Open Agenda

Health and Wellbeing Board

Monday 18 November 2019
2.30 pm
Ground Floor Meeting Room G02C - 160 Tooley Street, London
SE1 2QH

Membership

Councillor Peter John OBE (Chair)	Leader of the Council
Councillor Evelyn Akoto	Cabinet Member, Community Safety and Public Health
Councillor Jasmine Ali	Cabinet Member for Children, Schools and Adult Care
Andrew Bland	Accountable Officer, NHS Southwark,CCG
Cassie Buchanan	Southwark Headteachers Representative
David Bradley	Chief Executive, SLAM NHS Foundation Trust
Sally Causer	Executive Director, Southwark Law Centre
Kevin Fenton	Strategic Director of Place and Wellbeing
Ross Graves	Managing Director, NHS Southwark, CCG
Deborah Hayman	Chief Executive, Community Southwark
Dr Jonty Heaversedge	Chair, NHS Southwark, CCG
Eleanor Kelly	Chief Executive, Southwark Council
Catherine Negus	Healthwatch Southwark
Clive Kay	Chief Executive, King's College Hospital NHS Foundation Trust
Councillor David Noakes	Opposition Spokesperson for Health
David Quirke-Thornton	Strategic Director of Children's and Adults' Services
Dr Yvonneke Roe	Clinical Lead for Prevention and Early Action, NHS Southwark, CCG
	Representative, Guy's & St Thomas Foundation Trust (tbc)

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Contact

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

Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 8 November 2019

PRINTED ON RECYCLED PAPER

Health and Wellbeing Board

Monday 18 November 2019
2.30 pm
Ground Floor Meeting Room G02C - 160 Tooley Street, London SE1 2QH

Order of Business

Item No.	Title	Page No.
1.	**WELCOME AND INTRODUCTIONS**	
2.	**APOLOGIES** To receive any apologies for absence.	
3.	**CONFIRMATION OF VOTING MEMBERS** Voting members of the committee to be confirmed at this point in the meeting.	
4.	**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.	
5.	**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.	
6.	**MINUTES** To agree as a correct record the minutes of the meetings held on 4 March and 26 June 2019.	1 - 18
7.	**PRESENTATION FROM SUNSHINE HOUSE LOOKED AFTER CHILDREN TEAM AND CARELINK**	

Item No.	Title	Page No.

Dated: 8 November 2019

Agenda Item 6

Health and Wellbeing Board

MINUTES of the OPEN section of the Health and Wellbeing Board held on Monday 4 March 2019 at 11.30 am at Ground Floor Meeting Room G02C - 160 Tooley Street, London SE1 2QH

PRESENT: Councillor Peter John OBE (Chair)
Councillor Evelyn Akoto
Councillor Jasmine Ali
Cassie Buchanan
Sally Causer
Kevin Fenton
Ross Graves
Eleanor Kelly
Catherine Negus
David Quirke-Thornton
Dr Yvonneke Roe

OFFICER SUPPORT: Everton Roberts, Constitutional Team

1. APOLOGIES

Apologies for absence were received from Andrew Bland, Councillor David Noakes, Dr Jonty Heaversedge, Dr Matthew Patrick, Paul Rymer and Ian Smith.

2. 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 following items were circulated after the main agenda despatch.

Supplemental Agenda No.1

- System wide approaches to tackling inequalities in Southwark

- NHS Long Term Plan and Inequalities
- Brexit preparedness: preparations for a 'no deal' EU exit

Supplemental Agenda No.2

- Minutes – 21 November 2018
- Health Inequalities in Southwark – Public Health
- Healthy Communities Scrutiny Commission: Bells Garden Estate Approach
- Brexit preparedness – Council Update
- Youth Violence and Knife Crime in Southwark

4. DISCLOSURE OF INTERESTS AND DISPENSATIONS

There were no disclosures of interests or dispensations.

5. MINUTES

Due to the late circulation of the Minutes it was agreed that they be deferred to the next meeting to enable board members the opportunity to review them.

6. THEME: TACKLING HEALTH INEQUALITIES

The board received presentations on tackling health inequalities from Jin Lim, Consultant in Public Health, Ross Graves, Managing Director, NHS Southwark Clinical Commissioning Group, Councillor Barrie Hargrove, Chair of Healthy Communities Scrutiny Commission and Professor Kevin Fenton, Strategic Director of Place and Wellbeing.

Jim Lim highlighted the following:

Smoking

- Considerably higher prevalence in both routine and manual workers, 1 in 4 estimated to be smokers compared to 1 in 10 for other occupations.
- Higher smoking prevalence for people on lower incomes

Obesity

- Southwark has higher rates, but seen a slight fall over the last 2 to 3 years. Strong association with depravation, higher obesity rates in more deprived areas. Implications for the sort of services required and how the services are targeted.

Sexual health and reproductive health

- Strong inequalities dimension
- Black women have poorer reproductive and sexual health
- Higher STI and HIV rates in MsM communities
- Late diagnosis in black African and other ethnicities

Cancer screening and bowel cancer screening

- Noticeable inequalities around bowel cancer screening, incident rates tend to be higher for people living in the most deprived areas.
- Bowel screening uptake is lower amongst people in more deprived areas,

particular from people who don't speak English as their first language and people from a black ethnic background.

Breast cancer screening

- Differential in survival rates – much lower in areas of high deprivation.
- Black women less likely to attend for breast cancer screening

Cervical cancer

- Women from most deprived groups, less likely to attend cervical cancer screening, also other groups, women with learning disabilities and women with disabilities are less likely to take up the screening service.

Hunger and food poverty

- Doing quite a detailed joint strategic needs assessment on food poverty, in process of developing a food poverty strategy. It's estimated that in London about a third of children have problems concentrating at school due to hunger. Relatively large proportion of children in Southwark (just under 10,000).
- Local data around food bank use, just under 50% of the recipients are children. High food bank use during the summer months.

Key actions short term / immediate impact

- Improving access to maternity services, early registration for pregnant women.
- Detection of common conditions and management, such as diabetes and vascular diseases.
- Increase uptake of cancer and sexual health screening across all communities for detection and treatment.
- Work that can be done around Health Improvement Services to address inequality - Smoking cessation, alcohol interventions, increasing physical activity, health eating, addressing poverty in general and income

Wider determinants

- Building strong cohesive neighbourhoods,
- Good quality employment, housing and education

Jin Lim also report on a presentation on health inequalities to the Healthy Communities scrutiny commission. The discussion around the presentation was that while there was good quality data across the borough, there was an opportunity to drill down into a neighbourhood, and to pilot an estate based approach to looking at inequalities. Looking at data held by services, such as health improvement services, local providers (GPs) and the uptake of the services and outcomes, and to also hold some focus groups with local people to understand their experiences and how inequalities and health inequalities is affecting them.

Councillor Barrie Hargrove gave a presentation on the scrutiny commission into health inequalities.

Councillor Hargrove reported that in terms of health, the commission wanted to focus on 'social health' not just physical health and mental health, as they were all integral to each other.

He informed the board that the commission looked at an estates based project around one

estate (Bells Garden Estate, Peckham), with a view to building on the strengths that were already there. The estate had its own community centre and had a number of activities taking place including some exercise activities, and some healthy eating activities.

The idea was to see how the council could assist them to reinforce healthy initiatives on the estate and actually get the residents themselves to take ownership of their own public health with support. Recognising that one of the problems with people's poor health outcomes was their knowledge of the importance of making healthy lifestyle choices in terms of exercise and eating, etc., this is where the scrutiny commission members felt that they could add some value to what was already going on and try to give the local residents more awareness of public health. They would be meeting with the tenants and residents association on 13 March 2019.

The scrutiny commission was due to meet again in April where they would be finalising their scrutiny commission report.

Ross Graves gave a presentation on system wide approaches to tackling inequalities and the delivery of the Southwark Five Year Forward view, which was the key strategic document for both the CCG and the Council and had the support of system partners.

Ross reported on three areas, the work that they were doing as part of the STP and emerging integrated care system across south east London, what they were doing at place and neighbourhood level within the borough, and Southwark Bridges to health and Wellbeing which was the strategic approach to commissioning between the council and the CCG.

Professor Kevin Fenton reported on the NHS long term plan which had been released earlier in the year, which gives a strategic vision of the direction of the NHS. Within the plan there had been a strong focus on health inequalities from NHS nationally, with the creation of new structures, new ways of working and news ways of engaging communities.

Professor Fenton informed the board that he had given the presentation to the King's Fund very recently and was on the health and wellbeing board agenda for reference as it critiqued the plan, identified opportunities for those working in local government to work with the NHS on inequalities, and highlighted some gaps in the long term plan and what was important for the local systems to be doing to help to bridge that gap. He stressed that the NHS was taking this seriously and that this was one of the strongest narratives that he had seen on health inequalities coming from an NHS strategic plan.

The board discussed issues arising from the presentations and asked questions.

In summing up the discussion Professor Fenton highlighted the following take away points:

- Firstly was to acknowledge the progress that had been made, (acknowledging the stark data). Improvement was being made on many indicators and that improvement was being driven by change 'place' through regeneration, the focus on educational attainment, the strengthening that has been happening within the health service, GP practices were better and are improving.

- But with the acknowledgement that the purpose of the session was to highlight that there is more to do and a bit of a way to go, and the more that the system leaders understand the nature of the problem and where there should be focus and

collaboration, the higher the likelihood of success. What Professor Fenton was hearing from board members is that they should use their assets, schools, businesses, the community themselves in order to help address these inequalities. To use information differently and more smartly and share data to identify where the inequalities are and address them.

- The presentation on the scrutiny commission highlighted the importance of identifying some exemplars, where the system goes a little bit deeper (in addition to the universal programmes already in place), to try to demonstrate what does more coordinated and targeted efforts look like and what impacts it could have, so whether it's through regeneration programmes or through Great Estates programmes the system is able to touch the lives of some of the most deprived residents in the borough. This thinking and approach should be built on.

7. COUNCIL POLICY AND RESOURCES REVENUE BUDGET 2019-20

Councillor Victoria Mills, Cabinet member for finance, performance and Brexit informed the board of the decisions taken by the council in respect of its annual policy and resources revenue budget 2019-20.

8. BREXIT PREPAREDNESS

Ross Graves, Managing Director, NHS Southwark Clinical Commissioning Group introduced the report.

RESOLVED:

That the progress being made by the CCG and partners in responding to and implementing national guidance be noted.

9. LAMBETH, SOUTHWARK AND LEWISHAM SEXUAL AND REPRODUCTIVE HEALTH STRATEGY 2019-24

Kirsten Watters, Consultant in Public Health introduced the report.

RESOLVED:

1. That the new Lambeth, Southwark and Lewisham (LSL) Sexual and Reproductive Health Strategy 2019-24 be approved.

2. That it be noted that separate detailed action plans will be produced on a yearly basis, delivery of which will be overseen by the LSL Sexual Health Commissioning Partnership Board.

10. COMMUNITY SAFETY - YOUTH VIOLENCE

The board received a presentation from Stephen Douglass, Director of Communities on youth violence and knife crime in Southwark. The board also heard from some Southwark Youth Advisors.

11. HEALTH AND WELLBEING BOARD WORK PLAN 2018-20

RESOLVED:

That the work plan for 2018 – 2020 be noted.

The meeting ended at 1.35pm

CHAIR:

DATED:

Health and Wellbeing Board

MINUTES of the Health and Wellbeing Board meeting held on Wednesday 26 June 2019 at 4.30 pm at Ground Floor Meeting Room G02C - 160 Tooley Street, London SE1 2QH

PRESENT:
Councillor Peter John OBE (Chair)
Councillor Evelyn Akoto
Councillor Jasmine Ali
Andrew Bland
Cassie Buchanan
Kevin Fenton
Ross Graves
Dr Jonty Heaversedge
Catherine Negus
David Quirke-Thornton
Dr Yvonneke Roe
Deborah Hayman (Observer – Community Southwark)

OFFICER SUPPORT:
Everton Roberts, Constitutional Team

1. APOLOGIES

Apologies for absence were received from Sally Causer, Eleanor Kelly, Councillor David Noakes and Dr Matthew Patrick.

Apologies for lateness were received from Andrew Bland.

2. CONFIRMATION OF VOTING MEMBERS

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

3. ELECTION OF VICE-CHAIR

It was moved, seconded and,

RESOLVED:

That Jonty Heaversedge be appointed vice-chair for the 2019-20 municipal year.

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

There were no additional items.

5. DISCLOSURE OF INTERESTS AND DISPENSATIONS

There were no disclosures of interests or dispensations.

6. MINUTES

RESOLVED:

That the minutes of the meeting held on 21 November 2018 be approved as a correct record and signed by the Chair.

The minutes for the meeting held on 4 March 2019 would be submitted to the next meeting for approval.

MEETING THEME: WHOLE SYSTEM TRANSFORMATION

PRESENTATIONS ON THE THEME

David Quirke-Thornton, Strategic Director of Children's and Adults' Services and Jonty Heaversedge, Chair of the Clinical Commissioning Group provided some introductory comments to the theme.

David Quirke-Thornton highlighted that there had been a lot of conversation in government and wider society about integration and that the focus had mainly been on the NHS and adult social care, older people in hospital and delayed transfer of care. He stressed that for Southwark that the interest was in early life, prevention, public health and whole system transformation.

He highlighted that in the absence of the green paper on Adult Social Care which had been awaited for two and half years that it was difficult for people in the health and social care field to look to the future with confidence and vision. He stated however, that despite this the council would be taking the opportunities of change in the NHS to also change social care and the wider council services and partnerships, creating something new and meaningful, which was about partnerships with the council as a major landlord, with schools, the police, NHS and social care, all coming together and valuing public health and the public health approach to having a very hopeful vision for the communities within

Southwark. He conveyed the view that the partnerships were not about joining entities, but more about creating something new that will make a significant difference to the people of the borough and enable them to realise their best potential.

Jonty Heaversedge impressed upon the board that it was hard to describe what whole system transformation meant as there were multiple systems and a need to understand a really complex landscape of different providers and different systems and to make sense of those in a way that enables improved outcomes.

He explained that people in Southwark received care within the borough, so there was a need to understand the importance of the system within the borough. Also people received care locally within their neighbourhoods and that there were a lot of changes taking place, particularly in the primary care space around development of primary care networks and thinking about greater integration and collaboration between partners in social care, mental health, and clinical care from general practice. He further explained that parallel to this, people in southeast London used acute services which were not confined to their boroughs, so it was important to think about the system across Southeast London as a whole. It was also necessary to understand people holistically and all of their needs as some needs would be met by hospitals and some would need to be met elsewhere. It was therefore important to think about systems at different levels.

Dr Heaversedge referenced previous discussions around the importance of thinking about the Southwark population and how the system can identify outcomes, and collectively make best use of the Southwark pound and the resources available to improve outcomes for the residents of Southwark.

He stressed that the task was to create and nurture the right environment so that the systems could flourish in the context of Southeast London boroughs, very local neighbourhoods and at community level.

7. SOUTHWARK FIVE YEAR FORWARD VIEW - PRESENTATION

Ross Graves, Managing Director of the Southwark NHS CCG presented the report.

In taking the report as read, Ross Graves briefly reminded members of the original premise around the Five Year Forward View agreed in 2015 which became the shared strategic document for system transformation for the period 2016 – 2021. He reminded the board that the strategy focused on populations (rather than institutions or providers), value for money, outcomes over cost, getting best value for money from the collective resources, on how to empower residents, being holistic and co-ordinated in service delivery and being more proactive and focussed on an agenda around prevention, as well as treatment.

He stated that real progress had been made and over the next 18 months there was opportunity to accelerate this through Partnership Southwark, the development of CCG system reform which was moving towards an integrated care system approach and the introduction of place based boards.

He reported that progress had been made in terms of traditional commissioning, which was now more joined up. An example of this was the joint mental health and wellbeing strategy.

RESOLVED:

That the contents of the report be noted, in particular:

- The progress made by the Council and the CCG over the first three years of the Forward View, and
- The next steps for Partnership Southwark and system reform.

8. PARTNERSHIP SOUTHWARK - PRESENTATION

Sam Hepplewhite, Director of Integrated Commissioning, NHS Southwark CCG, Genette Laws, Director of Commissioning, Southwark Council and Jay Stickland, Director of Adult Social Care, Southwark Council, gave an overview of the work they were doing on the development of Partnership Southwark.

RESOLVED:

That the contents of the report be noted, in particular

- Progress to date on the development of Partnership Southwark
- The case for change and priorities for the next two years
- The key role of the Neighbourhood Model and the Southwark Bridges to Health and Wellbeing approach.
- Ambitions and next steps.

9. SOUTH EAST LONDON CCGS SYSTEM REFORM - PRESENTATION

Andrew Bland, Accountable officer for NHS Southwark CCG gave a presentation to the board on the Clinical Commissioning Group System reform across south east London.

