**24.9**

* Actual published figures

16. Ambition Outcomes For Year 6 – Excess Weight

Chart 4: Year 6 actual Excess Weight Trajectories (2012/13 – 2014/15) and Projected Trajectories (2015/16 – 2019/20) for Southwark, London and England



17. There currently appears to be a slight upward trend for obesity in Year 6 for Southwark, London and England. Modelling based on the historical Year 6 obesity levels trends show that:

- If trends continue the Southwark Reception obesity levels will increase to an estimated 28.1% by 2019/20
- **Option 1 provides a Southwark ambition to reduce the level to 26.4% by 2019/20, equivalent to approximately 10% reduction over five years. The ambition would seek to halt any further increase and bring it down to levels seen around 2009/10 and 2010/11**
- **Option 2 provides a Southwark ambition to reduce the level to 24.9% by 2019/20, equivalent to approximately 20% reduction over five years. The ambition would seek to bring down the Year 6 obesity level to the lowest ever seen since the introduction of the NCMP.**

18. Assuming the current trends for London and England continue, this would mean that for options 1 and 2 Southwark would not only halt the expected increase but there would also be a prevalence reduction and a closing of the gap between the Southwark and England. For option 2, the ambition would be to bring the Southwark Year 6 excess weight to a similar level to London by the end of the five year period.

Table 4: Year 6 actual excess weight figures (2012/13 – 2014/15) and projected figures (2015/16 – 2019/20) for Southwark, London and England

	2012/13*	2013/14*	2014/15*	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Southwark (%)	44.2	43.8	43.6	**44.4**	**44.9**	**45.4**	**45.9**	**46.4**
London (%)	37.4	37.6	37.2	**38.0**	**38.2**	**38.5**	**38.7**	**39.0**
England (%)	33.3	33.5	33.2	**34.0**	**34.1**	**34.3**	**34.5**	**34.7**
Southwark Option 1 (%)	**44.2**	**43.8**	**43.6**	**43.1**	**42.6**	**42.2**	**41.7**	**41.3**
Southwark Option 2 (%)	**44.2**	**43.8**	**43.6**	**42.5**	**41.7**	**40.7**	**39.8**	**38.9**

* Actual published figures

SUMMARY OF PROPOSED AMBITIONS

19. **Ambition Outcomes For Reception Year - Obesity**

a) **Option 1** provides a Southwark ambition to reduce the level to **12% by 2019/20,** equivalent to approximately 15% reduction over five years

b) **Option 2** provides a Southwark ambition to reduce the level to **11.3% by 2019/20**, equivalent to approximately 25% reduction over five years

20. **Ambition Outcomes For Reception Year - Excess Weight**

a) **Option 1** provides an ambition to reduce the level to **25.0% by 2019/20**, equivalent to approximately 10% reduction over five years

b) **Option 2** provides an ambition to reduce the level to **23.6% by 2019/20**, equivalent to approximately 20% reduction over five years

21. **Ambition Outcomes For Year 6 - Obesity**

a) **Option 1** provides a Southwark ambition to reduce the level to **26.4% by 2019/20**, equivalent to approximately 10% reduction over five years. The ambition would seek to halt any further increase and bring it down to levels seen around 2009/10 and 2010/11

b) **Option 2** provides a Southwark ambition to reduce the level to **24.9% by 2019/20**, equivalent to approximately 20% reduction over five years. The ambition would seek to bring down the Year 6 obesity level to the lowest ever seen since the introduction of the NCMP.

22. **Ambition Outcomes For Year 6 - Excess Weight**

a) **Option 1** provides a Southwark ambition to reduce the level to **26.4% by 2019/20**, equivalent to approximately 10% reduction over five years. The

ambition would seek to halt any further increase and bring it down to levels seen around 2009/10 and 2010/11

b) **Option 2** provides a Southwark ambition to reduce the level to **24.9% by 2019/20**, equivalent to approximately 20% reduction over five years. The ambition would seek to bring down the Year 6 obesity level to the lowest ever seen since the introduction of the NCMP.

RECOMMENDATIONS

The Health and Wellbeing Board is requested to:

23. Agree which outcome(s) they would want to adopt and for which Year group. From a Public Health perspective, it is important to focus on prevention and early action, thereby shifting the population distribution towards healthy weight. Public Health is therefore recommending that at least one outcome relates to reducing excess weight at Reception Year. This will provide an emphasis on prevention during early years to increase the proportion of children who maintain healthy weight. In addition, as obesity levels seem to almost double between Reception and Year 6, looking at excess weight would reduce the proportion children who may not be obese at Reception year but would be at risk of becoming obese during their time in primary school. It would also offer the opportunity for appropriate early intervention for those identified as either overweight or obese at Reception.

24. Agree in principle, the relevant resources and Partnership commitments required to deliver the agreed ambition(s). More detailed working of these will be taken forward and developed through the obesity strategy development senior leaders group with a view that there is a clear action plan to deliver the ambition(s) which will be reflected in the Southwark Obesity Strategy being developed.

Agenda Item 8

Item No. 8.	Classification: Open	Date: 28 January 2016	Meeting Name: Health and Wellbeing Board
Report title:		Southwark Smoking Data and Options for 5 year smoking prevalence Outcome Ambitions	
Wards or groups affected:		All	
From:		Ruth Wallis, Director of Public Health, Lambeth and Southwark	

RECOMMENDATIONS

1. The board is requested to:

   a) Receive an update on the most up to date Southwark data for smoking
   b) Note the evidence based interventions required to effectively tackle smoking in the borough
   c) Consider and agree the proposed 5 year outcome ambitions for smoking prevalence that Southwark should seek to work towards.

EXECUTIVE SUMMARY

2. Smoking is the single most preventable cause of ill health, health inequalities and premature mortality in the borough. Smoking prevalence in Southwark is slightly lower (but not significantly lower) than the London and England averages both for the general adult population (16.3%) and for routine and manual workers (23.4%).

3. An update on current action around smoking was presented at the last Health and Wellbeing Board meeting. The board requested that the latest relevant data and proposals for ambition outcomes for smoking be presented at a future meeting. This report provides the smoking data as well as the proposed 5 year Southwark ambition options for smoking.

4. Based on current trends Public Health has modelled different trajectories and is proposing the following smoking prevalence outcome ambitions:

   - **Reduce smoking prevalence in the Southwark general adult population to 14.5% by 2019/20** (approximately 23% reduction over 5 years)

   - **Reduce smoking prevalence in the Southwark routine and manual occupations population to 20.2% by 2019/20** (approximately 23% reduction over 5 years)

BACKGROUND INFORMATION

5. The Public Health Outcomes Framework provides annual local smoking prevalence for the general population and for routine and manual workers. This offers the opportunity to assess current achievement and the ability to set future

targets. Over the last decade, local focus has been mainly on stop smoking services and 4 week quits, smoking cessation is a highly cost effective intervention, however on its own, it will not deliver a reduction in smoking prevalence. A comprehensive tobacco control approach is required of which smoking cessation is one of the evidence based interventions. The Health and Wellbeing Board has requested potential outcome ambitions around reducing smoking prevalence in Southwark.

KEY ISSUES FOR CONSIDERATION

6. The Health and Wellbeing Board will need to decide on the potential smoking prevalence 5 year ambition offered for the general population and routine and manual workers. Agreeing the local ambitions for smoking will also require commitments to implement sustained evidence based interventions and the associated resources necessary. There is a recognition that there are financial challenges across the different organisations locally. This means that if the Health and Wellbeing Board want to set ambitions that are stretching yet achievable with the appropriate approach and resources, then tough decisions may need to be made by the Partnership. The interventions required are:

- Making tobacco less affordable
- Stopping the promotion of tobacco
- Effective regulation of tobacco products
- Helping tobacco users to quit
- Reducing exposure to secondhand smoke
- Effective communications for tobacco control

Policy implications

7. Tackling smoking is incorporated within the priorities of the Southwark Health and Wellbeing Strategy

Community impact statement

8. Smoking is the single most preventable cause of health inequalities. Apart from ill health, smoking contributes to household poverty, criminal activity of illegal sales, fires and social care costs. Effectively tackling smoking with a focus on more deprived communities will help to address all of these.

Legal implications

9. There are no specific legal implications.

Financial implications

10. There are financial implications for working towards the ambitions agreed. At a very minimum, the current budget for smoking needs to be maintained (including contribution from Trading Standards) to meet the outcome ambition for the general population. However if health inequalities are to be properly addressed then additional investment is required.

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 Smoking Data and Options for 5 year Smoking prevalence Outcome Ambitions

AUDIT TRAIL

Lead officer	Ruth Wallis, Director of Public Health, Lambeth & Southwark	
Report Author	Bimpe Oki, Consultant in Public Health, Lambeth and Southwark	
Version	Final	
Dated	15 January 2016	
Key decision?	Yes	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer title	**Comments sought**	**Comments Included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Date final report sent to Constitutional Team		15 January 2016

APPENDIX 1

SOUTHWARK SMOKING DATA AND OPTIONS FOR 5 YEAR SMOKING PREVALENCE OUTCOME AMBITIONS

Author: Bimpe Oki, Consultant in Public Health, Lambeth and Southwark
January 2016

INTRODUCTION

1. Smoking is the single most preventable cause of ill health, health inequalities and premature mortality in the borough. Household spending on tobacco contributes to poverty and illicit tobacco fuels crime and can disrupt community safety.

2. The Public Health Outcomes Framework provides annual local smoking prevalence for the general population and for those routine and manual occupations. This offers the opportunity to assess current achievement and the ability to set future targets. Latest figures (2014) show that smoking prevalence in Southwark is lower than the London and England average both for the general adult population (16.3%) and for routine and manual workers (23.4%).

3. Over the last decade, the focus locally has been mainly on stop smoking services and 4 week quits. Smoking cessation is a highly cost effective intervention, however on its own, it will not deliver a reduction in smoking prevalence. A comprehensive tobacco control approach is required of which smoking cessation is just one of the evidence based interventions. An evidence based approach includes all of the following components:

    - Stopping the promotion of tobacco
    - Making tobacco less affordable
    - Effective regulation of tobacco products
    - Helping tobacco users to quit
    - Reducing exposure to secondhand smoke
    - Effective communications for tobacco control.

4. Southwark Health and Wellbeing Board has requested for proposals for ambition outcomes for smoking. This paper provides a brief explanation of how Public Health has come up with the 5 year ambition options for smoking outcomes and what these are. It important to note that significant effort is required to implement the evidence based interventions which may require additional investment to reinforce a comprehensive tobacco control approach, beyond just stop smoking services.

LATEST SMOKING RELATED DATA

5. There are no longer national targets for smoking. Over the last decade efforts were made to achieve nationally set 4 week quit targets through local Stop Smoking Services. The Public Health Outcomes enables local areas to track progress are focused around smoking prevalence. The most up to date smoking related Public Health Outcomes (IHS, 2014) reveal a reduction in smoking

prevalence nationally, regionally and locally. Southwark has had a significant reduction from 20.7% to 16.5%. There has also been a reduction in smoking prevalence in routine and manual workers from 29.3% to 23.4%. The reason for this is unclear and this data will continue to be monitored to ascertain if these figures are just anomalies for the year 2014.

Table 1: Smoking Related Public Health Outcomes

	England	London	Southwark
Smoking prevalence (18+)	18.0%	17.0%	**16.5%**
Smoking prevalence (routine and manual)	28.0%	25.3%	**23.4%**
Smoking prevalence at age 15	8.2%	6.1%	**4.5%**
Smoking status at time of delivery	11.4%	4.8%	**3.1%**

6. Southwark continues to record, collate and submit 4 week quit data. Nationally and in London there has been a reduction in the number of people setting a quit date since 2011/12, however quit rates have been quite satisfactory and consistent over the years (51% for England and 50% for London). The situation in Southwark is similar with respect to fewer numbers setting the quit dates but the average quit rates has gone down. In 2014, 2,769 smokers set a quit date and 1,050 were successfully quit at 4 weeks (37%). This is equivalent to 1,124 per 100,000 population setting a quit date and 426 per 100,000 population quitting.

Table 2: Southwark Stop Smoking Service Quit Data (2011/12 – 2014/15)

Year	No Setting a Quit	No. of Quitters	Success rate
2011-12	4224	1685	39.9%
2012-13	3842	1538	40%
2013-14	3208	1369	43%
2014-15	**2769**	**1050**	**37%**

7. Stop Smoking data is collected on a quarterly basis; for 2015/16, quarters 1 and 2 data are now available. A total of 1,016 smokers have set a quit date with 332 quit at 4 weeks (33% success). The data shows the variation in quit rates for the different providers.

Table 3: Southwark Stop Smoking Service Data 2015/16 Quarter 1 (April – June 2015)

Provider	Setting Quit Dates	Quitters	Success Rate
GP Practices	385	73	19%
Pharmacies	74	38	51%
GSTT Specialist	58	31	53%
SLAM	33	25	75%
Total	**550**	**167**	**30%**

Table 4: Southwark Stop Smoking Service Data 2015/16 Quarter 2 (July - Sept 2015)

Provider	Setting Quit Dates	Quitters	Success Rate
GP Practices	297	66	22%
Pharmacies	76	53	70%
GSTT Specialist	63	33	52%
SLAM	30	13	43%
Total	**466**	**165**	**35%**

8. Public Health has conducted a Health Equity Audit on the Southwark Stop Smoking Service (2011 – 2014). Analysis showed that positively, most smokers from ethnic and deprivation groups were accessing the service in line with need. However, men and those aged between 20 and 29 years old were not accessing the service in line with need. In terms of successful 4 week quits, smokers of working age, vulnerable and deprived groups and to a lesser extent men and those from the Caribbean ethnic group were less likely to be quit at 4 weeks.

9. The results of the Health Equity Audit (HEA) suggests that the Southwark Stop Smoking Service is generally accessible to majority of the smokers who need it most, however they are less likely to be quit at 4 weeks. Although further investigation is required, the low quit rates currently seen in quarters 1 and 2 (2015/16) may be as a result of those now accessing the service being from more disadvantaged groups. They are likely to be more heavily addicted to tobacco and so may require intensive support beyond the service being offered. Based on the findings of the HEA and the review on tobacco control,. Public Health has provided recommendations for the future commissioning of stop smoking services to ensure a service model supports those at greatest need.

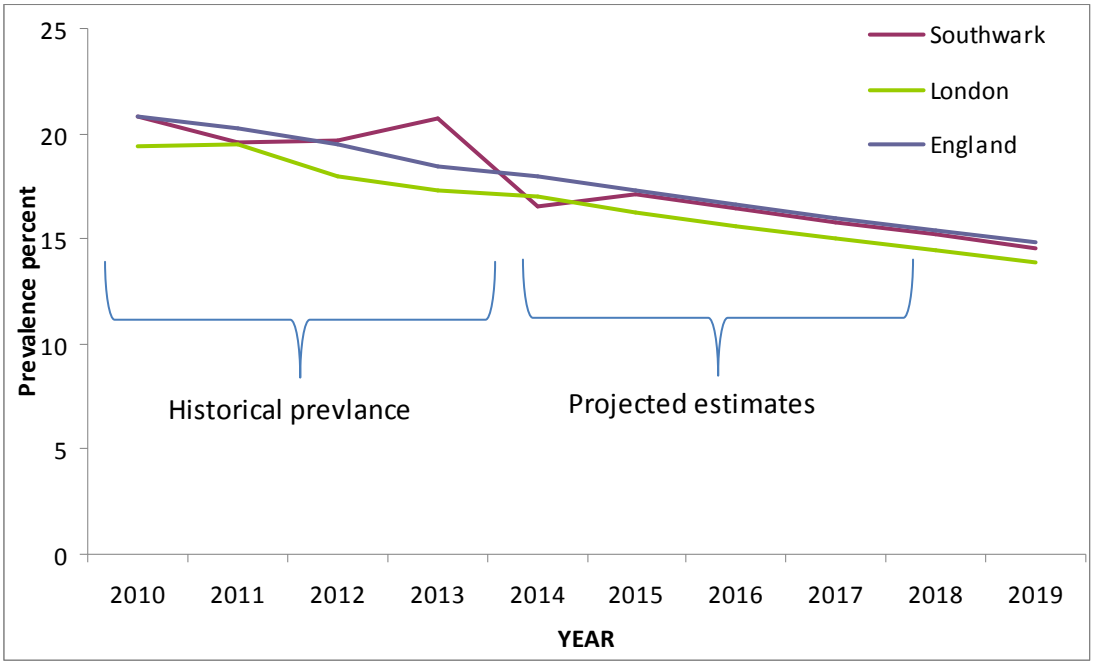
MODELLING APPROACH

10. Smoking prevalence data are published in the Public Health Outcomes. The figures are derived from the Integrated Household Survey. Public Health looked at historical patterns of smoking prevalence from 2010 to the most recent 2014. Using the actual trends, projections were made for different scenarios; looking at what the continued current trend would look like in 5 years time. As smoking

prevalence continues to decrease, it will become even more challenging to seek faster reductions; in addition clarification is still required regarding the significant prevalence reduction seen in 2014 to ensure this is not just an anomaly. Public Health has therefore sought to take a pragmatic approach regarding the appropriateness of identifying any specific ambition outcomes. Assumptions for the modelling have been made on the basis that the current regional and national interventions and trends continue.

AMBITION OUTCOMES FOR SMOKING PREVALENCE (ADULT POPULATION)

Chart 1: Trajectories showing actual Smoking Prevalence (2010 – 2014) and Projected Prevalence (2015 - 2019) for Southwark, London and England



11. Smoking prevalence in Southwark is slightly lower than the London average for the adult population (16.3%). Current trends indicate a reduction in prevalence. There was a significant reduction in Southwark smoking prevalence in 2014 and it is unclear how real this is. Public Health has therefore used the London average to model future trends for Southwark.

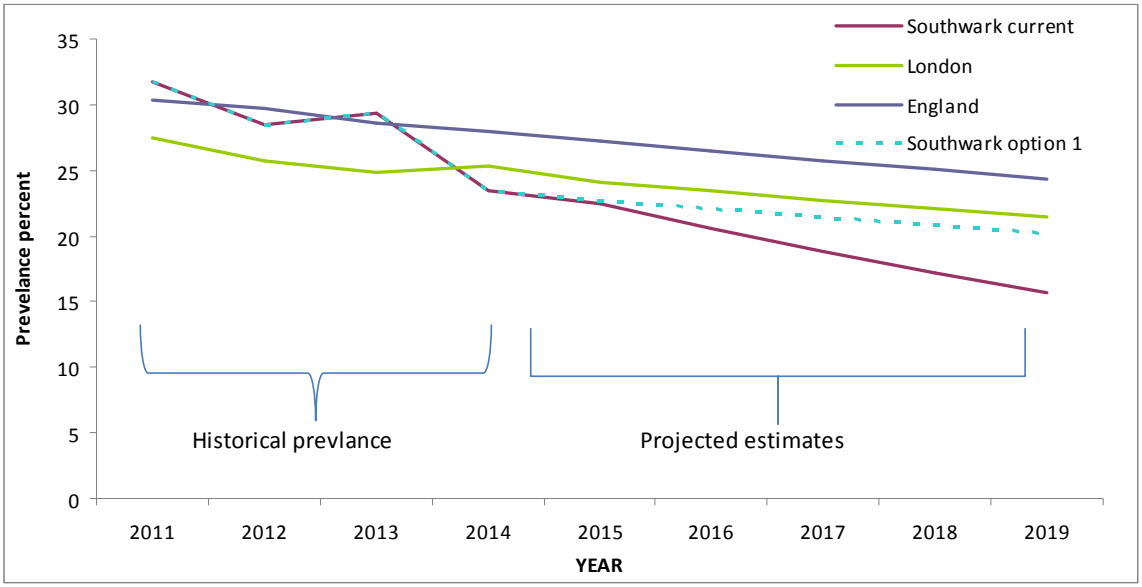
12. Based on current trends, if at a minimum, the level of local investment as well as national and local efforts are maintained, then we could see an almost 23% reduction over 5 years for the general adult population to a **smoking prevalence of 14.5% by 2019/20.** This appears to be a realistic but sufficiently ambitious outcome.

Table 5: Actual Smoking Prevalence (2010-2014) and Projected Smoking Prevalence (2015-2019) for the Adult Population in Southwark, London and England

Period	2010	2011	2012	2013	2014	*2015*	*2016*	*2017*	*2018*	*2019*
Southwark (%)	**20.8**	**19.6**	**19.7**	**20.7**	**16.5**	***17.2***	***16.5***	***15.8***	***15.2***	***14.5***
London (%)	19.4	19.5	18.0	17.3	17.0	*16.2*	*15.6*	*15.0*	*14.5*	*13.9*
England (%)	20.8	20.2	19.5	18.4	18.0	*17.3*	*16.6*	*16.0*	*15.4*	*14.8*

AMBITION OUTCOMES FOR SMOKING PREVALENCE (ROUTINE AND MANUAL OCCUPATIONS)

Chart 2: Actual Smoking Prevalence for Routine and Manual Occupations (2010 – 2014) and Projected Prevalence (2015 - 2019) for Southwark, London and England



13. Smoking prevalence in Southwark (2014) of 23.4% is lower than the London and national average both for the general population (16.3%) and for routine and manual workers. Due to the sharp decline in the proportion of smokers in this group in 2014 and without any further clarification of the validity of this figure, Public Health has modelled a future trajectory to similar to the expected rate of decline for London.

14. A 5 year smoking prevalence ambition of **20.2% by 2019/20** for routine and manual workers, equivalent to a 26% reduction is being proposed. Working towards this 20.2% prevalence outcome by 2019/20 (much lower than the 5 year London and England projected averages) will require significant effort and additional investment to reinforce a comprehensive tobacco control approach, beyond just stop smoking services.

Table 6: Actual Smoking Prevalence (2010-2014) and Projected Smoking Prevalence (2015-2019) for Routine and Manual Occupations in Southwark, London and England

Period	2010	2011	2012	2013	2014	*2015*	*2016*	*2017*	*2018*	*2019*
Southwark (%)		**31.8**	**28.5**	**29.3**	**23.4**	***22.5***	***20.5***	***18.8***	***17.2***	***15.7***
London (%)		27.5	25.7	24.9	25.3	*24.1*	*23.4*	*22.8*	*22.1*	*21.5*
England (%)		30.3	29.7	28.6	28.0	*27.2*	*26.5*	*25.7*	*25.1*	*24.4*
Southwark Option 1(%)		**30.3**	**29.7**	**28.6**	**28**	***22.8***	***22.1***	***21.5***	***20.8***	***20.2***

SUMMARY OF PROPOSED AMBITIONS

15. **Smoking Prevalence Adult Population**
    - ***Smoking Prevalence of 14.5% by 2019/20*** (23% reduction over 5 years)

16. **Smoking Prevalence Routine and Manual Occupations**
    - ***Smoking Prevalence of 20.2% by 2019/20*** (26% reduction over 5 years)

RECOMMENDATIONS

The Health and Wellbeing Board is requested to:

17. Agree the proposed 5 year smoking prevalence ambition outcomes for the general adult population and those in routine and manual occupations

18. Agree in principle, commitment to implement sustained evidence based interventions and seeking to securing the associated resources necessary. As smoking makes a significant contribution to health inequalities in the borough, it is important that there are appropriate resources to support those who may be at greater risk of smoking.

Agenda Item 9

Item No. 9.	Classification: Open	Date: 28 January 2016	Meeting Name: Health and Wellbeing Board
Report title:		Project proposal on enhancing the impact of planning policy on health outcomes and inequalities in Southwark and Lambeth	
Ward(s) or groups affected:		All (Southwark and Lambeth)	
From:		Director of Planning	

RECOMMENDATIONS

1. That the Health and Well-Being Board support the proposal that has been put forward for the Guys and St Thomas's Charity Health Innovation Fund on enhancing the impact of planning policy on health outcomes and inequalities in Southwark and Lambeth.

2. That members endorse the aims of the project, support its objectives and request further updates on the progress of the project subject to funding being agreed by the Guys and St Thomas's Charity.

BACKGROUND INFORMATION

3. Improving the nation's health through better planning and design to reduce the impact of a poor physical and natural environment is a Public Health England (PHE) priority1. The government's public health strategy 'Healthy lives, healthy people', explicitly recognises that "health considerations are an important part of planning policy". The Marmot Review highlighted the need for planning to address health inequalities and develop healthy and sustainable places and communities. There are many ways in which planning can influence the 'wider determinants of health' (see figure 1). Health related planning policy issues include:

    - Housing provision, including in terms of affordable housing/housing mix, design (low carbon energy efficient design, space, daylight, etc) and older people's housing
    - Active travel (encouraging walking and cycling and public transport use)
    - Social infrastructure e.g. education provision, faith venues, community facilities
    - Employment provision
    - Public realm design, green space and play space
    - Health service provision and access
    - Air quality
    - Food e.g. hot food takeaway exclusion zones around schools; food growing

KEY ISSUES FOR CONSIDERATION

4. An outline of the proposed project is attached at appendix 1 and is summarised below.

5. The important link between how places are planned and developed and the health of the communities who live in them is increasingly recognised by planners. However the links between the wider determinants of health, health outcomes and health inequalities are not always explicitly and fully addressed in planning documents.

6. For this innovative action research project we propose a focus on three key themes:

   A. Assessing the influence of the built environment on social interaction and social isolation
   B. Addressing obesity and inactivity through creating 'healthy-weight environments'
   C. Improving health service provision and access

7. It is proposed that the project will use intensive social research with people in Southwark and Lambeth to discover the factors in their lives and their interaction with their environment which are likely to become important determinants of health. This information will be used in the detailed planning of new neighbourhoods.

8. For example, in Southwark, the mainly industrial and commercial area around the Old Kent Road has been designated an 'Opportunity Area' in the London Plan and will be transformed over the next 20 years to become highly accessible mixed use areas providing a wide range of employment opportunities, social infrastructure, shops and other services and open space to serve around 20,000 new homes. Such a transformation of a large part of the borough could potentially have far reaching impacts on the health of the new population moving into the new homes and the existing population in established residential neighbourhoods that surround the area. The aim of the project is to acquire a deeper, more detailed understanding of the lifestyles of local people so that the planning of the new area can optimise the opportunities for improving public health.

9. The success of the project depends on strong leadership to think about ideas, suggest and carry through new ways of working and influence change. The Health and Well Being board is important as this can assist with making change happen to ensure that the health improvements take place within Lambeth and Southwark.

Policy implications

10. The project is intended to shape planning policy and inform regeneration programmes in the two boroughs. In Southwark it will inform the New Southwark Plan and the Old Kent Road Area Action Plan currently being prepared. It should lead to better coordination between planning, regeneration and public health policy.

Community impact statement

11. The purpose of planning policy is to facilitate regeneration and beneficial development ensuring that community impacts are taken into account. Plans such

as the New Southwark Plan and the Old Kent Road Area Action Plan require equalities analysis to be carried out. The proposed project will assist in the carrying out of these analyses and help ensure that the plans have a positive impact on different groups.

Resource implications

12. The project will contribute to the resources available for the preparation of planning and regeneration policy in the two boroughs.

Legal implications

13. There are no specific legal implications arising from this report.

Financial implications

14. Funding for the project is sought from the Guys and St Thomas's Charity Health innovation Fund. This should cover all costs including project management in Southwark and Lambeth.

Consultation

15. The proposal will facilitate enhanced public involved and consultation in the preparation of planning and regeneration policy.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

Director of Public Health

16. Public health was involved in the scoping and development of the project proposal. The opportunities offered by the Old Kent Road transformation can contribute towards improving the health of the local population as well as to mitigate any potential negative impacts. The project will enable work to begin to establish a good baseline to inform local needs assessment as well as support more robust evaluation of the OKR transformation and its impact on population health. The www.southwark.gov.uk/jsna and the Director of Public Health's Annual Public Health Reports identify key issues for Southwark including this geographical area as including unhealthy weight, physical inactivity, tobacco use, common long term chronic health conditions and opportunities for enhancing health and community provision. The project proposal will inform 'healthier' place shaping. Public health is represented on the Project Steering Group and will continue to input to the project.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None	N/A	N/A

APPENDICES

No.	Title
Appendix 1	Proposal for Guys and St Thomas's Charity Health Innovation Fund

AUDIT TRAIL

Lead Officer	Simon Bevan – Director of Planning	
Report Author	Simon Bevan	
Version	Final	
Dated	15 January 2016	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Director of Public Health	Yes	Yes
Cabinet Member	No	No
Date final report sent to Constitutional Team		15 January 2016

APPENDIX 1

Proposal for Guys and St Thomas' Charity Health Innovation Fund

Project proposal: Enhancing the impact of planning policy on health outcomes and health inequalities in Southwark and Lambeth

Overarching objectives

- To test key assumptions underlying existing Southwark and Lambeth planning policies and guidance aimed at improving health outcomes and reducing health inequalities:
    - Are our assumptions robust?
    - How can we enhance the health outcomes delivered through planning?
- To use this learning to inform the development and adoption of new planning policies and guidance as part of the New Southwark Plan and Old Kent Road Area Action Plan in Southwark and the Lambeth Local Plan in Lambeth; and to inform our support to neighbourhood planning
- To use this learning to inform improved monitoring and evaluation of the impacts of planning policy on health outcomes and health inequalities

Introduction

The responsibility of Southwark and Lambeth Councils to promote public health has been strengthened through the Health and Social Care Act 2012. In the context of local government cuts the new Local Plans being developed in both boroughs will be important tools for securing improved public health outcomes and reducing costs to the NHS.

Improving the nation's health through better planning and design to reduce the impact of a poor physical and natural environment is a Public Health England (PHE) priority[1]. The government's public health strategy 'Healthy lives, healthy people', explicitly recognises that *"health considerations are an important part of planning policy".* The Marmot Review highlighted the need for planning to address health inequalities and develop healthy and sustainable places and communities. There are many ways in which planning can influence the 'wider determinants of health' (see figure 1). Health related planning policy issues include:

- Housing provision, including in terms of affordable housing/housing mix, design (low carbon energy efficient design, space, daylight, etc) and older people's housing
- Active travel (encouraging walking and cycling and public transport use)
- Social infrastructure e.g. education provision, faith venues, community facilities
- Employment provision
- Public realm design, green space and play space
- Health service provision and access
- Air quality
- Food e.g. hot food takeaway exclusion zones around schools; food growing

Focusing on built environment interventions can also open up the possibility of developer contributions to fund healthy lifestyle infrastructure such as green spaces.

The important link between how places are planned and developed and the health of the communities who live in them is increasingly recognised by planners. However the links between the wider determinants of health, health outcomes and health inequalities are not always explicitly and fully addressed in planning documents (Kent County Council, 2014[2]).

[1] https://www.gov.uk/government/news/healthy-people-healthy-places-building-a-healthy-future

[2] http://healthsustainabilityplanning.co.uk (this toolkit was researched and project managed by team member Dr Doug McNab, previously at AECOM/URS). See also: The scope for tackling obesity in Medway through the built environment (Medway Council, 2013).