Andrew Bland informed the board that the system reform arose out of national policy and local ambition in January 2019. He advised that the NHS long term plan made over 130 commitments, and also invited the opportunity to look at the shape and scope of CCGs, and to develop a multi layered approach to how commissioning decisions are made with partners. There was a programme of work that would seek to merge CCGs across the six parts of southeast London into one CCG from 1 April 2020. That same piece of work was happening in the other parts of London with the areas divided as follows - south west, north west, north central and north east.

Andrew Bland explained that if there was a merger of the southeast London CCGs into one CCG, then at the same time there would be a need to create place based boards. He explained that nationally a ‘place’ is regarded as a population between 150,000 and 500,000. This was similar to the size of the various boroughs in south east London.

He informed the board that CCGs had been asked to look at the reform from a system level, how pathways across many boroughs get managed appropriately and decisions made in a coherent way both at borough and neighbourhood level. He reported that Southwark had opted for two primary care networks which were quite sizeable. Across south east London, there would be 34 primary care networks in total.

Andrew Bland reported that there would be tiers of the system of which to make decisions which was welcomed, because there were parts of Southwark residents care that needed coherence and decision making across south east London as someone's care might start in one part of the region and end in another. However the vast majority of decisions for local people would need to happen with the local authority and local partners. He welcomed the idea of taking a very localised view at ward level and neighbourhood level as to what people needed, as the wider areas of Southwark, i.e. Dulwich, Peckham and Camberwell and up into the north of the borough were not similar.

He indicated that the SELCCG wanted to delegate a significant part of its budget to each borough's place based board to take local decisions, but importantly to take them with a board that had health and social care representation rather than just health. He reported that as a minimum the SELCCG would like to delegate the hospital spend to that board, with formal delegation of decision making powers, but to be populated by its partnership of health and social care.

Andrew Bland advised that an application to have a southeast London CCG would have to be made at the end of September for it to come into force on the 1 April 2020. Also as a CCG for south east London there would be one governing body so there would be a need to have place based boards for each borough.

He informed the meeting that from 1 April 2020, every borough in southeast London must adopt one of the three areas for the delegation to work, Level 1, Greater Involvement, Level 2 Aligned Commissioning, Level 3, Joint Commissioning (see page 61 of the agenda for detail).

It was signalled by the chair of the board during the discussion that Level 3 would be the preferred option for Southwark.

RESOLVED:

That the contents of the report be noted.

DISCUSSION ON THE THEME

The board discussed issues arising from the presentations and asked questions.

The following is a summary of the discussion:

Jonty Heaversedge reported that in relation to the children and young people, there had already been quite a lot of work across Lambeth and Southwark on the provider side with commissioners around the children and young people's programme. He explained that through the commissioning approach, they were trying to define groups within the population who have similar needs, so that they can bring those people who are responsible for providing care for those patients in that population together. He reported that Claire Leema in Southwark did some work with Dr Bob Klaber based at Imperial College London on how to stratify children and young people in a way that recognises need differently and allows for the consideration of services that reflect that need better.

Action point

Jonty Heaversedge to provide Genette Laws with more information about this work.

It was pointed out that a challenge of integration, whether at local level or at southeast London level was how data and intelligence was used to help characterise populations to better evaluate and improve services. In response to this it was reported that there was a work stream around data and data sharing and that progress was being made on what could be done now with the systems that were currently in place. It was also reported that data analytics were being used at two levels, at population level for the purposes of planning ahead and targeting the areas needed and also in terms of individual interventions – using data shared within the system to enable early intervention.

A board member reported that at a recent Adult Safeguarding Board meeting there had been a discussion about a number of anonymised case studies reported by local councillors in relation to people being discharged from hospital into the community prematurely. The board member commented that communication between the different departments seemed to be a cause of the problem which needed to be improved urgently. The board member also hoped that with the new partnerships to be formed across southeast London, that the ideas of Southwark Partnership, the fairer future vision and what was good about Southwark were maintained, whilst having equality of service on the ground.

Following on from this, a question was asked about how data would be used from a governance perspective to get quality assurance so that there wouldn't end up being place based 'pockets' of excellence and some communities suffering as a result. Andrew Bland re-iterated the importance of looking at issues from a local perspective and recognised that there were different populations across southeast London and that the partners would have to hold SELCCG to account in respect of assuring that this didn't happen. He indicated that health and wellbeing boards in every borough would have a really clear role in doing this. He stressed he was not seeking to merge health and wellbeing boards but was trying to tie up partnerships. He saw the place based boards as a key driver in getting things done.

In respect of hospital discharges Andrew Bland explained that one of the questions he had been asked by King's College Hospital is why neighbouring authorities have different discharge processes and that at anyone time they may be in contact with 14 different authorities, essentially to do the same thing and at their end there is no difference about that process between boroughs. He stressed the importance of being discerning about what was genuinely local and what should be consistent across the boroughs.

In terms of data and pockets of excellence Andrew Bland felt that this was more of a question for provider alliances such as Partnership Southwark coming together with commissioners and as it would be for other alliances across southeast London.

It was acknowledged that from borough to borough, community to community, people were experiencing different outcomes currently from a health perspective. It was expressed that the only way to improve this was to start to create some greater consistency of standards and the use of data to understand much more effectively the kind of care people are receiving and the outcomes they are obtaining because of that. It was stressed that because of the movement that there was across southeast London that it

was necessary to have that southeast London footprint as well. This would be a solution to the problem rather than exacerbate it.

A member of the board stressed that it was really important in the communication of this initiative, that it was made clear that it would be a different way of working as opposed to formalising what was already there.

10. CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH AND WELLBEING

The Board heard from Genette Laws, Director of Commissioning, Southwark Council, Kirsten Watters, Consultant in Public Health and Sam Hepplewhite, Director of Integrated Commissioning, NHS Southwark CCG.

Genette Laws emphasised that it was important to have a clear and shared definition of what had been agreed at the November 2018 health and wellbeing board meeting in respect of the 100% target of meeting the needs of children and young people experiencing mental health issues. She informed the board that the definition was that we will take a whole system approach and aspire to improve outcomes and care for every child and young person, regardless of the level of need, or severity. In terms of what this meant, Genette Laws referred the board members to the Thrive model that was contained in the agenda. It showed that whilst there were some excellent specialist services in Southwark, what was needed was more early intervention and prevention and that the partners should be seeking to do reduce the stigma, build resilience, and involve children and young people and their families as part of finding solutions so that they are producing for themselves how they take their needs forward.

Genette Laws stressed that wellbeing needed to be everyone's business and that the workforce beyond health and social care should be looked at also. Particular reference was made to schools because that was where children and young people spend most of their time, but also other places that young people go to such as leisure services. She advised that consideration needed to be given as to how to broaden out support for the workforce to be able to support young people. In terms of action, Genette Laws advised that a working group had been established dedicated to early intervention / prevention which was being lead by Kirsten Watters, Consultant in Public Health, Children and Adults Services.

Genette Laws reported on four key areas of focus:

- Open access drop-in services - A number of exemplars had been visited (the visits are summarised in the appendices to the report).
- More support for schools - this was being focused on and led by the £2 million pounds investment from the council in terms of supporting mental health in schools. The lead member through the member officer policy unit was conducting a survey to understand what was already available in schools, some of the good practices that existed and where there were areas that needed further support/review so that the best could be made from the £2 million pounds that was available.
- Providing more support for parents and families - there were a number of good services already available for example, the parent and communities team, who work in some very small neighbourhoods across the borough. Consideration needed to be given as to how this work could be harnessed to further support

parents who know their children best to be able to support them.

- Digital self help – The council had recently commissioned as a borough an 18 month pilot online counselling service (Kooth), this service was available across the whole of Southeast London. Whilst commissioned at scale, thought had been given to how it would be delivered locally. There were a series of workshops on the horizon to focus on how to really take early intervention and prevention forward.

Kirsten Watters reported on other areas of work that had taken plan. She informed the board that Public Health had been leading a number of programmes of work, detailed below:

- A review of self harm case notes had been undertaken and SLaM were looking in more depth at self harm, as this was a key issue of which there was little evidence and understanding of at the present time. An Annual Public Health report had been produced on the emotional health and wellbeing of adolescence (the annual public health report had been circulated with the agenda for information). The report looked at some key themes around emotional health and wellbeing, particularly, in terms of loneliness, parenting, and relationships.
- A new specialist registrar with an expert interest in public health, mental health had been appointed. They would be scoping out what is meant by good mental health and emotional wellbeing, both in adults and young people, and looking at how to measure this in terms of feeling good, but also functioning well in terms of school readiness, attendance, etc.
- A new joint strategic needs assessment on what public health, mental health and wellbeing is, across all age groups had been finalised. This supported the young people's emotional health and wellbeing needs assessment which had been previously presented to the board.

Kirsten Watters also informed the board that her team had been looking at developing a scorecard approach to measure progress so that they knew they were on the right track and also doing well. A key task of the group leading on early intervention and prevention would be to bring this all together, making it coherent and meaningful for professionals and for communities and families, and to enable progress to be tracked.

Sam Hepplewhite explained to the board that this was one of the joint team working arrangements between the CCG and the council and that there was a strategic context to it which linked to the conversations around Partnership Southwark. Sam Hepplewhite further explained that whilst the working arrangements were not at a stage of full integration (level 3) one plan, one budget, they had done things slightly different this year, in that they had started to align planning and spend with the council and had aligned their investment into mental health services with the investment of the council so that there was no duplication, resulting in the Southwark pound being used in the most appropriate way. Two of examples of this were investment around CAMHS and perinatal health.

Points raised in the discussion.

The importance of being mindful of language used when discussing mental health with young people. Through discussions held at the Southwark Serious Youth Violence panel, mental health came up as one of the big issues for young people but also the stigma around ‘mental health’.

A question was raised around co-production with parents as well as with young people and also about supporting and upskilling the wider workforce across the whole health and care system, including the police, schools, and the council. Genette Laws reported that work with parents and families was being undertaken by experts in engagement who already have forums available such as the active communities network who bring families together from where the family is based. The approach to consultation was also changing, moving away from the traditional tick box exercise towards engaging more in dialogue.

With regard to upskilling the workforce, Genette Laws informed the meeting that they were not yet at the point of having plan in terms of how training will be undertaken, however the forum for where discussions on this will take place had been identified. The children and young people's commissioning development group had been repurposed into the Southwark's children and young people's partnership. It was no longer focused on commissioners and included providers that were wider than health and care. This forum would enable conversations about appropriate levels of training. Genette Laws stressed that they did not want a one size fits all approach and that there was a need to be proportionate about what the different members of the workforce will need in order to be able to either support someone or have enough information to direct someone to the right place.

Cassie Buchanan informed the board that the peer review programme referred to in the report appendix was already taking place in Southwark and that the programme set up to build capacity in schools already existed in Southwark, it was titled 'leading a mentally healthy school' and was being led by London teachers school Alliance. The programme had been co-developed by John Ivans who leads the hospital school at the Maudsley and practitioners in schools. Cassie Buchanan advised the board that the programme would greatly benefit from further input from health. She also informed the board that instead of being consulted, schools wanted to be given permission to lead on this work themselves and be supported in co-developing something that sits within education, rather than feeding into a work stream.

Action point

Sam Hepplewhite, Genette Laws, Kirsten Watters to meet with Cassie Buchannan to discuss leading on the work relating to emotionally healthy schools.

RESOLVED:

1. That the report be noted as an update following the presentation of the Southwark Joint Review of Emotional Wellbeing and CAMHS Services.

2. That the proposals outlined in the report be agreed as part of the implementation plan and subsequent progress reporting to the Board.

11. DEVELOPING OUR NEXT 5 YEAR PLAN - KING'S HEALTH PARTNERS

The board received a presentation from Jill Lockett, Professor John Moxham and Joseph Casey from King's Health Partners on the King's Health Partners new 5 year strategic plan.

Following the presentation, Jill invited the board to ask questions which she would take away and review. Questions were asked around the following:

- Sustainability of the workforce and innovation, and also the role of robots in the health service in the future.
- Making best use of the opportunities from King's being located in the borough in terms of creating learning and employment opportunities for young people and the diverse communities of Southwark.
- Work with schools and raising aspirations.
- Workplace wellbeing and a robust engaged sustainable workforce.
- Articulating and raising the profile of King's Health Partners unique ambitions.
- Using every contact with patients to improve health and wellbeing, not only with patients but also with the families and communities of where the patients are coming from – maximising the reach of excellence to communities and to patients.
- Achieving impact and the capitalising affect that is being had within hospitals, into community based care, across community assets and within communities generally.
- Partnering with Southwark in researching children and young peoples mental health needs and also partnering with Southwark in work they are doing on autism.

CORE BUSINESS

12. BETTER CARE FUND - UPDATE ON 2018/19 DELIVERY AND 2019/20 PLANNING

Sam Hepplewhite, Director of Commissioning and Integrated Care, NHS Southwark CCG and Genette Laws, Director of Commissioning, Southwark Council introduced the report.

Sam Hepplewhite informed the board that the national planning guidance for Better Care Fund guidance was still awaited and that officers were therefore going to continue during 2019/20 in the same way as for the previous year. She anticipated that when the guidance was eventually issued that the there would be a very short timetable to return information and therefore sought to put in place arrangements which enabled the return of the Better Care Fund submission without needing to come back to the Board if the timetable did not allow.

RESOLVED:

1. That the impact of the delayed publication of national planning requirements for the Better Care Fund for 2019/20 (detailed in paragraph 8 -11) be noted.

2. That Option (b) be agreed as the option to enable the Health and Wellbeing Board to formally agree the submission of the Better Care Fund plan (along with three signatures: Chair of the CCG, Strategic Director of Children's and Adults' Services, and the Chair of the Health and Wellbeing Board).

3. That the potential changes to the Better Care Fund for 2020/21 (paragraph 15 of the report) be noted.

4. That the performance on the key BCF targets during 2018/19 (paragraph 16 of the report) be noted.

13. SOUTHWARK JOINT MENTAL HEALTH AND WELLBEING STRATEGY DELIVERY PROGRAMME ANNUAL REVIEW

Sam Hepplewhite, Director of Commissioning and Integrated Care, NHS Southwark CCG and Genette Laws, Director of Commissioning, Southwark Council introduced the report.

RESOLVED:

1. That the progress to date in the delivery of the Joint Mental Health and Wellbeing Strategy delivery programme be noted.

2. That the developing plans for alignment with Partnership Southwark's Primary and Community Mental Health work stream be noted.

3. That it be noted that a review of the work streams is taking place so that areas are rationalised to support more effective and efficient delivery of the action plan.

14. SOUTHWARK PRIMARY CARE COMMISSIONING COMMITTEE - HEALTH AND WELLBEING BOARD REPRESENTATIVE 2019/20

RESOLVED:

That Councillor Evelyn Akoto be re-nominated as the named member to attend the (NHS Southwark) Primary Care Commissioning Committee in the capacity as a non-voting member from the health and wellbeing board for the 2019/20 year.

REPORTS FOR INFORMATION

The following items have been included on the agenda for information only.

15. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT - MENTAL WELLBEING AND RESILIENCE IN YOUNG PEOPLE

The report for this item was circulated with the agenda for information only. There was no discussion on the item.

16. A FOOD SECURITY PLAN FOR SOUTHWARK (RECENT REPORT TO CABINET)

The report for this item was circulated with the agenda for information only. There was no discussion on the item.

17. DIGITAL PUBLIC HEALTH IN SOUTHWARK: OUR STRATEGIC APPROACH (RECENT REPORT TO CABINET)

The report for this item was circulated with the agenda for information only. There was no discussion on the item.

18. INTRODUCING A COUNCIL ADVERTISING POLICY IN SOUTHWARK (RECENT REPORT TO CABINET)

The report for this item was circulated with the agenda for information only. There was no discussion on the item.

The meeting ended at 6.45pm

CHAIR:

DATED:

Agenda Item 8

Item No. 8.	Classification: Open	Date: 18 November 2019	Meeting Name: Health and Wellbeing Board
Report title:		Improving Immunisation Coverage in Southwark	
Ward(s) or groups affected:		All	
From:		Kevin Fenton, Strategic Director of Place and Wellbeing	

RECOMMENDATION

1. To note the work going on locally to improve immunisation coverage in Southwark.

BACKGROUND INFORMATION

2. Immunisations are the safest and most cost-effective way of protecting individuals and communities from vaccine-preventable diseases. They prevent disease at the individual level and also can achieve a level of population coverage that confers herd immunity; a form of indirect protection that occurs when a large percentage of the population has become immune to an infection.

3. Globally, immunisation programmes are considered one of the greatest public health interventions in terms of measurable impact on population morbidity and mortality. Despite this, we continue to see regular outbreaks of vaccine preventable diseases locally, nationally and internationally.

4. Recent work undertaken in Southwark has identified that local vaccination coverage for several vaccination programmes has declined and some have now fallen below both locally and nationally agreed targets.

5. This has led to a call for local strategic action and leadership to combat these declining coverage trends and protect our population against preventable diseases.

KEY ISSUES FOR CONSIDERATION

6. We have integrated national, regional and local policy to ensure we take an evidence-based, whole-systems approach to improving immunisation coverage. This has involved bringing together all partners involved in commissioning, quality assurance and provision of immunisations in Southwark, including consideration of opportunities in the developing primary care organisations.

7. A detailed action plan has been developed, covering immunisation programmes across the life course – pre-school, school aged and adult. Ambition targets have been set: to achieve a 5% relative increase in coverage for each programme by March 2021.

Pre-school immunisations

- Immunisations in pre-school children are mostly delivered in primary care. Exceptions are BCG in babies which is delivered on behalf of the maternity unit by GSTT Community team, and the first dose of hepatitis B for babies

born to hepatitis B positive mothers which is given in the maternity unit.
- Uptake of pre-school immunisations in Southwark generally falls below targets although it is fairly consistent with the rest of London.
- For pre-school immunisations the main areas of work are:

    - Promoting the MMR vaccine to all age groups
    - Improving the process and for hepatitis B in high risk babies
    - Increasing uptake of flu vaccine in 2 and 3 year olds, particularly those at risk

School-aged immunisations

- Immunisations given in schools to school-aged children include HPV, Meningitis ACWY, Td/IPV booster as well as flu.
- In Southwark, immunisations to school-aged children are delivered by HRCH Hounslow and Richmond Community Healthcare.
- Uptake is generally comparable or better than for London, although recently HPV uptake has decreased.
- For school-aged immunisations the main areas of work are:

    - Improving uptake of HPV in girls and introducing self consent
    - Introducing HPV in boys
    - Improving flu uptake in primary school children with use of e-consent

Adult immunisations

- The routine immunisations offered to adults are Pneumococcal (PPV), shingles and pertussis for pregnant woman while flu is offered to those aged 65+ years of age and to those in clinically at-risk groups.
- All are administered in the GP setting however; PPV and Flu are also commissioned for delivery through pharmacies while a pilot has taken place in 2018 to commission pertussis through maternity clinics in Southwark.
- Coverage for PPV and Shingles in Southwark was lower than the London average and below target.
- For adult immunisations the main areas of work are:

    - Improving uptake and reducing the large variation in shingles uptake by introducing call/recall systems in practices
    - Improving flu uptake in clinically at risk groups

8. We have identified the five key priority areas that we need to focus on in order to achieve our vision over the next two years (2019-2021):

    - Reducing inequality and improving uptake in the underserved
    - Community engagement and promotion
    - Data sharing and quality improvement
    - Service delivery, call and recall
    - Guidance, training and development

9. Implementation of the action plan has started, with detailed work being undertaken around:

    - local guidance for practice call/recall systems
    - development of a practice dashboard

- standardizing EMIS searches and coding
- promotion of MMR
- improving access for home-schooled children
- engagement in Latin-American communities
- improving the consent process in schools

10. Oversight and monitoring of the action plan comes from the Lambeth & Southwark Immunisation Steering Group.

Community impact statement

11. The action plan aims to improve vaccination coverage across the whole of Southwark and across all immunisation programmes. Certain actions will target underserved and low uptake groups specifically, in order to ensure that work reduces inequalities.

Resource implications

12. There are no immediate resource implications as all actions being taken rely on improving current systems and processes, utilizing existing resources and depend on the goodwill of staff working within the field of immunisations to undertake extra work where necessary.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	Improving Vaccination Coverage

AUDIT TRAIL

Lead Officer	Kevin Fenton, Strategic Director of Place and Wellbeing	
Report Author	Sarah Robinson, Head of Programmes, Health Protection	
Version	Final	
Dated	7 November 2019	
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		7 November 2019

Improving Vaccination Coverage
Report to the Health & Wellbeing Board

Health Protection Section

Southwark Public Health Directorate, Place & Wellbeing

November 2019

GATEWAY INFORMATION

Report title:	**Improving Vaccination Coverage in Southwark: Report to the Health & Wellbeing Board**
Status:	Public
Prepared by:	S Robinson
Contributors:	M Sharma
Approved by:	K Fenton
Suggested citation:	e.g.: Improving Vaccination Coverage in Southwark: Report to the Health & Wellbeing Board. Southwark Council: London. November 2019.
Contact details:	publichealth@southwark.gov.uk
Date of publication:	7 November 2019

CONTENTS

Slide 3

Immunisations are effective at protecting individuals & populations from vaccine-preventable diseases

INTRODUCTION

- Immunisations are the safest and most cost-effective way of protecting individuals and communities from vaccine-preventable diseases.[1] They prevent disease at the individual level and also can achieve a level of population coverage that confers herd immunity; a form of indirect protection that occurs when a large percentage of the population has become immune to an infection.[1, 2]

- Globally, immunisation programmes are considered one of the greatest public health interventions in terms of measurable impact on population morbidity and mortality.

- In England, the impact of immunisations has been equally significant. In the 1950s, there were nearly 120,000 cases of pertussis annually; by 2011 this had reduced to just 1500. There were more than 60,000 cases (3,800 deaths) from diphtheria in the 1940s but by 2017, this had reduced to 5 reported cases annually.[3] More recently, the HPV vaccine introduced 10 years ago has been shown to reduce HPV infection by 86% and consequently a potential risk of cervical cancer by 70%.[4]

- Despite this, we continue to see regular outbreaks of vaccine preventable diseases locally, nationally and internationally.

1. WHO: Strategic Advisory Group of Experts on Immunization *Assessment Report of the Global Vaccine Action plan*. 2018. Date Accessed: 20 Jan 2019.
2. WHO *European Vaccine Action Plan 2015-20*. 2019. Date Accessed: 18 Jan 2019.
3. NHS Choices *Vaccination save lives*. 2018. Date Accessed: 19 Dec 2018. Available from: www.nhs.uk/conditions/vaccinations.
4. Mesher, D., et al., *The Impact of the National HPV Vaccination Program in England Using the Bivalent HPV Vaccine: Surveillance of Type-Specific HPV in Young Females, 2010-2016.* J Infect Dis, 2018. **218**(6): p. 911-921.

Vaccination coverage is below targets and outbreaks of vaccine-preventable diseases regularly occur

WHY WE NEED A LOCAL STRATEGIC ACTION PLAN

Recent work undertaken in Southwark has identified that local vaccination coverage for several vaccination programmes has declined and some have now fallen below both locally and nationally agreed targets.

Some of the reasons driving a decline in coverage in Southwark are related to:

- Societal inequalities that have led to underserved groups less able or willing to access immunisations due to a variety of barriers such as fear, distrust, language , poor health literacy, marginalisation or poor access to health services.
- Vaccine hesitant groups fed by misinformation
- Inadequate call and recall systems and fragmented data systems

The challenge for Southwark may indeed be greater, given existing inequalities in the borough, high prevalence of known underserved groups and the fact that global warnings and recent disease outbreaks highlight greater challenges may lie ahead.

This has led to a call for local strategic action and leadership to combat these declining coverage trends and protect our population against preventable diseases.

Public Health and the CCG have taken a strategic approach to address barriers and improve uptake

BARRIERS TO UPTAKE

Stakeholders across Southwark were consulted through interviews and questionnaires to identify factors affecting immunisation uptake in Southwark.

Several of the barriers reporgted related to the challenge of managing a highly mobile population in Southwark, inconsistent call/recall systems, trust among recipients of information received by patients/parents and financial prioritisation by providers.

Barrier	Detail
Population movement	In and out of London; between boroughs; from abroad; within Southwark. High number of temporarily housed families & individuals not registered with a GP
Movement of staff	Higher turnover of staff in GP practices and community roles
Staff understanding and promotion	Health Visitors and School Nurses have capacity to influence immunisations to a greater extent through modifications to their agreed roles
Parents' knowledge and understanding	Lack of awareness of changing immunisation pathways and availability. Lack of appreciation of severity of diseases
Accessibility of GPs	Large families and underserved groups can face a logistical challenge of attending GP. There is a shortage of trained immunisation workforce
Trust in the information they receive	Inconsistent messages and information patients suspect may not be accurate, being denied detail may create vaccine hesitancy. Needs to be more clear, concise and consistent.
Financial Incentivisation	Current contracts may not adequately incentivise practices to prioritise immunisation uptake other than for flu.
Inconsistent call/recall systems	Inconsistency in and unsystematic call/recall systems across practices were highlighted as a major barrier.
Consent process for school immunisations	Logistical barriers.
Data recording, data accuracy and data flow onto reporting systems	Complexity in coding, recording and reporting leaves considerable room for error in the system, meaning inaccuracies then transfer through to nationally reported data. This is a challenge at both GP level and in settings other than GPs where immunisations are given.

A detailed action plan has been developed and ambition targets set to achieve our vision in the strategy

OUR VISION

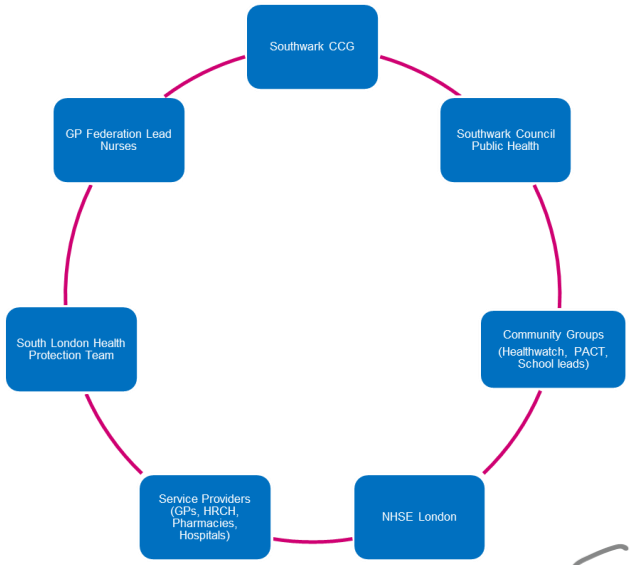
Our vision is to improve coverage in vaccination programmes across the life course to protect population health and reduce inequalities, by addressing barriers to uptake and improving access to services

To realise our vision a detailed action plan has been developed and ambition targets set:

- to achieve a 5% relative increase in coverage for each programme (based on the most recent coverage data) by March 2021. Where this 5% relative increase exceeds the London target, the London target has been used.

We have integrated national, regional and local policy objectives to ensure we take a collaborative whole-systems approach to improving immunisation coverage.

This has involved bringing together all partners involved in commissioning, quality assurance and provision of immunisations in Southwark as depicted.



Ambition targets for pre-school immunisations have been set to achieve a 5% increase in coverage

COVERAGE TRENDS AND AMBITIONS: PRE-SCHOOL

- Immunisations in pre-school children are mostly delivered in primary care.
- Exceptions are BCG in babies which is delivered on behalf of the maternity unit by GSTT Community team, and the first dose of hepatitis B for babies born to hepatitis B positive mothers which is given in the maternity unit.
- Uptake of pre-school immunisations in Southwark generally falls below targets although it is fairly consistent with the rest of London (Table 2).
- **For pre-school immunisations the main areas of focus are MMR, hepatitis B in high risk babies and flu in 2 and 3 year olds**

Table 2: Pre-school coverage, targets and ambitions

Immunisation	Area	2015/16	2016/17	2017/18	Trend	London Target	Strategy Ambition
DTaP/IPV/Hib/HepB @12 mths	SWK	86.3	89.6	90.6		95%	95%
	LON	89.2	88.8	89.2			
	ENG	93.6	93.4	93.1			
PCV @ 12 mths	SWK	86.5	89.6	91.4		95%	95%
	LON	90.0	89.2	89.7			
	ENG	93.5	93.5	93.3			
Rotavirus @ 12 mths	SWK		85.6	87.9		95%	92%
	LON		89.2	86.5			
	ENG		89.6	90.1			
MenB@ 12 months	SWK			89.4		95%	94%
	LON			87.9			
	ENG			92.5			
DTaP/IPV/Hib/HepB @ 24 mths	SWK	91.6	93.7	92.5		95%	95%
	LON	92.2	91.6	91.7			
	ENG	95.2	95.1	95.1			
PCV @ 24 mths	SWK	85.4	88.5	86.1		90%	90%
	LON	85.6	84.5	84.3			
	ENG	91.5	91.5	91.0			
Hib/MenC @24 mths	SWK	85.6	88.8	87.5		90%	90%
	LON	85.9	84.2	85.1			
	ENG	91.6	91.5	91.2			
MMR (Dose 1) @2yrs	SWK	86.1	88.5	87.8		90%	90%
	LON	86.4	85.1	85.1			
	ENG	91.9	91.6	91.2			
MMR (Dose 2) @5yrs	SWK	85.3	86.9	81.8		85%	85%
	LON	81.7	79.5	77.8			
	ENG	88.2	87.6	87.2			
DTaP/IPV (Booster) @ 5 years	SWK	74.0	78.6	83.5		90%	88%
	LON	78.3	76.9	75.9			
	ENG	86.3	86.2	85.6			
Flu (aged 2 years)	SWK	29.1	28.9	35.8		50%	40%
	LON	26.6	30.3	33.2			
	ENG	35.4	38.9	42.8			
Flu (aged 3 years)	SWK	30.7	33.1	35.1		50%	40%
	LON	28.8	32.6	33.3			
	ENG	37.7	41.5	44.2			

Target reached
Within 5% points of target
At least 5% points below target

School age immunisation ambition targets have been set to achieve a 5% increase in coverage

COVERAGE TRENDS AND AMBITIONS: SCHOOL-AGED

- Immunisations given in schools to school-aged children include HPV, Men ACWY, Td/IPV booster as well as flu.
- In Southwark, immunisations to school-aged children are delivered by HRCH (Hounslow and Richmond Community Health Care).
- Uptake is generally comparable or better than for London, although recently HPV uptake has decreased (Table 3).
- **For school-aged immunisations the main areas of focus are HPV and flu**

Table 3: School age coverage, targets and ambitions

Immunisation	Area	2015/16	2016/17	2017/18	Trend	London Target	Strategy Ambition
HPV (Dose 1)*	SWK	89.7	86.4	72.9		90%	90%¥
	LON	83.9	83.8	81.0			
	ENG	87.0	87.2	86.9			
HPV (Dose 2)**	SWK	84.5	84.2	80.7		90%	88%¥
	LON	80.7	77.7	78.4			
	ENG	85.1	83.1	83.8			
Td/IPV	SWK	93.7	79.2	81.7		80%	80%
	LON	69.2	77.1				
	ENG	79.1	82.3				
Men ACWY	SWK	65.6	60.8	83.2		80%	80%
	LON	61.5	67.1				
	ENG	76.4	79.0				
Flu (School-years)§	SWK		46.9	48.9		50%	50%
	LON	40.2	43.8	47.8			
	ENG	55.1	55.4	59.6			

Target reached
Within 5% points of target
At least 5% points below target

Ambition targets for adult immunisation programmes have been set to achieve a 5% increase in coverage

COVERAGE TRENDS AND AMBITIONS: ADULT PROGRAMMES

- The routine immunisations offered to adults are Pneumococcal (PPV), shingles and pertussis for pregnant woman while flu is offered to those aged 65+ years of age and to those in clinically at-risk groups.

- All are administered in the GP setting however; PPV and Flu are also commissioned for delivery through pharmacies while a pilot has taken place in 2018 to commission pertussis through maternity clinics in Southwark.

- Coverage for PPV and Shingles in Southwark was lower than the London average and below target (Table 4).

- **For adult immunisations the main areas of focus are shingles and flu**.