For this innovative action research project we propose a focus on three key themes:

A. **Assessing the influence of the built environment on social interaction and social isolation**
B. **Addressing obesity and inactivity through creating 'healthy-weight environments'**
C. **Improving health service provision and access**

The justification for focusing on each of these themes and the proposed approach is set out below. Interactions between the themes will be drawn out in the final report.

This work will ultimately help to shape healthier places in both Southwark and Lambeth by complementing and deepening ongoing efforts to better engage with local people, tap into their visions of the places where they live and 'co-design' changes to the built environment.

Figure 1: The wider determinants of health[3]

[3] Barton, H. and Grant, M. (2006) A health map for the local human habitat. The Journal for the Royal Society for the Promotion of Health, 126 (6). pp. 252-253. ISSN 1466-4240 developed from the model by Dahlgren and Whitehead, 1991.Dahlgren G, Whitehead M (1991). "The main determinants of health" model, version accessible in: Dahlgren G, and Whitehead M. (2007) European strategies for tackling social inequities in health: Levelling up Part 2. Copenhagen: WHO Regional Office for Europe.

A. Assessing the influence of the built environment on social interaction and social isolation

The Public Health Reports for Southwark and Lambeth recommend that social relationships and community development should be made policy priorities. Projects that create and sustain social ties make people's lives healthier and build community cohesion, allowing people to effect change in their local area and reducing the need for state-led interventions[4].

Indicators of social isolation in Southwark and Lambeth's Public Health Outcomes Frameworks indicate social isolation levels significantly above the England average with a significant proportion of adult social care users (60%) and adult carers (60-70%) reporting not having as much social contact as they would like.

Recent work by Public Health England (PHE, 2015)[5] highlights the impact of social isolation[6] and social relationships on health behaviours, physical and mental health, and risk of mortality. A recent meta-analysis suggests that social isolation can increase the risk of premature death by around 30%[7]. While social isolation is more commonly considered in later life, it can occur at all stages of the life course. Social isolation is viewed as a health inequality issue because many of the associated risk factors (e.g. poor maternal health, teenage pregnancy, unemployment, illness in later life) are more prevalent among socially disadvantaged groups.[8]

Importantly the PHE[9] report also recognises the significant impact that the built environment and accessible, affordable transport infrastructure can have on whether or not a person becomes socially isolated; for example through influencing physical access to family and friends, health services, community centres, shops and all the other types of places and spaces that enable people to build and maintain their social relationships. Safe public spaces, with pavements to walk on and lighting, are also identified as part of the physical infrastructure that helps people to maintain social connections.

Designing the streets to be conducive to walking is also likely to encourage social connectivity[10]. Hence there is a direct link here between this research theme and theme 2 which includes a focus on addressing obesity through encouraging walking.

This project will seek to understand where residents of Southwark and Lambeth go to meet others, be it for planned meetings or spontaneous social interactions. Proceeding from the premise that creating and sustaining social ties is good for health and wellbeing, this research will seek to understand what places or spaces (e.g. faith venues, community halls, cafes, pubs, leisure centres, football pitches, schools, parks, high streets) are most important for different groups of residents to sustain and build social relationships and feel part of their community. For example, are community facilities such as community halls[11] important for this

[4] http://www.london.gov.uk/sites/default/files/LondonHealthInequalitiesStrategy.pdf
[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf
[6] Reducing social isolation is a priority for social care and public health, as reflected in shared indicators across both the Public Health Outcomes Framework and the Adult Social Care Outcomes Framework.
[7] http://www.nhs.uk/news/2015/03March/Pages/Loneliness-increases-risk-of-premature-death.aspx
[8] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf
[9] Ibid
[10] Boyce C. Walkability, Social Inclusion and Social Isolation and Street Redesign. Built Environment 2010;36(5):12.
[11] Southwark and Lambeth have reasonable provision of community space such as public halls and community centres, however many such spaces provide limited functions. There is now a significant focus on encouraging provision of flexible, multi-purpose community uses and on co-location of such 'social infrastructure' both with housing, and with other social infrastructure uses.

purpose or are most people more likely to socialise at the local cafe or restaurant? Which facilities or spaces are important for which groups (e.g. specific age groups or ethnicities) and why (e.g. ties to user group, affordability, distance and accessibility, opening times, fear of crime, perceived barriers to entry)? Do people perceive changes, for better or worse, in the opportunities provided for creating and sustaining social ties in their local neighbourhood? What could be done to improve such opportunities in future? Are 'virtual' networks or other non-place-based social relationships of significant importance to people's sense of identity?

This element of the study is likely to involve a combination of:

- A large scale survey using telephone and/or face to face interviews of residents across Southwark and Lambeth. This is likely to involve use of a stratified random sample to collect representative and statistically robust findings.
- Follow-up qualitative engagement (e.g. using focus groups or short on-street interviews) targeting specific areas or groups (e.g. groups at high risk of social isolation such as the elderly[12], single parents, disabled people or people affected by benefits cuts), allowing more in-depth investigation of particular issues relevant to planning identified through the survey. This could include mapping key places and spaces for social interaction within regeneration areas and identification of opportunities for improvement.

The research findings will be used to inform improved planning policies, including in the Old Kent Road AAP, and/or guidance aimed at shaping places in a way that maximises opportunity for all residents – no matter their age, wealth, ethnicity or background – to create and sustain social relationships. For example, if the research reveals the importance of communal space in housing schemes for social interaction then this might be important evidence to support stronger policies on securing such space as part of new developments. Or it could highlight a need for improved design of high streets and other public spaces to encourage walking and facilitate interaction, for example a need for better provision of seating and ground level public toilets (issues often highlighted by older people), safe crossings and/or and design reduces the likelihood of antisocial behaviour.

A key anticipated medium term outcome of this project will therefore be reduced social isolation and enhanced social networks in Southwark and Lambeth, with knock-on health and wellbeing benefits for local people and potentially also reduced health inequalities. PHE (2015)[13] notes that while the cost of social isolation to local government and the NHS is difficult to determine, successful interventions to tackle social isolation reduce the burden on health and social care services and are typically cost-effective and can have a high social return on investment.

[12] This could include consideration of design features of "dementia friendly environments" such as having obvious entrances to buildings, distinctive features at junctions, frequent pedestrian crossings and wide, flat, smooth footways; see http://www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Viewpoints/Viewpoint25_AtAGlance.pdf

[13] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461120/3a_Social_isolation-Full-revised.pdf

B. Addressing obesity and inactivity through creating 'healthy-weight environments'

Obesity prevention and reduction is a global public health priority as a result of the worldwide increase in obesity prevalence and its associated chronic diseases; obesity and inactivity are causes of coronary heart disease and increase the risk of conditions such as type 2 diabetes, raised blood pressure, Alzheimer's disease, colon cancer and depression. Obesity is a priority health issue in Southwark and Lambeth, particularly amongst children; in Southwark 42.7% of children aged 10-11 are classified as overweight or obese, which compares to the England average of 33.9% and is equivalent to the highest value for England 42.8%[14]; the rate for Lambeth is also above the England average at 39.3%[15].

Obesity is a complex problem that requires action from individuals and society across multiple sectors[16]. One important category of determinants of obesity is the opportunities for calorie intake and calorie expenditure (or a lack thereof) in the physical environment. Certain environments may be more 'obesogenic' than others, such that they are more likely to promote weight gain and obesity in individuals or populations[17]. Hence planning has an important role to play in shaping a 'healthy-weight environment'. The Public Health Reports for Southwark and Lambeth recommend investment in a long-term approach to improve healthy weight, including through planning policies.

However, it remains a challenge to identify the physical environmental factors with the greatest impacts on (the development of) overweight and obesity. 'The Marmot Review: Implications for Spatial Planning' identified strong evidence that that provision of green space effectively improves mental health; less strong/inconclusive evidence that provision of green space improves levels of physical activity; and anecdotal evidence that local access to healthy foods improves diets. A recent review (Mackenbach et al, 2014)[18] indicated that *"the available research does not allow robust identification of ways in which that physical environment influences adult weight status, even after taking into account methodological quality".* This is understandable due to the difficultly in demonstrating causality between changes in the built environment and obesity outcomes.

A lack of robust evidence cannot be a reason for inaction, and the evidence does suggest that positive health outcomes can be expected by shaping an environment that is less 'obesogenic'. PHE (2013)[19] indicate that creating an environment where people actively choose to walk and cycle as part of everyday life can have a significant effect on public health and reduce inequalities in health, and that improving the quality of the food environment around schools can also influence children's food purchasing habits, and their future diets[20].

This study will seek to contribute both to identifying the most effective planning policies for addressing inactivity and obesity in Southwark and Lambeth, and contribute to the wider literature and practice-based evidence on 'healthy-weight environments', including through enhanced monitoring and evaluation of the impacts of new planning policies. A key recommendation from 'Planning Healthy Weight Environment' (TCPA, 2015)[21] was to strengthen evaluation of the impact and effectiveness of planning policies and decisions.

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[14] Southwark Public Health Outcomes Framework 2014
[15] Lambeth Public Health Outcomes Framework 2014
[16] See Tackling obesities: future choices (UK government foresight report, 2007)
[17] http://www.biomedcentral.com/1471-2458/14/233#B5#B5
[18] http://www.biomedcentral.com/1471-2458/14/233
[19] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256796/Briefing_Obesity_and_active_travel_final.pdf
[20] https://www.gov.uk/government/news/healthy-people-healthy-places-building-a-healthy-future
[21] http://www.tcpa.org.uk/pages/health.html

Tackling obesity and creating 'healthy-weight environments' through planning cuts across many planning issues. Taking into account PHE (2013)[22] and research completed in Southwark, Lambeth and London, we propose to focus on two specific areas:

- **Walking -** A recent Council consultation in Southwark[23] identified safe, accessible and well lit walking routes as the second most import feature of an attractive neighbourhood/estate after high quality buildings. What interventions would best encourage more young people to walk for local trips, including to school and to other key places (e.g. shops, clubs)? Is it about improved signage, better 'permeability' of neighbourhoods, improved environment, safer routes or ensuring provision of accessible local shops, services and community infrastructure? Are there other factors that planning policy should address? In Southwark, this work would inform the development of a Walking Strategy, to complement Southwark Council's award-winning Cycle Strategy (2015)[24], as well as related planning policy and guidance (e.g. draft policies relating to new 'Low Line' and Peckham Coal Line walking routes).
- **Planning for healthy food** – the impact of hot food takeaways has been well researched, including social research in Lambeth to inform their planning policy on this issue. This research does not therefore seek to focus on this any further. Instead, it will explore the demand for improved access to affordable, fresh, healthy food through markets or local food growing projects.

This element of the study will focus on engaging people in a sample of more deprived areas in Southwark and/or Lambeth. It is likely to involve a combination of:

- Targeted telephone or face to face interviews (sample frame to be developed with public health); followed by focusing in on specific sub-areas or groups for more in-depth engagement using:
- Participatory mapping of walking routes (e.g. using mapping tools on mobile phones)
- Focus groups with school children, facilitated through engagement with schools or youth groups, or other groups of interest

The research would build on existing research and practice, including Active Design[25], community mapping work in Southwark to support 'active design'[26], the boroughs' Physical Activity and Sports Strategies, Lambeth's Food Flagship work and a project underway in Peckham to pilot town centre improvements that improve pedestrian safety[27].

A key anticipated medium term outcome of this project will be increased activity levels and reduced obesity rates, particularly amongst children. Given that the cost of inactivity to the NHS is estimated at £4.8 million per year in Lambeth alone[28] this could generate significant direct savings to the NHS. Action to tackle inactivity and obesity will also have wider benefits. For example, evidence indicates that more walking and cycling can support local businesses and promote vibrant town centres; reduce air pollution and congestion; and increase the number of people of all ages out on the streets, making public spaces seem more welcoming and providing opportunities for social interaction and children's play (PHE, 2013[29]). Moreover, targeting improvements in more deprived areas is likely to have a proportionately greater impact on physical activity and food access, thereby reducing health inequalities.

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[22] www.gov.uk/government/uploads/system/uploads/attachment_data/file/256796/Briefing_Obesity_and_active_travel_final.pdf

[23] Consultation on 11,000 new council homes.

[24] Given that much research has already been conducted in Southwark and across London on cycling demand and barriers to cycling we suggest the focus here should be on walking.

[25] http://www.sportengland.org/facilities-planning/planning-for-sport/planning-tools-and-guidance/active-design/

[26] Dalton-Lucas, R. 2015. Developing a community mapping tool to support 'active design'.

[27] https://tfl.gov.uk/info-for/media/press-releases/2015/july/road-safety-improvements-to-make-town-centres-safer-for-pedestrians

[28] https://www.lambeth.gov.uk/sites/default/files/active-lambeth-draft-lambeth-physical-activity-and-sports-strategy-january-2015.pdf

[29] See footnote 21.

C. Improving health service provision and access

Good access to health services and health and wellbeing advice is critical to supporting improved health outcomes for the populations of Southwark and Lambeth. New health infrastructure must be planned as part of wider area regeneration to ensure that both existing and new populations can be provided for.

In line with the New Models of Care programme outlined in the NHS 5 Year Forward View[30] and the aspirations of the Healthy New Towns programme[31], the project would seek to explore how the significant level of regeneration proposed in the area could offer the opportunity to design modern services from scratch, with few legacy constraints (i.e. existing services) that operate in other areas - integrating health and social care, but potentially also other public services such as welfare, education and affordable housing. Thus it will aim to add to wider learning about how health and care services could be integrated to provide better outcomes at the same or lower cost.

The research will address such questions from a user perspective, asking people how they currently access health and social care services and how they think local provision could be improved. Key research questions could include: How should health service provision be best designed and located to meet the needs of local people in a cost effective manner? Is there local demand for new models of provision such as integrated health hubs providing health services alongside social care and residential nursing services?[32] Would people like to see co-location of health services with other types of services, for example welfare providers?

As for the theme above, this element of the study will focus on engaging people in a sample of more deprived areas (so as to maximise potential impacts on health inequalities). It is likely to involve a combination of:

- Targeted telephone or face to face interviews (sample frame to be developed with public health);
- Surveys of users of 'standard' GPs to see what they would like to see change; and
- Surveys of users of innovative new facilities such as the West Norwood Health and Leisure Centre (opened in August 2014), an integrated centre for health and wellbeing incorporating a leisure centre, Lambeth Council customer centre, GP and dental services, community health services and a community space for hire. Should planning policy be explicitly supporting the further development of such facilities?

This element of the project would fit with wider work being progressed in Southwark on becoming a more age-friendly borough. Southwark Council successfully applied to the World Health Organisation (WHO) to be officially recognized as an age-friendly borough and Southwark's Cabinet recently agreed to hold a borough-wide community conversation on making Southwark an age-friendly borough and supporting residents to age well (e.g. understanding people's experiences of the borough and identifying what the gaps are that the action plan should address). Team member Doug McNab participated in the co-design workshop with key partners and academics that took place in September 2015 to kick off the work.

[30] https://www.england.nhs.uk/ourwork/futurenhs/

[31] http://www.housinglin.org.uk/Topics/browse/Design_building/Neighbourhoods/?&msg=0&parent=8578&child=9629

[32] For example see example of The Gateway Centre in Middlesborough - http://www.housinglin.org.uk/HousingRegions/NorthEast/?parent=1019&child=9882

Methodology

This methodology has been formulated jointly by planning and public health experts in Southwark and Lambeth Councils, drawing on the extensive knowledge and experience of our project Steering Group (see further details below). We have not involved service users or the public in formulating the methodology as this is not appropriate to the type of project proposed here, although we have drawn on previous social research and engagement with local people in developing this proposal (e.g. research on the impacts of the Bermondsey Spa regeneration project; work with SLAM on mental wellbeing impact assessments; and work commissioned to explore health and housing issues for 'hidden' populations). We would emphasise that the whole focus of this project is on engaging with local people and better understanding how planning policy and guidance can be shaped to enhance their health outcomes.

Uncertainty surrounds the extent to which environmental changes lead to a change in behaviour around diet or activity. **Cultural beliefs and perspectives** about quality and safety appear to be strong drivers (Medway Council, 2013). Community engagement is therefore very important to ensure that planned environmental changes reflect the priorities and concerns of the affected population.

The methodology is broken down into discrete tasks below:

Task 0: Inception meeting following selection of social research team

Task 1: Intensive social research with local people in Southwark and Lambeth

- Task 1A: Assessing the influence of the built environment on social interaction and social isolation (see section above)
- Task 1B: Addressing obesity and inactivity through creating 'healthy-weight environments' (see section above)
- Task 1C: Addressing fuel poverty and impacts on heath outcomes (see above)
- Task 1D: Produce full report, including technical appendices, detailing the methods used and the findings of tasks 1A-1C.

Output: Full research report
Time: 8 months in total (6 months for tasks 1A-1C and 2 months for task 1D)

Task 2: Review of existing planning frameworks in Southwark and Lambeth and identification of amendments to existing and emerging planning policies and guidance based on the findings from task 1.
Output: A concise report proposing specific revisions to planning policies and guidance, setting out the justifications and evidence for each amendment. This would be used to justify making and adopting changes to the policy documents themselves.
Time: 3 months (adopting the changes to the planning documents themselves will take longer due to the statutory plan making process)

Task 3: Develop enhanced approach to monitoring and evaluation of the impacts of adopted planning policies on health outcomes and health inequalities. The aim would be to devise process, output and outcome indicators of performance. The approach will be developed in consultation with the charity and with reference to the latest research and good practice on monitoring the impacts of environmental interventions targeting wider determinants of health (e.g. reports from Institute of Health Equity). Indicators selection will be informed by Annex 2 of *Fair Society, Healthy Lives* (Marmot 2010). Suitable methodologies for demonstrating the attribution of impacts will be explored, noting that this can be challenging for these types of interventions.
Output: Monitoring and evaluation framework document.
Time: 3 months

Task 4: Implementation and reporting of monitoring and evaluation of impacts of adopted policies on health outcomes and health inequalities. Reporting would form part of each council's authority monitoring report, which is produced annually, though this health monitoring and evaluation might realistically be undertaken on a less regular basis e.g. every five years (particularly given that impacts are only anticipated in the medium term).
Output: A health monitoring report produced on an ongoing basis; wider dissemination of findings will be undertaken via appropriate channels.
Time: Ongoing; we are not seeking funding for this element but we would share the findings with the Charity and collaborate with them on wider dissemination.

Population groups to be engaged in the project will be determined based on range of factors including demographic data and local health data, but could include:

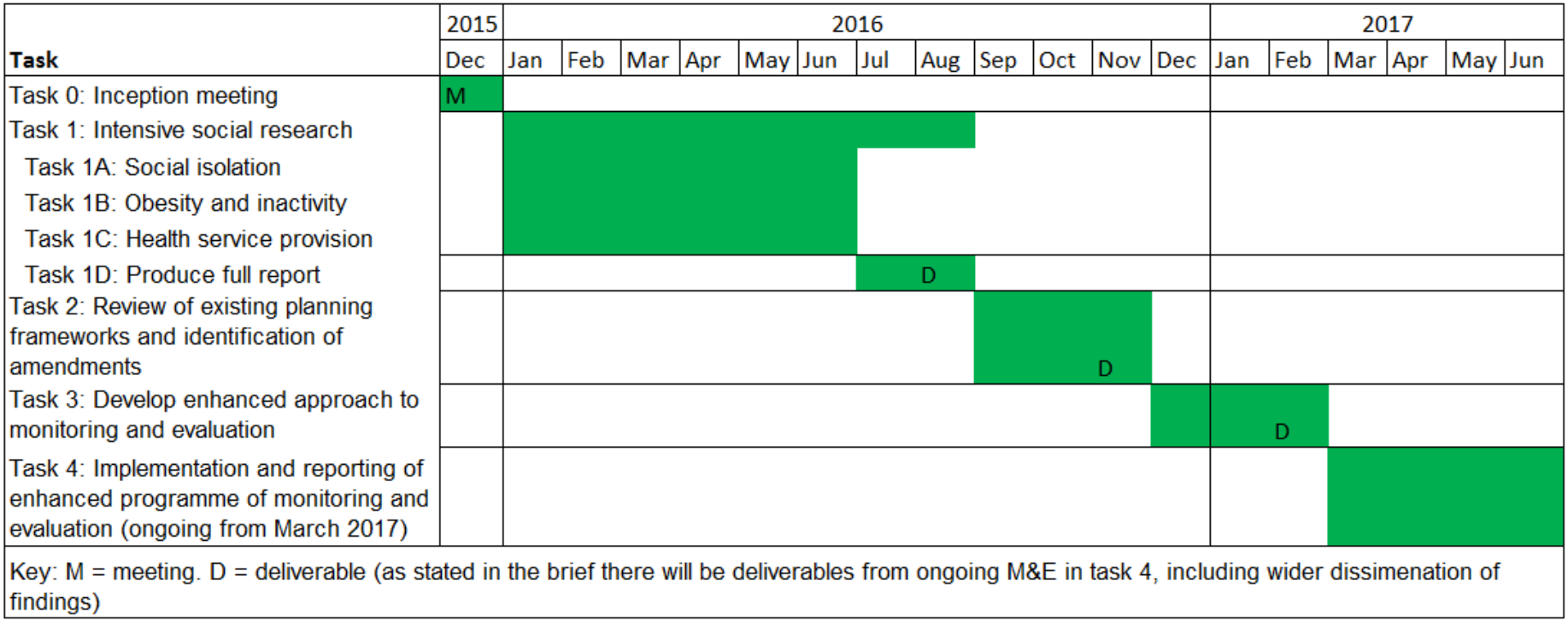
- Young, middle aged and old
- Range of ethnicities
- Range of geographical locations
- Range of housing circumstances (e.g. private home owners, private renters, social renters)
- Long term residents and newer arrivals

We will make a conscious effort to engage with those population groups that do not often participate in consultations due to age, disinterest, lack of time or lack of knowledge of the consultation taking place.

Project plan

Our project plan is shown in the Gantt chart overleaf. This will be developed further and agreed with Guys and St Thomas' Charity prior to commencing the research.

Figure 3: Project plan



Project team and governance

Our project team, including a Steering Group with senior expertise across health and planning, has been assembled specifically for this project. Planning and Public Health leads have been closely involved in formulating this project and are represented on the Steering Group. Thus we have the necessary high level leadership to deliver the project successfully.

Simon Bevan (Director of Planning, Southwark) will be Project Director, responsible for overall delivery.

Juliet Seymour (Planning Policy Manager, Southwark) will be Project Manager, responsible for day to day management of the research team and steering group (supported by Doug McNab) and liaison with Guys and St Thomas' Charity. Juliet will provide regular progress reports to the charity, at intervals to be agreed.

A Steering Group (SG) will oversee and advise on project implementation. The proposed steering group is shown below. The steering group will meet every three months to review progress and next steps.

Steering group members:

Person	**Role/ expertise brought to project**
Simon Bevan, Director of Planning, Southwark	Project director / strategic planning
David Joyce, Director for Planning and Development, Lambeth	Strategic planning lead for Lambeth / strategic planning
Ruth Wallis Director of Public Health, Southwark and Lambeth	Southwark and Lambeth public health lead / public health
Juliet Seymour, Planning Policy Manager, Southwark	Project manager and strategic planning lead for Southwark / strategic planning
Dr Doug McNab, Planning Policy, Southwark	Southwark strategic planning support / strategic planning, health-planning links
Veronica Thiel, Public Health, Southwark/Lambeth	Public health support / public health
Bimpe Oki, Public Health, Southwark/Lambeth	Public health support / public health
Sarah Totterdell, Senior Strategy Officer, Community Participation	Community consultation support / community consultation and equalities
Leona Staple, Regeneration, Southwark	Regeneration lead / regeneration
Ravi Baghirathan, Deputy Director, Healthy New Towns project	Expert advisor / healthy new towns
Prof Yvonne Rydin, Professor of Planning, Environment and Public Policy, UCL	Expert advisor / planning, urban design and health

The research tasks (Tasks 1A-1D) will be undertaken by an expert social research team (commissioned following agreement of the funding) and project managed by the project manager. A detailed brief for consultants and selection criteria will be agreed with the SG; the criteria will include a need to demonstrate experience of conducting social research with the target population groups and a strong approach to research ethics (e.g. MRS accreditation).

The full methodology including a risk log (with ratings and identified mitigation measures) and a more detailed project plan, developed by the research team in accordance with this brief and under the supervision of the project manager, will be agreed with Guys and St Thomas' Charity prior to commencement.

Overcoming barriers to adoption

There are few barriers to adopting new planning policy and guidance that is informed by the research findings. Planning and public health leads are closely involved in formulating this project. The Cabinet and Portfolio Holders for Lambeth and Southwark will adopt the new planning policies and guidance. The proposals have been discussed with the decision makers and have their support.

Budget / funding required

Southwark and Lambeth are committed to creating stronger links between planning and public health. However the current local government funding constraints make this very challenging. We are therefore seeking full funding of this project of £110,000 (see initial budget breakdown below, this will be refined based on discussions with the charity and development of a more detailed project plan).

We believe the project is an excellent fit with the objectives of the Guys and St Thomas' Charity Health Innovation Fund and that this project would therefore justify sole funding by the charity.

This is a highly innovative proposal that seeks to use focused research to directly inform planning policy for improved health outcomes. As we are a non-for profit organisation and given that SG members will provide their time at no cost to the project and task 4 (monitoring, evaluation, reporting and wider dissemination) will be completed at no cost to the charity we believe our proposal demonstrates excellent value for money.

Proposed budget breakdown:

The total cost of the project is £110,000. This budget is broken down in the table below against the tasks listed in the methodology and project plan.

Task	**Estimated cost**
Task 1: Intensive social research	£100,000 (Task 1A ~£40,000; Task 1B ~£30,000; Task 1C ~£30,000)
Task 2: Review of existing planning frameworks and identification of amendments	£5,000
Task 3: Develop enhanced approach to monitoring and evaluation	£5,000
Task 4: Implementation and reporting of enhanced programme of monitoring and evaluation	No cost to charity

Agenda Item 10

Item No.	Classification:	Date:	Meeting Name:
10.	Open	28 January 2016	Health and Wellbeing Board
Report title:		Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21	
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 *Delivering* the *Forward View* and the associated planning guidance for 2016/17.
   - Note requirements of the CCG and partners included in the planning guidance.
   - Play an active role in the development of the Sustainability and Transformation Plan, which is proposed to be developed across south east London in 2016/17.
   - 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. NHS England, NHS Improvement (the new body which will bring together Monitor and the NHS Trust Development Authority), the Care Quality Commission, Public Health England, Health Education England and NICE published the *NHS Five Year Forward View* on 23 October 2014. The Forward View set out a vision for the future of the NHS.

3. In December 2015 the same national health and care bodies in England published *Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21*, setting out the steps to help local organisations deliver a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances.

4. The planning guidance is backed up by increased NHS funding, including a new Sustainability and Transformation Fund which will support financial balance, the delivery of the Five Year Forward View, and enable new investment in key priorities.

5. As part of the planning process, all NHS organisations are asked to produce two separate but interconnected plans:

   - a local health and care system 'Sustainability and Transformation Plan (SPT)', which will cover the period October 2016 to March 2021; and
   - a plan by organisation for 2016/17. This will need to reflect the emerging Sustainability and Transformation Plan.

6. The appended briefing note summarises the requirement of the national guidance and sets out the requirements of partners in Southwark and south east London.

BACKGROUND INFORMATION

7. The CCG presented its Operating Plan 2015/16 to the Health and Wellbeing Board in March 2015.

KEY ISSUES FOR CONSIDERATION

Policy implications

8. The emphasis on system-wide planning through the Sustainability and Transformation Plan, which is proposed to be developed over a south east London 'footprint'.

9. A continued strong emphasis on increasing investment in prevention and public health.

10. The continued development of the Better Care Fund as a mechanism to support integration and reduce rates of hospital admission

11. National support for local areas to test new approaches to contracting and commissioning.

Community and equalities impact statement

12. The CCG and proposed south east London STP partnership 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

13. There are no specific legal implications identified at this stage.

Financial implications

14. The full financial implication of the planning guidance is currently being modelled and will be detailed in full to the Health and Wellbeing Board at its next meeting.

BACKGROUND PAPERS

Background Papers	Held At	Contact
Southwark JSNA Southwark CCG Operating Plan 2015/16 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	Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

AUDIT TRAIL

Lead Officer	Andrew Bland, Chief Officer, NHS Southwark, Clinical Commissioning Group
Report Author	Kieran Swann, Head of Planning and CCG Assurance
Version	Final
Dated	12 January 2016
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Strategic Director of Children's and Adults' Services	No	No
Date final report sent to Constitutional Team		15 January 2016

APPENDIX 1

NHS Southwark Clinical Commissioning Group

Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

Southwark Health & Wellbeing Board

January 2016

NHS Planning Guidance 2016/17–2020/21

NHS Southwark Clinical Commissioning Group

Delivering the Forward View guidance recognises that local NHS systems will only become sustainable if they accelerate their work on prevention and care redesign. NHS England is requesting local systems quicken the pace of transformation early in 2016 to build momentum for future years.

Planning by individual institutions will increasingly be supplemented with planning by place for local populations.

The NHS is required to produce two separate but connected plans:

1. A five year **Sustainability and Transformation Plan (STP),** place based and driving the *Five Year Forward View*.
2. A one year **Operational Plan for 2016/17**, borough-focussed but consistent with the emerging STP.

Local Health System STPs

- This is a local **place-based** blueprint for accelerating the implementation of the *NHS Forward View*. It involves 5 key elements:

  i) Local leaders working as a team

  ii) A clear shared vision for the local community

  iii) Agreed strategic priorities to make it happen

  iv) Execution against the plan

  v) Learning and adapting.

NHS Planning Guidance 2016/17–2020/21

NHS Southwark Clinical Commissioning Group

- An STP will cover the period between October 2015 and March 2021 and will be subject to **formal assessment in July 2016.**
- It will cover all areas of CCG and NHS England commissioned activity including: specialised services, primary medical care, better integration with local authority services, prevention and social care.
- The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

Local systems are first being asked to focus on creating an overall local vision, thinking about three overarching questions:

1. How will you close the health and wellbeing gap?
2. How will you drive transformation to close the care and quality gap?
3. How will you close the finance and efficiency gap?

Transformation 'footprints'

Local health and care systems must make proposals on the geographic scope of their STP by **29 January 2016** for national agreement. 'Footprints' should be locally defined, based on existing working relationships, patient flows and taking account of the scale needed to deliver the services, transformation and public health programmes required.

The 'footprint' for Southwark is proposed to be south east London, consistent with the geography for *Our Healthier South East London*.

NHS Planning Guidance 2016/17–2020/21

NHS Southwark Clinical Commissioning Group

Transformation funding

For 2016/17 only there is limited available additional transformation funding run through separate processes.