Table 4: Adult coverage, targets and ambitions

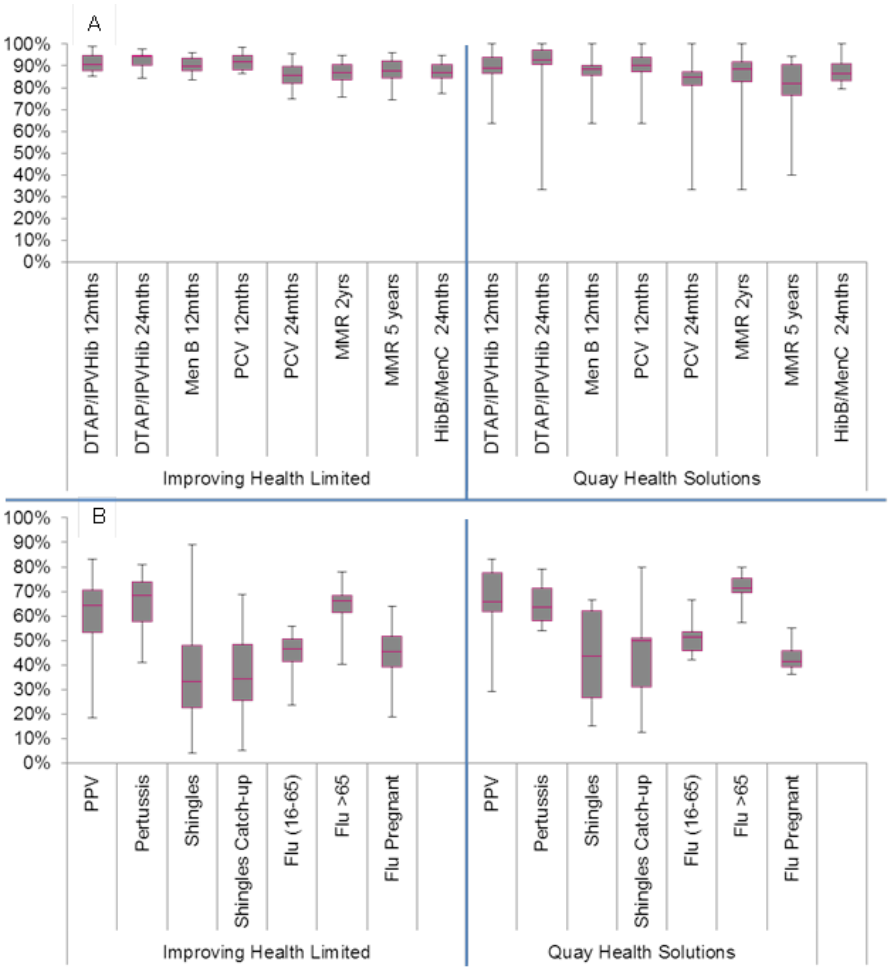
Immunisation	Area	2015/16	2016/17	2017/18	Trend	London Target	Strategy Ambition
PPV	SWK	56.9	56.7	57.7		75%	63%
	LON	65.3	64.3	64.4			
	ENG	70.1	69.8	69.5			
Shingles	SWK	42.3	30.4	29.2		60%	45%
	LON	47.1	41.3	37.5			
	ENG	54.9	48.3	41.0			
Maternal Pertussis	SWK	56.5	72.9	71.4		70%	70%
	LON	49.8	72.6	60.2			
	ENG	60.7	72.6	70.8			
Flu (6mths-64 years at risk)*	SWK	44.4	47.3	44.2		50%	49%
	LON	43.7	47.1	45.4			
	ENG	45.1	48.6	48.9			
Flu (aged >64)	SWK	66.6	65.3	66.2		75%	71%
	LON	66.4	65.1	66.9			
	ENG	71.0	70.5	72.6			
Flu (pregnant)	SWK	40.8	40.9	44.9		50%	50%
	LON	38.6	39.5	41.1			
	ENG	42.3	44.9	47.2			

Target reached
Within 5% points of target
At least 5% points below target

Vaccination coverage for some programmes varies significantly by practice

VARIATION BY PRACTICE

- Southwark immunisation coverage masks considerable variation in uptake across practices as illustrated by the box and whisker plots opposite.
- The middle pink line represents the median coverage, the box itself is the interquartile range, while the minimum and maximum ‘whiskers’ highlight the full range of coverage values
- For pre-school programmes, the greatest variation is seen in MMR. For adult programmes much greater variation is seen across all immunisations, particularly for shingles.
- This data highlights clear scope for shared learning from practices reporting higher coverage

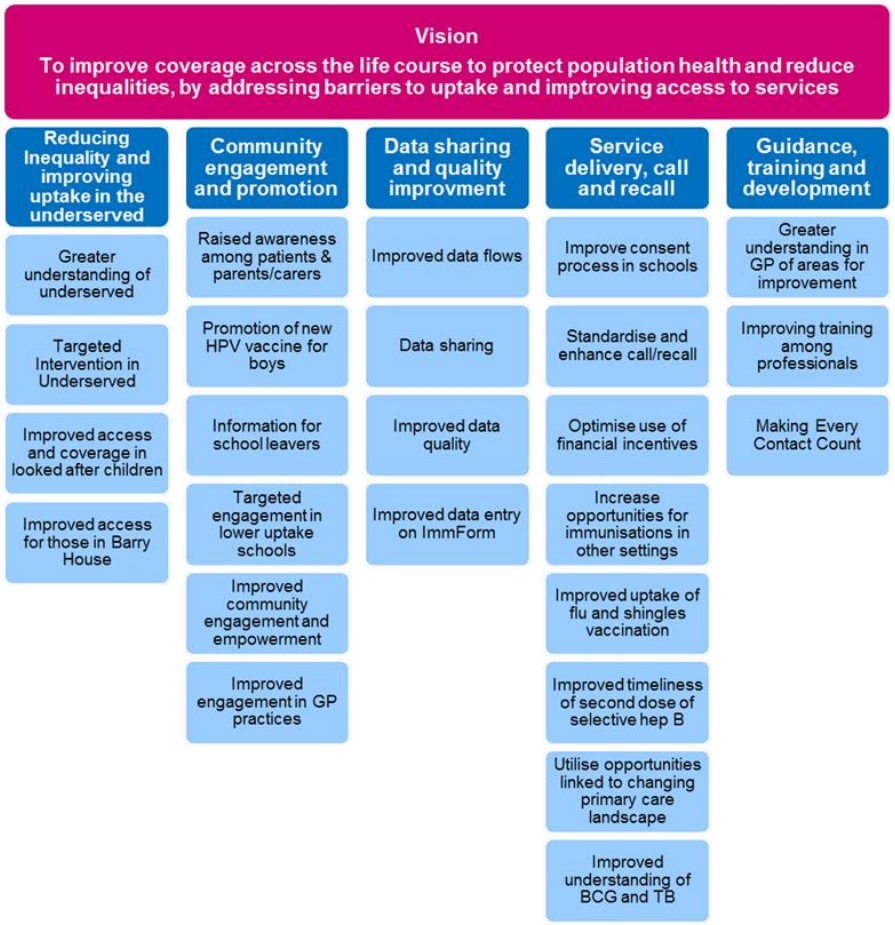


Five key priority areas were identified in the strategy and a detailed action plan developed for each

KEY PRIORITY AREAS FOR ACTION

We have identified the five key priority areas that we need to focus on in order to achieve our vision over the next two years (2019-2021):

- Reducing inequality and improving uptake in the underserved
- Community engagement and promotion
- Data sharing and quality improvement
- Service delivery, call and recall
- Guidance, training and development



Reducing inequalities and improving uptake in the underserved is a key priority

KEY PRIORITY AREA 1

Reducing inequalities and improving uptake in the underserved

- Central to our action plan is ensuring the needs of people who are disadvantaged or suffer inequality leading to or arising from reduced immunisation uptake are addressed as a priority**.** Evidence suggests that these groups require more targeted intervention to meet their differing needs.

What works?

- Understanding the prevalence, location of underserved groups in the community and how they access services. (NICE, DoH)
- Removing logistical barriers to access for those with disability or language barriers e.g. mobile or home-based immunisation, incentives for parents to bring their children for immunisation; special clinics solely for immunisation. (NICE)
- Health professionals checking the immunisation history of new migrants, including asylum seekers, when they arrive in the country. (NICE)
- Checking the immunisation status of looked-after-children (LAC) during their initial health assessment, the annual review health assessment and statutory reviews. Ensuring outstanding immunisations are addressed as part of the child's health plan. (NICE)
- Peer-led approaches where people with lived experience (for example, people who have been homeless, or who are from particular cultural backgrounds) are working alongside health and social care professionals to provide information that is accessible and appropriate to the “target group”. (NICE)
- Partnership working with local organisations (for example, drug and alcohol services) and voluntary sector groups working with underserved populations (such as carers or people who are homeless). (NICE)

Improved communication strategies, effective leadership and public health campaigns are key

KEY PRIORITY AREA 2

Figure 3: Vaccine hesitancy spectrum

Community engagement and promotion

- Vaccine hesitancy, defined as delay in acceptance or refusal of vaccines despite availability of vaccination services, is complex.
- Fundamentally, the vaccine hesitant can be divided into 4 main categories:
  - those driven by **convenience; t**hose who underestimate the risk (**complacency**); those who weigh up (**calculation**); those who lack **confidence**
- Central to tackling this spread of disinformation and addressing all levels of hesitancy is a need for community engagement and promotion based around improved communication strategies, effective clinical and political leadership and public health messaging campaigns.

What works?

- Transparent, concise and easy to understand communication. (Lancet)
- Using pharmacies, retail outlets, libraries and local community venues for disseminating accurate, up-to-date information on immunisation with links to further information on trusted websites (NHS Choices) and avenues to ask for further information. (NICE)
- Ensuring all staff involved in immunisation services are trained with communications skills and ability to answer questions. (NICE, PHE)
- Checking immunisation records when a child joins a nursery, school, playgroup. (NICE)
- School nursing teams, working with GP practices and schools, providing information in an appropriate format (NICE)
- Heads, governors, children's services, imms coordinators working with parents to encourage schools to become venues for vaccination.
- Providing information in a variety of formats on the benefits of immunisation against infections, tailored for different communities.(NICE)
- Working with statutory and voluntary organisations, such as parents groups and those representing people with relevant medical conditions, to increase awareness of vaccination among eligible groups (and their parents or carers, if relevant).(NICE)
- Using workplaces to deliver prompts in various printed/digital formats which include information about vaccination locations and times.(NICE)

Data flow and data quality have been cited as barriers to improving uptake of immunisations

KEY PRIORITY AREA 3

Data sharing and quality improvement

- Understanding the flow of information between immunisation systems is key to knowing how to intervene, whether interventions are successful and how data capture can be improved. This ranges from ensuring quality data recording and capture through to transmission of this information onto local and national reporting systems.

- Administration of immunisations in settings other than GP (schools, pharmacies, hospitals), requires notification of the GP in a timely and accurate way. Data flow and data quality have been cited by stakeholders as a barrier to improving uptake.

What works?

- Ensuring local healthcare commissioning organisations and GP have a structured, systematic method for recording, maintaining and transferring accurate information on vaccination status. Vaccination information should be recorded in patient records, child health record and the child health information system (CHIS) and should be reconciled and consistent.(NICE)
- Clinical systems should be used for identifying eligible groups and working out vaccine supply. (NICE)
- Private providers having clear processes to allow them to inform the relevant GP practice about an immunisation administered under private care. (NICE)
- Ensuring up-to-date information on vaccination coverage is available and disseminated to all those responsible for immunisation. (NICE)
- Ensuring staff are appropriately trained to document vaccinations accurately in the correct records using the right Read codes. (NICE)
- Having systems in place to ensure regular update and maintenance of the databases for recording immunisation status. This should involve ensuring records are transferred when someone moves out of the area, while also following up on information to ensure it is not duplicated or missing. (NICE)
- Integrating local care pathways for hepatitis B vaccination for high risk babies born to infected mothers which will allow health professionals to provide advice and support to prevent hepatitis b transmission, to highlight the importance of the vaccination timing, how to access it and a robust and mapped means of patient follow up through information systems such as CHIS. (NICE)

Better quality call and recall systems in general practice are key to improving coverage and reducing variation

KEY PRIORITY AREA 4

Service delivery, call and recall

- Increasing access, optimising service delivery and systematic call/recall have all been demonstrated to be key components in achieving good immunisation coverage.

- Variation in coverage occurs in general practice, and also within school programmes. Improvements in call and recall systems can have a significant impact on both overall coverage and reducing inequalities.

- Providing immunisation services through pharmacy's, hospitals and hub clinics can also play an important role in improving service delivery across the lifecourse

What works?

- Systematic multicomponent call/recall (including call, text messages, letters and email). (Cochrane, NICE)
- Tailoring invitations for immunisation and reminders when someone does not attend appointments. (NICE)
- Improving access to immunisation services by extending clinic times, and evening/weekend services in primary care and pharmacy. (NICE)
- Targeted strategic work with practices and schools identified to have lower than average coverage. (DoH)
- Ensuring enough appointments are available so that all patients, children in particular, can receive vaccinations on time. (NICE)
- Ensuring parents and patients know how to access immunisation services. (NICE).
- Providing multiple opportunities and routes for eligible people to have their vaccinations through community pharmacies, GP surgeries or clinics they may attend regularly for a chronic condition.(NICE)
- Commissioners raising awareness among providers about financial remuneration linked to vaccination.(NICE)
- Using quality indiacators (eg QOF) to encourage and incentivise provider to meet targets. (NICE)
- Ensuring young people fully understand what is involved in immunisation so that those who are aged under 16 can consent to vaccinations while simultaneously ensuring parents have opportunities to address concerns. (NICE)

Regular updates and training are essential for those who deliver and advise on immunisations

KEY PRIORITY AREA 5

Guidance, training and development

- Fundamental to delivery of immunisations is the adequate training and development of healthcare staff. Increasing challenges around vaccine hesitancy, regular changes to the schedule and and a greater number of vaccinations require providers to remain updated.

- Immunisation advice and administration now takes place in a multitude of settings e.g. general practice, schools, hospitals, prisons, occupational health, maternity, neonatal and paediatric services, pharmacies, sexual health clinics, long term care settings.

- Stakeholder feedback emphasised the need for timely two-way communication between providers and commissioners around areas where there are greatest challenges.

What works?

- Ensuring all staff involved in immunisation services are appropriately trained with annual updates particularly around the knowledge and communications skills needed to handle challenging questions. (NICE, PHE)
- Ensuring health professionals who deliver vaccinations have received training that complies national minimum standards for immunisation training. (PHE, NICE)
- Assigning dedicated staff (for example, a flu or MMR vaccination champion) to increase immunisation awareness and uptake.(NICE)
- Training peers to vaccinate their co-workers e.g. for flu and encouraging uptake and challenging barriers e.g. that the flu vaccine can give you flu. (NICE)
- Making every contact count (MECC) – making the most of opportunities for raising awareness and offering vaccination. (NICE)

An implementation group are taking forward actions developed in the strategy

IMPLEMENTATION & GOVERNANCE

Stakeholders involved in the development of this strategy are committed to taking action to improve coverage.

- An implementation group has been set up to drive forward the actions at the operational level. This group is working closely with stakeholders from Southwark Local Authority (e.g. education, communications), CCG Teams (e.g. primary care and medicines optimisation), Federations, NHSE London, school providers, GSTT Community and LAC teams, as well as Community Southwark and Healthwatch as needed for specific actions.

- It is the combined knowledge, expertise and resource of members of the implementation group from across the healthcare system that will be essential in driving this work forward.

- The existing Lambeth & Southwark Immunisation Steering Group provides senior oversight and will monitor progress against the action plan at each meeting and resolve or escalate issues. The Steering Group are accountable to the CCG Quality & Safety Committee who will be kept informed of progress via the quarterly report submitted.

- The strategy and action plan was signed off by the CCG Integrated Governance and Performance Committee in April 2019.

Work has already started on implementing the strategy and action plan

SUMMARY AND NEXT STEPS

- Declining trends in coverage for certain immunisation programmes and regular outbreaks of vaccine-preventable disease have led to the development of a Southwark Immunisation Strategy and Action plan.

- Ambition targets have been set to improve coverage in immunisation programmes across the life course by 2021.

- Implementing the action plan has started, with detailed work being undertaken around:
  - local guidance for practice call/recall systems
  - Development of a practice dashboard
  - consideration of opportunities with neighbourhoods/PCNs/Federations
  - standardizing EMIS searches and coding
  - promotion of the MMR vaccine
  - improving access for home-schooled children
  - engagement in Latin-American communities
  - improving the consent process in schools

Agenda Item 9

Item No. 9.	Classification: Open	Date: 18 November 2019	Meeting Name: Health and Wellbeing Board
Report title:		The Southwark public health approach to serious youth violence prevention	
Ward(s) or groups affected:		All	
Cabinet Member:		Councillor Evelyn Akoto, Community Safety and Public Health	

RECOMMENDATIONS

1. That the Health and Wellbeing Board notes the overview of serious youth violence in Southwark.

2. That the Health and Wellbeing Board accepts the recommendations of the joint strategic needs assessment (JSNA).

BACKGROUND INFORMATION

Local context

3. Serious youth violence (SYV) is a particularly pertinent issue in Southwark. Southwark has the fourth highest volume of knife crime among all London boroughs and recognized gang activity, including county lines drug supply.

4. SYV is a complex and multi-factorial manifestation of wider issues and exposure to violence has significant negative impacts on a young person's mental wellbeing and physical health. Beyond the individual affected, SYV carries a high cost to health and social care, education, communities, police, and the criminal justice system. Young people involved in / at-risk of becoming involved in violence are – principally - vulnerable. In looking to support and safeguard these young people, their wider relationships and environment must be considered. There is clear evidence that the places in which young people live and grow have an important role in determining their risk and vulnerability. Risk for becoming involved in violence also has a strong inequalities gradient, with the most disadvantaged being the most likely to be at risk.

5. The public health approach to any issue relies on a thorough understanding of the data and epidemiology. The public health approach is both upstream (looking at the root causes) and at-scale (looking at the population, rather than the individual). It supports a multi-faceted response that considers underlying risk factors ranging from the characteristics and experiences of the individual, the relationships they have, to the community and society in which they live. The range of factors that affect the likelihood of becoming involved in violence mean that tackling SYV requires a collaborative, partnership responsive inclusive of the wider determinants of health. Efforts to prevent SYV should include a range of universal, targeted, and specialist interventions which seek to (1) prevent the development of risk factors, (2) prevent initial involvement in violence, and (3) mitigate the impact of violence and prevent reoccurrence.

6. This JSNA was undertaken to develop our understanding of the determinants of SYV and the epidemiology of violence locally, and to identify opportunities for prevention and improved collaborative working. While recognising the substantial overlap between youth violence and wider vulnerability and exploitation, the scope of the JSNA was limited to SYV, which was herein defined as all incidents of violence against the person involving young people aged 10-24 years. Data were analysed from the Metropolitan Police Service (Met), health, and the Southwark Youth Offending Service (YOS) to develop a picture of the burden of SYV locally. This JSNA is intended to compliment the extensive engagement undertaken as part of both the Cross-Party Youth Violence Panel and the Southwark Extended Learning Review, both of which published recommendations for a local response in early 2019.

Key Findings

7. Southwark has a large population of young people aged 10-24 years. Our adolescents are more deprived and more diverse than the general Southwark population. These characteristics need to be considered when looking at risk of involvement in violence and when looking to implement preventative interventions. Deprivation in particular tends to cluster with other risk factors for violence, such as adverse childhood experiences. Furthermore, living in a deprived area can also mean that developing and fostering protective factors to overcome adversity can be more challenging.

8. Data from the Met, health, and YOS suggest that SYV in Southwark increasingly involves a sharp object and that the age profile of those involved is getting younger.

   - Southwark has the third highest number of stop & searches among London local authorities. Stop & searches disproportionally affect young people, males, and those of minority ethnic groups. In 14-20% of instances of stop & searches of Southwark young people, further action is taken. Violence against the person (VAP) is the most common offence committed by young offenders in Southwark. Incidents of VAP involving Southwark YP have decreased over the past three years but use of an offensive weapon has increased dramatically.
   - There have been no major fluctuations in the overall number of LAS call-outs to young victims of assault over the last three years. However, the age profile of victims is increasingly younger. Emergency admissions for assault with a sharp object have not reduced in line with assaults overall and are over 5x higher in young people than in those aged over 25 years.
   - Despite high levels of first-time entrants to the youth justice system, Southwark has a low rate of offending and re-offending compared to other London local authorities. Young people involved in the criminal justice system tend to be young males of BAME ethnicity.

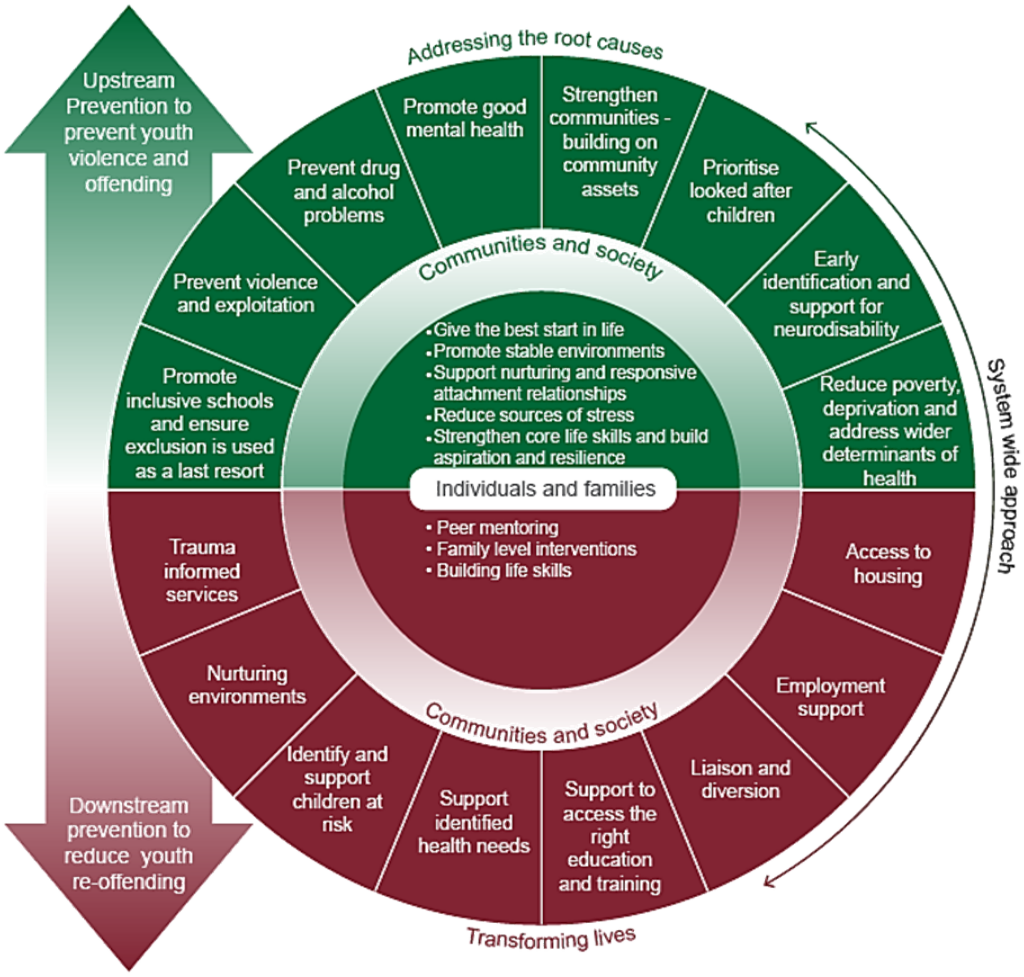
9. The JSNA focused on risk factors for violence most commonly identified among Southwark youth offenders. They include:

   - Adverse childhood experiences: local estimates of adverse childhood experiences suggest there are more children with $\geq$ 4 adverse childhood experiences (ACEs) in Southwark than the national average; prevalence is especially high among young offenders

- Being a looked-after child, child in need, or subject to a child protection plan: the rate of entry into care as a looked-after child is substantially greater in Southwark than in London or England
- Having a special educational need or disability: more Southwark children are identified as having a special educational need or disability than in London or England
- Being excluded or having attendance issues at school: Southwark has a higher rate of primary school fixed-period exclusion, secondary school fixed-period exclusion, and secondary school permanent exclusion than the London average
- Mental and/or physical health concerns: around half of Southwark young offenders had a mental health concern and there was substantial overlap between poor mental health, substance use, and poor physical health

Recommendations

10. The JSNA makes a number of recommendations derived from the literature, the local epidemiology, and the Southwark Extended Learning Review and Cross-Party Panel. Recommendations are organised under themes, where within scope, identified by a recent (2019) Public Health England Report *Collaborative approaches to preventing offending and re-offending by children*:



Reference: Public Health England (2019) Collaborative approaches to preventing offending and re-offending by children

Addressing the root causes

Theme(s)	Recommendation	Suggested owner
Promote inclusive schools / Trauma-informed services	Undertake an in-depth review of school exclusions (formal and informal), managed moves, and home schooling in Southwark to understand the profile of young people affected and explore the impact on wider vulnerability	Children's Services
	Work with schools to embed a trauma-informed approach (e.g. attachment, regulation and competency) and ACE-awareness, which recognises that disruptive behaviour may be a manifestation of trauma, and clarify support available for those young people	CYP & EI steering group
Prevent exploitation	Undertake needs analysis of vulnerability and violence to develop a fuller picture of vulnerability in the borough	Community Safety
	[See identification and support of children at risk]	N/A
Prevent drug & alcohol problems	Continue to work with schools and school nursing to develop modern and relevant PSHE lessons that promote healthy behaviours	Education / Public Health
	Continue to promote and improve uptake of Healthy Young People (HYP) within schools and youth settings to improve access for young people to substance misuse support services	Public Health
	Further examine the use and impact of cannabis in Southwark adolescents to explore links with offending and exploitation	Community Safety
Strengthen communities	Ensure communities and VCS groups are included in the steering group to take forward the recommendations from this JSNA, the Extended Learning Review, and Youth Violence Panel	LA
Promote good mental health	Support whole-settings approaches to promoting mental wellbeing	LA & CCG
	Support schools (including alternative provision) and school nursing to develop curricula on mental wellbeing and early identification	Public Health
	Develop workstream for the Council on children and young people's mental wellbeing and early intervention, coordinating interventions across children's settings (e.g. children's centres, schools, PRU, etc.)	CYP & EI steering group
	Explore the role of social media in violence, including in inciting violence and transmitting and replaying traumatic events	LA & MPS
	Increase understanding within the Council, CCG, and the community of the impact of ACEs and ways to improve family wellbeing	LA & CCG

	Review support available to parents whose mental health needs do not meet the threshold for clinical support	Children's & Adult's Services / Public Health / CCG
LAC	Review offer of support to care leavers at this critical transition point	Children's & Adult's Services
Relationships / Family-level interventions	Review current offer of support available to parents of children of all ages and their families, in a range of settings	Children's Services / Public Health
	Work with schools to develop RSE that is inclusive of vulnerability and exploitation, and of coercive relationships	Public Health / Education
Core life skills	Continue to work with schools and school nursing to develop modern and relevant PSHE lessons that emphasise and support emotional awareness	Public Health / Education

Transforming lives

Theme(s)	**Recommendation**	**Suggested owner**
Liaison & diversion	Continue to explore and take up opportunities to trial diversion programmes locally	Youth Offending Service
Support access to education & training	Review support for young people transitioning to secondary education and/or between mainstream and alternative provision	Children's Services / Education
Support identified health needs	Continue to promote and improve uptake of Healthy Young People (HYP) within schools and youth settings to improve access for young people to substance misuse and sexual health support services	Public Health
	Review parental health offers, including pathways into parental mental health and adult substance misuse services	CYP MH Steering Group / Children's Services
	Ensuring strong links between young people's services and young people in alternative provision or being home-schooled	Education / All
Identify and support children at risk	Ensure schools have clear safeguarding pathways and are able to identify and appropriately refer at-risk children	Children's Services / Education
	Ensure a common language around safeguarding is used by parents, schools, and services so that parents are able to identify when a child is at risk / vulnerable and to understand where and how to seek support	Children's Services / Education
	Work with schools to develop RSE that is inclusive of vulnerability and exploitation, and of coercive relationships	Public Health
	Continue with Keeping Families Strong approach, ensuring sustainability and empowerment of families	Children's & Adult's Services
Peer mentoring	Continue to support peer mentoring initiatives, particularly as part of rehabilitation	YOS

Cross-cutting recommendations

Theme(s)	Recommendation	Suggested owner
Coordination	Develop clear governance pathways for SYV work streams across the Council, as per the Southwark Extended Learning review	Southwark Safeguarding Children's Board
	Develop a directory of services and interventions in place to prevent youth violence (primary, secondary, and tertiary prevention), including Council and VCS initiatives. This directory should be made publically available to improve the accessibility of referrals and should be used as the support offer underpinning the forthcoming community harm and exploitation hub	Community Safety / All
Collaboration	Establish/identify a steering group to take forward recommendations from this JSNA and from the Southwark Extended Learning Review and Youth Violence Panel, ensuring the group is inclusive of a wide range of Council department as well as members from the VCS	ELR board / All
	Encourage steering group members to embed an identification of vulnerable children and young people into all policies	All
	Continue with the wide range of activities currently ongoing to provide early intervention, prevent youth violence, and support those affected	All
Data sharing	Continue to improve data sharing amongst departments involved in serious youth violence and vulnerability, to ensure a shared, complete vision for the borough	All
Dissemination	Develop a communication plan to disseminate the findings of this report more widely alongside reports on the Community Crime and Exploitation Hub and narrative of vulnerability, which will be presented to Cabinet in December 2019	Public Health / Community Safety

APPENDICES

No.	Title
Appendix 1	The Southwark public health approach to serious youth violence prevention

AUDIT TRAIL

Cabinet Member	Cllr Evelyn Akoto, Community Safety and Public Health	
Lead Officer	Kevin Fenton, Strategic Director of Place and Wellbeing	
Report Author	Talia Boshari, Public Health Policy Officer) Kirsten Watters, Consultant in Public Health) Caroline Thwaites, Assistant Director Community Safety & Partnerships	
Version	Final	
Dated	6 November 2019	
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	Yes	Yes
Date final report sent to Constitutional Team		6 November 2019

The Southwark public health approach to serious youth violence prevention

Southwark's Joint Strategic Needs Assessment

Healthcare Public Health Team

Southwark Public Health

October 2019

GATEWAY INFORMATION

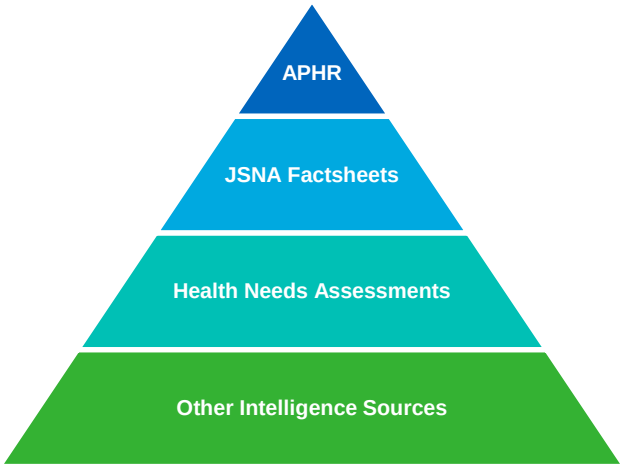
Report title:	**The Southwark public health approach to serious youth violence prevention**
Status:	Public
Prepared by:	T Boshari
Contributors:	Nora Cooke-O'Dowd, Samantha Field, Chris Williamson, Kelly Wilson, Luton Sinfield, Javier Montoya
Approved by:	K Watters & C Thwaites
Suggested citation:	The Southwark public health approach to serious youth violence prevention. Southwark's JSNA. Southwark Council: London. 2019.
Contact details:	publichealth@southwark.gov.uk
Date of publication:	29 October 2019

Health Needs Assessments form part of Southwark's Joint Strategic Needs Assessment process

BACKGROUND

The Joint Strategic Needs Assessment (JSNA) is the ongoing process through which we seek to identify the current and future health and wellbeing needs of our local population.

- The purpose of the JSNA is to inform and underpin the Joint Health and Wellbeing Strategy and other local plans that seek to improve the health of our residents.
- The JSNA is built from a range of resources that contribute to our understanding of need. In Southwark we have structured these resources around 4 tiers:



Tier I: The Annual Public Health Report provides an overview of health and wellbeing in the borough.

Tier II: JSNA Factsheets provide a short overview of health issues in the borough.

Tier III: Health Needs Assessments provide an in-depth review of specific issues.

Tier IV: Other sources of intelligence include Local Health Profiles and national Outcome Frameworks.

- This document forms part of those resources.
- All our resources are available via: www.southwark.gov.uk/JSNA

CONTENTS

Young people are increasingly involved in serious violence and are disproportionately affected by knife crime

INTRODUCTION

While overall crime in England has reduced substantially over the past 20 years (as captured by the Crime Survey for England & Wales), the incidence of less frequent, higher impact crimes (serious violent offences) has increased.[1,2]

- Police-recorded homicides have increased over the last four years, excluding victims of terrorist attacks[2]
- Police-recorded offences involving a knife / sharp instrument have increased by 8% over the last year[2]

Most of these lower-volume higher-harm incidents of violence tend to be concentrated in metropolitan areas, such as London.

- Since October 2017 in London, police have recorded a monthly downward trend in knife crime but an increase in the highest level of harm: 81 knife-related homicides were recorded in 2017[3]
- Across London, nearly half of all victims and offenders of knife crime are under 25[3]

This is a particularly pertinent issue in Southwark, which currently experiences the fourth highest volume of knife crime among all London boroughs.[5]

Data on violent crime reveal increasing involvement of young people as both victims and perpetrators of violence.

- Nationally and locally, drug supply and country lines business models are in operation and are a strong driver of violence[1,6]
- These models are built upon the exploitation of vulnerable children and adults

References

1. Home Office (2018) Serious Violence Strategy
2. Office for National Statistics (2019) Crime in England and Wales: year ending March 2019
3. MOPAC (2018) MOPAC Evidence & Insight . Knife crime – what we know…
4. Stephen Douglass (2018) 'Overview of Youth Violence and Knife Crime in Southwark' *Southwark Youth Violence Panel meeting 13 December 2018* Southwark Council, London
5. House of Commons (2019) Home Affairs Committee: Serious youth violence. Sixteenth report of session 2017-19
6. Violence and Vulnerability Unit (2019) Southwark Extended Learning Review

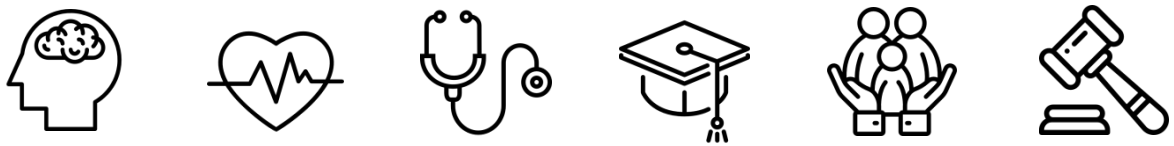
Violence is a manifestation of wider issues; prevention must consider a person's environmental context

INTRODUCTION

Serious youth violence (SYV) is a complex and multifactorial manifestation and symptom of wider issues.