The STPs are the single application and approval process for transformation funding for 2017/18 onwards.

From April 2017 onwards the most credible STPs will secure the earliest additional funding. Key points for consideration will be:

- the scale of **ambition** and track record of **progress already made**,
- the **reach** of the local process,
- the strength and unity of local **partnerships**
- the confidence in the **implementation plan.**

Operational Plans for 2016/17 are borough-focussed and regarded as year one of the Five Year STP. The CCG Operating Plan will:

- Look at how quality and safety will be maintained and improved.
- Identify and mitigate risks through a contingency plan.
- Outline how they link up and support with local emerging STPs .
- Reconciling finance with activity.
- Demonstrate a planned contribution to efficiency savings.
- Present plans to deliver the ‘must-dos’ (see next slide).

NHS Planning Guidance 2016/17–2020/21

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Whilst developing long-term plans for 2020/21, the NHS has a clear set of plans and priorities for 2016/17 that reflect the Mandate to the NHS and the next steps on *Forward View* implementation.

There are 9 'must do's for local systems in 2016/17

1. Develop a **high quality, agreed STP**, achieving key identified milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.
2. Return the system to aggregate **financial balance**.
3. Develop a local plan to address the sustainability and quality of **general practice.**
4. Meet standards for **A&E** and **ambulance waits.**
5. **RTT**: that more than 92% of patients on non-emergency pathways wait no more than 18 weeks.
6. Deliver the 62 day **cancer waiting standard** and improve one year survival rates.
7. Achieve the two new **mental health** access standards (50 % of people experiencing first episode of psychosis to access treatment within two weeks; and 75% of people with relevant conditions to access talking therapies in six weeks; 95% in 18 weeks).
8. Transform care for people with **learning disabilities**, improving community provision.
9. Improve quality and implement an affordable plan for organisations in **special measures**.

NHS Planning Guidance 2016/17–2020/21

NHS Southwark Clinical Commissioning Group

Financial allocations

- For 2016/17 the **CCG allocation for Southwark** will rise by 3.05% in 2016/17, but will decline significantly in future years.
- **Primary Medical Care Spending** will rise by 4-5% each year (in London)
- **Specialised services funding** will rise by 8% in London in 2016/17 with growth of at least 4.5% each subsequent year.
- The CCG and Councils will need to agree a joint plan to deliver the BCF in 2016/17.
- Commissioners must increase investment in mental health services each year.

The real term elements of growth in CCG allocations for 2016/17 onwards will be contingent upon the development and sign off of a robust STP during 2016/17.

Returning NHS Providers to balance

- During 2016/17 the NHS Trust/FT sector will be required to return to financial balance. £1.8bn of income from the 2016/17 Sustainability and Transformation Funding will replace Department of Health funding. Distribution will be assessed on a case by case basis by NHS Improvement and agreed with NHS England.
- Trusts need to focus on cost reduction not income growth.

Assessing CCG and health economy performance

A new Ofsted-style CCG framework will be introduced and use to assess CCGs' performance. The CCG Assessment Framework will includes health economy metrics to measure progress on priorities set out in the mandate and the NHS planning guidance including overall Ofsted-style assessment for each of cancer, dementia, maternity, mental health, learning disabilities and diabetes, as well as metrics on efficiency, core performance, technology and prevention.

HWB implications of NHS planning guidance

NHS Southwark Clinical Commissioning Group

Delivering the Forward View is particularly relevant to the work of health and wellbeing boards in the following ways:

- The emphasis on system-wide planning through the Sustainability and Transformation Plan, which will be developed over a south east London 'footprint' here.
- A continued strong emphasis on increasing investment in 'addressing the health and wellbeing challenge' through better prevention and public health (e.g. early cancer detection, diabetes self-management, obesity).
- The continued development of the Better Care Fund as a mechanism to support integration and reduce rates of hospital admission. The CCG and local authority will need to agree a joint plan to deliver the BCF in 2016/17, taking account of what has worked and what has not.
- NHS England and NHS Improvement have indicated their openness to new approaches to contracting being adopted in local areas. This relates to the shared ambition for commissioning for outcomes and population cohorts, as described in the CCG and Council's *Five Year Forward View for Southwark*.
- The Health and Wellbeing Board will be asked to endorse a refreshed CCG Operating Plan.

Agenda Item 11

Item No. 11.	Classification: Open	Date: 28 January 2016	Meeting Name: Health and Wellbeing Board
Report title:		Southwark Five Year Forward View	
Ward(s) or groups affected:		All wards	
From:		Andrew Bland, Chief Officer, NHS Southwark CCG David Quirke-Thornton, Strategic Director of Children's and Adults' Services	

RECOMMENDATIONS

1. The board is requested to:

   - Review the attached joint-strategy and to endorse the document.

EXECUTIVE SUMMARY

2. **We can improve the way that our local health and social care system operates to bring about better outcomes**
   Southwark commissioners across health and social care are committed to improving the health and wellbeing of Southwark people. The experiences of people who use services, and their families and carers, shows that existing arrangements do not always deliver the best outcomes for people, and there can be significant improvements if we work together using new approaches. This is about improving quality and overall value, it is not about cuts**:** if funding wasn't an issue we would still want to radically improve outcomes.

3. **Improving the system requires fundamental changes in how we all work**
   We want a system that works to improve health and social care outcomes for Southwark people, instead of simply focusing on maintaining current service arrangements. Our local ambition is to create a much stronger emphasis on prevention and early action as well as deeper integration across health and social care, and wider council services (including education). To support this change we will increasingly join together commissioning budgets and contracting arrangements to incentivise system-wide improvement. We will focus on specific populations, including particularly vulnerable groups. We will put ever greater emphasis on the outcomes achieved in addition to the quantity of activity delivered. This means moving away from a system with lots of separate contracts and instead moving towards inclusive contracts for defined segments of the population which cover all of the various physical health, mental health and social care needs of people within that group. These contracts will be available to providers who can bring together the skills required to meet these needs. Our aim is to empower the development of multi-specialty community providers serving populations of 100,000-150,000 people, with access to excellent specialist networks when required.

4. **We are confident we can enable this scale system-wide transformation** Southwark Council and NHS Southwark CCG have been working on this agenda for several years with partners across Southwark, Lambeth and South-East London. As a result there are exciting examples that demonstrate new ways of working between providers of services and with the wider community of service users, families, carers and local residents. There is also a growing sense of system leadership and a recognition of the scale of change required across all parts of the health and social care system.

5. We will develop an action plan and highlight the investment necessary to deliver the ambitions set out in this local Five Year Forward View. We will publish this detailed plan in March 2016.

BACKGROUND INFORMATION

6. The Health and Wellbeing Board received a presentation of the strategy at the last meeting, and it discussed and welcomed the principles described.

KEY ISSUES FOR CONSIDERATION

Policy implications

7. A continued strong emphasis on increasing investment in prevention and early action and the development of community resilience.

8. A focus on place-based approaches to integrating health and social care delivery systems.

9. A focus on the practical importance of system wide partnership, particularly in relation to the development of enabling infrastructure such as emerging Local Care Networks or system-wide information systems.

Community and equalities impact statement

10. The central purpose of this strategy is to support the commissioning of proactive and person-centred services which, in aggregate, improve population level outcomes and reduce health inequalities.

11. This overarching document will set a framework for specific other health and social care strategies, each of which will require the completion of an equalities impact assessment.

Legal implications

12. There are no specific legal implications at this stage.

Financial implications

13. The full financial implication of the joint strategy will be described in the supporting Into Action document.

BACKGROUND PAPERS

Background Papers	Held At	Contact
Southwark JSNA Southwark CCG Operating Plan 2015/16 Southwark Health and Wellbeing Strategy Southwark Council (2015) Together we can deliver a better quality of life in Southwark: Our Vision for Adult Social Care	www.southwarkccg.nhs.uk	Kieran Swann Head of Planning & CCG Assurance 0207 525 0466

APPENDICES

No.	Title
Appendix 1	Southwark Five Year Forward View: 2016/17 – 2020/21

AUDIT TRAIL

Lead Officer	Andrew Bland, Chief Officer, NHS Clinical Commissioning Group
Report Author	Mark Kewley, Director of Transformation and Performance Dick Frak, Director of Commissioning
Version	Final
Dated	12 January 2016
Key Decision?	No

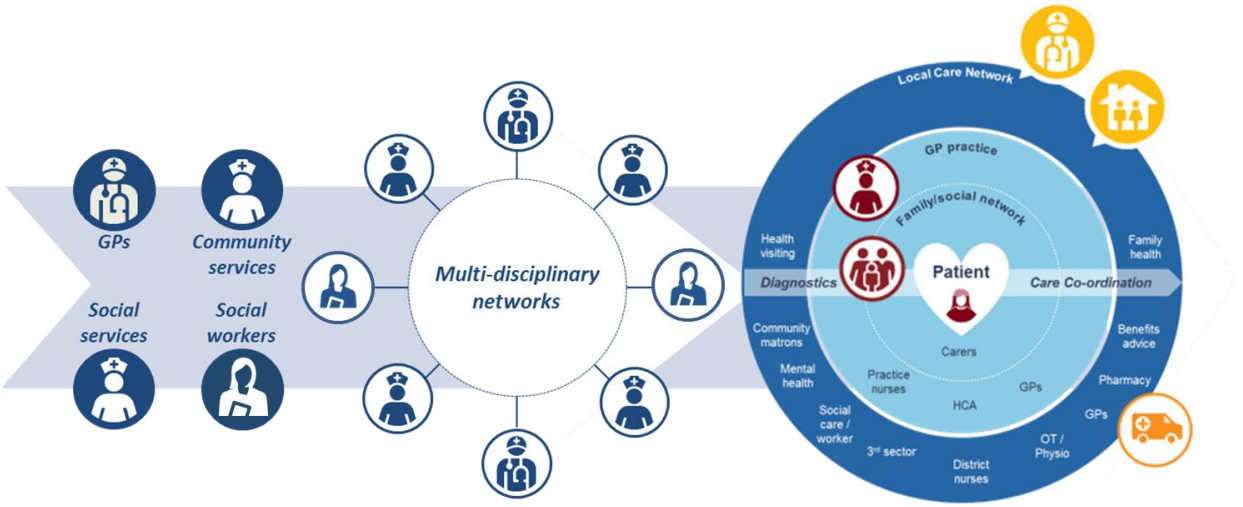
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Date final report sent to Constitutional Team		15 January 2016

APPENDIX 1

Southwark Five Year Forward View:

[DRAFT – Version 4]

2016/17-2020/21



NHS Southwark Clinical Commissioning Group

Southwark Council

Contents

Summary

We can improve the way that our local health and social care system operates to bring about better outcomes

- Southwark commissioners across health and social care are committed to improving the health and wellbeing of Southwark people. The experiences of people who use services, and their families and carers, shows that existing arrangements do not always deliver the best outcomes for people, and there can be significant improvements if we work together using new approaches.
- This is about improving quality and overall value, it is not about cuts**:** if funding wasn't an issue we would still want to radically improve outcomes.

Improving the system requires fundamental changes in how we all work

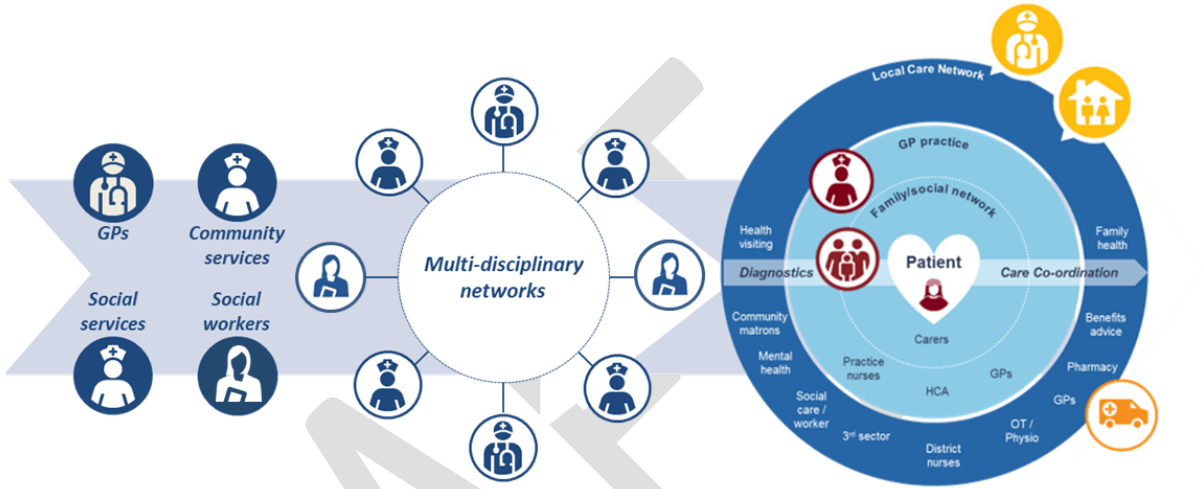
- We want a system that works to improve health and social care outcomes for Southwark people, instead of simply focusing on maintaining current service arrangements.
- Our local ambition is to create a much stronger emphasis on prevention and early action as well as deeper integration across health and social care, and wider council services (including education).
- To support this change we will increasingly join together commissioning budgets and contracting arrangements to incentivise system-wide improvement. We will focus on specific populations, including particularly vulnerable groups. We will put ever greater emphasis on the outcomes achieved in addition to the quantity of activity delivered.
- This means moving away from a system with lots of separate contracts and instead moving towards inclusive contracts for defined segments of the population which cover all of the various physical health, mental health and social care needs of people within that group. These contracts will be available to providers who can bring together the skills required to meet these needs.
- Our aim is to empower the development of multi-specialty community providers serving populations of 100,000-150,000 people, with access to excellent specialist networks when required.

We will contract on the basis of populations rather than providers.
We will focus on system value rather than contract prices.
We will emphasise that 'how' care is delivered is important not just 'what' care is delivered.

We are confident we can enable this scale system-wide transformation

- Southwark Council and NHS Southwark CCG have been working on this agenda for several years with partners across Southwark, Lambeth and South-East London. As a result there are exciting examples that demonstrate new ways of working between providers of services and with the wider community of service users, families, carers and local residents. There is also a growing sense of system leadership and a recognition of the scale of change required across all parts of the health and social care system.
- We will develop an action plan and highlight the investment necessary to deliver the ambitions set out in this local Five Year Forward View. We will publish this detailed plan in March 2016.

Figure 1 – Over time we are developing better ways to work together, which is good for citizens, care staff and commissioners



What this mean for me as a…	Traditional models [Small molecules] *Working as isolated units*	More integrated working [Small cells] *Working as small joined-up teams*	Accountable care [Living system] *Working as a dynamic and complex system*
…service user	• Sometimes services are good, sometimes they are not, it's a bit of a lottery • I feel looked after in an emergency but at other times I'm left confused and disempowered • I have to fit around the system and it's inconvenient	• I know more about what is going on • Clinicians know more about what has happened in my care • People ask me about what I need • I'm feeling more confident about how to live well, and what to do when I start to feel like I'm getting unwell	• I feel in control of my life and the care I receive, and I know what's going on • Professionals work together to support me • The little but important things are thought about
…staff member	• I'm isolated with little opportunity to work in a team • I'm frustrated at the lack of coordination • There is little opportunity to sort things out creatively, at the root of the problem	• I get help from others when confronted with complex situations • I'm developing new relationships and connections • I can sort out the things that count	• I feel part of a team and I am learning new things that make me feel more confident in what I do • I feel I'm able focus on the things I'm good at and let others do what they are good at
…commissioner	• I try to take responsibility for detailed pathway design • I focus on the transactional rather than the transformational	• I can spend more time thinking about what people actually want from services (outcomes) rather than just tracking inputs, targets and expenditure	• I spend my time looking at whether we are really delivering quality outcomes for people for the funding we have. I can see the wood for the trees

1 Introduction

We want to enable the best possible health and social care outcomes for Southwark people and families. We set this out in this *Southwark Five Year Forward View*. It describes Southwark Council and NHS Southwark CCG's shared vision for local services, the changes needed in our health and care system, and the actions we will take to make this happen.

What do we expect to be different in five years?

Over the next five years we will support what already works well, and we will introduce more collaborative ways of working across the health and social care system. Many things will continue as they do now, but we are also aiming to support positive improvements both for local residents and for the formal and informal workforce within our health and care system.

We will continue to have a vibrant and diverse voluntary and community sector, working closely at the heart of communities with general practitioners and social workers as central professionals. We will also continue to benefit from the range of skills within major acute hospitals and our local specialist mental health trust. These are some of the vital and valuable foundations of our local system and they are the basis upon which a more person-centred and coordinated system will be built. But we do need the system to work differently. In five years our local system should feel better for service users and their families, and for people who work within it, as illustrated in Figure 1.

- This will mean a much more empowering experience for local people. We want people to feel that all services are working with them in a supportive way, be that about accessing better education support, better council housing, debt advice or about having greater self-determination and self-care in relation to health and social care services. It also means making the health and care system fit for the 21st century so that people can make use of everyday technology, as well as new assistive technologies, to feel in control of their health and wellbeing.
- This will mean much greater formal integration and coordination between the different providers of health and care services. Local providers will operate collaboratively within mature and robust multispecialty community provider networks, referred to locally as Local Care Networks. These networks will share accountability for the outcomes of their local population, and they will use evidence and experience to plan and organize the local delivery system, including by working together to develop and share the infrastructure required to provide residents with a 21st century service.
- This will mean much greater integration between local health and social care funding. Commissioners will be much better able to measure and track the health and care outcomes that really matter to people. They will also be able to allocate available resources to fund activities that maximize those outcomes for Southwark people.

What is the purpose and content of the rest of this document?

The purpose of this document is to stimulate a discussion about how to make this potential future a reality in Southwark. Transformation at this scale will only be effective if we approach it comprehensively. As commissioners we have an important leadership role in setting a direction and actively supporting this process.

In this document we describe the reasons we think that change is needed, we set out the direction in which we want the system to develop, and we describe what this will mean in practice for service users and people who work within the system, particularly as part of the newly emerging Local Care Networks.

In further developing our approach we will work closely with our wider partners, including local residents, service users, families and carers, local service providers and the local voluntary sector. This will inform the development of a plan to bring about practical change.

2 We think we need to do things differently

This section describes our reasons for thinking that change is both necessary and possible. We start by describing the common purpose that unites the Council and the CCG and but then highlight that our common purpose will only be achieved if we do more to improve the health and wellbeing outcomes and inequalities within our system, and if we do more to protect the financial sustainability of health and social care services. We end the section by reflecting on why we are confident these imperatives can be achieved, highlighting that some fantastic work has already begun which demonstrates the motivation and capability of residents, professionals and commissioners to improve services in Southwark.

2.1 Our common purpose is to improve health and social care outcomes for Southwark people within available resources

Southwark Council and Southwark CCG have a common purpose to enable the best possible health and social care outcomes for Southwark people and families. This is about much more than the absence of disease. Ours is a very positive shared purpose that takes the absence of disease as a starting point and recognises the wider and more fundamental importance of wellbeing. We will know that our vision is being achieved when we see:

- An increase in healthy life expectancy, adding life to years as well as years to life
- A reduction in health inequalities across communities in Southwark
- More people engaged in their own healthcare, so that individuals and families are directly involved in maintaining and improving their own health and wellbeing
- A greater proportion of people reporting better experiences when they use health and social care services

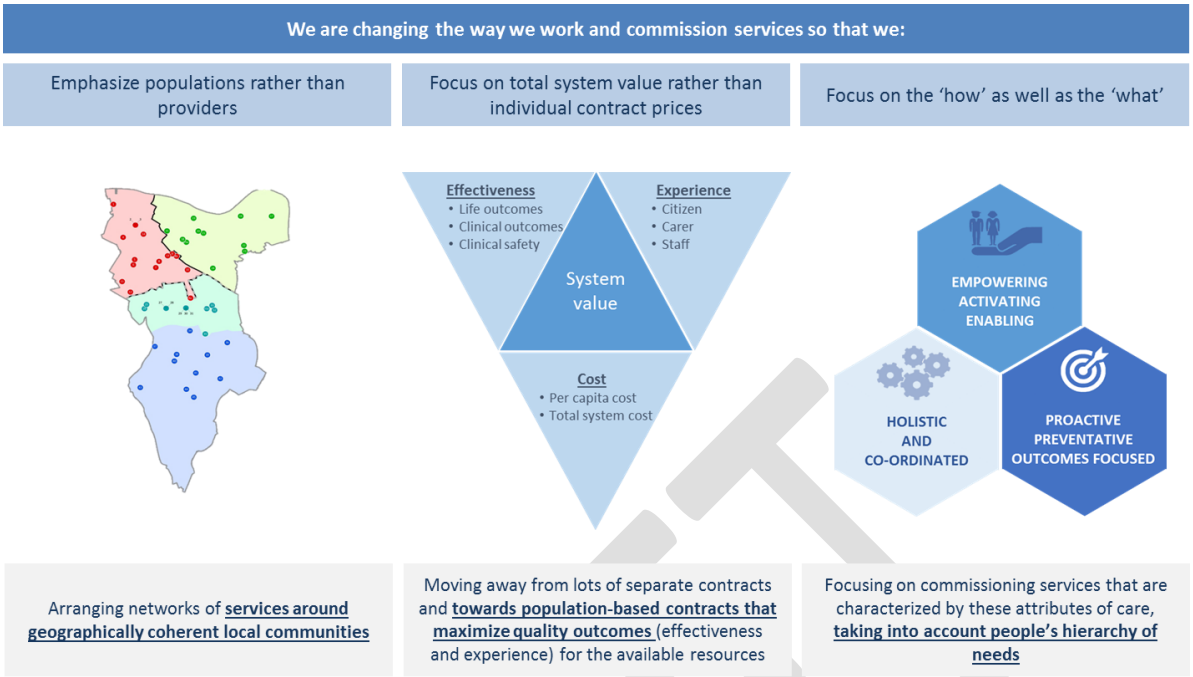
Improving people's wellbeing is about more than medicine and health care. A focus on people's wellbeing is about recognising the positive interrelationship between our social connectedness and our psychological and physical development. In addition to health and social care services, our shared agenda must also prioritise the importance of everyone's everyday social networks in relation to our health, our identity, our sense of self-determination and our overall quality of life. To achieve this we recognise the need to develop resilient and flourishing communities, which are supported by health and social care services that are genuinely person-centred and coordinated. That is not the type of system that we commission at present.

To commission a system that is aligned to our purpose we will apply three main principles:

1. We will focus on population outcomes (and outcomes for particular groups) rather than on the arrangement of existing service providers
2. We will focus on the whole system and its value rather than individual contract prices
3. We will be clear about the characteristics we expect services to demonstrate recognising that these must take into account people's health and social care needs and be sensitive to the social, environmental and cultural context within which a person lives

These are described in more detail below and illustrated in Figure 2 and Figure 3.

Figure 2 – The three main pillars of our approach



We want to focus on populations

Our common purpose is simple to present but hard to deliver. To achieve the best possible health and care outcomes for Southwark people we must move away from concentrating just on what quantity of activity we need to purchase from existing providers in current models of care. Instead we need to move towards new ways of working that creates within the collection of health and social care providers a shared responsibility to proactively manage and improve the wellbeing of the local population. This will mean that providers will need to work together to really understand the needs of the local population, and the holistic needs of any one individual, and to then bring together services which can serve those needs best.

We want to focus on value

We want to achieve the best health and social care outcomes for Southwark people using the funding resources available across health and social care. This requires us to really understand and measure the outcomes we want to achieve (in terms of safety, effectiveness and the person's experience of care services), and to fully understand the total cost of support across all settings of care. It also requires commissioners and providers to assess how resources are currently allocated and to shift those resources away from low value activities and towards activities that create better outcomes.

We want to focus on the characteristics of good care

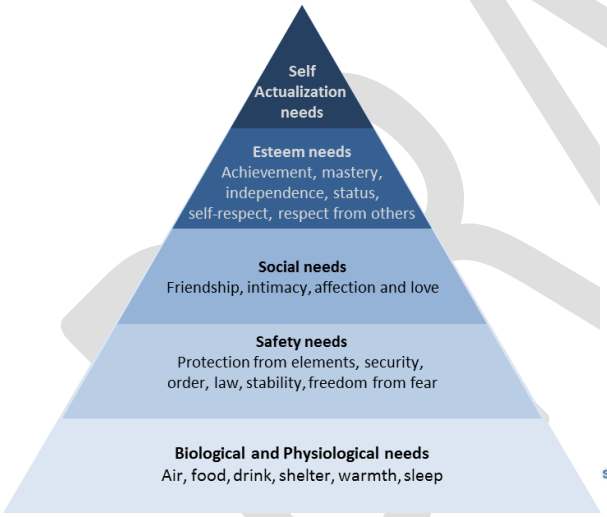
How health and social care is delivered is very important to people, particularly so because the services we commission are often received when people feel unwell and vulnerable. At these points we want Southwark people to feel cared for with dignity and respect, and to feel informed about their options in relation to treatment and support. We think this is best achieved when services are designed to empower people to be in control of their own health and wellbeing, and when services work with people as 'whole people' taking into account the full range of a person's capabilities and needs. We also recognise the importance of dealing with problems before they reach crisis point: our approach must increasingly support early intervention and prevention, rather than simply waiting to deal with the consequences of poor health. All of these

concepts can be illustrated with reference to Maslow's hierarchy of needs and the wider social determinants of health.

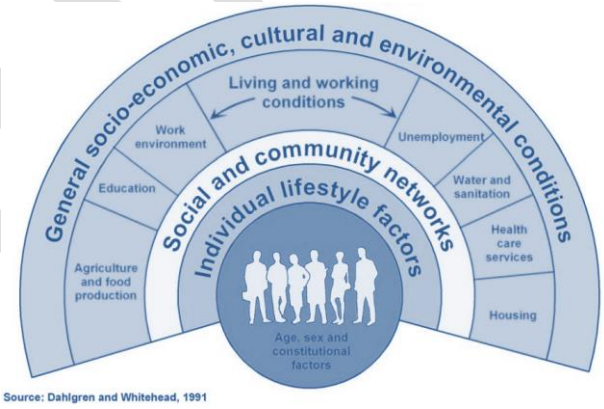
- *Understanding our hierarchy of needs* – we all have a range of social needs, from the most basic and fundamental need for food and warmth through to needs around self-esteem and reaching our full potential. Resourceful communities empower citizens to meet these needs. Meeting basic needs creates wellbeing and can reduce the likelihood of many socially determined health and social care needs, for example by reducing social isolation. Good health and social care services recognise people's various needs and address them in partnership with the person. The best services also recognise people's esteem needs and capacities and they therefore help people to develop independence and mastery, for example by supporting people to feel confident in self-managing their long term conditions.

- *Understanding the social determinants of health* - Social, economic and environmental conditions influence the health of individuals and populations. They include the conditions of daily life and the structural influences upon them, themselves shaped by the distribution of money, power and resources at a local, city, regional, national and international level. They can determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances. There is also a clear link between the social determinants of health and health inequalities.

Figure 3 – A person's health and wellbeing is related to the needs and assets they have, and these are influenced and to a large degree determined by wider social, political and economic factors



Maslow's hierarchy of needs



Social determinants of health

Some of these principles are already being tested in action through innovative work in the borough. Examples of these can be seen in the appendix. In addition, Section 4 describes what this will all mean in practice in the future, highlighting the difference that these approaches can make for individuals as well as the practical changes that this represents for people who work within local services.

2.2 More needs to be done to improve care outcomes for local people

2.2.1 We know that outcomes and equality can be improved across the borough

Southwark is a diverse and vibrant borough of almost 300,000 people, and it's growing significantly: we expect a population increase of 21% over the next ten years[1]. The Southwark Joint Strategic Needs Assessment[2] shows that local people's health outcomes have improved in a number of important areas, including reductions in infant mortality; better, more comprehensive care for people at the end of their life; and improved outcomes for people living with HIV. Since 2010 life expectancy has continued to rise for people living in Southwark. But there are real challenges too: health inequalities remain stark. Too many people live with preventable ill health, or die early.

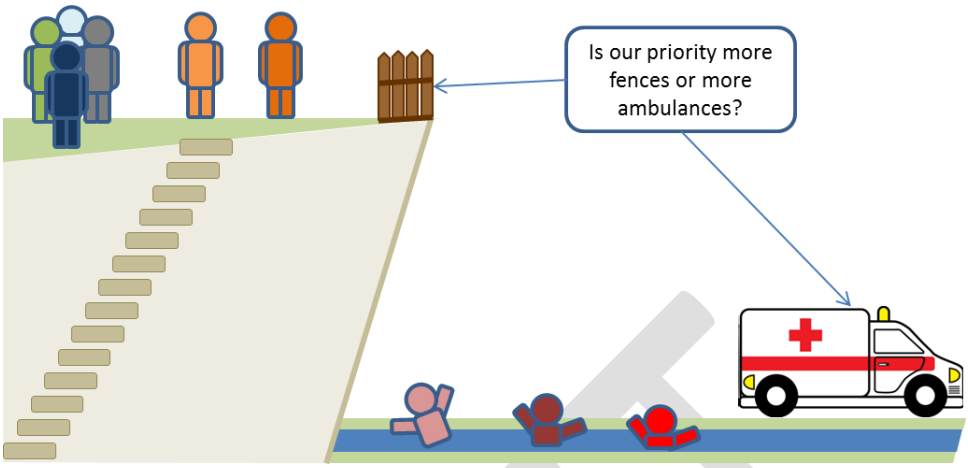
- ***Health inequality:*** In the borough there is a difference in healthy life expectancy between the richest and poorest in our population of 9.6 years for males and 7.7 years for females.
- ***Heart disease:*** Southwark people are more likely to die prematurely from cardiovascular disease than people living in similar parts of London.
- ***Respiratory disease:*** Chronic obstructive pulmonary disease (COPD) and lung cancer cause relatively high numbers of preventable early deaths and ill health in Southwark.
- ***Diabetes:*** There is significant variation in the management of patients with diabetes in Southwark and a high number of people are living with undiagnosed diabetes.
- ***Alcohol and liver disease:*** Rates of preventable early deaths from liver disease and alcohol-related hospital admissions are significantly higher in Southwark than they are in similar London boroughs.
- ***Mental illness:*** Southwark has a high prevalence and comparatively poor outcomes for people with low and medium-level mental ill-health. There is significant unmet need too.
- ***Obesity:*** Childhood obesity levels in the borough are amongst the highest in England. Adult obesity is also higher than the London average.
- ***Dementia diagnoses:*** Only about two-thirds of the predicted numbers of patients with dementia are diagnosed, and effective management of patients is highly variable.
- ***Admission of older people to acute hospital:*** Hospital admission rates and health related quality of life for older people is higher than in similar areas of London with rates of falls-related admissions particularly high.
- ***Access to GP appointments:*** Patients and members of the public consistently tell us that they often find it hard to get an appointment with their GP.

Whilst we know that services do often respond well to crises, we know that too little focus is given across the system to prevention and early intervention. It is not sufficient to just deal with the consequences of illness. We have to find ways of reducing the volume of people who need crisis support in the first place. Prevention and early intervention is the best way to achieve this, and over time much more of our resources need to be invested into such activities. As Figure 4 illustrates, this is about taking the right preventative approach 'upstream' to avoid having to deal with the consequences of crises 'downstream'.

[1] Southwark Demography Factsheet, May 2014

[2] www.southwark.gov.uk/jsna

Figure 4 – We need to find more approaches that are successful at dealing with existing demand for services, whilst reducing future demand. That means building more fences, rather than simply purchasing more ambulances.



2.2.2 We know that people's day-to-day experience of health and social care services can improve

We have health and social care services that achieve great things on a daily basis, and which are staffed by skilled and committed people. It is also true that on a daily basis there are residents who are left feeling confused and frustrated by the inconsistent way that services currently operate. For example, a recent Special Inquiry by Healthwatch found that[3]:

- People can experience delays and a lack of coordination between different services
- People can feel left without the services and support they need after discharge
- People can feel stigmatized and that they are not treated with appropriate respect
- People don't always feel involved or informed in decisions about their care
- People can feel that their full range of needs is not being considered

These are experiences that are all too common across the country. When individual cases are looked at in detail they point to poor experiences, poor effectiveness and inefficiency, and often they result from systemic arrangements rather than isolated mistakes. We know that our providers of health and social care can, and do, deliver life-saving and life changing services that are safe, effective, respectful, empowering and coordinated. We now need to ensure that this is delivered consistently, particularly at a time when services are facing significant funding challenges.

[3] Safely Home, Health Watch England Special Inquiry, 2015 – accessed at: http://www.healthwatch.co.uk/safely-home

Figure 5 – The voices of Southwark people: statements from Healthwatch's 1000 lives research

2.3 More needs to be done to protect the financial sustainability of the system

If funding wasn't a challenge we would still want to radically improve the system

Improving outcomes for people is the burning ambition that inspires and guides our work: if funding wasn't a challenge we would still want to radically improve the system. This is because many of the things that cause frustration are things that we can do something about – either by making better use of new technologies, or by changing the way we work together within and across organisations. However, there is a very large financial challenge across the system, and this makes the improvements not only desirable but absolutely necessary.

As commissioners our choice is about how we invest the significant resources in our local health and social care system to maximise the quality of services for our citizens. We don't believe that 'more of the same' is the best option. Our challenge is to ensure people are supported and treated in the right place at the right time according to need, with much more care delivered closer to home in local communities.

However, the answer is not as straightforward as simply moving resources out of hospitals. As the size and needs of the population grows, our real challenge is to deal with growing demand within existing capacity. Based on current trends this would represent a great achievement and it would enable us to invest efficiency savings and funding growth in new models of community based care rather than in additional hospital capacity.

2.4 We have confidence we can improve value across the system by building on the good progress already started in Southwark

Whilst our ambition is significant we are not starting from scratch: already local residents, commissioners, care professionals and managers have begun to demonstrate new ways of working together.

- We have brought CCG and council budgets together in our Better Care Fund, and we were one of only six areas nationally to have those plans assured without conditions. This fund has been invested in admission avoidance, better supported discharge, and more coordinated and proactive care delivery.
- Collectively we have made tangible progress towards developing the foundations of a Local Care Network model. In particular there has been significant collaboration between federations of general practices in both the north and the south of Southwark. Through these federations GPs have a way of working together at scale to improve and enhance core services. The two federations have been established, licensed by the CQC, and they have both begun to deliver extended access to primary care (7 days a week 8am-8pm).
- Collectively we have strongly supported innovative work on developing and implementing new models of diabetes care. This has improved care for local residents and it acts as an exemplar for how we should support people to manage when they have multiple long term conditions. Our local approach with partners has developed a model that addresses the medical, psychological, and social needs that a person has. 98% of our GP practices signed up in 2013/14. Independent evaluation shows significantly improved detection and HbA1c control. Over two years Southwark practices achieved a ten percentage point increase in detection and have moved from the bottom to the top of comparison groups.
- Collectively we have made real progress in developing a functionally integrated information technology system. We now have a comprehensive use of the EMIS Web system in primary care. This system enables primary care and commissioners to share data. We have also supported providers to develop a Local Unified Care Record using linked clinical data systems across the three foundation trusts and into primary care. This hugely powerful development allows a hospital and general practice care teams to see, at the point of care, patient data from the other local trusts and specific aspects of the primary care record.[4]
- Collectively we have supported the emergence of a strong, vibrant and energetic network of residents who are actively involved in supporting changes in the health and social care system. Within the borough each general practice has established a Patient Participation Group (PPG) to enable regular engagement with people on the practice register, and there are locality PPGs that support the sharing of information and experience across a larger network. These groups are also connected with the Southwark and Lambeth Citizens' Forum and Citizens' Board which supports people to meet, discuss and influence the way that the local system works, for example through active participation in service improvement initiatives such as the Southwark and Lambeth Integrated Care (SLIC) Programme.

[4] We know that many people assume that care teams already share information about them in order to provide high quality care. Unfortunately that is not always the case in the current system. This lack of communication can compromise a person's care. Our new Local Unified Care Record system makes data sharing much more timely, systematic and secure. Access to this data is for the purpose of providing better care, and care teams will seek consent to view records (unless the situation is life-threatening or a person is incapacitated). Each participant provider has information available about the fair processing of data, and patients are able to express a preference about whether to benefit from this service. More information can be found here: [DN. Insert link]

3 We think that we have to address some complex issues and adopt a thoughtful approach to change

Section 2 describes our reasons for thinking that change is needed. This section describes our understanding of the problems that we must address and describes the approach that we think is needed in creating the conditions within which this system-wide transformation can happen in practice.

3.1 The issues we are facing

Transformation of the current system will require us to tackle a variety of complex and interrelated issues, but there are three major root-causes we need to address, recognising that there is not a 'one size fits all' solution.

- **The fragmented arrangement of organisations and professions can reinforce boundaries and can make it too difficult to work together and to work consistently**
- **The fragmented contracting arrangements can make it difficult to move resources to where they are needed to deliver what really matters to people**
- **The disempowerment of service users and carers can create confusion and risks making people passive recipients of care**

This section looks at these root-causes in turn. For each issue we describe the problems we face, the way we are going to tackle them, and the partnership offer we are making within the system to enable that change. These high level commitments start with what we are already working on and where we expect to make important developments in the short term (the next one-to-two years), and some are more developmental leading to change in medium term (three-to-five years).

3.1.1 We face a fragmented arrangement of organisations and professions which reinforces boundaries and that can make it too difficult to work together and to work consistently

The problems we face

Changing demands on the workforce: long term trends are changing the functions needed in the health and care workforce. New technology and knowledge opens up new possibilities for diagnosis and treatment of severe or rare conditions, meaning that we need to nurture the development of people in sub-specialist roles; but demographic changes, and in particular the increase of frailty and complex health or care needs, mean that we also need to develop a local workforce who are "expert generalists". These factors occur at a time when we are facing significant reductions in the number of people in key professions like general practice, emergency medicine and community nursing, for example as people retire. There is also growing recognition of the opportunity for new roles to develop that make much greater use of people's skills, including both the qualified/professional workforce, as well as self-management and self-directed support by individuals experiencing significant health and social care needs themselves.

Cultures of isolation – rather than cooperation: there is less value created when professionals and organisations work in comparative isolation rather than in collaboration, where there is much greater scope to develop and deliver high quality services for people and fulfilling careers for staff.

- General practice is the foundation of the local NHS system because of the range of skills that practice teams can offer to their patients, and because of the deep local and personal

knowledge that informs GP care. However, the current operating model of general practice acts to exacerbate the quality and financial challenges faced by practices in Southwark because it can isolate professionals from one another and reinforce operating models that are too small to be financially or operationally viable. Encouragingly, practices in Southwark have begun to work together as formal federations so that they can benefit from greater collaboration and scale to address some common challenges, for example:

  - There has been underinvestment in staff development. Our workforce is our greatest asset yet GP practices working in isolation find it very difficult to release staff members for training or to invest in their development. It will take collective action to coordinate investment in the development of shared staffing arrangements (for example, a staff bank) but this type of development is required to help general practice to develop the necessary capacity and flexibility required by new ways of integrated working.
  - Investment in new ways of working and new infrastructure can be more easily afforded it is done together– for example, sharing additional capacity such as the Extended Primary Care Access Service, or sharing 'back office' functions and IT systems. Working together presents new opportunities to think creatively about new ways of doing things and to share the resources needed to develop new capacity and capabilities.
  - Challenging variation in general practice – some people get fantastic primary care and others do not. This demonstrable variation needs to be understood and acted upon. It is easier to do this when practices work together to analyse what is happening and to inform collective quality improvement projects.

- Delivering high quality care is often a team activity requiring people with different specialist skills to work together, and often for specialist equipment being available in the same place at the same time. In addition, in some specialties, there is strong evidence that the outcomes for people are better when care is provided by a professional or team that undertakes high volumes of that work and/or in an environment that is dedicated to that activity (for example lengths of stay are shorter, and rates of revision and rates of infection are lower, in 'elective centres' for planned orthopaedic surgery in which beds are ring-fenced for patients receiving planned surgery)[5].

Fragmentation and complexity: Health and social care organisations are staffed by highly skilled and passionate people but, because of the way organisations and responsibilities have developed over time, people have ended up working within an array of organisations that work independently of one another. The resulting complexity of the total system can leave staff and residents feeling confused and disempowered. Direct consequences of this include:

- Variation in clinical practice and care delivery because there are too few agreed pathways or care standards consistently used by providers of care;
- A lack of active coordination across services (in times of need or during transfers of care) leaving people at risk of confusing duplication or of "falling between the gaps";
- Professionals often working in isolation from others, reducing a sense of team-working and making it difficult for people to retain and develop their skills; or
- Operational management systems being developed for organisationally specific purposes which then reduce the ability of different organisations to work together.

[5] Getting It Right First Time (GIRFT) – A national review of adult elective orthopaedic services in England, available at: http://www.boa.ac.uk/latest-news/press-release-girft-report/

How we are going to tackle this

At a local level we recognise that developing new relationships takes time and investment. In Southwark we have already seen success in change through the Primary Care Development Programme which has established a group of 'Emerging Leaders' in primary care, and supported the development of two GP federations across the borough. We will continue to take this approach to support the development of new relationships across a broader range of providers. Importantly this emerging model of primary care will bring the benefits of working together at scale, whilst protecting the essence of high quality and local general practice and the clinical relationship between people and their local care professionals.

Our aim is to support the development of multi-specialty community providers serving populations of 100,000-150,000 people

Our aim is to support the development of multi-specialty community providers serving neighbourhood geographies of 100,000-150,000 people, which are structured around high quality primary care, community care, and social care. We expect that these Local Care Networks (LCNs) will bring together doctors, nurses, social workers, therapists, housing support workers, home carers and voluntary sector groups to work together with a shared ambition to support the needs of individuals and improve health outcomes for the population.

We will also actively participate in work across south east London to describe the standards of care we expect for our populations, focusing on six care pathways: Community based care (the delivery of coordinated services through Local Care Networks); Children and young people; Maternity; Urgent and emergency care; Planned care; and Cancer.

Specific actions:

- We will continue to invest in and support the development of local GP federations to enable better joint working across primary care, particularly in relation to GP access, the delivery of preventative services, and the development and delivery of proactive and coordinated population health management for people with multiple long term conditions. This will include the establishment of a Clinical Effectiveness Group (CEG) to support practices to identify priority areas for quality improvement and to establish practical ways of analysing and addressing these issues to reduce variations in practice and outcomes.
- We will provide developmental support to the two newly emerging Local Care Networks in the borough, ensuring that the Community Education Provider Network (CEPN) and our work on IT interoperability practically supports the workforce and systems development required to deliver person-centred and coordinated care. This includes the widespread implementation of a new Local Unified Care Record, which will enable care teams in health and social care to access integrated electronic patient records at the point of care delivery. We also plan further development to create an integrated care record that is directly accessible to patients and service users.
- We will work with other local commissioners and providers to develop a comprehensive and coordinated approach to estates development across the borough. This will include completion of the Dulwich hospital redevelopment by 2019 and consideration of other large scale strategic developments in the north-west of the borough (Blackfriars, Elephant & Castle, and the Aylesbury Estate), and in the north-east of the borough (Rotherhithe, Surrey Docks & Bermondsey) which together will experience a 35-40% population increase by 2030.

3.1.2 We face a fragmented contracting arrangement that can make it difficult to move resources to where they are needed to deliver what really matters to people

The problem we face

Care services in the NHS and local authorities have for a long time been commissioned on the basis of existing institutions and the services they deliver, with funding and incentives based on the amount of activity undertaken and the cost of specific units of activity. This has created a very complex system of contracting with different contracts held by different organisations for the delivery of specified inputs and outputs. In practice this arrangement reflects and reinforces unhelpful boundaries and incentives at the interfaces between different providers of care. Looking back, this type of arrangement can be explained as a consequence of historic funding arrangements and provider structures. Looking forward, this type of arrangement is an active barrier to the greater integration and coordination of health and social care services.

Faced with the level of complexity in the commissioning system, professionals and providers can find it difficult to deal with the holistic needs of the people they support. Professionals are too often left feeling constrained in the support they can provide because they can only perform the task that they are commissioned to deliver, even when that creates unhelpful duplication or where there are better ways to address someone's needs. In addition this often excludes voluntary groups and services that could offer support can't make a contribution; and service users - particularly the most vulnerable - are too often left navigate the system themselves or risk falling between the gaps.

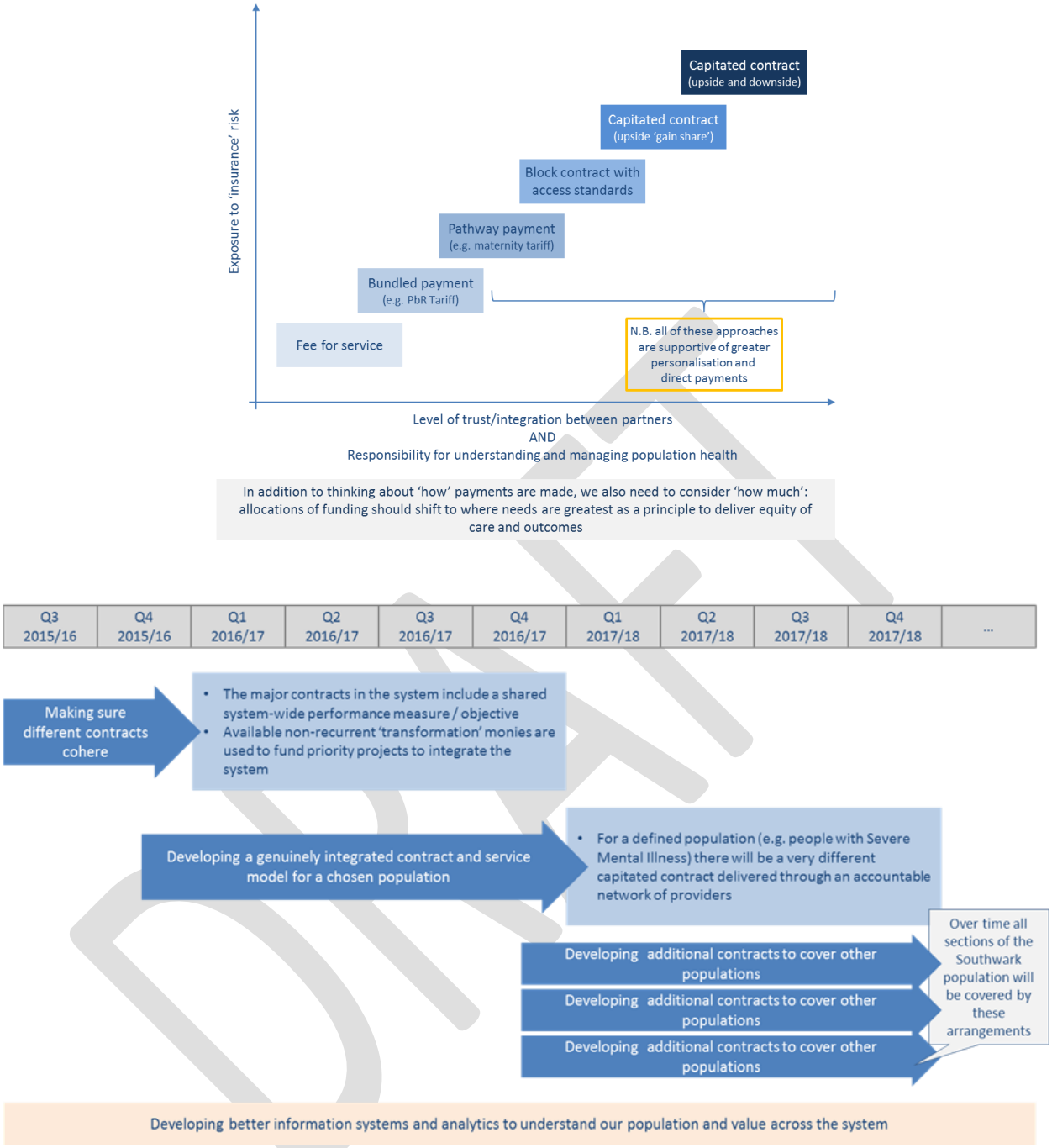
How we are going to tackle this

To support the transformation described in this *Southwark Five Year Forward View*, the Council and the CCG will establish a Commissioning Partnership Team. Over time, and with a jointly agreed remit, this team will become the vehicle for developing and delivering joint strategic intentions across health and social care with strong links to education, public safety and public health. This development will help us to achieve greater equity and better outcomes for Southwark people by addressing the social as well as the physical determinants of health and wellbeing. The Commissioning Partnerships Team will support the pooling of resources and the alignment of decision-making so that we achieve progressively more integrated health and social care commissioning, and the development of increasingly population-based provider contracts. This new team will begin work in 2016/17.

In addition we will continue to play a full and active role in developing a transformation partnership across Southwark and Lambeth. The purpose of this partnership will be to coordinate and commit to collective strategic priorities and to oversee the delivery of those commitments. This will be aligned with the development and implementation of the South East London Commissioning Strategy: *Our Healthier South East London*. The plans we are developing at a borough, cross-borough and sub-regional level must align and mutually reinforce one another. This will be supported by the development of a single Sustainability and Transformation Plan (STP) across the six boroughs of South East London.

In future we will explore the options to formally bring together service contracts either through lead contractor arrangements or through alliancing approaches, to fund services on the basis of an agreed per-person amount (capitated sum), and to offer those contracts for an extended duration to give providers incentives to integrate and invest in service development. And we will make contracts increasingly performance related, with increasing amounts of the total contract value being contingent upon the achievement of specified outcomes. As Figure 6 illustrates, these proposed changes in contracting cannot and should not happen in one single step, a phased transition is required.

Figure 6 – Description of the stepwise movement towards capitated budgets for our populations



Specific actions:

- In developing contracts for the forthcoming year (2016/17) we will work with providers to refine existing bilateral arrangements to support greater systemic coherence. This includes seeking changes to primary care contracts through the PMS Review, a re-tendering of home care services by the Council and a coordinated approach to acute, community and mental health contracts. In all of these contracts we will seek to encourage more collective incentivisation and to align investment in priority areas that help to improve performance in relation to specific system-wide goals, for example the reduction of emergency bed days, and the reduction of delays at the point of discharge from hospital. As part of this approach we will make available non-recurrent transformation investment to help providers turn aspirations into action (for example in the development of Local Care Network projects).

- In 2016/17 we will undertake focused work to develop new strategic approaches to specific population – such as Children & Young People and adults with multiple long term conditions – and we will explore the potential to develop new capitated and outcomes-based contracts in some areas, for example for adults with serious mental illness, or people with learning disabilities. We will invest in the development and measurement of outcomes (for example building on the user experience "I" statements described in Section 4) and we will work with providers to establish a baseline and to subsequently agree improvement ambitions. We will also explore the options to formally bring service contracts together either through lead contractor arrangements or through alliancing approaches.

3.1.3 We recognize that the disempowerment of service users and carers can create confusion and risk making people passive recipients of care

The problem we face

Too often people do not act with confidence in managing their own health and during their interactions with the health and social care system. This represents a real problem given how much we rely on people themselves to make sense of the fragmented services they receive. The problem is biggest for the most vulnerable people in Southwark and it is further complicated when adding in people's interactions with housing, employment and social care services. This problem is made worse because all too often people are kept in the dark: people are unable to see, add to, or control their health records and too often experience services that talk about them rather than with them.

People should play an increasingly active role in determining their health outcomes and begin to work in partnership with care teams rather than being as passive recipients of services. This means supporting a culture change for care professionals so that we focus on what people can do rather than what they can't do. Similarly it necessitates a culture change in our residents and service users so that people understand what to expect from the services they receive and are confident enough to take control of their health and care.

In addition, the wider communities in which people live – and which make such an important contribution to people's lives – are underused as a resource to enhance wellbeing. This means that we spend time dealing with the symptoms of illness (such as depression) rather than dealing with some of the root causes (such as social isolation). There are vibrant and diverse communities in Southwark with passionate and skilled people: we need to make use of that valuable asset to a much greater extent than we do at present.

The way we are going to tackle it

Already there are service users, carers, professionals and voluntary sector workers who are putting people at the centre of care. We know, for example, that parents play a central and skilled role in looking after children with severe health needs; some of our local general practices and hospitals ensure that people can access their care information and see the referral and discharge letters sent between clinicians; and increasingly people with complex needs are working with professionals to receive a direct payment or personal budget and to develop proactive care plans and care coordination. We want to build on this so that health and care services systematically seek to:

- **Activate and support individuals:** supporting informed choices and self-management through empowerment, changing the style of clinical consultations (for example by using decision support tools) and providing appropriate education and skills development; enabling a step change in the use of technology; and increasing the use of personal budgets.

- **Activate communities to build social capital and resilience:** letting people know what services are already available and how to access them; and supporting the development of a wider network of voluntary and community support
- **Change professional cultures:** supporting professionals to change the nature of their conversations with people, especially those with long term conditions who can and do develop expertise in their health conditions; and supporting professionals to feel part of multidisciplinary teams that have relationships with, and access to, the support within our communities

Specific actions

- We will continue to invest in the development of our Patient Participation Groups and work with them and other partners, like our local Healthwatch, to amplify the voice of our patients so that services are developed with local people, and we will strengthen the role that local citizens can play within our overall approach to transformation
- We will continue to invest in the development and availability of structured support for self-management, and we will continue to support the development and testing of innovative referral and care navigation services, such as Southwark SAIL (Safe And Independent Living)

3.2 We need to learn from local experience to effectively support transformation on this scale

3.2.1 We will take a supportive and developmental approach to transformation

We have learnt that neither 'top-down' nor 'bottom up' approaches to change can work on their own. At its heart, ours' is a strategy of relationship building, culture change and community development that will create clarity and freedom for people to work together in new ways alongside the system leadership to commit resources and implement lasting change.

- **Ours is a strategy about relationships and culture change.** This will require us to work differently and in a way that will energise and liberate our staff and citizens to put resourceful communities and individuals at the heart of health and social care.
- **Professionals need to be supported to think creatively** about a wide range of responses to a person's needs; and in order to do so they will need support to operate across our distributed local networks and settings of care, rather than through orthodox hierarchies and within the traditional confines of buildings
- **We need to reimagine our 'workforce'** and engage with the fact that our citizens – as service users, parents of carers and members of resourceful communities – have significant capabilities and want to feel in charge.

In practical terms this will be supported by a variety of tasks which will require investment and system-wide working in order to*:*

- **Support organisational development and wider citizen participation** – this work cannot be successful if it is always an 'add-on' to the day job, but embedding service transformation within core roles requires investment to release people's time. It also requires considerable support for organisational development and communications at a transformational scale.
- **Support workforce development** – we need to fundamentally redefine what we mean by 'workforce' so that we can really make use of our local professional and informal resources. We will need to work with a variety of partners to undertake a systematic analysis of the functions that are needed in the delivery of different types of care, and to determine how

best to use and develop a formal and informal workforce to have the skills, capabilities and behaviours needed to deliver those functions effectively.

- **Create an explicit mandate to be bold and to 'reimagine the rules'**, both real and perceived, that currently force retrenchment to narrowly defined interests. This will involve working through detailed technical minutiae as well as confronting large strategic choices, for example balancing means-testing and universal provision, or resolving funding coverage for registered or resident populations.

3.2.2 We will build a strong local partnership to oversee and govern this system-wide transformation

Working within the mission and constitutions of the CCG and Council, we will seek to enable the realisation of this plan by establishing a strategic partnership with citizens, commissioners and providers of health and social care services. This partnership will work together to develop, practically support, and to oversee a programme to transform how care is commissioned and provided. In practice this means:

- Bringing together partners with a common vision and a desire to work together
- Aligning partners´ individual strategic intents to develop a shared partnership strategy for system-wide transformation in Southwark and Lambeth, within which there is: prioritisation of what changes are needed to commissioning and service delivery; agreement about what we will each do as individual organisations or in partnership, including changing the distribution of resources (money and people), changing processes of working together, and changing the way we manage risks; and coordination of our various activities so that they happen in concert and are mutually reinforcing and collectively identifiable as a common programme
- Supporting and resourcing changes in the practice of commissioning and the practice of service delivery, including but not limited to leadership development, stakeholder engagement and 'on the ground' help to try new ways of working
- Holding each partner to account for doing what we said we would do
- Assuring ourselves that our collective actions are improving care for our local population

Our general expectation is that this strategic partnership will, first and foremost, practically support the development of Local Care Networks within Southwark. In this model, LCNs will represent both a locus of activity and of accountability, and transformation investment will be made available where LCNs can demonstrate a joint-commitment to deliver on specific priorities.

Where transformation projects and activities would benefit from coordination or support at a borough level, across Southwark and Lambeth, or across south east London and London geographies we will put in place mechanisms to do that, for example:

- agreeing at a borough level specific work on integrated 'Out Of Hospital' services relating to, for example, domiciliary care and community nursing or enhanced care home support
- agreeing at Southwark and Lambeth level to undertake joint work on technical issues associated with commissioning development (population analytics and the development of new contracting models), or to do with infrastructure development and the establishment of new interoperable information systems; or specific service developments relating to, for example, admission avoidance, improvements in inpatient care pathways, and changes to specialist clinic models for long term conditions
- agreeing at a south east London level to the various priority service developments for LCNs, for example establishing multi-disciplinary working to actively manage people with complex needs

- agreeing at a London level to prioritise transformation work on helping general practices to work collaboratively and at scale to improve access, coordination and prevention.

4 We think delivery of this Forward View will make a real and felt difference to local people and staff

4.1 We hope to see different services and different relationships developing between professionals and with service users

4.1.1 Current services struggle to respond to a persons' complex needs

An illustrative example of a person's story

M is a man in his early sixties living in South London. He moved into London ten years ago to find work. He has had a variety of jobs in that time but he has recently been made redundant. He lives alone in rented accommodation. Most of his social network and friendships were gained at work. Since losing his job, M is meeting fewer people. He has become worried about his rent, growing debt and making ends meet.

M has insulin-dependent diabetes and experiences depression. He knows he should manage his diabetes, for example, his doctor has advised him to monitor his blood sugar levels, eat better and exercise more. M thinks he should do this but in practice it feels hard: going to a gym would be another expense and it is quick and easy to eat take-away food, particularly when you are living alone. Recently M has been feeling like things are getting a bit too much. His only real comfort has been alcohol and he has been drinking more lately.

M has been feeling like things are getting out of control in terms of his health. He has been taken to A&E by the police on four occasions in the past six months because he had collapsed in the street following particularly heavy drinking. They were very nice in A&E, letting him sober up and then giving him a sandwich before being discharged. His diabetes has been a real problem too and he called an ambulance twice in the past month where he has been seen in the A&E department at the local hospital and admitted into the acute assessment unit. The doctors told him he had experienced hypoglycaemia because he'd had too little food. When he was in hospital he saw other people around him who also had diabetes. They were a bit older than him and had more serious problems: one person next to him had had a heart attack related to her diabetes, and she told M that she had had to have an amputation last year because her leg ulcers got really bad. She told M that the operation had been very good and the staff had been very kind, but she was sad because she wished someone had helped her before it was too late. When M was discharged he was very worried; he didn't want to have a heart attack or end up needing an amputation but he didn't know what to do.

In today's health and care system a large amount of the resources are used to purchase high quality amputations or to provide crisis and recovery systems for people experiencing heart failure and heart attacks. These are provided by highly skilled and dedicated professionals and the care is needed because there are ever more people needing treatment for these complications of poorly managed diabetes.

Nationally we spend £7.7 billion per year on dealing with complications associated with type 1 and type-2 diabetes. Of this more than £3 billion is spent on treating myocardial infarction, ischaemic heart disease, heart failure and other heart and circulatory problems. Almost £1 billion

is spent on treating kidney failure; another £1 billion is spent on treating neuropathy, stroke, foot ulcers & amputations, and other conditions such as retinopathy.[6]

There are also some excellent examples of services trying to do things in a more supportive and preventative way, but collectively we spend much less on these services. In this current system many people are left asking whether this is the best way to use the available resources we have, or is there a better way?

4.1.2 We think that Local Care Network services will work with people differently

A system that genuinely focuses on populations and total value would seek to behave proactively and to identify M early and to support him as a 'whole people', understanding his needs and capabilities. This would mean:

- GPs, nurses, social workers and hospital consultants bringing existing data together to identify groups of people with high needs, including individuals like M. They would then act on that information to provide people like M with appropriate support.
- A care team would have time to really understand M's life and his needs, getting to know what is important to him and what goals he has. Using techniques such as motivational interviewing, goal-setting and proactive care planning, care teams would be able to help M to take some positive first steps in taking control of his whole life. For M, this would feel like working with an expert care team, rather than just being treated or being told what to do. Importantly, M's mental health and emotional needs are considered as being just as important as his physical health needs. This would mean that psychologists and psychiatrists form an integral part of the local multi-disciplinary care team.
- Depending on his personal care plan, M could then be supported to access peer-support groups so that he can meet and hear from other people who are going through similar things (see the appendix for a case study on SAIL); he could access structured education resources and self-management support to feel more confident in living well with conditions such as diabetes; with the assurance that if things do go 'off-track' that there is a care team member that he can contact quickly.
- In addition, he would find it much easier to access social activities and local groups, not necessarily related to health improvement but just to feel more connected in the community, and better able to meet people and make friends. This would also include finding really practical advice so that he has support to address non-medical issues such as housing, debt-management, benefits advice, and employment.
- And it would be easier to live a healthier life because our communities will increasingly recognise and support health and wellbeing, for example: M would find it easier to exercise because he would know where the local parks are and know they are safe and he can access free gyms and swims; and he would find it easier to cycle or walk to the shops because the roads are safe, the pavements repaired and streets are well lit (see the appendix for a case study on Southwark Healthy High Streets).