- The places in which young people live and grow have an important role in determining their risk of vulnerability and involvement in violence and there is a strong inequalities gradient, with the most disadvantaged being most likely to be at risk
- Young people involved in / at risk of becoming involved in violence are, principally, vulnerable. In looking to support and safeguard these young people, their wider relationships and environment must be considered (contextual safeguarding)
- Involvement with and exposure to violence has significant negative impacts on a young person's emotional wellbeing as well as physical health

Beyond the individuals affected, SYV carries a high cost to health and social care, education, police, and the criminal justice system.



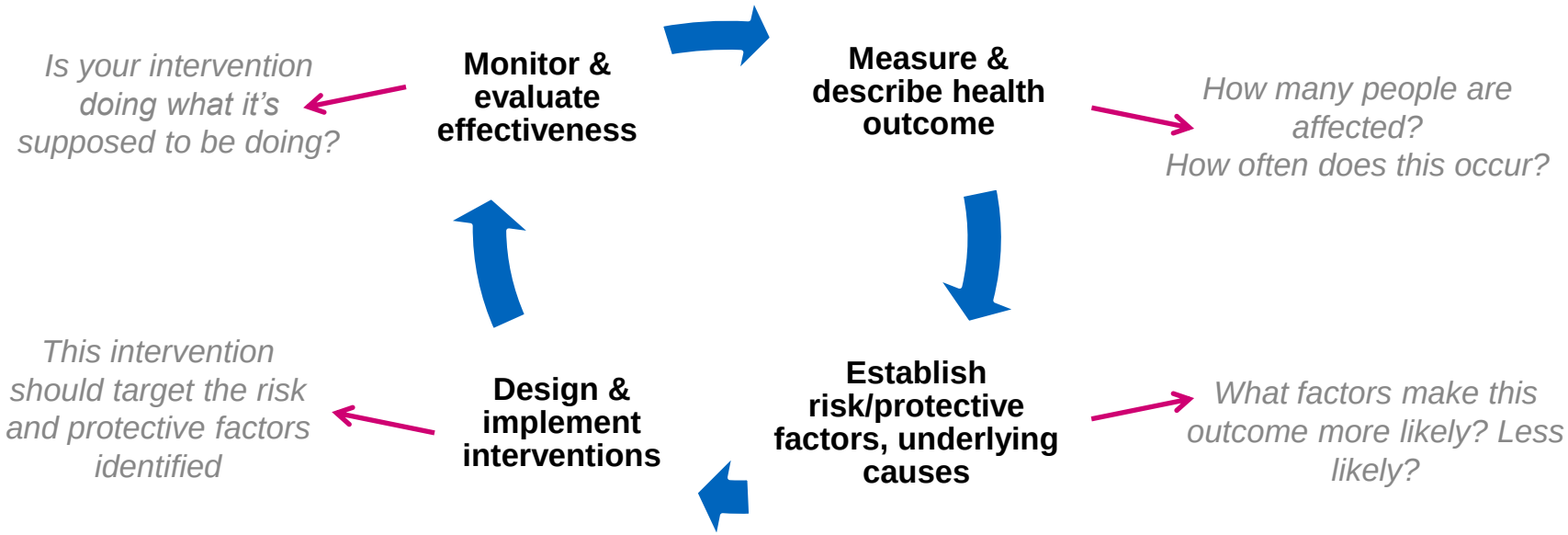
Violence is increasingly considered a public health issue with root cases that we can seek to address and prevent.

References
1. Home Office (2018) Serious Violence Strategy
2. MOPAC (2018) MOPAC Evidence & Insight . Knife crime – what we know…
3. House of Commons (2019) Home Affairs Committee: Serious youth violence. Sixteenth report of session 2017-19
4. Violence and Vulnerability Unit (2019) Southwark Extended Learning Review

The public health approach relies on an understanding of the epidemiology and robust monitoring and evaluation

PUBLIC HEALTH APPROACH

The public health approach to any issue relies on a thorough understanding of the data and epidemiology.



The public health approach is both upstream (looking at the root causes) and at scale (looking at the population, rather than an individual).

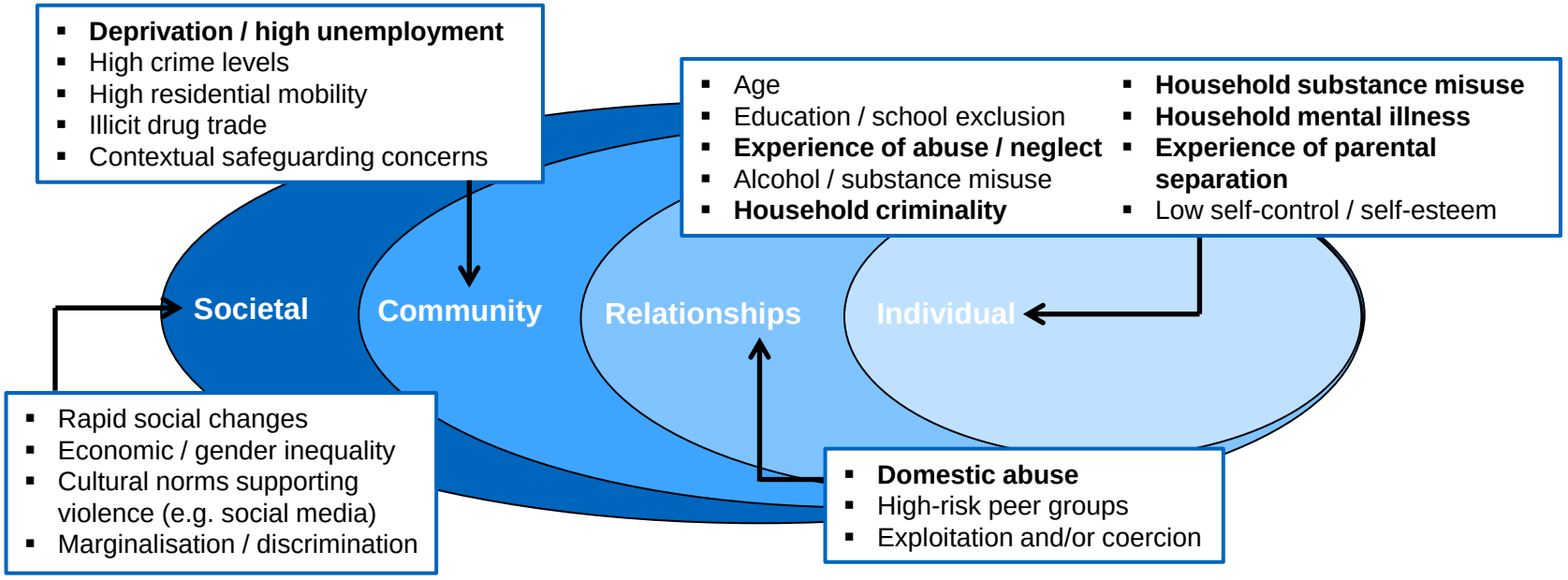
It supports a multi-faceted response and uses a framework to look at risk factors and identify areas for intervention that spans from the individual, to their relationships, the community they live in, through to society.

Violence is a public health issue with root causes that can be collaboratively addressed

PUBLIC HEALTH APPROACH

The public health approach considers a range of factors and experiences for their impact on a person's risk for violence, including adverse childhood experiences ('ACEs').

- The public health approach suggests that no single factor can explain a person's risk for violence
- Rather, it is the collection and multiplicity of factors at various levels that determines the likelihood of an individual's involvement



The range of factors that affect the likelihood of becoming involved in violence means that SYV requires a collaborative, partnership response.

References
1. WHO (2018) Violence Prevention Alliance. The ecological framework
2. Home Office (2018) Serious Violence Strategy

Return to *risk factors*

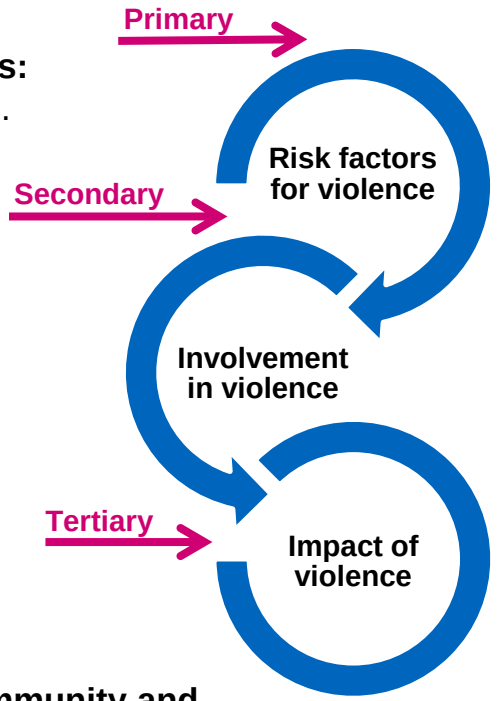
Violence is a public health issue with root causes that can be collaboratively addressed

PUBLIC HEALTH APPROACH

The public health approach to SYV is underpinned by a focus on prevention and importantly, partnership working.

When thinking about individuals and families, prevention occur at three levels:

1. Primary prevention: preventing the development of risk factors for violence e.g. by reducing adverse childhood experiences or supporting vulnerable parents/families to build self-efficacy
2. Secondary prevention: preventing violence before it occurs e.g. through community policing strategies or diversion programmes
3. Tertiary prevention: reducing the long term impact of violence, such as rehabilitation and reintegration of offenders and support for victims



These layers of prevention are focused on three target groups:

1. Universal: approaches aimed at groups or the general population without regard to individual risk e.g. curricula delivered in all schools
2. Targeted: interventions targeted at people with one or more risk factor
3. Specialist: interventions for those who have committed violence to prevent reoccurrence

Risk factors for and involvement in violence can also be mitigated by the community and environment in which people live. Preventative activities centred around place and the built environment should also be considered e.g. investing in and developing safer streets, estates, and living spaces, or building community cohesion.

These responses should be delivered collectively by Local Council, statutory health and social care services, youth offending service, police, probation, and by the range of voluntary providers working in our borough.

A growing literature strengthens the evidence for a public health approach to violence across London and England

PUBLIC HEALTH APPROACH

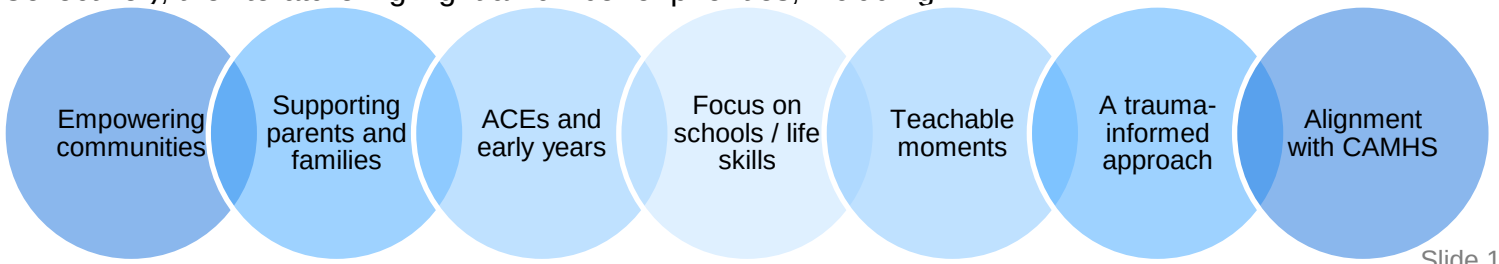
Glasgow Police established a Violence Reduction Unit (VRU) in 2005 in response to high levels of violent crime. Adopting a public health approach, the VRU was successful in reducing violence and has been recently been adopted nationally. In 2018, London established its own VRU.

- The VRU is credited for Scotland being largely unaffected by the rise in violence seen in England[1] However, its success must be balanced by against key differences with London: locally, crime is traditionally more widespread and authority is dispersed across 33 local authorities
- Furthermore, England is faced with the added dimension of county lines and criminal exploitation, which nationally impacts on drugs as a driver to violence

A growing literature in England has strengthened the evidence base for this approach: focusing on primary prevention by reducing risk factors and promoting protective factors across the life course.

- Department of Health (2012) Protecting people, promoting health: a public health approach to violence prevention for England
- Local Government Association (2018) Public health approaches to reducing violence.
- Youth Violence Commission (2018) Interim report
- Hobart V and Lindfield L (2018) Serious youth violence in London: developing a public health approach to violence prevention and reduction. Interim findings
- College of Policing (2019) Knife crime: evidence briefing
- Public Health England (2019) Collaborative approaches to preventing offending and re-offending by children

Collectively, the literature highlight a number of priorities, including:



References
1. London Councils (2019). Member Briefing: A public health approach to youth violence

This needs assessment aims to identify opportunities to prevent youth violence, taking a public health approach

AIMS & OBJECTIVES

Using the public health approach, this report aims to
- **clarify and understand the determinants and causal pathway towards violence in Southwark**
- **identify opportunities for prevention**
- **strengthen our partnership working**

The objectives of the project are to:
- Understand the **epidemiology of serious youth violence** (SYV) using a variety of data sources, including Metropolitan Police, Youth Offending Service, and London Ambulance Service data
- Understand **local drivers of violence** and **variation in risk** (geographic, ethnic, sex, age), considering violence from a public health, systems-wide perspective
- Outline **current offer** to prevent youth violence, using an ecological model and a public health approach
- Identify **opportunities to improve collaborative working** locally to provide holistic support
- Support the **evaluation and impact** of efforts to address SYV in Southwark

Definition of SYV in this report: all incidents of violence against the person involving young people aged 10-24 years.

The overlap between youth violence and wider vulnerability and exploitation (including drug trade) is well-established and recognised locally.[1] However, for the purposes of this report, the scope was limited to SYV. A wider needs assessment is underway on community harm and exploitation.

Note: analysing and understanding the epidemiology of SYV can only tell us so much and it is important to complement these data with meaningful engagement with professionals and members of the public who are involved in or who have been exposed to SYV. This JSNA does not include any engagement with stakeholders as this report is intended be read alongside the extensive engagement carried out as part of the Southwark Youth Violence Panel and Southwark Extended Learning Review.

References
1. Violence and Vulnerability Unit (2019) Southwark Extended Learning Review

CONTENTS

National committees were established in 2017 to identify opportunities to prevent SYV

NATIONAL POLICY CONTEXT

In 2017, the Youth Violence Commission - a cross-party initiative - was established to examine the root causes of youth violence across England, Scotland, and Wales.[1]

To identify opportunities to prevent youth violence, the commission engaged with a range of professionals and members of the public, including housing, communities, faith groups, and young people.

An interim report was published in July 2018 and identified six evidence-based areas of focus:

- Developing a national Public Health Model
- Focusing on early years and early intervention
- Reforming of youth services
- Improving support in schools
- Increasing employment opportunities
- Investing in community policing and reviewing the drugs approach

The final report is anticipated in 2019 and is expected to include proposed solutions to these six areas.

Also in 2017, an All-Party Parliamentary Group (APPG) on Knife Crime was set up to discuss:[2]

- Reasons for carrying knives
- Root causes and prevention
- Social media
- Policing, drugs, and county lines
- Sentencing and prisons

The APPG brought together MPs alongside 16 young people who had been convicted of, or a victim of, knife crime.