4.1.3 We think that delivery of this LCNs approach will change the arrangement of professionals and teams across organizational boundaries

To provide care and support in the way that this *Southwark Five Year Forward View* envisages will require a change in the ways that professionals work together, and in how those professional groups work with residents. Put simply we need to move to an arrangement where staff from different disciplines work together as part of a team, with a shared responsibility for

[6] From Health Innovation Network Structured Education Toolkit, referencing Hex N et al [D.N. add full reference]

the health and wellbeing of a local population covering natural and coherent localities of 100,000-150,000 people. This relies on the presence of multi-specialty community teams operating as the practical delivery system of a Local Care Network (LCN).

Figure 1 provides an illustration of the journey towards Local Care Networks, and of the progressive integration of the professionals that constitute an LCN's multi-specialty community team. As that diagram sets out, in each Local Care Network a multi-specialty community team needs to:

- include all individual general practice staff within the locality, operating as part of an effective and collaborative federation which can – individually or jointly – deliver core and enhanced primary care services (drawing on existing and new roles such as clinical pharmacists and care navigators)
- include social workers, operating on a geographical basis, whose clients live within the locality
- include the district nursing services, community mental health teams and the home care services that operate within the LCN, recognising that this will require those teams to have an alignment with the LCN geography and strong functional integration across those services
- include named specialists (for example consultant or specialist nurses in paediatrics, general and elderly medicine, and mental health) who can provide accessible outreach and support and who can act as a point of contact when resident from a locality require inpatient care
- formally link to the urgent response and post-acute care services, such as Enhanced Rapid Response and @home, so that preventable admissions are reduced and transitions into and out of hospitals are timely, well planned and coordinated
- formally link to the wider network of institutions that support people in their daily lives, for example local schools, community pharmacists, care homes, nursing homes, and other local voluntary and community sector providers.

A multi-specialty community team is just that: it is a team not a meeting. That means that these teams are composed of named people who know one another, who work together in pursuit of a shared goal, who operate using a clear, explicit and mutually agreed approach, who communicate with one another, and who recognise their shared responsibility and accountability for improving the health and wellbeing of the locality population. As part of their development multi-specialty community teams will need to agree and adopt effective joint processes to help to:

- **Provide improved prevention:** promoting health and wellbeing and reducing the onset of disease
- **Provide improved access:** identifying need early and providing timely access to services and effective treatment
- **Provide improved coordination:** Actively identify people with additional need or complexity (for example people with three or more long-term conditions) and work with them to effectively manage their health and achieve personal outcomes. This will require agreed processes to identify people with high need, to work with that group to stabilise and maintain people's health, to respond proactively to any escalation in needs, to plan for and respond to the onset of crisis, and to plan for and support effective and timely post-acute care when people leave the hospital.

4.2 We hope to see different outcomes and experiences of care

Both Southwark Council and Southwark CCG have worked closely with local residents, service users and their families and carers to understand the things people would like to be able to say about their experiences of a health and social care system. These "I" statements are the outcomes that people say are important.

In a population focused system that aims to deliver value and thinks about more than medicine and more than healthcare, people will be able to say:

- *I have systems in place to help at an early stage to avoid crisis and as small a disruption as possible if a crisis happens.*
- *I can manage my own health and wellbeing (or condition) and I am supported to do this (including having access to information and being able to stay healthy).*
- *I can plan my care with people who work together to understand me allow me control and bring together services to achieve the outcomes that are important to me.*
- *I (am able to) live the life I want (and get the support I need to do that).*
- *I feel (am) safe, secure and protected from harm.*

Similarly, in work done in preparation for retendering of Southwark Homecare services, the following "I" statements were developed with people currently using Home care. In a population focused system that aims to deliver value and thinks about more than medicine and more than healthcare, people will be able to say:

- *I want you to be honest with me.*
- *I want to feel safe and protected from abuse.*
- *I want to be treated with dignity, empathy and respect at all times.*
- *I want regular and replacement carers who know me and respect who I am, my culture and my beliefs, and what is important to me.*
- *I want suitably trained and supported care staff.*
- *I want to receive clear good quality information right from the beginning.*
- *I want to know where to go for advice.*
- *I want to know how much this will cost me right from the start.*
- *I have the right to choose how I live my life and be as active and go outside as I want.*
- *I want to stay living in my own home and maintain my community, social, cultural and religious networks.*
- *I want to be able to speak to someone who I can understand and who understands me, in the way that I have agreed works best for me.*
- *I want my family and friends to be involved and consulted with my consent.*
- *I expect that the quality of my care does not depend upon me having family or friends who advocate on my behalf.*

If we are successful, the system we will commission and support will be able to deliver services that allow an increasing number of Southwark people to say that these 'I' statements have been met.

5 Next steps

5.1 We will use our Forward View as the starting point for all of our organizational strategies

As we describe in section 3.1.2, the Council and the CCG will work closely together to develop and deliver our commissioning responsibilities. This will involve the development of commissioning strategies for particular population groups. It will also involve the development of plans to create supporting infrastructure, such as IT and estates. All of these plans will take the vision and principles describe in this document as their starting point so that everything we do on this agenda is focused on delivering the actions we have set out in this document.

An illustrative depiction of this relationship is shown in Figure 7. Further summary information about the specific plans that are referenced can be found in the appendix.

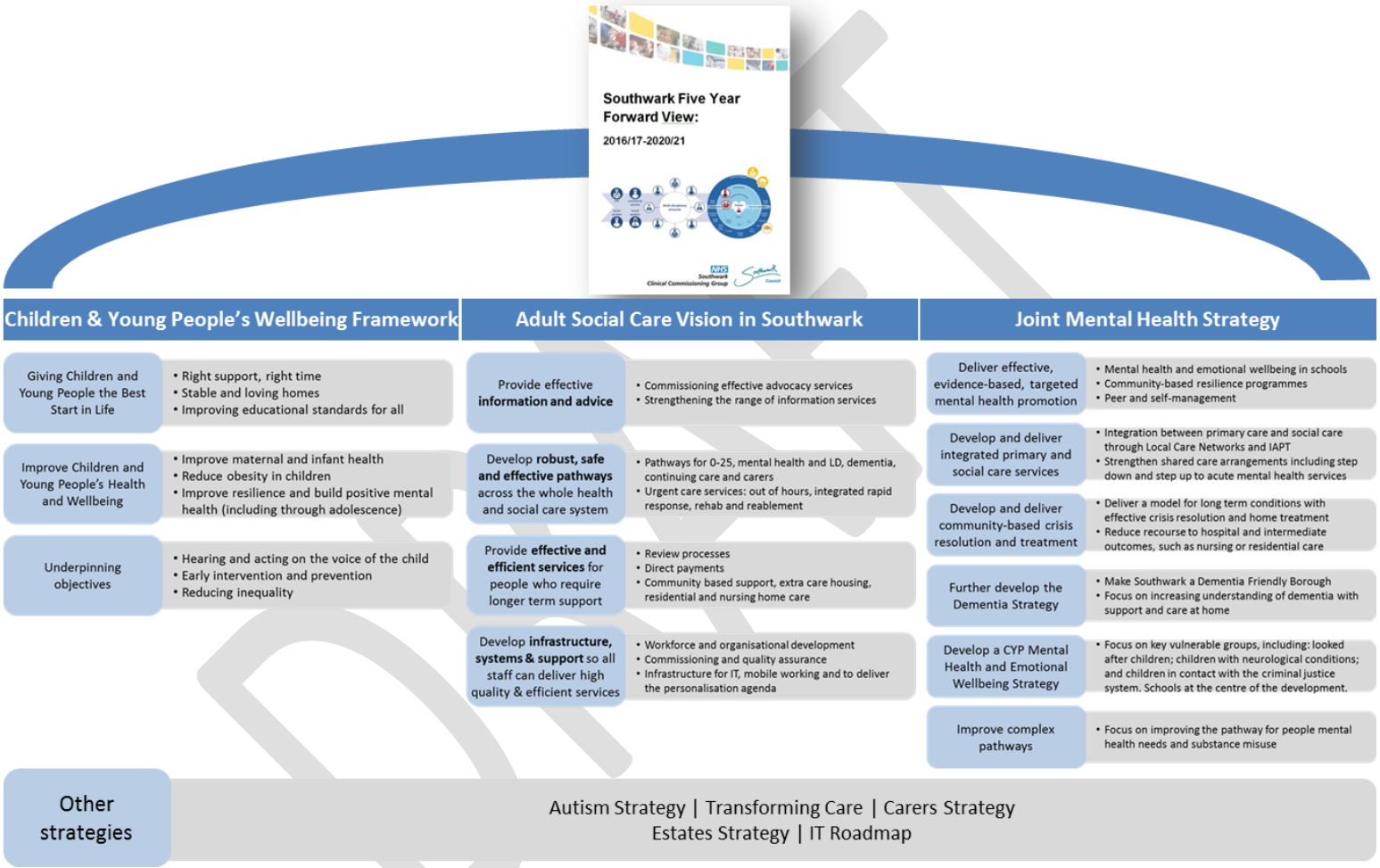
5.2 We will develop an 'Into Action' document to describe our detailed plan for 2016/17

This Forward View is intended to stimulate discussion to inform and structure a programme of meaningful change with the Council, the CCG and with our wider partners.

In this document we have described the need for a transformation to improve health and social care outcomes for Southwark residents, by increasingly integrating commissioning, forming wider partnerships. We have also described how providers of services will be supported and incentivized to work together and with service users to co-produce good outcomes for Southwark people.

We have set out the main aspects of our strategy but recognise that we must continue to develop this Forward View into a specific action plan. To that end our commitment is to share and discuss this strategy with our main partners and citizens and to follow this document with an accompanying plan, *'Southwark Forward View: Into Action',* in March 2016.

Figure 7 – Description of the relationship between the Southwark Forward View and our other strategic documents



Appendices

Local Case Studies

Taken from the Early Action Commission

Case study: Safe and Independent Living

Safe and Independent Living (SAIL) is a social prescribing scheme that is being delivered in partnership with Age UK, and aims to build and maintain a list of activities and services offered by the local Voluntary and Community Sector. SAIL works through a simple yes-or-no questionnaire, which acts as a guide for anyone working in the community to quickly identify an older person's needs. Each question is associated with a partner agency, so a 'yes' to any question operates as a flag to bring that person to the attention of that particular organisation. All partner agencies have agreed to accept all referrals through SAIL and to contact the client within two weeks of being notified. Age UK acts as the hub for the scheme, receiving completed SAIL questionnaires, forwarding them to the appropriate partner agency within 24 hours of receipt and following up the referral with the older person to ensure their needs are met. In this way, SAIL integrates health activities and services offered by the public and voluntary sectors. It is a good example of how partnership working can contribute to early action through signposting and communication.

Case Study: Southwark Healthy High Streets

Southwark Healthy High Streets (SHHS) aims to bring together public health, planning, licensing, trading standards and transport, as well as work with local communities, to explore ways of changing Southwark's high streets to help make people's lives healthier. Its key objectives include: promoting a healthier eating and living environment through restrictions on the number and distribution of fast food and licensed outlets, betting shops and pay day loan companies; promoting active travel through high street design – including good cycling infrastructure, bike hire and walking opportunities; supporting communities to make use of underused public spaces and supporting the high street revitalisation programme in Southwark.

These work-streams are a good example of upstream ambitions because they look at the high street holistically. SHHS illustrates place shaping ambitions in that it moves beyond an understanding of problems arising from decisions of individuals, to the local conditions that shape their behaviours and choices. It is also an example of partnership working and building on assets: the initiative brings together and co-ordinates people and organisations from different sectors and provides funds for community organisations to develop and implement ideas for healthy high streets. As such, SHHS place-shapes by bringing together the regulatory power of local bodies (e.g. in restricting certain shops) and creativity of the community through funding local initiatives.

Population-based commissioning: an overview

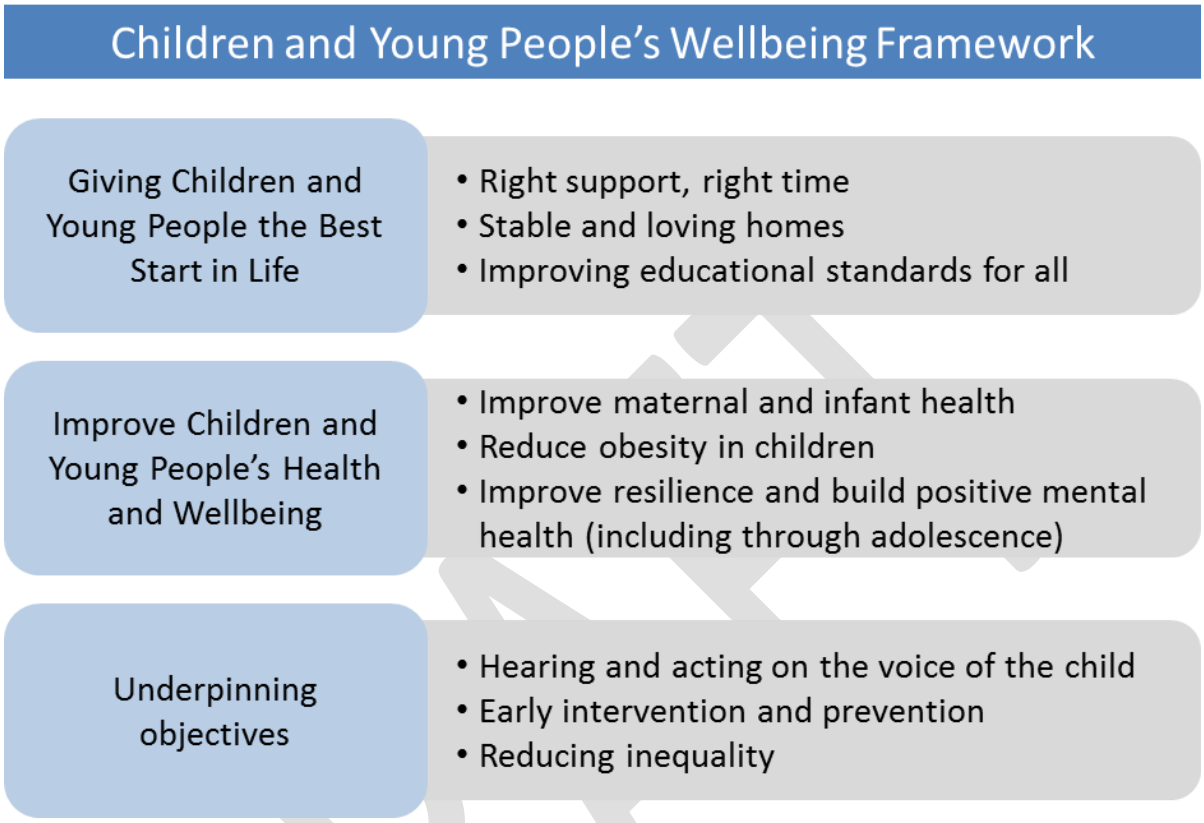
To move to a system where commissioners can offer population-based contracts that focus on the improvement of outcomes, a variety of steps need to be undertaken. These generic steps will be an important part of the approach taken by all of the CCG's commissioning programme boards.

- **Segmentation**: overall we need to determine how we – as commissioners – can describe our total population so that we can put people into groups based upon the similarity of their needs. These groups need to be mutually exclusive and collectively exhaustive.
    - We have already made some progress in identifying relevant population groups, for example people with Serious Mental Illness, people with learning disabilities, and people with frailty and multiple long terms conditions.
- **Resource availability**: for any given population segment we need to determine the resources that we have available to spend on their care. This involves an analysis of total system spend on each group, linking together information from all parts of the health and care system, and thinking about the shift in resource required to genuinely invest in prevention and early interaction.
- **Outcomes identification**: for any given population segment we need to determine what outcomes matter to people in the group and how we would measure those outcomes in practice. This work should be centered on service users and involve clinicians, commissioners and public health experts. Outcome indicators should cover the entire pathway but be relatively few in number to ensure a clear focus for delivery and improvement.
- **Service specification**: for any given population group we should be able to describe – at a high level – the core components of support that we think defines high quality care.
    - This specification should be informed by work with existing providers to understand the barriers within existing models.
    - It is important that this specification focuses on the attributes or characteristics of care and avoids overly detailed specification of inputs, processes or outputs; the detailed service descriptions should be described by providers and it is the job of a commissioner to appraise providers on the credibility and value of the models they propose.
- **Provider development and market testing**: commissioners can only expect a positive response to new contracts if there are indeed providers or networks which are able to respond effectively. Commissioners will work proactively with providers (both incumbent and potential new entrants) to support the development of relationships and an understanding of new ways of working and new operating models.
- **Approach to contracting**: for any given population segment we will need to define what contracting model(s) we want to offer. This includes options appraisals of the different contracts available, a description of the mechanisms for incentives and risk-sharing that it would include, and a description of the contract duration.
- **Approach to procurement**: for any given population segment we will need to develop detailed descriptions of our planned procurement process, ensuring compliance with regulatory requirements. Within the process our assessment should take into account an understanding of the feasibility of delivery, for example by seeking a view on workforce availability and development plans during the delivery phase.

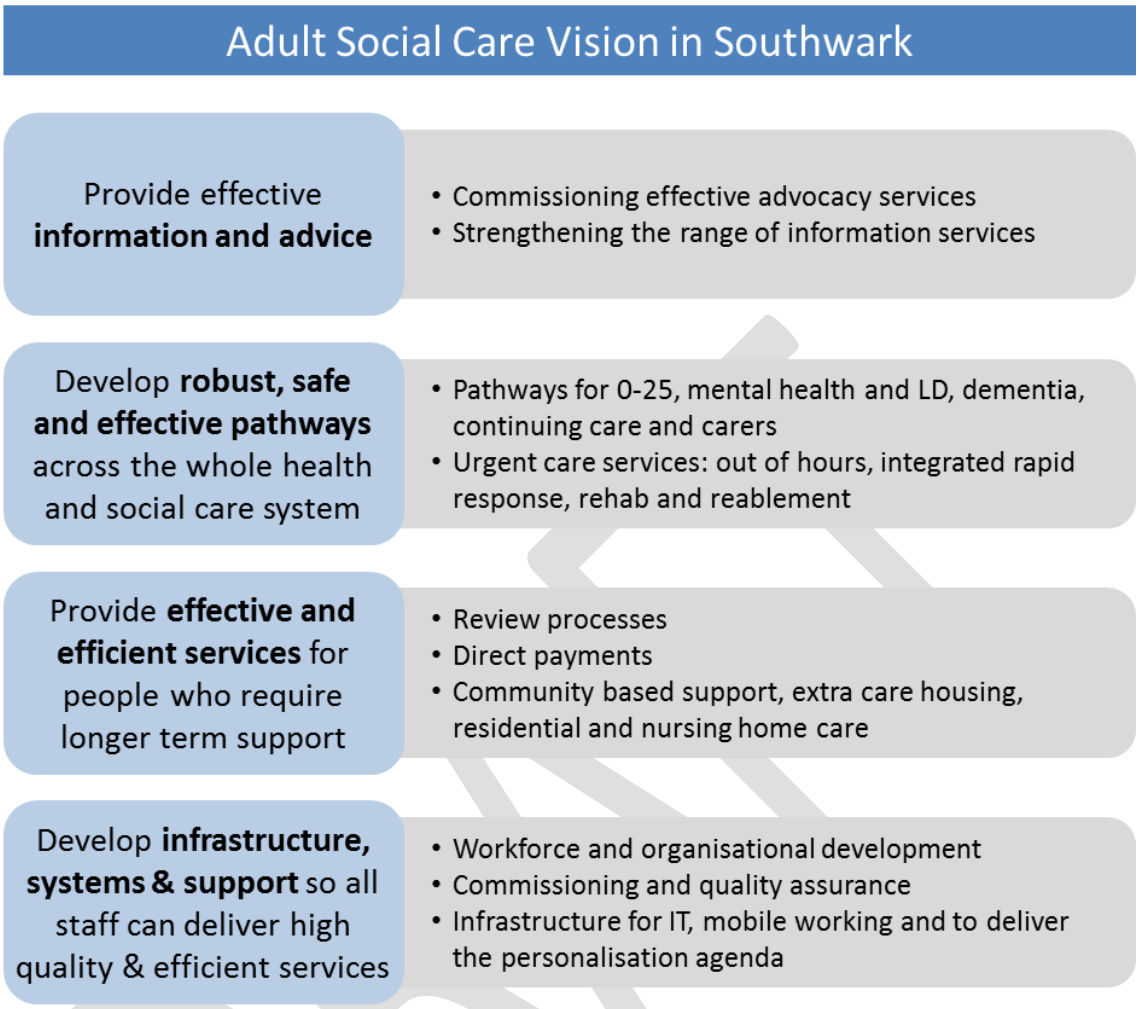
Over the next five years we will use this generic approach to commissioning in order to develop several capitated outcomes-based contracts. Ultimately, when taken together, we anticipate capitated contracts will cover the total population of Southwark.

Supporting Local Strategies

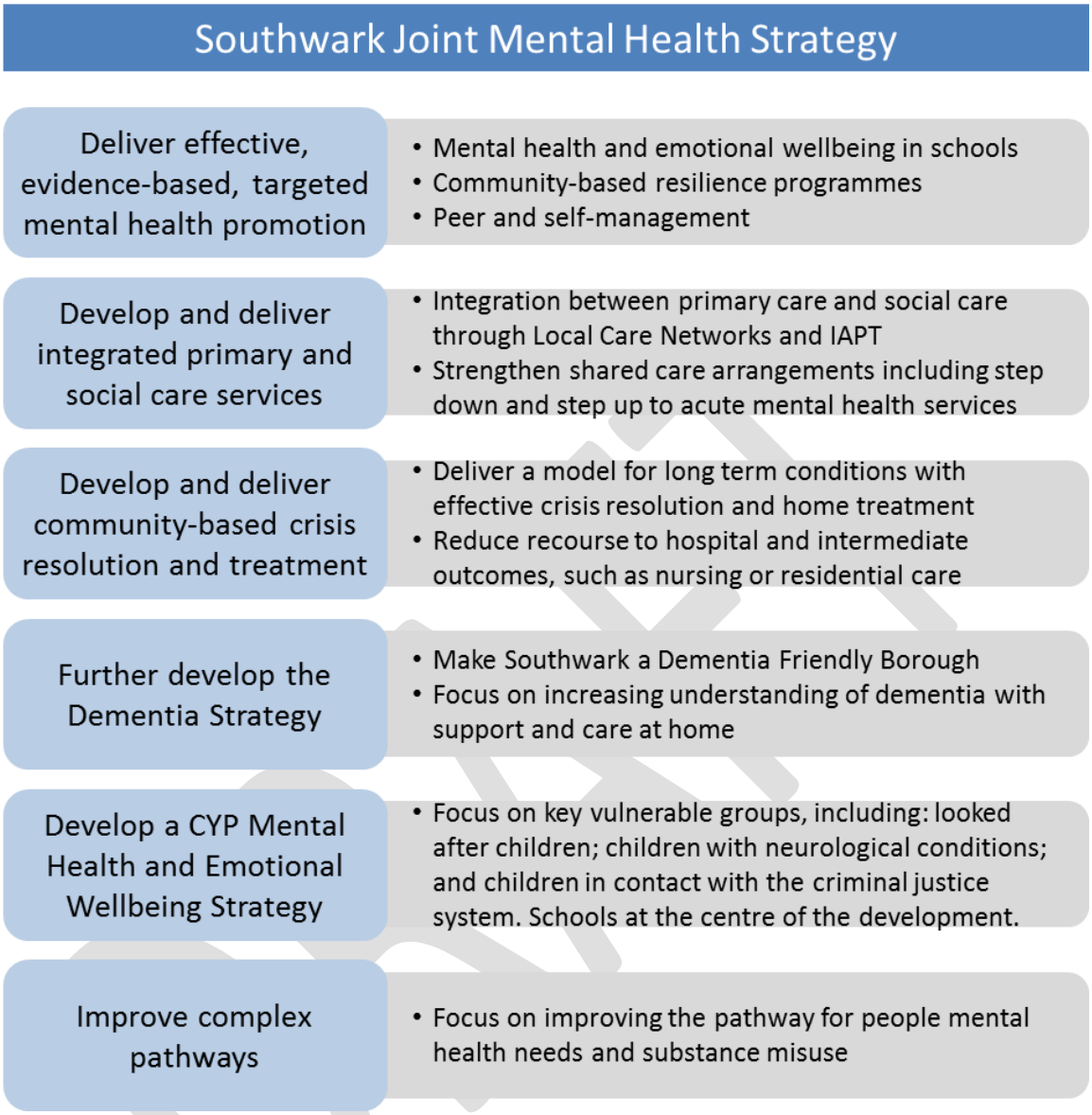
Children and Young People's Wellbeing Framework



Adult Social Care Vision



Joint Mental Health Strategy



Glossary

[DN. To be completed]

Word or phrase	What we mean when we use it
•	•
•	•
•	•
•	•
•	•
•	•
•	•

References

These references are intended to inform the Southwark Five Year View and set some of the context in which it is written:

1. **Michael Marmot (2015)** *The Health Gap*
   Succinctly sets out on a local, national and international context the social determinants of health and how empowerment and social action can address limitations to wellbeing.

2. **Southwark Council (2015)** *Together we can deliver a better quality of life in Southwark: Our Vision for Adult Social Care*
   Sets out the overall operating vision for adult social care delivery in Southwark.

3. **NHS Southwark Clinical Commissioning Group & Southwark Council (2015-16)** *Children and Young Person's Joint Wellbeing Strategic Framework*
   This Strategic Framework for the period 2016-2012 is a collaborative piece of work between Southwark Council and NHS Southwark CCG to bring into a single framework commissioned services across Education, Health and Social Care.

4. **NHS SE London CCGs (2015)** *Our healthier South East London: Help us improve your local NHS.*
   A paper published in May 2015 setting out the health and related social care issues facing SE London and introduces the idea of Local Care Networks (LCNs).

5. **Southwark Council (2015)** *Southwark's Families Matter*
   The 2015-2020 Early Help Strategy, empowering every child, young person and family to live happy, fulfilling lives in their local community.

6. **The Early Action Commission (2015)**
   An in-depth review of the system-wide shift that is required to support a proactive system that is effective in preventing and reducing ill health

Agenda Item 12

Item No. 12.	Classification: Open	Date: 28 January 2016	Meeting Name: Health and Wellbeing Board
Report title:		Southwark Safeguarding Children Board Annual report 2014-15	
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 Southwark Safeguarding Children Board Annual Report at appendix 1.

BACKGROUND INFORMATION

2. This report relates to the work of the Board and its partner agencies in the financial year 2014-15 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. Statutory guidance in Working Together to Safeguard Children (2015) 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 second annual report to the Board.

4. 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. The Annual Report was agreed by the SSCB in September 2015. The guidance also advises that the annual report is presented to the Chair of the Health and Well Being Board.

KEY ISSUES FOR CONSIDERATION

5. The 2014/15 SSCB annual report provides information on the effectiveness of partnership working in Southwark and evidence of a busy and productive year. The main priorities of the Board have included the prevention and response to neglect, early help, and child sexual exploitation.

6. During 2014/15, the Multi Agency Safeguarding Hub (MASH) has become more established, with the SSCB reviewing the multi agency thresholds and work on Families Matter which created debate and discussions about thresholds. There have been signs of improvements in the number and appropriateness of referrals from contact. With changes and systems for completing assessments brought in through Social Work Matters, timescales for completing the assessments should

improve.

7. In 2014/15 Southwark met the Troubled Families phase 1 target and the SSCB led the next phase of development of Family Matters. Two multi agency events took place in June and July 2015, chaired by the SSCB Independent chair. This is in addition to the continued focus on the core business of the Board - child protection and the safety of looked after children

8. The Board held a well received conference focusing on working with young people, including child sexual exploitation and missing from home, school or care. The event was attended by 165 partners with strong engagement from health, children social care and education and supported the strategic and operational conversations about Southwark's response to the safeguarding challenges for adolescents.

9. During 2014/15 the Board has established the 'Changemakers' group of young people. The changemakers have attended two board meetings and also provided input to the SSCB annual conference.

10. The annual report offers development areas for improvement for the Board to take forward in the 2015/16 work plan. These include:

    a) Continuing to improve engagement with children and young people
    b) Undertaking the local prevalence and development work around Female Genital Mutilation such as developing referral pathways and sharing good practice between partner agencies to safeguard children at risk of FGM
    c) Combining the SSCB training strategy with the learning and improvement framework.
    d) Developing local practice from intervention to enforcement around multi agency Child Sexual Exploitation Strategy, including children and young people missing from home, care and school.
    e) 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	Hannah Edwards SSCB Development Manager
Link: https://www.gov.uk/government/publications/working-together-to-safeguard-children		
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/	Hannah Edwards SSCB Development Manager
Link: http://www.nspcc.org.uk/preventing-abuse/child-protection-system/wales/child-practice-reviews/		

APPENDICES

No.	Title
Appendix 1	Southwark Safeguarding Children Board Annual Report 2014/15

AUDIT TRAIL

Lead Officer	Michael O'Connor, Chair of the Safeguarding Board
Report Author	Hannah Edwards, Development Manager Safeguarding Board
Version	Final
Dated	15 January 2016
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No

13.9.15

APPENDIX 1

Southwark Safeguarding Children Board

Annual Report
2014/15

If you have any comments on this report please email Michael O'Connor, the independent chair of Southwark Safeguarding Children Board at SSCB@southwark.gov.uk

13.9.15

Contents

13.9.15

1. Foreword from the independent chair of Southwark Safeguarding Children Board

This is my second Annual Report as the Chair of Southwark Safeguarding Children Board (SSCB). It has been another busy and productive year and this is reflected in the work highlighted in the 2014/15 priorities. This report also provides an overview of safeguarding practice in Southwark and identifies the priorities for 2015/16.

During this year the SSCB established the Changemakers group of young people. This group provides the SSCB with direct access to the views of young people. The young changemakers attended two Board meetings and provided input to the annual SSCB conference. The conference this year focused on safeguarding and adolescents. I also met with the Changemakers group to hear and discuss their views on safeguarding issues. The young people identified their priority issues and plan to set out principles and values to guide staff and volunteers working with them. Further details are set out in section 4.

The board has been working with partners across the borough on the priorities of early help, more assertive practice around neglect, and child sexual exploitation (CSE). Last year, the board held the system to account on developments around "best start" now known as 'Families Matter' which is Southwark's response to Troubled Families and services that make sure children, young people and families receive early help as soon as problems and issues arise. The SSCB led two Families Matters workshops and the local authority then undertook the lead for developing services. Our whole system challenge on neglect has shown some positive improvements, for example, during 2014/15 no (zero) children and young people were the subject of a second child protection plan within 2 years of the previous plans which indicates practice has been effective in addressing safeguarding issues.

Child Sexual Exploitation (CSE) was a priority for all agencies during 2014/15. The CSE sub-group led this work and developed the CSE Strategy which enabled a review of the current position. As a result, there is a stronger focus on preventing CSE and on CSE risk assessment. By the end of March 2015, 995 staff had completed CSE training. The CSE audit completed in January 2015 is informing future developments and a review of the strategy and implementation plan is due to take place in autumn 2015.

This year we have continued to develop and challenge how we use data and audit to develop practice and improve safeguarding outcomes. We worked with partners to develop a multi agency data framework to support whole system accountability, debate and challenge for safeguarding performance and outcomes. In supporting the learning from more qualitative information, we have reviewed the multi-agency audit programme on the learning, action and impact from past audits to support developments in our priorities. Two further multi-agency audits took place during the year on distant placements and on CSE, and summary findings are detailed in this report. We have invested in how we can better learn from Serious Case Reviews (SCRs), and are now using the "Welsh model" for SCRs and a case review that uses a systematic approach to promote respectful challenge and for a thorough understanding of agency action in each case. The Section 11 Challenge Panel continues to provide a vehicle for challenge between agencies in compliance with statutory duties around safeguarding.

The SSCB vision is set out in the next section of this report. The 2015/16 priorities are summarised and the SSCB business plan details how the priorities will be achieved.

I look forward to continuing to work with local partners to improve the safeguarding of children and young people.

Michael O'Connor, Independent Chair

Vision

All children in Southwark have the right to be safe and protected from harm. We will work together to protect children and young people through high quality services that enable children to reach their full potential and achieve the best possible outcomes**.**

Responsibilities

The SSCB will ensure 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 concerned 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 that provide services for children and young people ensure they are safe and monitor service quality and impact.

Key Strategic Questions for the SSCB

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 children and young people are safe? This includes early help.
- **Are all partner agencies meeting their statutory responsibilities** as set out in Working Together 2015 chapter 2?
- **Do all partner agencies quality assure practice** and is there evidence of learning and improving practice?
- **Is training on early help and safeguarding monitored and evaluated** and is there evidence of training impacting on practice? This includes multi-agency training.

2015/16 SSCB Priorities

Thematic priorities

- Families Matter
- CSE and children and young people who go missing
- Domestic abuse and adult misuse of alcohol
- Preventing violent extremism
- Female Genital Mutilation

Other safeguarding groups and issues

- Safeguarding children with SEND
- Children in need
- Looked after children and the role of the independent reviewing officer (IRO)
- The impact of Social Work Matters on safeguarding
- Private Fostering

Learning & Improvement

- Learning and development framework
- SSCB training programme and its impact
- Further work on the multi-agency data set and audit programme
- Disseminating learning from case reviews

Improving Governance

- Continuing to improve engagement with children and young people
- The work of the LADO
- Developing a set of SSCB values
- SSCB communication strategy including website
- Producing a governance handbook

13.9.15

2. Purpose of the Southwark Safeguarding Children Board (SSCB)

'Working Together to Safeguard Children' (2015, statutory guidance) sets out the statutory responsibility of the Local Safeguarding Children Board (LSCB). As a minimum, LSCBs are required to:

- Assess the effectiveness of the help being provided to children and families, including early help
- 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
- Quality assure practice, including through joint audits of case files involving practitioners and identifying lessons learned
- Monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children

Working Together also sets out requirements regarding Annual Reports. These are summarised in the table below and signposted to where this information can be found within this annual report.

Requirement	**Where covered in Annual Report**
"The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area."	This annual report covers early help and safeguarding.
"The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the Health and Wellbeing board."	The 2015/16 work plan includes dates when the Annual Report will be considered by key individuals and groups
"The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action."	Section 5 assesses the effectiveness of help being provided. Section 6 sets out quality assurance and performance management arrangements. The 2015/16 work plan includes proposals for addressing the areas for development identified.
"The report should include lessons from reviews undertaken within the reporting period."	Section 6.3 focuses on audits of case files and 6.4 on case reviews.
"The report should also list the (financial) contributions made to the LSCB by partner agencies and details of what the LSCB has spent, including on Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training."	Section 7.3 covers financial information.

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3. Local context

3.1 Key facts

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. 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 Analysis (JSNA).

The June 2015 Public Health England child health profile of Southwark highlights the following key findings.

Children's Health in Southwark

- The 0 to 19 years population is 67,600 which is 22.6 % of all residents in Southwark. This is slightly lower than the London average
- The latest figures for children under 16 living in poverty is 28.6% which is higher than the London average of 23.7%
- 25,207 or 79% of school children are from minority ethnic groups.
- 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)
- Infant and child mortality rates are similar to the English average
- Children in Southwark have worse than average levels of obesity. 12.8% of children aged 4-5 and 26.8% of children aged 10-11 are classified as obese
- In comparison with 2008-2011 the rate of young people aged 10-24 years who are admitted to hospital as a result of self harm is higher in the 2011-2014 period. Nationally levels of self harm are higher among young women than young men
- In 2013, 158 children entered the youth justice system for the first time. This is a higher rate than the England average

3.2 Local approaches

3.2.1 Social Work Matters

In September 2013, after extensive consultation with social care staff and with partner agencies, Southwark Social Care published *Social Work Matters* which sets out a vision for social work in Southwark. Social Work Matters is a whole system transformation programme. A key driver of the social work model was to support more assertive practice on neglect and introduce new ways of working, such as reflective practice, to enable us to work in a different way around entrenched needs of the family. It builds on the good social work practice already taking place in Southwark, developing a more reflective and systemic approach through creating Practice Groups. A robust project management approach was used to manage the change process incrementally and the new practice groups were established in 2014. The SSCB will be evaluating the impact of these changes early in 2016. Other evidence based tools sit alongside Social Work Matters such as Signs of Safety, a framework for social work practice and partner agencies, it provides a strengths-based methodology

to working with families and involves a child and parent focused approach to understanding issues and developing 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.

13.9.15

4. Involving young people in the work of the SSCB

Do you feel safe? Do you feel guarded?
Or do you get the feeling that you're falling deeper into a pit and no one can find you?
Do you feel like a rag that's being used and discarded?
No purpose, no identity, no destiny
Rape is under reported
Neglect seems like the order of the day
Where negativity becomes reality
Integrity isn't just a word
It's the part of you that wants to do right and be respected
Do you feel locked up in the prison of hopelessness?
They make you do things you don't want to do
Make you ask yourself the question: Who? Who am I?
Do you feel safe? Do you feel guarded?

By: Precious and Devontai

During 2014/15 the chair established and funded support for the Changemakers group of young people. During 2014 the group met weekly for two hours in term time. The chair met with the Changemakers Group outside of Board meetings.

The Changemakers attended two Board meetings. At their second Board meeting the group facilitated a workshop exercise involving mapping their priorities against the priorities identified by Board members. This exercise resulted in agreement that the Changemakers will develop principles to guide professionals and volunteers when working with children and young people.

The Changemakers Group identified the following safeguarding priorities; progress of which will be reported to the SSCB in January 2016:

- Making sure that people are aware of what safeguarding is (awareness)
- Being straightforward (honesty and transparency)
- Making sure young people know where they need to go for protection and safety (awareness and services working together)
- Making sure those in the sector of safeguarding are devoted and committed and make sure children are safe (safer recruitment and quality assurance)
- Being aware some children and young people may not come to the attention of services – such as young people 'sofa surfing' when they don't feel they can stay at home (good referral process and awareness about private fostering).

The Changemakers provided feedback on the draft child sexual exploitation strategy. The strategy incorporated their views that there should be support for increasing parental awareness and that schools should use PSHE (Personal, Social and Health Education) to promote how young people can protect themselves against sexual exploitation.

The young people also engaged in the consultation on SH24, an online sexual health advice service.

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The Changemakers took part in the annual SSCB conference. Interviews with their peers informed their presentation to the conference. Extracts from the Changemakers' presentation to the conference are detailed below:

Changemakers – views on CSE

What CSE means to us

"Child Sexual Exploitation is someone abusing their power to take advantage of a person in a vulnerable position in exchange for sexual favours. A child is someone under the age of 18"

We think children who are the following are more vulnerable

- *Homeless*
- *Lack of friends and social network*
- *Have issues with parents*
- *Children who lack stuff*
- *Someone who lacks confidence*

Suggestions to make Southwark safer

- *Phone numbers at bus stops*
- *Workshops at schools*
- *Talking to young people about their issues*
- *Making them go home earlier*
- *More police patrols*
- *Anonymous places to go to talk to someone*
- *Just to be there for them*

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5. Effectiveness of safeguarding in Southwark

5.1 Families Matter

Families Matter is the name for Southwark's approach to early help services. Families Matter also includes Southwark's response to the national Troubled Families initiative. In 2014/15 Southwark met the Troubled Families phase 1 target and began planning for phase 2.

During 2014/15 the SSCB led the next phase of development of Families Matter. The approach was informed by the learning from the 2012/13 SSCB work on "best start" and neglect. Two multi-agency events took place in June and July 2015 chaired by the SSCB Independent Chair. Following these events the Council undertook the lead responsibility for the further development of Families Matter services.

Some key early help facts for 2014/15 are noted below:

Early Help Key Facts 2014/15

- Southwark Advocacy and Support Services (SASS) provides domestic violence advocacy and support services. In 2013/14 SASS undertook 91 CAFs. This increased to 197 in 2014/15
- In 2013/14 social care stepped-down 50 cases to the Early Help Service. In 2014/15 this increased to 84 cases
- 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 is at 4.8%, 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 seventh 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 2,830 in 2013/14 to 2,884 in 2014/15
- Meanwhile, the number of referrals to Children's Social Care has decreased from 3,533 in 2013/14 to 2,717 in 2014/15. Work is being undertaken to understand these figures and the relationship between increased Early Help referrals and lower referrals into Social Care
- Over 1,000 children have benefitted from a place in early years provision as part of the National 2 Year Old Offer. We continue to see increases in take up of 3 – 4 year olds 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)

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5.2 Initial access and assessment

In early 2015 as part of the development of Families Matter, the SSCB led a review of the multi-agency thresholds. The work included using case examples to explore understanding of thresholds and the appropriate response to best meet needs. This review of the thresholds will be completed in 2015/16.

The table below provides information on contacts, referrals and assessments, including comparative and trend information where available.

Indicator	**2012/13**	**2013/14**	**2014/15**	**Statistical neighbour average 2014/15**	**London average 2014/15**
Number of contacts completed	Previous years not available		6,323	Not published nationally	
% of contacts which led to a referral			53%		
Number of referrals completed in the year	3,450	3,533	2,716	2,826	2,782
Rate of referrals completed in the year per 10,000 under 18	580	582	440	501	478
% referrals started within 12 months of previous open referral	19%	18%	11%	14%	16%
% referrals which led to an assessment	71%	65%	64%	Due to LA changes to assessments processes national figures not comparable	
% referrals with an outcome of NFA	18%	23%	2%	8%	8%
Number of single assessments completed	Single assessment introduced in 2014/5		1,734	2,705	2,573
Rate of single assessments			281	442	446
% single assessments completed within 45 days			55%	81%	80%

During 2014/15 the MASH became more established, the SSCB began to review the multi-agency thresholds and work on Families Matter created debate and discussion about thresholds. This is beginning to show signs of improvement in regard to re-referrals, NFA, and improvements in the number and appropriateness of referrals from contact. With the changes and systems for completing assessments brought in through Social Work Matters, timescales for completing assessments should improve. The SSCB will continue to scrutinise initial access information including further analysis of the source of contacts and referrals, conversion rates throughout the process and activity resulting in no further action.

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5.3 Child Protection and challenging neglect

As at 31 March 2015, 309 children and young people were the subject of a child protection plan. This represents a decrease from 31 March 2014 when 327 children were the subject of a child protection plan, but is higher than the 31 March 2013 figure of 272. The 2015 number equates to a rate of 50 per 10,000 which is significantly higher that the latest comparative figures available for statistical neighbours and the London average as illustrated in the table below.

Indicator	2012/13	2013/14	2014/15	Statistical neighbour average 2014/15	London average 2014/15
Number of children with a child protection plan (CPP)	272	327	309	255	236
Rate with a CPP per 10,000 as at 31 March 2015	46	54	50	44	41

Although the CPP rate at 31 March 2015 appears to be higher than might be expected, the rate of Section 47 enquiries started is lower than the latest comparative information available and the rate of initial child protection conferences is also slightly lower. This audit shows thresholds are being applied well and children and families are not being involved in child protection processes when this is not required. However, less than 50% of Section 47 enquiries result in an Initial Conference. This is similar to statistical neighbours and the English average. 89% of conferences lead to a child protection plan. This might indicate decisions to progress to an initial conference are correct, but it is worth investigating further that multi-agency debate and challenge is happening at initial conferences.

The table below also notes that in 2014/15, 64% of initial child protection conferences happened within the required 15 days from the start of the Section 47 enquiry. This is similar to the latest comparative figures available.

Indicator	2012/13	2013/14	2014/15	Statistical neighbour average 2014/15	London average 2014/15
Number of Section 47s started	725	648	610	882	797
Rate per 10,000 Section 47s started	122	107	99	153	137
% Section 47s led to initial child protection conferences (ICPC)		59%	49%	Not published nationally	
Number of initial child protection conferences (ICPCs)*	334	384	316	345	325
Rate per 10,000 ICPCs	56	63	51	60	56
% conferenced that led to CPP	87%	88%	89%	87%	86%
% ICPCs within 15 days of start of Section 47	49%	68%	64%	69%	68%

*does not include children who became the subject of a CPP through a “transfer-in” conference.

Social Work Matters and Signs of Safety have been used to support practice on tackling children subject to neglect and where there are entrenched needs within the family. Whilst initial child protection plan activity has reduced over the last three years, the number of children remaining at risk of significant harm for 1-2 years has increased from 27% in 2012/13 to 46% in 2014/15. This is highlighted in the table below which also shows that the number of children with plans ending between 6 months and 1 year reduced from 41% in 2013/14 to 32% in 2014/15.

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The table below also includes information on the percentage of children who became subject of a CPP for a second or subsequent time where performance is below the average for other local authorities.

CPP Plans	2012/13	2013/14	2014/15	Statistical neighbour average 2014/15	London average 2014/15
% CP plans ending under 3 months	17%	13%	14%	19%	18%
% CP plan ending 3 to 6 months	6%	8%	3%	8%	10%
% CP plans ending 6 month to 1 year	34%	41%	32%	40%	41%
% CP plans ending 1 year to 2 years	27%	34%	46%	28%	27%
% CP plans ending over 2 years	16%	4%	6%	7%	4%
% of children who became subject of a CPP for a second or subsequent time	17%	9%	9%	14%	14%

In 2014/15 there were no (zero) children and young people who were the subject of a child protection plan within two years of a previous plan. 28 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 as part of the SSCB in depth-analysis referred to above. A public health needs assessment was commissioned by the board and local authority to better understand the needs of this group and inform future practice developments across both Families Matter and safeguarding services.

A report from the Social Care Quality Assurance Unit was received by the SSCB in June 2014. In 2015/16 the SSCB will continue to monitor child protection plan performance information. The intention is to include indicators on multi-agency participation and involvement. A child protection audit is planned and an in-depth analysis of all available quality and performance information is planned for September 2015. This will include looking at the effectiveness of child protection planning and the monitoring of agreed action.

During 2014/15 work took place to ensure the SSCB data set reflected multi-agency contributions to the child protection process. Acute hospital trusts began to report on invitations and attendance at conferences and reviews and plans are in place for recording reports provided for conferences and reviews.

5.4 Children in Need

It is important to note that the large majority of vulnerable children and young people are worked with under Section 17 of the Children Act. The table below illustrates this noting that as at 31 March 2015 there were 2,186 children in need cases open to social care. Unlike the number of CPP and LAC, this figure increased from 1,730 cases as at 31 March 2014. Further analysis of these figures will take place, including analysing age and ethnicity. The SSCB also plans to scrutinise other information available about children in need including evidence of ensuring multi-agency approaches are taken to working with vulnerable children who are in need of help and support, but who are not at risk of significant harm.

Total Children in need by different categories as at 31 March	2014	2015
Number of children with a child protection plan (CPP)	327	309
Number of LAC	550	505
Number of Care Leavers	320	287
Number children in need*	2,927	3,243
Number of cases open to social care	1,730	2,186

* will also include some assessments being completed

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5.5 Looked after children

5.5.1 SSCB in-depth report on looked after children

In February 2014 the SSCB received a detailed report on looked after children. The executive summary highlighted the following strengths and areas for development:

Strengths
Reducing overall numbers of children in care
Capturing, and acting on, the views of children and young people e.g. Speakerbox – the Children in Care Council and Young Inspectors work which led to the development of the 16 plus accommodation strategy
Responding to concerns raised by children and young people e.g. commissioning St Christopher's Fellowship to provide additional support to those who have gone missing
Working in partnership to identify and address issues with providers e.g. CSE concerns in Kent
Joint working between health and social care on the health of looked after children

Areas for development
Providing safer, better quality and stable placements
IROs escalating concerns and triggering management action
Securing more suitable accommodation and support for care leavers
Improving timeliness of health assessments
Improving tracking educational progress of children in care and care leavers

The report noted the number of children looked after is on a downward trend over the last three years from 560 at 31 March 2013, to 505 at 31 March 2015 however the rate of looked after children is still high when compared to similar local authorities. During 2014/15 the local authority introduced an Accessing Resources Panel which is enabling closer analysis of the reasons why children and young people come into care. In particular those entering and ceasing care for short periods of time which shows signs of increase over the last few years.

5.5.2 LAC placements

The February 2014 SSCB report on LAC included findings from audits and views of children and young people, it focused on a number of safeguarding issues relating to:

- Distant placements
- Placement stability and sufficiency

The table below summarises the 2014/15 performance information on placements. It is important to note that children and young people have mixed views on placements. Some are often keen to move closer to Southwark, whilst others do not want to move from placements where they are happy, even if placements are a long way from home. Using the latest comparative figures available, Southwark places a slightly higher proportion of children looked after more than 20 miles from home. The percentage placed in residential provision is lower than similar authorities but higher proportions of residential placements are more than 20 miles from Southwark. Placement stability is much the same as similar authorities. During 2014/15 the local authority updated the Sufficiency Strategy which will have an impact in future years.

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Indicator	2012/13	2013/14	2014/15
Number of CLA placed more than 20 miles from home	95	120	115
% CLA placed more than 20 miles from home	17%	22%	23%
% placed in residential care	10%	11%	11%
% placed in residential care who are placed more than 20 miles from home		76%	72%
Number of CLA with 3+ placements in year April-March	75	97	61
% with 3+ placements in year April-March	14%	17%	13%
% CLA living in same placement for over 2 years*	63%	61%	68%

Exact definition = % CLA at end of period who have been looked after continuously for over 2.5 years who are living in same placement for over 2 years

5.5.3 Missing or absent placements

Of all children who were looked after during the year (775 CLA), 6% had at least one missing incident, which was in line with comparators. On average CLA in Southwark had 3.2 missing incidents, this was lower than comparators (England 4.7, London 4.9, SN 3.8). There were 20 children in Southwark with multiple missing incidents in the year.

Of all children who were looked after during the year (775 CLA), 4% had at least one absent incident, which was broadly in line with comparators (England 3%, London 4%, and SN 5%). On average CLA in Southwark had 3.2 absent incidents, which was lower than comparators (England 4.1, London 3.7, SN 4.6). There were 15 children in Southwark with multiple absent incidents in the year.

5.5.4 Outcomes of looked after children

The percentage of CLA who were Convicted or subject to a final warning or reprimand in year more than doubled from 3% in 2013/14 to 7% in 2014/15. This was higher than comparators (England 5%, London 6%, and SN 6%).

The proportion of CLA in Southwark who were identified as having a substance misuse problem doubled from 3% in 2013/14 to 6% in 2014/15. Only a quarter of these children received intervention for their problem, which is lower than comparators (England 49%, London 49%, SN 56%).

Overall the health care and development assessments of CLA in Southwark has slightly improved. The proportion with annual health assessments increased from 91% in 2014 to 92% in 2015, developmental assessments (under 5s) from 92% to 100%, and immunisations from 70% to 74%. Dental checks have slightly reduced from 85% to 84%. Compared to other local authorities, Southwark's performance for annual health assessments and developmental assessments were higher, and immunisations and dental checks were lower.

In 2014/15 an SDQ score was submitted for two-thirds of CLA in Southwark, which was lower than comparators (England 72%, London 82% and SN 84%). For those with an SQD score, around a half had a normal SDQ score, and 37% had a score of concern, which was an increase from 35% the year before.

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5.5.5 Care Leavers

The table below provides information on care leavers including the following:

- The number of care leavers remains stable.
- The percentage of care leavers in touch with social care also reduced from 88% to 82%. The percentage of care leavers in education, employment and training and living in suitable accommodation also reduced from 2012/13 and 2013/14.

Indicator	2012/13	2013/14	2014/15	Statistical neighbour average 2014/15	London average 2014/15
Number of care leavers	320	287	290	56	165
Percentage of care leavers in education, employment and training	46%	46%	43%	53%	53%
Percentage of care leavers in suitable accommodation	81%	81%	78%	83%	83%

5.6 Female Genital Mutilation (FGM)

FGM is a priority for the SSCB and the SSCB Health Sub-group is taking the lead on FGM. The SSCB is improving how health, social care, police and education services and the community work in partnership to assess risk in order to prevent FGM occurring and provide effective support to girls, women and their families who are affected by FGM.

The SSCB agreed to a follow up to the December 2013 FGM case audit and received a report in June 2014 on FGM. The audit required ethical clearance from Health Boards and the Designated Nurse prioritised this work following her appointment in early 2015. The Public Health team is leading on the FGM audit and has now addressed the ethical issues, as data on FGM referral and treatment pathways is now anonymised. This will provide a baseline which can be used to measure the impact when further audit activity is undertaken. A report on the audit will be presented to the SSCB in the autumn 2015.

5.7 Child Sexual Exploitation (CSE) including missing from home, school and care

5.7.1 The CSE Sub-Group

The SSCB established a Child Sexual Exploitation sub-group in 2013 following a CSE conference. The CSE sub-group led on developing a CSE Strategy which was agreed by the SSCB in December 2014 following extensive consultation and reflection on the learning from Rochdale and other CSE case reviews.

5.7.2 The CSE Strategy

The SSCB's strategic intent is to:

- Prevent the occurrence of CSE
- Build intelligence and develop a problem profile of CSE locally
- Provide support which is timely and effective for victims of CSE
- Disrupt the activities of perpetrators
- Prosecute perpetrators.

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The SSCB is committed to implementing a coherent operating model for tackling CSE. Key commitments noted in the CSE strategy are:

- A CSE lead within each agency
- A 'problem profile', drawing on evidence from all agencies
- A CSE coordinator based in Southwark Council
- A CSE referral hub within the MASH (multi-agency safeguarding hub)
- Good co-ordination across other sub-groups and networks ensuring professionals and other adults in contact with children and young people are alert to risk factors and indicators of CSE
- End to end services, from prevention to rehabilitation and including a range of specialist and targeted support
- A strong contribution from the voluntary and community sector

An interim progress report in March 2015 highlighted a number of items as completed or progressing well including the following:

- Multi-agency online training made available from December 2014. By 31 March 2015, 995 professionals had completed CSE training. An impact evaluation of the CSE online training is due to take place in May 2015
- Specialist training for Practice Group Leads in social care
- 'Operation Makesafe' and a borough-wide awareness campaign launched online and in social media
- CSE protocol in place with thresholds amended
- Latest police data showed a significant increase in disruption activity. Southwark comparing well with other London boroughs
- The initial CSE risk assessment tool developed was reviewed as requested in the March 2015 letter from the Chief Social Worker

5.7.3 Learning from CSE practice

In January 2015 a CSE audit took place highlighting the following:

- In most cases audited young people had experienced neglect in their earlier years and the experience of CSE was seen to compound difficult family attachment styles and other issues arising from this. The relationship between neglect and CSE later in a young person's life may need further exploration
- School emerged as a clear resilience factor
- There was limited detail recorded on men who were carers or alleged perpetrators. This had an impact on the quality of the risk assessment
- There was good information recorded on processes followed, but little note of impact.
- Child sexual exploitation was not always named explicitly in casework although professionals were describing behaviour that would fit with CSE risks

A review of open cases took place in April 2014 to identify the characteristics of young people who may be at risk of CSE. The findings were consistent with national profiling of CSE victims:

- A large proportion of those at risk were children in care, spread evenly between placements in borough, within London and out of London
- Many were children frequently going missing from care
- Around half of the children at risk were still living at home
- The vast majority were in education, though some had poor or persistent absence
- A high proportion of those at risk had a special educational need

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5.7.4 CSE and missing from home, school and care

During 2014/15 improvements were made in monitoring children and young people missing from home, school and care. From April 2014 the CSE sub-group extended its remit to cover missing children and young people and children and young people being electively home educated.

A review of the impact of the CSE strategy will take place in 2015. This will include reviewing action taken in response to the CSE audit and reviewing processes in place for monitoring and taking action on children and young people missing from home, school and care.

5.8 The annual SSCB conference on safeguarding challenges for adolescents

The annual SSCB conference held in February 2015 focused on working with young people including CSE and missing from home, school or care. A summary of information from the conference is provided below.

Exploring the contemporary safeguarding challenges for adolescents and developing a partnership-wide response
Southwark Safeguarding Children annual conference - February 2015

Included input from:

- The Changemakers group
- MsUnderstood Project
- Young Minds
- London Bubble Theatre

Workshops at the conference covered:

- Risk of self-harm in adolescents
- Child sexual exploitation and adolescents
- Understanding the needs of young carers and their families
- Safeguarding and e-safety
- Working together to safeguard children looked after
- Transition planning – safeguarding young people living with disabilities and plan for safe transition into adulthood
- Theatre based workshop for young people and their chaperones
- Children missing from home and care

165 delegates including service users attended from a total of 45 agencies. Feedback was very positive with attendees requesting further learning and practice development around CSE.
Observations from delegates included:

- *This conference has broadened my understanding on how to support vulnerable children; the topics discussed were thoroughly dealt with*
- *I really enjoyed the presentations, especially George Curtis, Charlotte Levene & London Bubble. Great contents and great presentations!*

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5.9 Private Fostering (PF)

The SSCB received reports on private fostering in July 2014 and January 2015. The 2013/14 Private Fostering Annual Report was published in March 2015. In July 2014 the SSCB agreed there will be a multi-agency private fostering focus, not least since there has been a significant decline in the number of notifications.

The following actions on private fostering took place in 2014/15:

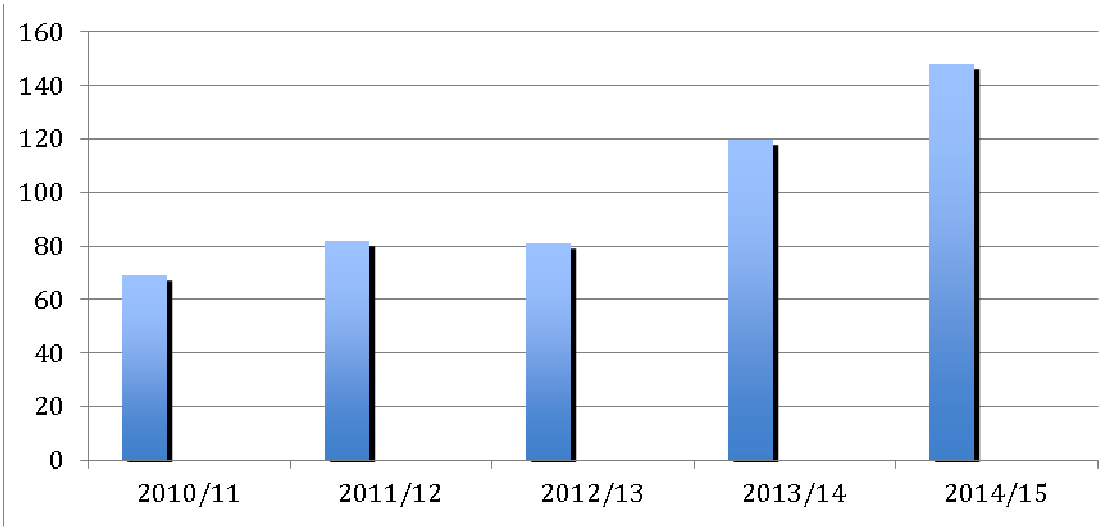
- Private Fostering Awareness week was held from 7 to 11 July 2014
- In January 2015 a letter was sent to all headteachers outlining the definition of private fostering, statutory duties and how to refer or seek advice. Private fostering was also an item in the Headteachers newsletter
- Private fostering has been a key priority of the education sub-group
- Training for Residents' Services Officers and their managers was held in January 2015
- Pilot programme is being developed for trial in one or two GP practices initially, looking at registrations and consultations as a key touch point in identifying private fostering
- Ensuring referral source data for private fostering notifications is monitored

A Private Fostering Annual Report for 2014/15 covering the seven national minimum standards for private fostering is due to be presented to the SSCB before the end of 2015.

5.10 Local Authority Designated Officer (LADO)

The local authority is required to designate responsibility for the management and oversight of allegations against people who work with children. In Southwark there is a LADO who undertakes this role, based within the Social Care Quality Assurance Unit. The LADO Annual Report for 2014/15 notes that since 2010 the number of referrals has more than doubled and that the "most likely explanation is increased awareness rather than any increase in the actual number of abuses by those working with children."

The bar chart below illustrates this increase.



The source of referrals information below represents the source of the disclosure by the child or young person.