Young people developed proposals for how to support young people away from violence. These included:

- Tackling the underlying causes of violent crime in communities
- Managing the role of media in perpetuating myths around knife carrying, and of exploiting vulnerable young people
- Schools providing better support to young people who are at risk of becoming involved in violence
- The importance of rehabilitation and mentors in supporting young people out of violence

References
1. Youth Violence Commission (2018) Interim Report
2. Smith N and Hughes T (2019) All-Party Parliamentary Group on Knife Crime

A national Serious Violence Strategy was released in April 2018 but has since been criticised

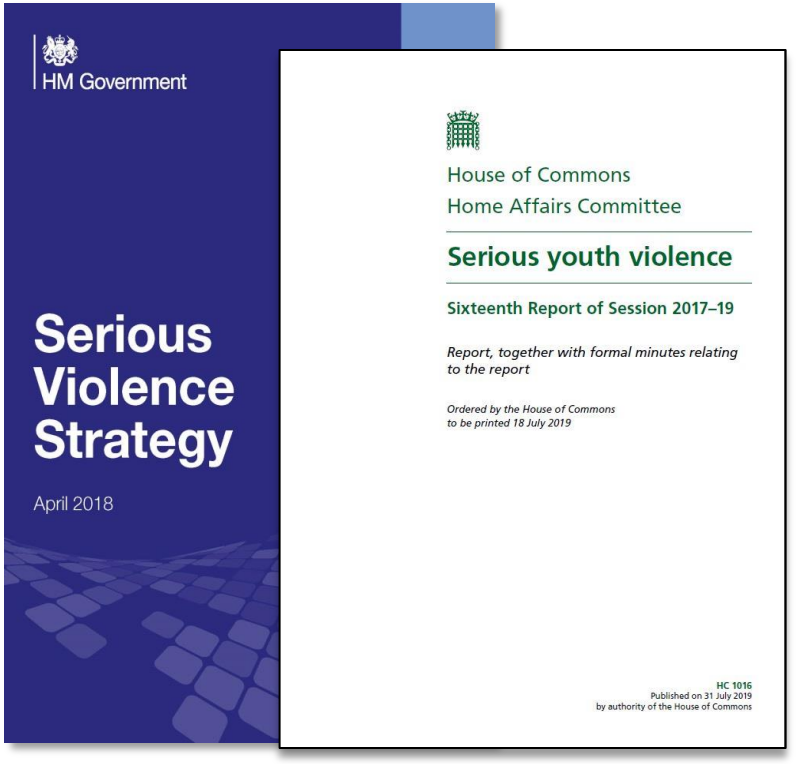
NATIONAL POLICY CONTEXT

The Home Office published a Serious Violence Strategy in April 2018 that encouraged a public health approach. The report covered four themes:[1]

1. Tackling county lines and misuse of drugs
2. Early intervention and prevention
3. Supporting communities and partnerships
4. Effective law enforcement and criminal justice response

While the Home Office report was welcomed for its inclusion and assessment of a broad range of factors contributing to youth violence, a 2019 Home Affairs Committee on serious youth violence[2] found it to have:

- Inadequately invested in understanding the epidemiology of SYV
- Neglected to include milestones or timelines for achieving progress
- Proposed solutions insufficient to address to the problem it outlined



References
1. Home Office (2018) Serious Violence Strategy
2. House of Commons (2019) Home Affairs Committee: Serious youth violence. Sixteenth report of session 2017-19

A multi-agency violence reduction unit was established in London in December 2018

REGIONAL POLICY CONTEXT

Local enforcement strategies are set out in the 2017-2021 MOPAC Police and Crime plan.[1] This was followed closely by the London Knife Crime Strategy[2] in response to the particular increase in knife crime with injury locally; action was pledged against the following priorities:

- Targeting lawbreakers
- Offering ways out of crime
- Keeping deadly weapons off our street
- Protecting and educating young people
- Supporting victims of knife crime
- Standing with communities, neighbourhoods, and families against knife crime

In December 2018, the Mayor of London launched a new violence reduction unit (VRU), following the successful model in Glasgow.

- The VRU will expand on the 2017 Knife Crime Strategy to cover four aspects of violence: domestic violence, violence against women and girls, homicide, and serious youth violence
- Membership consists of varied partners including the Mayor, health, education, probation, police, local authority, and representatives from the community
- Extensive community and professional engagement is ongoing and an operating model is anticipated by April 2019

References

1. Greater London Authority (2017) A Safer City for All Londoners. Police and Crime Plan 2017-2021
2. Greater London Authority (2017) The London Knife Crime Strategy
3. Laurence R (2018) *DRAFT Violence Reduction Unit Terms of Reference.* 29 October 2018. Violence Reduction Unit Partnership Reference Group. London
4. Abrams L (2019) *VRU Delivery Model Development.* 22 January 2019. Violence Reduction Unit Partnership Reference Group. London

Southwark has prioritised reducing youth violence across the Council and engaged with local communities

LOCAL POLICY CONTEXT

Within Southwark, local efforts to address knife crime and serious youth violence are consolidated within the Community Safety Partnership Knife Crime and Serious Violence Plan 2018/19. There are four strategic aims:

Protection of life — Reduction in youth violence — Bring offenders to justice — Support victims and witnesses

The action plan is led by senior officers at Southwark Council, police, probation, Education, and the fire brigade, recognising the complex multi-stakeholder environment in which youth violence exists.

December 2018 saw the inaugural meeting of the first Southwark cross-party panel on youth violence.

Over the course of six sessions, the panel sought evidence from a range of community members, service providers, and officers to build a picture of youth violence in Southwark and inform the Council's response.

Final recommendations were agreed in May 2019 and were categorised under five themes:

1. Early years and education
2. Mental health and the public health approach
3. Role models and parents/carers
4. Criminal justice and policing
5. Youth and community services

References

1. Councillor Evelyn Akoto (2019) 'Report and Recommendations of the Southwark Serious Youth Violence Panel' *Southwark Youth Violence Panel meeting 13 December 2018* Southwark Council, London

An extended learning review identified exemplary practice in tackling SYV but a complex partnership landscape

LOCAL POLICY CONTEXT

In February 2019, Southwark's Safeguarding Children's Board commissioned an Extended Learning Review (ELR) by the Home Office Violence and Vulnerability Unit.[1]

- Senior strategic officers, middle management, and practitioners from over 40 Council and voluntary & community sector organisations were interviewed

The ELR highlighted exemplary examples of good practice but also challenges/barriers to improvement:

Strong leadership	**Good interventions & initiatives**	**Reactive, overlapping efforts**
Progressive understanding of vulnerability	**Lack of ownership over youth violence**	**Cluttered, complex partnership landscape**

Recommendations from the report are extensive and suggested to be captured within a framework and a public health approach.

References
1. Violence and Vulnerability Unit (2019) Southwark Extended Learning Review

CONTENTS

Southwark young people are more diverse and more deprived than the general population

DEMOGRAPHICS

Approximately 54,400 young people aged 10-24 years are estimated to live in Southwark, 17% of our population. Our adolescents are more deprived and ethnically diverse than Southwark residents of other ages, which is important to consider when looking at the challenges and risk factors they face or when looking to import initiatives from elsewhere.

More of our adolescents live in our deprived areas than the general population.

- This difference is most marked in adolescents aged 10-17 years: 45% live in the most deprived quintile (20%) nationally compared to 38% overall
- 25% of children under 16 years are from low income families

Figure 1: Population by national deprivation quintile, 2017[2]

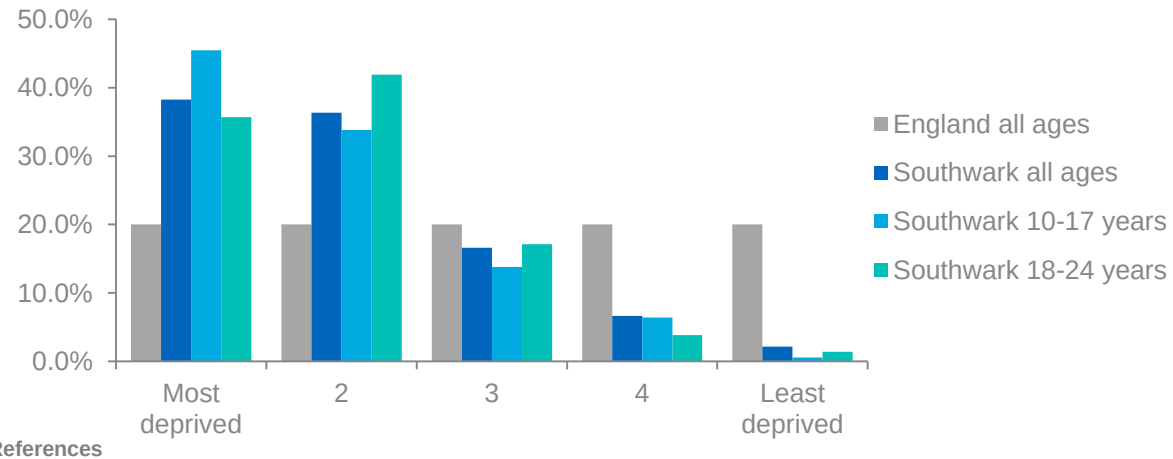


Table 1: Mid-year resident population estimates by single year of age in Southwark, 2017[1]

Age	Male	Female	Total
10 years	1800	1700	3500
11 years	1600	1600	3200
12 years	1700	1600	3200
13 years	1500	1400	2900
14 years	1400	1400	2900
15 years	1500	1300	2800
16 years	1400	1400	2800
17 years	1500	1400	2900
18 years	1500	1500	3000
19 years	1600	1700	3400
20 years	1700	2100	3800
21 years	2000	2200	4200
22 years	2200	2400	4600
23 years	2400	2700	5100
24 years	2700	3000	5700

Note: numbers may not tally due to rounding

References

1. GLA 2016-based housing-led ethnic group projections
2. ONS Mid-2017 population estimates for lower super output areas in England and Wales

Southwark young people are more diverse and more deprived than the general population

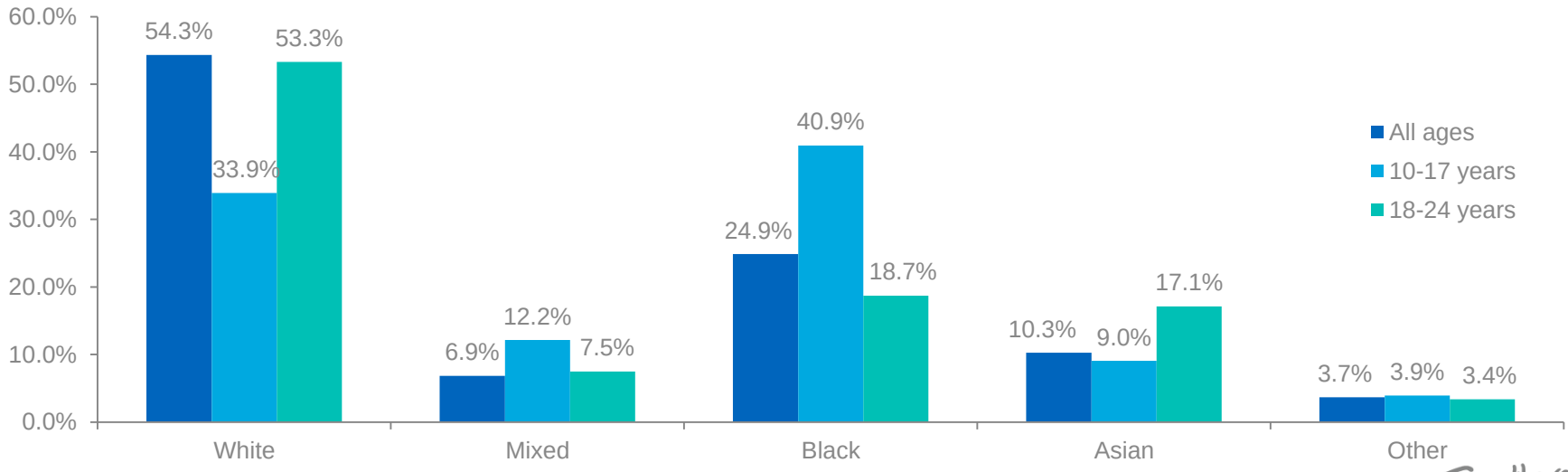
DEMOGRAPHICS

Southwark is a diverse borough with residents from a wide range of ethnicities and backgrounds. Over 120 languages are spoken, with just over 1-in-10 households having no members who speak English as a first language.

- Diversity varies markedly across age groups. Southwark young people are more diverse than our general population (Figure 2)
- Our school age population of young people (aged 10-17 years) is particularly diverse: almost twice as many young people are from a Black ethnic background than in the general population and in older adolescents

The demographics of Southwark young people differ from that of England and London and should be considered when translating interventions or initiatives to a local settings.

Figure 2: Ethnic diversity among adolescents in Southwark, 2016[1]



References
1. GLA 2017-based housing-led ethnic group projections

CONTENTS

A variety of datasets come together to develop the picture of youth violence in Southwark

EPIDEMIOLOGY

Over the past three years (15/16 – 17/18), there have been nearly 100,000 police-recorded crimes in Southwark.

- Of these, about a quarter (23.4%) were violence against the person
- Young people were involved in almost half (40%) of all incidents of VAP over this period

However, not all crimes are reported to the police: regional police forces in England suggest only 40% of violence is known to police.

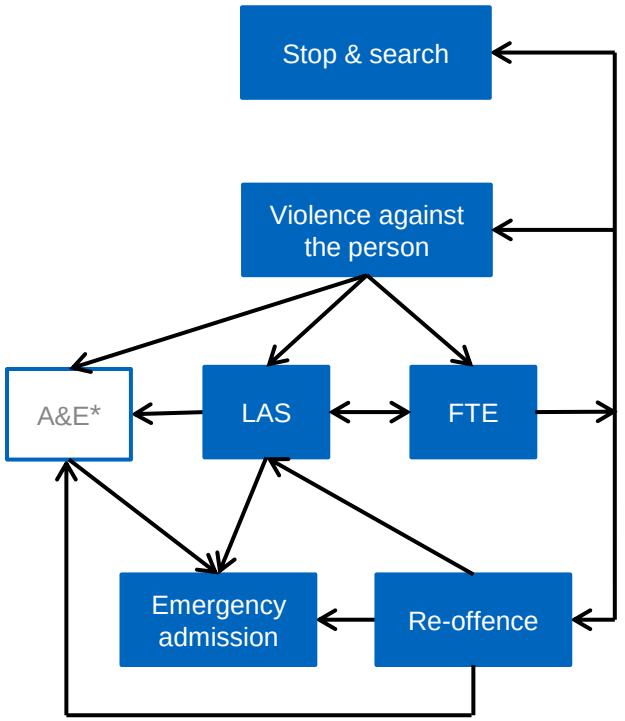
- Therefore to look only at police-recorded crime would underestimate the incidence of violence
- It would also underestimate the burden of violence as it accounts for perpetrators but not victims of violence. Though, it is broadly acknowledged that there is overlap between these two cohorts and that often, perpetrators have themselves been victims of violence

To develop a holistic picture of youth violence, a number of other datasets have been considered in tandem.

Police: data were available for stop & search and VAP, alongside Metropolitan Police Service public dashboards. A portion of people stop & searched will go on to receive an offence and be recorded as a first-time entrant to the youth justice system (FTE). Victims and perpetrators of VAP may be FTEs and/or come into contact with health services.

Health: some victims may report directly to health services and not involve police. Data were available for London ambulance service (LAS), A&E, and emergency hospital admissions. However, recording of A&E data is poor and largely incomplete and therefore not included in this analysis.

Youth Offending Service: data were available on first-time entrants to the youth justice system, re-offenders, and vulnerabilities in both cohorts.



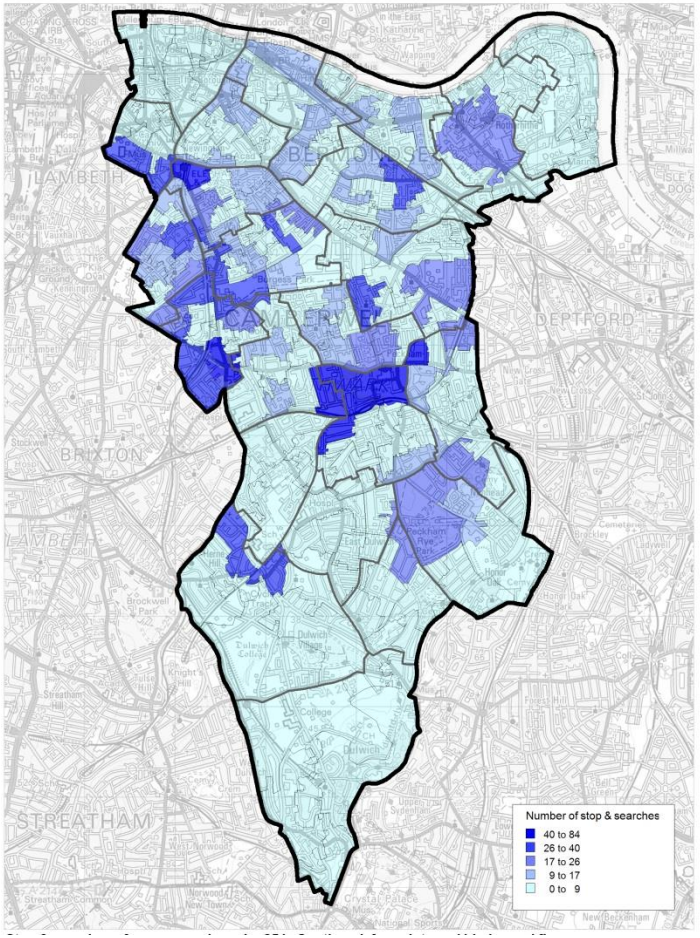
*Not included in analyses due to poor data quality

References
1. Metropolitan Police Service internal data. Crime data dashboard
2. S Ibbotson (2015) Public health matters: preventing the disease of violence
3. Hobart V and Lindfield L (2018) Serious youth violence in London: developing a public health approach to violence prevention and reduction. Interim findings

Stop & searches disproportionately affect young people; this may be a their first contact with police

EPIDEMIOLOGY: STOP & SEARCH

Figure 3: Stop & searches of young people under 25 for points and blades and firearms by LSOA, 2017-18



Stop & search powers help the police to tackle crime. It's targeted and intelligence-led, and practiced on people who are suspected of being involved in crime. It can also act as a deterrent to criminal behaviour.

Stop & search can be viewed as a controversial tool and can be a formative experience with young people. For many, it will be their first encounter with the police and shape their impression of authority.