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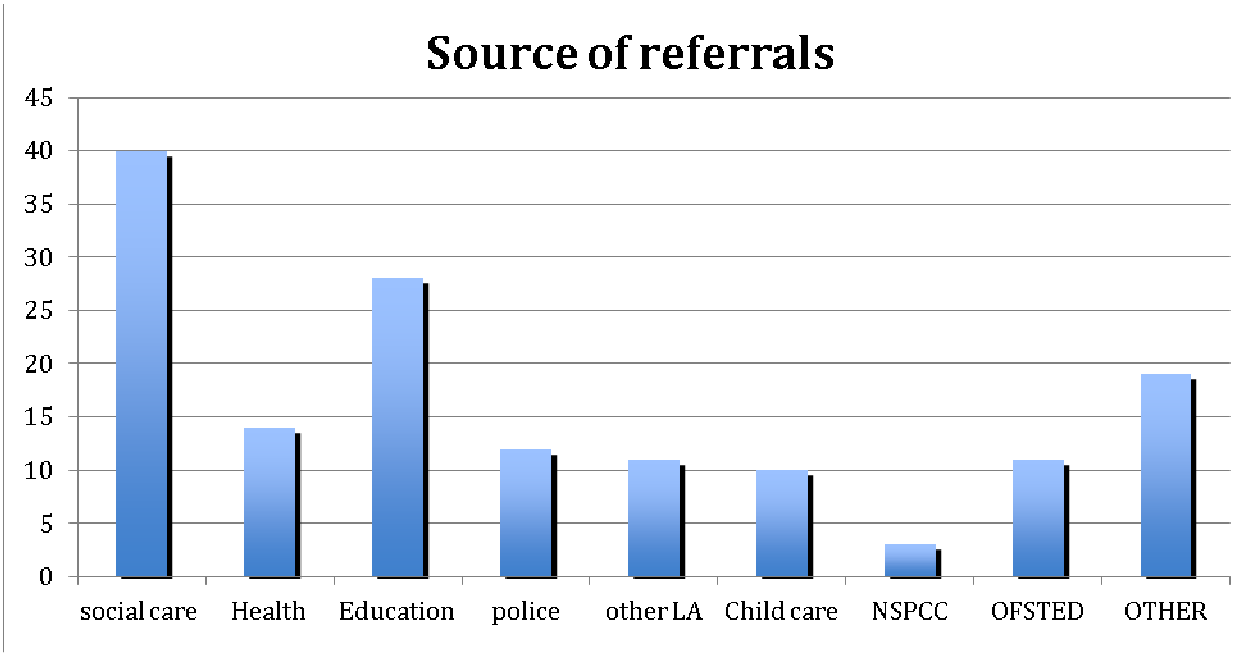

66 of the 148 referrals in 2014/15 resulted in a strategy discussion and of these 26 were substantiated, 11 unsubstantiated and 19 were unfounded or false.

The SSCB multi-agency data set improved over the year and the regular data supplied by acute hospital trusts includes the number of allegations against staff working with children and number reported to the LADO.

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6. Quality Assurance and Performance Management Arrangements

6.1 Section 11 Audit

The 2015 Section 11 Audit involved a peer Challenge Panel chaired by the SSCB Chair. The Panel comprised the Service Director for Children's Social Care, Head of Quality Assurance in NHS Southwark Clinical Commissioning Group (CCG), and a Detective Superintendent from the Metropolitan Police. 13 services and agencies took part in the peer challenge and action plans were drawn up by each agency and reported to the SSCB. The SSCB will receive a report monitoring progress with the Section 11 action plans in the spring 2016.

There is a safeguarding lead in Southwark education directorate who leads on the Section 175 process. There is a rolling programme of audits over a 2 year period.

6.2 SSCB data set

During 2014/15 the chair led work on ensuring the SSCB data set includes a range of indicators from all partner agencies. The data set now includes information on domestic abuse from the Community Safety Team, Multi-Agency Public Protection Arrangements (MAPPA) data from probation services, making use of the Metropolitan Police London Safeguarding Children's Board data set and health information including CAMHS monitoring data. The data set is also using information from Public Health England, including specialist substance misuse interventions provided for young people and information from the Drug and Alcohol Team (DAAT) on adults with substance misuse issues living with children and young people.

6.3 Multi-agency audit

During 2014/15 the Audit and Learning sub-group reviewed terms of reference and produced a composite audit action plan which draws together in one place learning and identified actions from audits undertaken since 2012. The impact of multi-agency audits is summarised below:

- Domestic Abuse audits (March 2012 & follow-up May 2013) led to training and workshops for staff and SSCB members. Child Protection chairs now attend the Multi-Agency Risk Assessment Conference (MARAC) panel to improve links between the two processes. Better information sharing has resulted and the follow-up audit appeared to demonstrate improved practice as a result
- Neglect audit (April 2013) drew attention to the importance of recognising medical, especially dental neglect. This was followed up in the SSCB conference and there were learning events for staff and SSCB to raise awareness of the issues
- CSE and Neglect audits (January 2012 and April 2013) looked at very similar cases and this helped to link long term neglect with CSE risk in older childhood. The findings have been presented to staff in learning events
- The Sexually Harmful Behaviour (SHB) audit (September 2013) identified some concerning practice in response to SHB referrals. A workshop involving managers took place on improving practice. A checklist was drawn up with managers to support staff with the assessment and response to SHB. The audit was presented to the designated teachers group and to health designated leads. A follow-up audit is proposed for 2015/16 to establish improvements in practice

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- The Family Focus audit (March 2014) was largely positive, it identified some concerns about the medical recording by the linked Health Visitor. These were addressed immediately by the Family Focus team to avoid loss of medical information in the future.

The audit and learning sub-group also carried out initial work on sharing information on the single agency audits which take place in partner agencies. A multi-agency audit plan for 2015/16 was agreed.

Two multi-agency audits took place in 2014/15. The audit of children placed far away from Southwark is referred to in section 5.5.2 of this report. The January 2015 CSE audit is referred to in section 5.7.

6.4 Case reviews

Following research into review models available the Serious Case Review (SCR) sub-group decided to test the Welsh case review model. The model is systems based and takes a 'strengths approach'. In 2014/15 the Welsh model was used for an SCR (Child R) and a management review (Child S). The process actively engages staff and includes learning events for frontline staff and other operational mangers. This promotes reflection, debate and challenge.

In 2014 the Department for Education (DfE) asked a number of local authorities to investigate information on child abuse by Jimmy Savile at a number of children's homes and schools. For Southwark Council, the information linked Savile with the Hollies Children's Home in Sidcup. The children's home was run by Southwark Council from 1965 until its closure in 1989 and the investigation was undertaken by an independent consultant.

There was a further independent investigation into a voluntary sector agency that arose from a local authority designated officer inquiry.

The Child R SCR has involved careful and appropriate consideration about publishing the review. The young woman, subject of the review, is aged 15 and there were differing views amongst SSCB members on publications.

The Child S case was used as a case example at the launch of the revised multi-agency thresholds event and was also shared at a meeting of designated safeguarding leads. The learning was further shared at a governance meeting of the CCG and used as a discussion prompt for looking at safeguarding quality assurance (QA) processes.

A further management review of Child T is taking place in 2015.

6.5 Training

The SSCB multi-agency safeguarding training strategy includes learning principles and identifies different levels of safeguarding training with guidance on who should attend each level. The core programme of training on offer is mapped against the training levels. The next version of the learning and improvement framework will be more specific about the number and job titles of staff requiring different levels of training, the core competencies required and information on the multi-agency training budget.

The training priorities for 2014/15 were influenced by work undertaken by the SSCB. For example, training was prioritised on neglect, CSE, domestic abuse and hard to engage families. Information on CSE, private fostering, domestic abuse and FGM was added to the content of all SSCB training.

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A variety of methods are used including traditional 'class-room' methods, e-learning, newsletters, lunch-time learning, and conferences. In addition there were designated lead days and 6 half-day child protection updates provided.

An annual training report is produced and in 2014/15 1,695 attendees from 121 organisations took part in multi-agency training. There has been a significant increase in training take-up since 2012 as illustrated in the table below:

Year	**2012/13**	**2013/14**	**2014/15**
Take-up	610	1,384	1,695

Feedback on the quality of the training provided is generally positive. During 2014/15 an impact evaluation survey was sent to participants and managers 3 to 5 months after completing the training. The response rate for participants was 36% and for managers was 21%. There was some evidence of training having a positive impact as noted in the tables below.

Knowledge and skills have been demonstrated in the workplace

Rating	**Individual**	**Manager**
Strongly agree	45%	36%
Tend to agree	45%	48%
Neither agree or disagree	7%	16%
Tend to disagree	3%	

Positive changes in performance and/or knowledge and skills have been sustained

Rating	**Individual**	**Manager**
Strongly agree	44%	29%
Tend to agree	48%	53%
Neither agree or disagree	7%	18%
Tend to disagree	1%	

The information provided by acute health trusts for the SSCB data set includes information on the percentage of eligible staff with up to date training for the four different safeguarding levels. During 2015/16 there are plans to set up systems for providing this information across the partnership.

A workforce development partnership summit attended by a range of partner agencies took place on 5 December 2014. Participants reviewed the current training programme available and some initial work was undertaken to improve the evaluation of training, including how best to monitor and assess impact.

6.6 Child Death Overview Panel (CDOP)

2014/15 CDOP data

- 23 deaths were reported comprising 11 neonates and 12 children.
- 22 cases were reviewed in this financial year with 21 (95%) deaths occurring within an acute hospital setting.
- The most common classification of death was neonatal death (11; 50%) followed by life limiting conditions (7; 32%).
- 5 (23%) cases had modifiable factors. The national figure in 2013/14 was 22%.

Summary of recommendations from the 2014/15 CDOP Annual Report

- Sudden unexpected death in infancy (SUDI) – A recurring theme. Partner organisations should ensure staff are trained with regular updates and audits to ensure quality.

13.9.15

- Domestic violence and risk to children – Recommendations include improving communication between medical professionals and social workers and improving risk assessments by ensuring social workers' awareness of evidence, challenging assumptions and improving supervision. Migrant families from countries experiencing conflict and violence should be adequately supported to prevent a perpetuation of violence.
- Youth violence – A public health approach to reducing youth violence is being considered and further implementation and evaluation is required.
- Safety in the home for young children – An awareness raising scheme regarding home safety (including SUDI) was piloted with housing officers, and safety equipment and literature scheme was made available to vulnerable families using non-recurrent funding. These schemes should be evaluated and sustained.

Progress on recommendations from 2013/14 CDOP Annual Report

- Youth violence – A public health needs assessment in Lambeth was completed and presented at the Lambeth Health and Wellbeing Board (HWB) and LSCB.
- Road/traffic safety and awareness – Transport for London has been informed of recommendations from last year's report and gave assurances regarding their staff training.
- Hospital staffing (midwifery) – Local units have provided assurances that they are reviewing staffing levels using birth rate planning tools to ensure national standards are met, and are providing enhanced caseload management for women with complex needs.
- Sudden unexpected death in infancy and safety in the home for young children - These two recommendations were addressed together. An awareness raising programme for housing officers was developed and implemented and a home safety equipment scheme for vulnerable families was commissioned.

13.9.15

7. SSCB Governance arrangements and activity

7.1 Meetings and events

During 2014 the role of the Safeguarding Board was clarified and the terms of reference reviewed and changed. The SSCB now meets 6 times a year and a Partnership Group meets 3 times a year. This arrangement enables the SSCB to have a strategic focus with the Partnership Group ensuring wider engagement of key stakeholders. A review of the Partnership Group will take place in 2015/16.

Information on SSCB membership is included at Appendix 1. There is good attendance at Board meetings from all partnership agencies.

During 2014/15 the following sub-groups met regularly:

- Audit and Learning
- Human Resources and Safeguarding (joint with Adults Safeguarding Board)
- Practice Development and Training
- Serious Case Review
- Child Sexual Exploitation
- Education
- Health
- Child Death Overview Panel
- Designated, Named and Lead Professionals Group

Appendix 2 provides information on chairing and frequency of meetings. Information on the work of the sub-groups is included in the sections above. The chairs of each subgroup meet three times a year with the SSCB chair to report on progress with implementing work plans and the impact of the work.

An initial joint meeting with the Adults Safeguarding Board on safeguarding and community engagement took place in February 2014. This meeting was hosted by Community Action Southwark and plans for this group to meet more regularly will be considered in 2015/16. Further details are provided below.

Community Action Southwark (CAS) is the umbrella body for the voluntary and community sector in Southwark. CAS is acutely aware that safeguarding and associated good practice is a complex and challenging area for this very diverse sector. To try and gain a better understand CAS hosted a Safeguarding Summit on 29th May 2014.

The summit's aim was to look at ways to improve cross-sector work in relation to safeguarding in Southwark's voluntary and community sector (VCS). A total of 30 participants from the voluntary and public sector attended the event. A number of actions/recommendations emerged from the event that grouped under the following themes:

- Reporting and relationships
- Training and development opportunities
- Improving communications
- Recognising difference

The outcomes of the summit have helped direct how CAS engages the voluntary and public sectors around safeguarding issues. One result was to shape how a Community Engagement sub-group would function. The summit identified that it was important that voluntary and community sector organisations took something away from the sessions – as well as the SSCB hearing community concerns and issues.

7.2 Links with strategic leaders and groups

The Independent Chair of SSCB met regularly with the Council's Chief Executive and Strategic Director of Children's and Adults' Services and also met with the Cabinet Member for Children and Schools. The Cabinet Member attends SSCB meetings.

The SSCB chair attended the Council's Cabinet and the Education and Children's Services Scrutiny Sub-Committee meetings to discuss the SSCB Annual Report 2013/14 and the CSE Strategy. The SSCB Annual Report was also discussed at the Health and Wellbeing Board. Close links were maintained with the Children's Trust through the work on Families Matter and the SSCB chair attended Children's Trust Board meetings.

Domestic Abuse Strategy

Following consultation with the SSCB it was agreed that the Southwark Domestic Abuse Strategy would be a joint strategy between the Safer Southwark Partnership, the Southwark Safeguarding Children Board and the Southwark Safeguarding Adults Board. The strategy was published in 2015 and there is a strong focus on prevention and awareness and early identification and support.

Work on the SSCB data set included ensuring information on domestic abuse from the Community Safety Team and from acute hospital trust providers is regularly reported.

7.3 SSCB Budget

The SSCB receives financial contributions from a number of agencies and other forms of in-kind support. The financial contributions for 2014/15 were as follows:

Contribution	**Total**
SLAM	£5,000
Southwark CCG	£20,000
Inner London Probation	£2,000
Police	£5,000
CAFCASS	£550
LB Southwark – Children's Services budget	£107,000
LB Southwark training – estimate from HR budget	£60,000
Sub-total Southwark contributions	**£199,000**
LB Lambeth - contribution for admin costs of joint CDOP panels	£5,000
Total from contributions	**£204,000**

13.9.15

SSCB income and expenditure in 2014/15 is outlined in the table below. The income and expenditure on training is an estimate and the cost of providing the CDOP function is not separated out from overall expenditure. Public Health is funding a detailed review of the CDOP function.
A review of financial contributions and the business support requirements for the SSCB will take place in 2015/16.

Income 2014/15	**£**	**Expenditure 2014/15**	**£**
Financial contributions noted above	204,000	Business Support Staff	62,249.53
		Independent chair	25,250.00
Carried forward from 2013/4	58,336.20	Reviewing officers - SCR	15,085.00
		Reviewing officers – Mgmt Review	5,890.05
		Investigating officer	11,555.00
		Catering Board meetings	703.40
		Printing	765.00
		Room hire	21,173.17
		Training	2,915.05
		Misc	300.00
Total income	262,336.20	**Total expenditure**	145,886.20

13.9.15

Appendix 1: SSCB Membership

Chair: Michael O'Connor, Independent Chair of SSCB

Vice Chair: David Quirke-Thornton, Strategic Director of Children's & Adults Services, Southwark Council

Membership of the SSCB
The following organisations/services are represented on the SSCB:

- Children's & Adults Services, Southwark Council
- Public Health, Southwark Council
- Housing and Community Services, Southwark Council
- Probation
- 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
- Primary and Secondary Schools
- Voluntary and Community sector
- Lay Members.

Frequency of meetings
The SSCB meets 6 times per year.

Contact: Southwark Safeguarding Children Board
160 Tooley Street
Hub 1
PO Box 64529
London SE1P 5LX

Tel: 020 7525 3306
Email: sscb@southwark.gov.uk

13.9.15

Appendix 2 SSCB Subgroups

SUBGROUP	CHAIR(S)	FREQUENCY OF MEETINGS
Serious Case Review Sub-group	Michael O'Connor Independent Chair, SSCB	Meets 4 times a year
Audit & Learning Sub-group	Jackie Cook, Head of Social Work Improvement and Quality Assurance (QA) / Tom Savory, interim QA officer Children's Social Care, Southwark Council	Meets 4 times a year
Child Death Overview Panel (CDOP) and **Neo-Nate Panel (joint with Lambeth)**	Abdu Mohiddin, Consultant in Public Health Southwark Council Gillian Holdsworth, Consultant in Public Health Southwark Council	Meets 4 times a year Meets 3 times a year
Child Sexual Exploitation Sub-group	Rory Patterson, Director of Children's Social Care Southwark Council	Meets 4 times a year
Community Engagement Sub-group	Gordon McCulloch, Chief Executive Officer Community Action Southwark	Group being established
Education Sub-group	Merril Haeusler, Director of Education Southwark Council	Meets 3 times a year
Health Sub-group	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 Sub-group	John Howard, Organisational Development Manager, Southwark Council /Clarriser Cupid Designated Nurse, Southwark CCG	Meets 4 times a year

Agenda Item 13

Item No. 13.	Classification: Open	Date: 28 January 2016	Meeting Name: Health and 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 2015 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. The report covers the following work streams:

    - Review of Public Health
    - National Child Measurement Programme (NCMP)
    - NHS Health Checks
    - Tuberculosis
    - Sexual Health
    - Health: A Lambeth Co-production (HALC)
    - Teenage pregnancy
    - Annual Report: Improving Public Health in Lambeth and Southwark 2013-2015

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	
Version	Final	
Dated	15 January 2016	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team		15 January 2016

Working together for the public's health

APPENDIX 1

Public Health in Lambeth and Southwark

Director of Public Health Report

October – December 2015

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 2015-2016. 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 some of the activities of the Lambeth and Southwark specialist public health team, work being done in partnership, and to provide information about public health issues relevant to Lambeth and Southwark, including alerting people to areas of concern or risk.

This quarter, summaries are on; the councils' review of the specialist Public Health function, the National Child Measurement Programme (NCMP), NHS Health Checks, Tuberculosis, Sexual Health, Health is Everyone's Business, Teenage pregnancy, and a new publication; Improving Public Health in Lambeth and Southwark 2013-2015.

Comments and suggestions for future issues are welcome. Please contact PHadmin@southwark.gov.uk

1. Review of the Public Health function in Lambeth and Southwark

Following the Health and Social Care Act (2012) and the transition of public health responsibilities to local government in 2012-13 Lambeth and Southwark councils agreed to a shared public health service. This operating model has Southwark Council acting as employer and host of the service on behalf of other partners. Over the summer of 2015 Lambeth and Southwark Councils conducted a brief review of the shared public health function. Following this both councils decided that they wished to have two separate public health departments from April 1st 2016.

In preparation for arrangements to implement the change, the public health team embarked on a process internally to review their understanding of the requirements for delivery of a high quality, efficient and strategic public health service and how two new departments might align most effectively to priorities of the two councils and the CCGs. The aim was to identify risks and opportunities of different models of working informed by experience and the literature, to develop a preferred approach and to promote a strong vision of public health for the future. The work has taken account of the substantial financial constraints in the system but acknowledged the continued ambition of the councils and CCG partners to promote the health and wellbeing of their populations

and reduce health inequalities.

By undertaking a SWOT (strengths, weaknesses, opportunities and threats) analysis of different models an approach with a discrete specialist team headed by a Director of Public Health was considered the most likely to be sustainable and effective and the most capable to deliver a quality assured product. However the approach to working with partners will need to be relational rather than hierarchical and look to achieve alliances through working directly with others across professional and organisational boundaries. Portfolios of public health staff will need to align with priorities in the Lambeth Community Plan, Southwark Council Plan, Health and Wellbeing Strategies and CCG Commissioning Strategies. Where CCGs and Councils look to operate in a more integrated way this will offer opportunities for public health to work efficiently especially in health and social care commissioning.

The work provides the basis for a business case and as background to anticipated consultation on proposed structures for two new departments. The intention is to have further discussions with partners and colleagues to assist the development of priorities and working arrangements in both boroughs in the future.

2. National Child Measurement Programme (NCMP) – Results 2014 -15

The National Child Measurement Programme (NCMP) is an annual measure of height and weight of children in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) in state maintained primary schools across England. Information gathered as part of the programme enables local planning and delivery of services for children. The information also supports population-level analysis of trends in growth patterns and obesity and provides an opportunity to increase public and professional understanding of healthy weight in children. The NCMP provides good quality data for the child excess weight indicators in the Public Health Outcomes Framework, and is an important part of the Government's approach to tackling child obesity.

The results of the 2014/15 (academic year) NCMP were published in November 2015. The table shows the latest figures. Lambeth and Southwark continue to have higher levels of obesity and excess weight than the London and national average in both Reception and Year 6

Table 1.
National Child Measurement Results (2014/15): Lambeth, Southwark, London and England

Area	Underweight		Healthy weight		Overweight		Obese		Excess Weight (Overweight and Obesity)	
Year	Yr R	Yr 6	Yr R	Yr 6	Yr R	Yr 6	Yr R	Yr 6	Yr R	Yr 6
Lambeth	**1.0%**	**0.8%**	**74.3%**	**57.7%**	**13.4%**	**14.6%**	**10.5%**	**27.2%**	**23.9%**	**41.8%**
Southwark	**1.6%**	**1.1%**	**72.0%**	**55.3%**	**13.4%**	**15.7%**	**13.0%**	**27.9%**	**26.4%**	**42.7%**
London	1.5%	1.6%	75.4%	60.7%	12.0%	14.6%	10.1%	22.6%	22.2%	37.2%
England	0.9%	1.4%	76.5%	65.1%	22.5	14.2%	9.5%	19.1%	21.9%	33.2%

Obesity in Reception year in Lambeth decreased from 12.2% in (2013-14) to 10.5% (2014-15). In Southwark, the obesity rate in Reception decreased slightly from 13.2% in (2013-14) to 13.0% (2014-15). In London the Reception obesity rate reduced from 10.8% (2013-14) to 10.1% (2014/15) in line with a similar reduction across England.

In Lambeth the rate of obesity in Year 6 has increased from 25.4% (2013-14) to 27.2% (2014-15). The Southwark obesity rate in Year 6 has also increased from 26.4% (2013-14) to 27.9% (2014-15). In London, there was a slight increase from 22.4% (2013/14) to 22.6% (2014/15). Southwark has the highest proportion of obese Year 6 children in the country.

For excess weight, the proportion of Reception Year children in Lambeth decreased from 24.8% (2013-14) to 23.9% (2014-15). In Southwark, Reception Year excess weight has also decreased from 28% (2013-14) to 26.4% (2014-15).

The proportion of Year 6 children with excess weight has increased in Lambeth from 41.2% (2013-14) to 41.8% (2014-15). In Southwark, there has been a slight decrease from 42.7% (2013-14) to 43.6% (2014-15). However, Southwark still has the highest proportion of Year 6 children with excess weight in the country.

3. NHS Health checks Programme trends and outcomes from 2012/13- 2014/15

The NHS Health Check programme is one of the mandated programmes to be delivered by local authorities as part of the Health and Social Care Act 2012. The NHS Health Check Programme is a five year rolling programme with twenty percent of the eligible population aged 40-74 years being offered a cardiovascular check each year. Of the twenty percent offered a cardiovascular check, seventy-five percent are expected to have completed a health check, based on Department of Health targets. The

table summarises performance in Lambeth and Southwark.

Table 2: Number of patients completing a cardiovascular health check annually in Lambeth and Southwark between April 2012 and March 2015

Borough	2012/13	2013/14	2014/15
Southwark	6,259	6,995	8,788 (42%)
*Lambeth**	4,228	4,667	5,383 (28%)

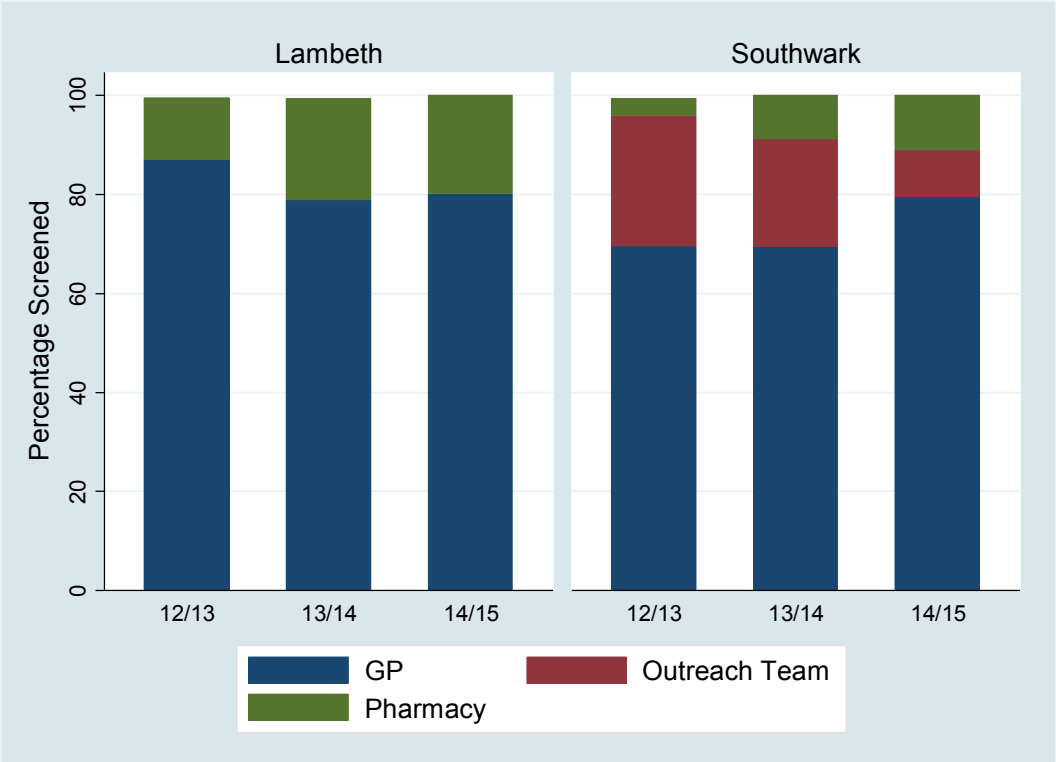
*These may be an underestimate of actual figures as not all data is uploaded into Health Check Focus system

Where screening was provided

Most patients had their cardiovascular health checks completed by their general practitioner (see Figure 1). The Health Checks outreach team was used more significantly in Southwark than in Lambeth to complete checks (this team focuses on promoting uptake in populations who maybe less likely to respond to the invitation to attend for a health check). Over time, the proportion of checks being carried out by GPs has increased in Southwark and decreased in Lambeth.

NB 323 checks were done by the outreach team in Lambeth (5%) but this is too small to show on the scale above.

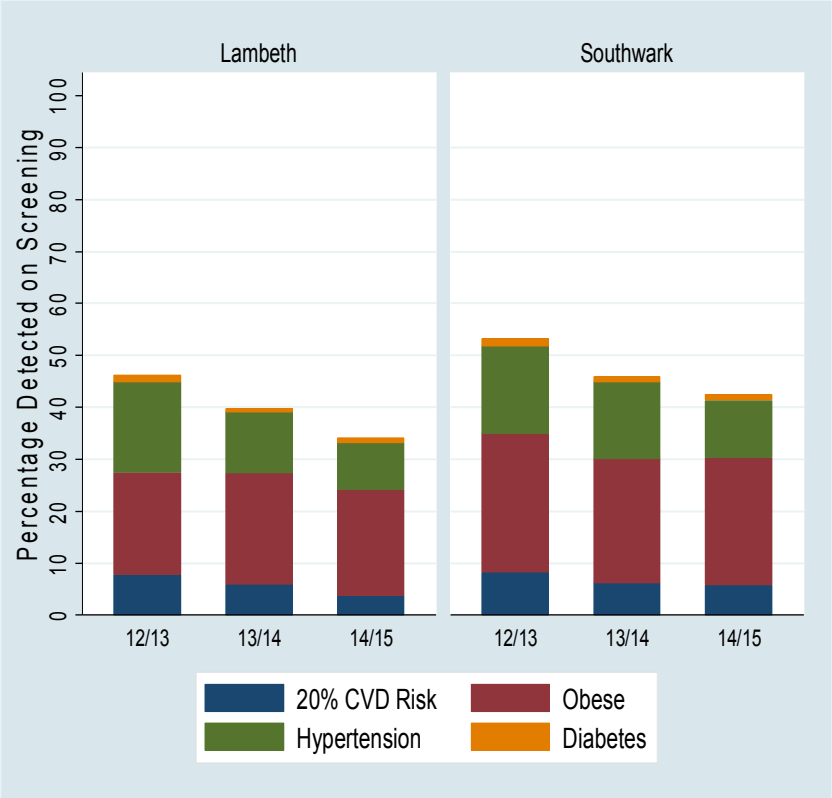
Figure 1: Breakdown of cardiovascular checks by provider



Detection of Cardiovascular Risk Factors

The Health Checks programme was able to detect several risk factors for cardiovascular disease among the population screened, as shown in Figure 2. Over 20% of the population screened annually in both Lambeth and Southwark were identified as being obese (BMI>30) and approximately 1% of those screened were newly diagnosed with diabetes mellitus as a result of the programme. The percentage detected with 20% CVD (cardiovascular disease) risk and hypertension decreased over this period and will be reviewed.

Figure 2: Percentage of patients screened that were found to have the following respective risk factors for cardiovascular disease; 20% Cardiovascular Disease Risk (Based on QRISK2[1]); Obesity (BMI>30); Hypertension (140mmHg/90mmHg); Diabetes Mellitus (HbA1c>6.5%)



[1] Hippisley-Cox J, Coupland C, Vinogradova Y, Robson J, Minhas R, Sheikh A, et al. Predicting cardiovascular risk in England and Wales: prospective derivation and validation of QRISK2. BMJ.2008;336 (7659):1475-82.

Table 3. Proportion of people screened with 20% Cardiovascular Disease risk; Obesity; Hypertension, or Diabetes Mellitus

	Lambeth			Southwark		
	2012/13	**2013/14**	**2014/15**	**2012/13**	**2013/14**	**2014/15**
20% CVD Risk	7.7	5.8	3.7	8.1	6.2	5.7
Obesity	19.7	21.4	20.4	26.9	23.9	24.6
Hypertension	17.4	11.8	9.0	19.8	14.8	11.0
Diabetes	1.3	0.7	1.0	1.4	1.0	1.1

People who are identified as being at risk are;

1) offered lifestyle advice and may be offered a referral to a behaviour change programme

2) referred to their GP if a long term condition is diagnosed, for further treatment.

Prescribed medication among people detected as at risk of cardiovascular disease

The outcomes of referral to a GP with either cardiovascular risk above 20%, or hypertension are shown in Figure 3. The percentage of patients prescribed medication to reduce cardiovascular risks increased over the duration of the programme in both Lambeth and Southwark. This will result in fewer deaths and less ill health from cardiovascular disease.

Statins

In 2012/13, 17.5% of patients identified with a 20% CVD risk were prescribed a statin in Lambeth and 7.5% of such patients were prescribed a statin in Southwark. By 2014/15 however this percentage had increased to 49.3% and 43.6% respectively. It is important to note that during this period new cardiovascular guidance from NICE (National Institute of Health and Care Excellence) did reduce the cardiovascular risk threshold (as calculated by QRISK2[1]) above which a statin was recommended from 20% to 10%[2]. Nevertheless, a greater adherence and propensity to prescribing of a statin is evident.

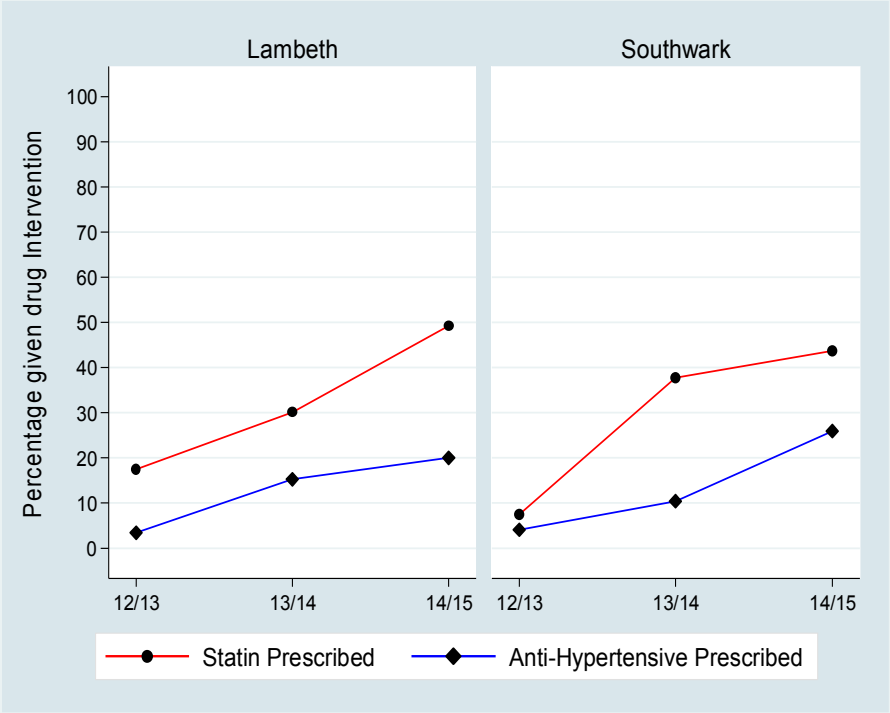
Anti-hypertensives

Among people identified as hypertensive at screening, the proportion prescribed anti-hypertensive therapy increased in Lambeth and Southwark during the study. By 2014/15, 20.0% in Lambeth and

[2] The National Institute for Health and Care Excellence. NICE clinical guideline 181: Lipid modification: cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease. Available from http://www.nice.org.uk/guidance/cg181 accessed online 7 October 2015.

25.9% in Southwark were on medication to reduce their blood pressure and cardiovascular disease risk,al though this is likely to be lower than optimal therapy. Under- recording may be an issue.

Figure 3: Percentage of patients with appropriate statin and anti-hypertensive prescribing in those detected with a 20% or higher cardiovascular disease risk and/or those diagnosed with hypertension (>140/90 mm Hg).



Screening for smoking and those at risk from alcohol intake

In total, 6,466 smokers and 4,516 individuals at risk of harmful alcohol intake (FAST Positive or AUDIT-C positive[3]) were newly identified as part of the health checks programme across Lambeth and Southwark between 2012 and 2015 (Figure 4). The proportion of these who then received targeted intervention is highlighted in Figure 5. The percentage of smokers referred annually for interventions to reduce/stop smoking in Southwark increased to 17.2% in 2014/15. However, in Lambeth, smoking referrals decreased from a high of 14.2% in 2013/14 to 7.0% in 2014/15. The percentage of patients at risk of harmful alcohol intake who received advice or referral also increased annually in both Lambeth and Southwark. In 2012/13, 54.5% of those at risk of harmful alcohol intake in Lambeth and 16.6% of those in Southwark received lifestyle advice or were referred on to help with reducing alcohol intake. By 2014/15 this had increased to 73.7% in Lambeth and 37.1% in Southwark.

[3] Public Health England. PHE Alcohol Learning Resources. Available from http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&child=4570 accessed online 7 October 2015.

Figure 4: Percentage of people screened identified as smokers or at risk of harmful alcohol intake

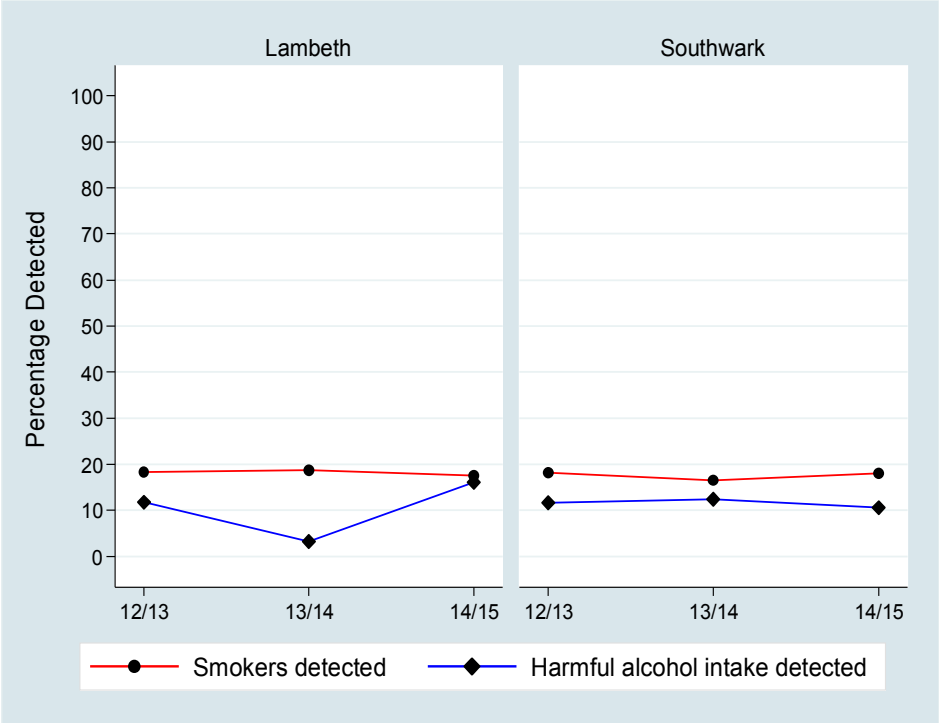
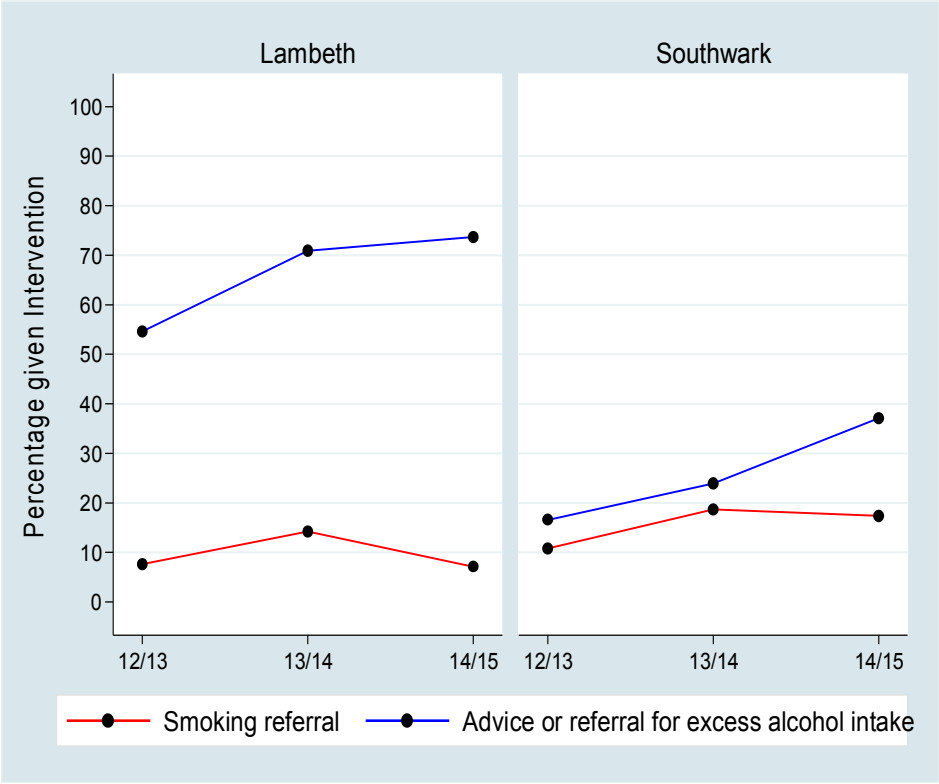


Figure 5: Percentage of people screened identified as smokers or at risk of harmful alcohol intake referred or given lifestyle advice for alcohol consumption



More information on other lifestyle advice offered to people receiving cardiovascular health checks will be reported on at a later date.

4. TB update

Latent TB testing and treatment programme

Tuberculosis (TB) is an infectious disease caused by bacteria belonging to the Mycobacterium tuberculosis complex. TB usually affects the lungs, but can affect other parts of the body, such as the lymph nodes (glands), the bones, and the brain. Infection with the TB organism may not develop into TB disease and the infection can stay latent for several years. Most TB is curable with a combination of specific antibiotics, taken for at least six months. TB is much less common than in years past but during the 1990s to 2005 the UK experienced a progressive increase in TB cases, and incidence (ie rate of new cases) has stabilised at a relatively high level since then.

The 'Collaborative Tuberculosis Strategy for England: 2015 to 2020 (PHE, NHS England, 2015)' was published in January 2015. It recommends that newly arrived migrants aged 16-35 years from countries with high TB incidence (PHE, 2014) are identified, screened and treated if found to have latent Tuberculosis (LTB).

This recommendation is based on these factors:

- Most cases of TB in the UK arise from reactivation of latent TB infection (LTBI)
- Latent TB screening among migrants is cost-effective
- The higher the incidence in the country of origin and the more recent the individual's arrival in England, the higher the risk of TB reactivation.
- Drug induced liver injury caused by the LTBI treatment increases and treatment benefits decrease with age. Therefore LTBI screening and treatment will be offered to people aged 16-35 years.

NHS England will offer financial support to develop the new pathway. Lambeth & Southwark CCGs have applied for funding for 2015-16 and 2016-17 as they are amongst the 59 CCGs nationally considered a priority for introducing latent TB testing of new migrants. Local TB rates are ≥20/100,000 and local TB notifications represent ≥0.5% of the total England TB numbers.

The LTBI screening will be phased in starting with practices located in areas of high concentration of migrants from high risk countries and /or with high numbers of detected active TB cases. LTBI screening will be offered to newly registered patients aged 15-35 years who have arrived in the past 5 years from countries with high risk of TB. This first phase will be evaluated at the end of the first year of implementation. Learning will inform future development of LTBI screening and treatment.

5. Sexual Health

Lambeth has the second highest and Southwark the fourth highest rates of sexually transmitted infections (STIs) in England. This is thought mainly due to the high proportion of the very diverse population who are young and, or mobile. This demography, combined with improved service access following modernisation mean there is a high demand for sexual and reproductive health services (SRH).

Lambeth and Southwark have had considerable success in reducing teenage pregnancy and late diagnosis of HIV, and of increasing chlamydia testing (another reason for the high rates of STIs). Rates of sexually transmitted infections continue to rise however and both boroughs continue to have high levels of risky sexual behaviours, shown by high reinfection rates and rates of syphilis and gonorrhoea. Abortion and repeat abortion rates also remain high, indicating a need for improved access to contraceptive services and in particular long acting reversible methods.

Given the high levels of need and high activity levels of SRH services and the requirement to make significant savings, work is going on to transform services for the future. The aim is to increase access to STI testing through online services, SH:24 www.sh24.org.uk and enhance contraceptive and STI testing and treatment in primary care and pharmacy.

This will be supported by a London wide programme to procure an online 'partner notification system' and a London online service which will direct people to the most appropriate local service (online, pharmacy, primary care and clinic).

6. Working with local authorities to make health everybody's business

The Public Health team have been working with senior staff across departments in the two councils to support colleagues to take a population health approach to their work and look for opportunities to improve health and wellbeing outcomes through council core business.

In Lambeth, *Health: A Lambeth Co-production* (HALC) started in November after planning and design with senior Council commissioners to ensure it was pitched appropriately. Two sessions have been held, and evaluation has been positive. Participants have identified an understanding of the wider determinants of health, statistics on health outcomes in Lambeth, and information on the relative disease burden on different populations as being valuable. They have expressed interest in learning more about public health in early years, resilience,

and addressing the wider determinants of health through efforts around engagement. The course will finish in Spring 2016.

Southwark Council's existing Leadership and Management Development Programme (LMDP) has offered an ideal opportunity for senior staff to learn about population health through additional *Healthy Futures Masterclasses* delivered by the Public Heath team. These were held in September and November 2015, with three groups attending sessions. Attendees are working on projects about obesity, alcohol and new psychoactive substances, and physical activity. The aim is for participants to work with public health colleagues to understand the impact on the population, underlying factors, current strategies and the potential for council core functions to make a difference. Further LMDP groups are expected to participate in masterclasses and projects in 2016.

7. Teenage Pregnancy

Under 18 conceptions for Quarter 3 2014 increased in both Lambeth and Southwark compared with the same quarter in 2013.

Lambeth

Lambeth under 18 conceptions

2014 third quarter data for Lambeth was published by ONS on 24th November 2015 and shows:

- The quarterly rate of under-18 conceptions was **30.2** per 1000 girls aged 15-17. That is a **61%** increase since the same quarter in 2013.
- The number of under-18 conceptions was **32, twelve** more conceptions than the same quarter in 2013.
- The rolling quarterly average is **32.5** conceptions per 1000 girls aged 15-17 which represents a **10%** increase since previous rolling average.
- The rolling quarterly average for England is **23.3** and **21.4** for London
- Under 18 conceptions in Lambeth increased in this quarter, this is the third quarter in 2014 that conceptions have increased

Figure 6. Lambeth under 18 conceptions by quarter

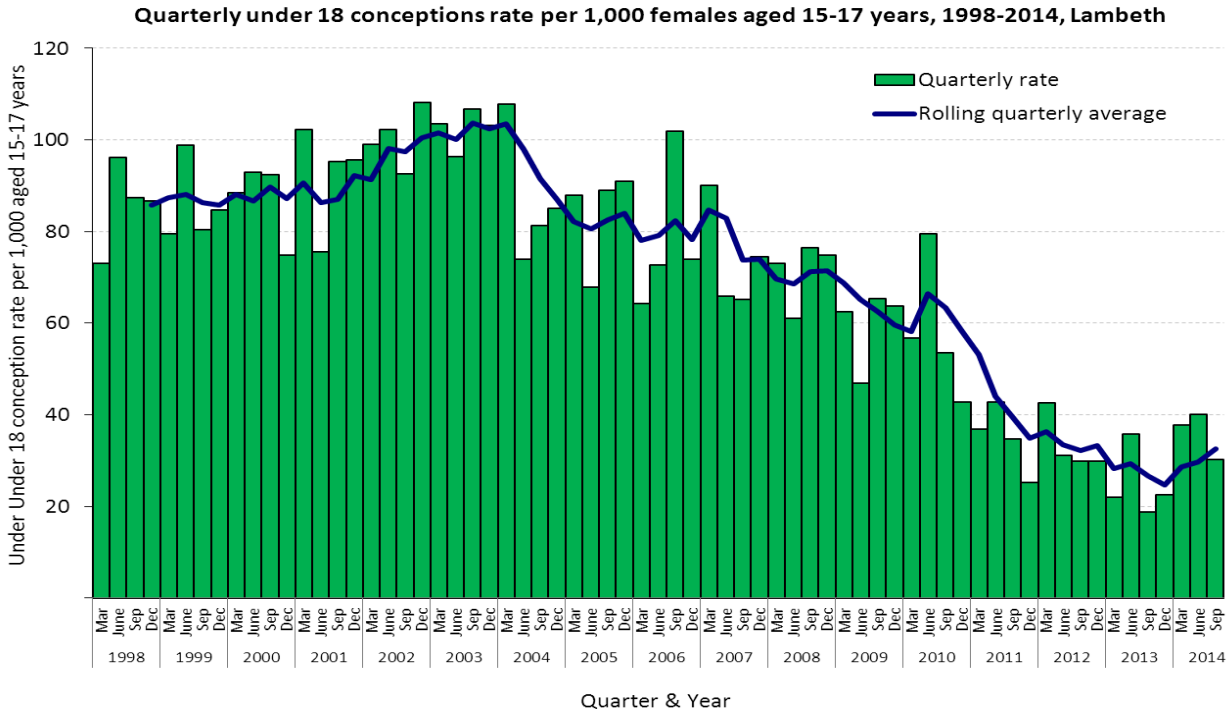
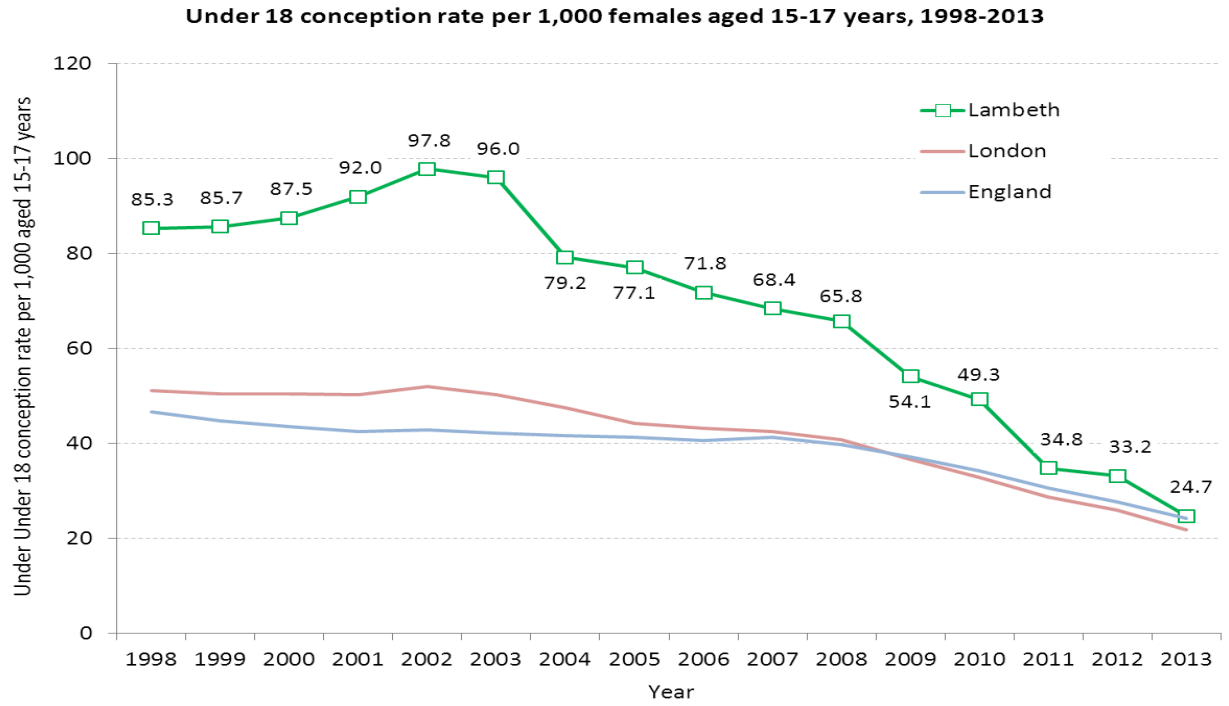


Figure 7. Lambeth under 18 conceptions by year



Southwark

Southwark under 18 conceptions

2014 third quarter data for Southwark which was published by ONS on 24th November 2015 shows:

- The quarterly rate of under-18 conceptions was **33.7**per 1000 girls aged 15-17. That is a **32%** increase since the same quarter in 2013.
- The number of under-18 conceptions was **34, eight** more conceptions than the same quarter in 2013.
- The rolling quarterly average is **29.1** conceptions per 1000 girls aged 15-17 which represents an **8%** increase since previous rolling average.
- The rolling quarterly average for England is **23.3** and **21.4** for London under 18 conceptions in Southwark increased in this quarter.

Figure 8. Southwark under 18 conceptions by quarter

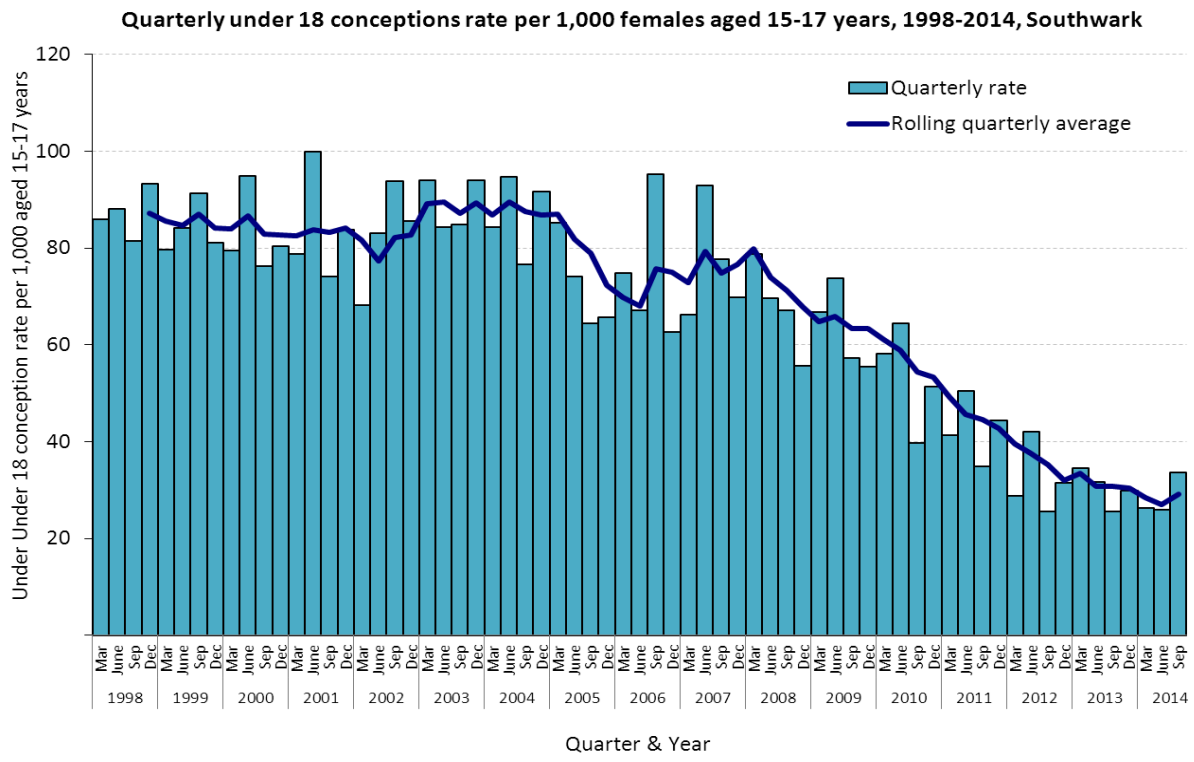
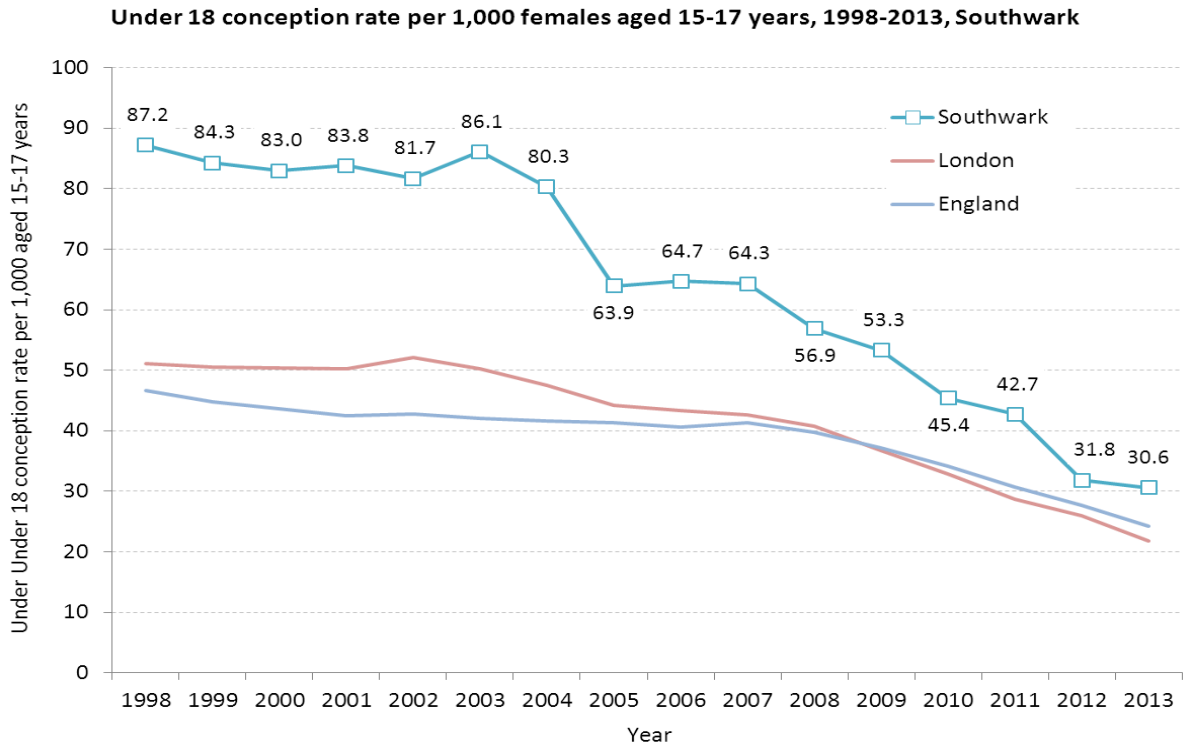


Figure 9. Southwark under 18 conceptions by year



Although overall it can be seen that over a long period of time under 18 conceptions have reduced substantially the recent increases are of concern especially as the annual rates remain higher than London and England in both boroughs. Annual 2014 under 18 conception data will be available in late February 2016.

8. Annual Report: Improving Public Health in Lambeth and Southwark 2013-2015

A Report on the work of the Lambeth and Southwark Public Health Team over the past couple of years is now available. The Report summarises some of the achievements, current work and future plans of the team. Two years on from the transition of public health responsibilities to local government, some good progress has been made. There is much to be proud of in terms of public health successes. The Lambeth and Southwark Public Health Team have been able to take forward some excellent programmes of work with local authority colleagues that tackle the underlying causes of ill health and inequality as well as continue to support health and social care commissioning colleagues. Life expectancy continues to improve and deaths in infancy are reducing but there remains considerable work to do. Over the next few months, the Lambeth and Southwark Public Health Team will undergo major re-structuring but we intend to continue to support partners to promote the health and wellbeing of Lambeth and Southwark people and to reduce inequality. To receive a copy please email phadmin@southwark.gov.uk

Agenda Item 14

Item No. 14.	Classification: Open	Date: 28 January 2016	Meeting Name: Health and Wellbeing Board
Report title:		Primary Care Joint Commissioning Committee – Health and Wellbeing Board Observer	
Ward(s) or groups affected:		N/a	
From:		Proper Constitutional Officer	

RECOMMENDATION

1. That the health and wellbeing board nominate a named member to attend the (NHS Southwark) Primary Care Joint Commissioning Committee and the South East London Primary Care Joint Commissioning Committee in the capacity as an observer from the health and wellbeing board.

BACKGROUND INFORMATION

2. The NHS Southwark Clinical Commissioning Group has in place a Primary Care Joint Commissioning Committee in response to an invitation by NHS England for clinical commission groups to expand their role in primary care commissioning.

KEY ISSUES FOR CONSIDERATION

3. The role of the committee is to work jointly with NHS England and in association with clinical commissioning groups in South East London, namely:

    - NHS Bexley Clinical Commissioning Group
    - NHS Bromley Clinical Commissioning Group
    - NHS Greenwich Clinical Commissioning Group
    - NHS Lambeth Clinical Commissioning Group
    - NHS Lewisham Clinical Commissioning Group
    - NHS Southwark Clinical Commission Group

    to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act except those relating to individual GP performance management. The joint committees of the six CCG's will usually meet together.

4. Various health professionals form the membership of the joint committee. In addition there is a standing invitation issued to the local Healthwatch, Local Medical Committee and Health and Wellbeing Board who may attend but not vote.

5. In order to facilitate attendance and participation of a health and wellbeing board member at the NHS Southwark Joint Committee meetings and the wider South East London Joint Committee a named member is sought to receive the agenda papers and attend the meetings.

6. It should be noted that both Andrew Bland and Dr Jonty Heaversedge (members of the health and wellbeing board) are members of the joint committee due to their

position in the NHS Southwark clinical commissioning group. As there is provision for a local Healthwatch representative to attend the joint committee it is proposed that the board representative be sought from the councillor/ officer membership of the health and wellbeing board. The cabinet member for public health, parks and leisure, Councillor Barrie Hargrove has within his portfolio, particular responsibility for the council's relationship with the NHS, it is therefore recommended that he be the nominated member to attend the joint committee.

Policy implications

7. There are no specific policy implications arising from this decision.

Community impact statement

8. There are no specific community impact issues arising from the nomination of a member representative for the board.

Resource implications

9. There are no significant resource implications identified. A number of the joint committee meetings will be held outside of the borough and therefore some travel costs may be incurred.

Legal implications

10. The Health and Wellbeing Board member representative will be attending the joint committee in the capacity as an observer and will therefore not have voting rights. There are no specific legal implications identified however the nominated representative is required to declare any relevant interests on the matters to be considered.

Financial implications

11. There are no specific financial implications.

Consultation

12. The Southwark clinical commissioning group, strategic director of children's and adults' services and councillors on the board have been consulted / made aware of the proposed recommendation.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
NHS Southwark Primary Care Joint Commissioning Committee Terms of Reference	NHS Southwark Clinical Commissioning Group, 160 Tooley Street, London SE1 2QH	Tom Bunting 020 7525 1720

APPENDICES

No.	Title
None	

AUDIT TRAIL

Lead Officer	Ian Millichap, Proper Constitutional Officer		
Report Author	Everton Roberts, Principal Constitutional Officer		
Version	Final		
Dated	14 January 2016		
Key Decision?	No		
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER			
Officer Title		**Comments Sought**	**Comments Included**
Director of Law and Democracy		No	No
Strategic Director of Finance and Governance		No	No
Cabinet Member		No	No
Date final report sent to Constitutional Team			14 January 2016

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Dated: 19 January 2016