Use of stop & search depends heavily on political and community appetite and policies, and may increase following an incident. Its use and outcomes are monitored and a key part of the process includes engagement with the wider community.

Over the past year (2017-18), Southwark had the third highest number of stops among all London boroughs.[2]

Stops of young people (aged 10-24) in Southwark accounted for the majority (about 65%) of all stop & searches in the borough.[1]

- As of July 2018, Rye Lane, Camberwell Green, and North Walworth had experienced the most stops, accounting for 30% overall
- Significantly less stops were made for firearms compared to points and blades over the same period, likely due to firearms being less available

References

1. Metropolitan Police Service. Advice and information: Stop and search

2. Metropolitan Police Service internal data, January 2016 – July 2018

Stop & searches disproportionately affect young people; this may be a their first contact with police

EPIDEMIOLOGY: STOP & SEARCH

Looking specifically at stops for points & blades and for firearms, Southwark young people stopped are almost exclusively male (97.9% and 100% respectively) and over the age of 15.[1]

- While young people of black ethnicity account for about a third of our adolescent population, they represent two-thirds of those stop & searched by the police (Figure 5)

In Southwark, the number of stop & searches for points and blades among young people aged under 25 doubled from 2016 (605) to 2017 (1,206); by mid-year 2018, the 2017 sum had nearly been surpassed (Figure 4).[1]

The majority of stops for points and blades occur between 14:00-22:00,[1] though this is likely due to more young people being out of school over these hours, rather than any meaningful trend.

Figure 4: No. stop & searches for points & blades and firearms in Southwark, January 2016 – June 2018[1]

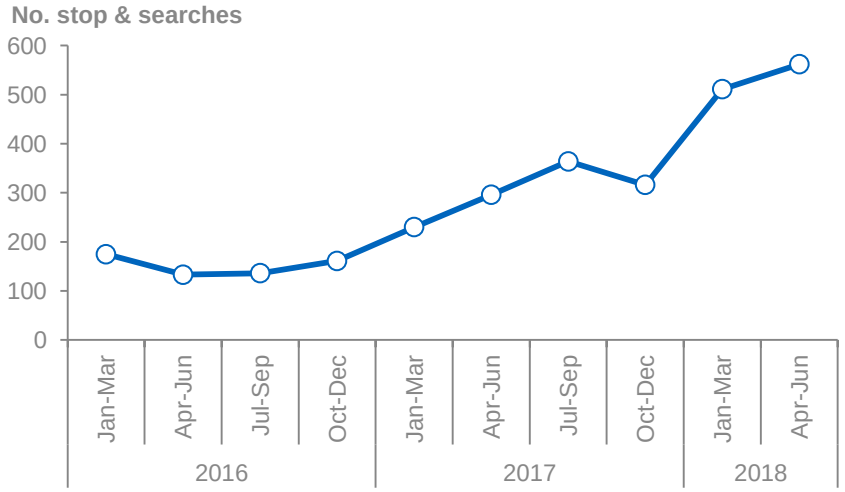
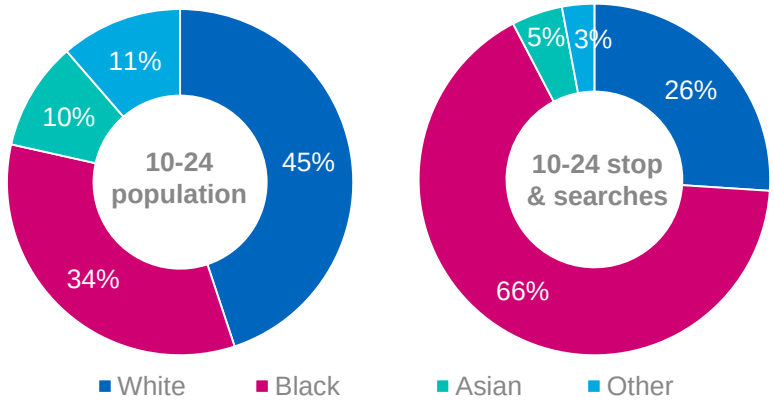


Figure 5: Stop & searches in Southwark by ethnicity, March 2018 – February 2019[2,3]



References

1. Metropolitan Police Service internal data, January 2016 – July 2018
2. Metropolitan Police Service. Stop and search dashboard
3. GLA 2017-based housing-led ethnic group projections

Stop & searches have increased year on year, with 20% resulting in further action

EPIDEMIOLOGY: STOP & SEARCH

Over the period for which data were available (January 2016 – June 2018), on average 20% of stops of Southwark adolescents for points & blades or firearms resulted in further action* being taken ('conversion').[1] However, this proportion declined from 2017 to 2018

Wards that experienced more stop & searches did not necessarily have a higher conversion (Figures 6 vs. 7).

- This may suggest stop & searches in these wards were less intelligence-led.
- However, conversion may be skewed by less selective stops following an incident (section 60 orders, the right to search people without suspicion)

The conversion proportion among young people in Southwark is slightly less than the conversion seen across all ages (29%).[2]

- Notably, stop & searches converting to action in London have increased substantially, from only 13% in 2012[3]

Figure 6: Stop & searches of young people for points & blades and firearms by ward, January 2016 – June 2018

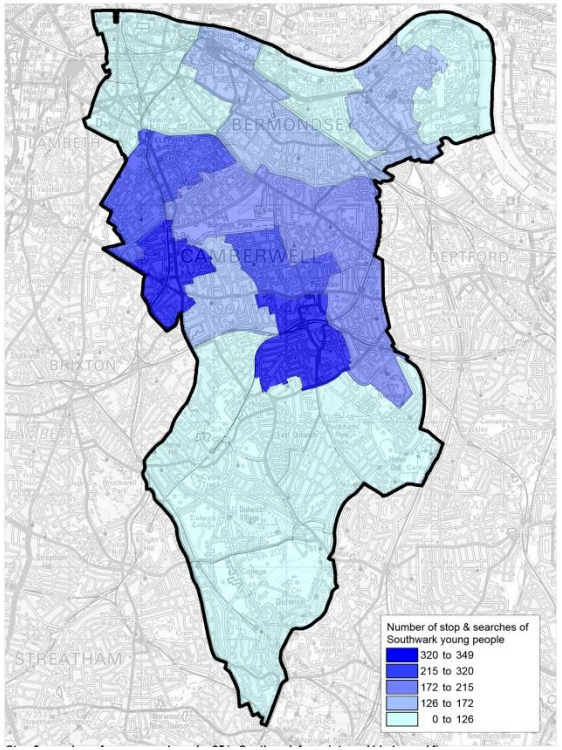
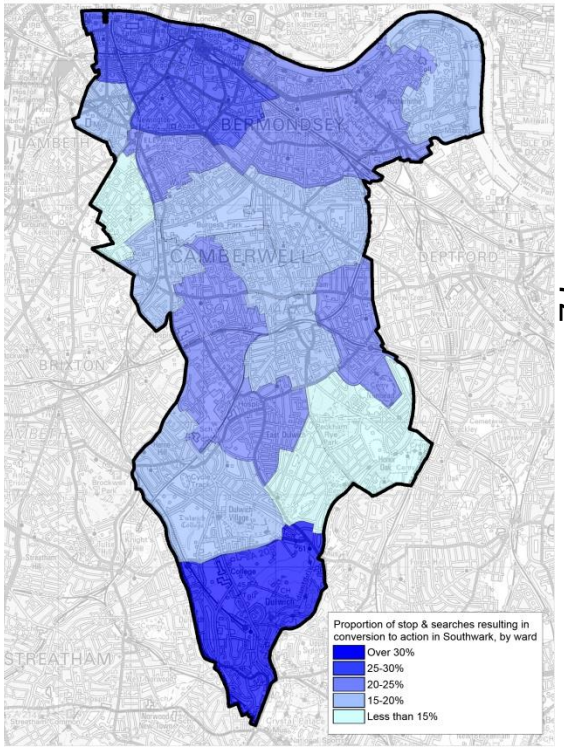


Figure 7: Conversions of stop & searches of young people for points & blades and firearms, January 2016 – June 2018



*Further action refers to any of the following outcomes: arrest, cannabis/khat warning, penalty notice, summons, community resolution, or caution

References

1. Metropolitan Police Service internal data, January 2016 – July 2018
2. Metropolitan Police Service. Stop and search dashboard
3. Greater London Authority (2017) The London Knife Crime Strategy

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Incidents of VAP in young people have decreased but the number of offences involving a weapon continues to rise

EPIDEMIOLOGY: VIOLENCE AGAINST THE PERSON

Violence against the person (VAP) is the most common offence type committed by Southwark young offenders.[1]

VAP encompasses a range minor offences (harassment, common assault) to serious incidents (grievous bodily harm, assault with injury).

- About 30% of offences committed by young people assessed by the Southwark youth offending service in 2017/18 were VAP – **double the proportion seen in 2013/14 (16%)[2]**

There has been little change in the number of incidents of VAP involving Southwark young people from 2015/16 – 2017/18.[3]

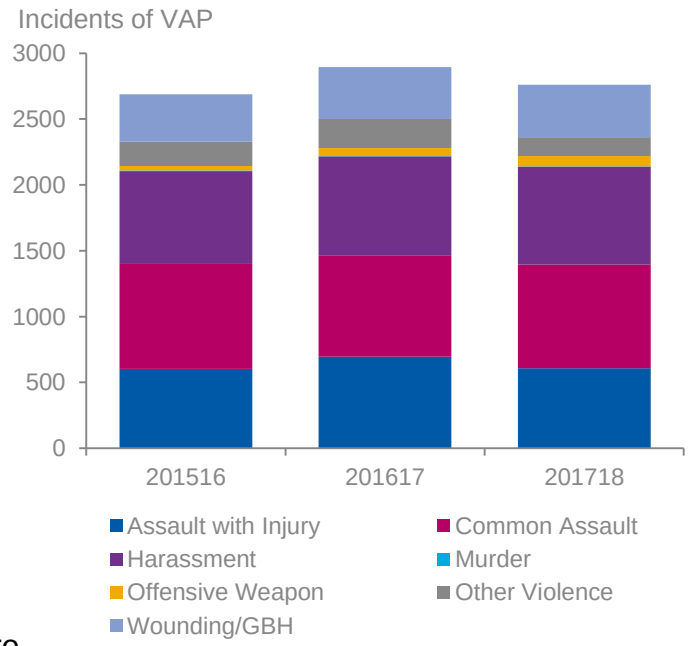
- Notably, the number of incidents involving an offensive weapon accounted for only 2.8% of all VAP in 2017/18
- However, this represented a **130% increase** from the number of adolescent offensive weapon incidents recorded two years prior (34 in 15/16 and 78 in 17/18)

In 2017/18, North Walworth and Rye Lane experienced the greatest number of incidents of VAP in young people.[1]

A 2018 analysis of youth violence in Southwark suggests that incidents involving young people predominantly occur after school hours, between 15:00-18:00.[2]

- While there was little difference in the gender of victims of youth violence as recorded by the police over the time period, suspects were disproportionately male (81%)[4]

Figure 8: Incidents of VAP in Southwark involving young people aged under 25 by offence type, 2015/16 – 2017/18



References

1. Southwark Youth Offending Service. Snapshot data of young people assessed using Asset Plus from October 2017 – September 2018.
2. MoJ and YJB for England and Wales (2019) Youth Justice Statistics
3. Metropolitan Police Service internal data, January 2016 – July 2018
4. Stephen Douglass (2018) 'Overview of Youth Violence and Knife Crime in Southwark' *Southwark Youth Violence Panel meeting 13 December 2018* Southwark Council, London

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southwark.gov.uk

The number of LAS call-outs to young victims of assault has been relatively stable but the age cohort is changing

EPIDEMIOLOGY: AMBULANCE CALL-OUTS

London Ambulance Service (LAS) data capture incidents of violence requiring emergency health support, including some incidents that may never be reported to the police.

There have been no major fluctuations in the number of LAS call-outs for assault victims in Southwark, or the proportion of call-outs for under-25s since 2015: (131 in 2015/16 – 148 in 2017/18).[1]

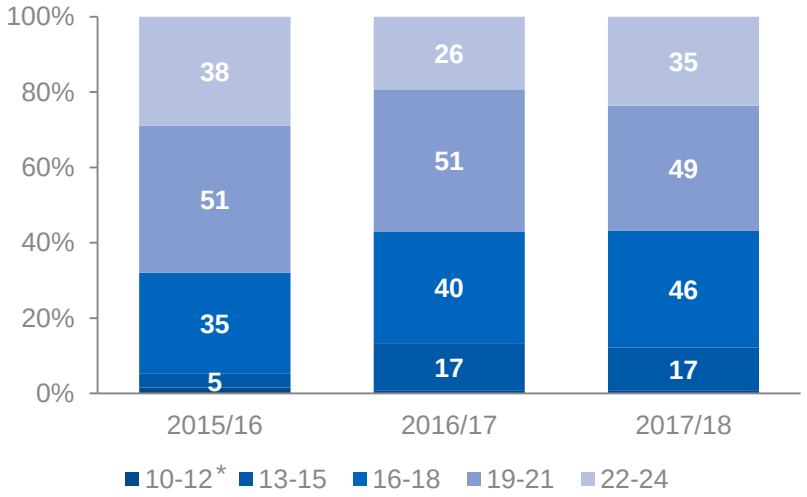
- Approximately one-in-three call-outs is for a victim aged under-25 years
- Contrary to analyses of police-recorded data, males have consistently accounted for about 80% of victims as recorded in health data

However, victims are increasingly younger, with a growing proportion comprising of 13-18 year olds.

There is significant variation in timing of LAS call-outs by time, day, and month, but this trend is seen equally among under- and over-25s.

- Call-outs over the 2015-2018 period tended to increase after 6pm, reaching a peak from 10pm-midnight
- In both age cohorts, call-outs were highest over the summer months from May to September
- Most call-outs occurred over the weekend

Figure 9: Age breakdown of under-25 assault victims, 2015/16-2017/18



*(n≤ 2, not shown)
n = number of events by age group

Methodology: LAS data on call-out incidences from 2015/16-2017/18 were analysed, including only those that had an age recorded. Incidents that included a code for 'assault' were analysed, removing those which specified sexual assault. Those under-25 were compared with those over-25 years of age. These data were limited by a lack of consistent coding and possible inaccurate demographic coding, especially in severe cases.

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References

1. Local Ambulance Service (LAS) internal data, January 2015- December 2018

Most LAS call-outs in young people result in the victim being taken to hospital and, increasingly, to a trauma centre

EPIDEMIOLOGY: AMBULANCE CALL-OUTS

The vast majority (80%) of under-25 victims of assault who call the LAS get taken to hospital.

- Most are delivered to A&E as a non-trauma call, however, **20% are taken to a major trauma centre** (MTC) – Kings or Royal London Hospital – used for more severe injury
- Seven percent have less serious injuries and are taken to an urgent care centre

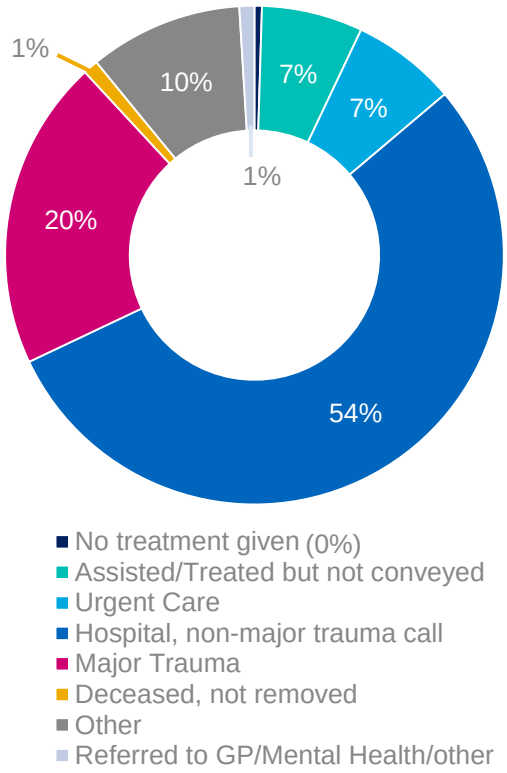
There has been an increase in the proportion of young people being taken to a MTC.

- Rates of MTC usage have risen from 18% in 2015/16 to 23% in 2017/18

Findings may suggest that the severity of injury among young victims of assault in Southwark is increasing.

- However, a change in major trauma criteria (e.g. reducing the threshold for sending a victims to a MTC) might also be driving these findings

Figure 10: Destination of LAS after call-out in under-25s in Southwark, 2015/16 - 2017/18



Methodology: LAS data on call-out incidences from 2015/16-2017/18 were analysed, including only those that had an age recorded. Incidents that included a code for 'assault' were analysed, removing those which specified sexual assault. Those under-25 were compared with those over-25 years of age. These data were limited by a lack of consistent coding and possible inaccurate demographic coding, especially in severe cases.

References

1. Local Ambulance Service (LAS) internal data, January 2015- December 2018

Emergency admissions for assault with a sharp object have not decreased in line with admissions for other assaults

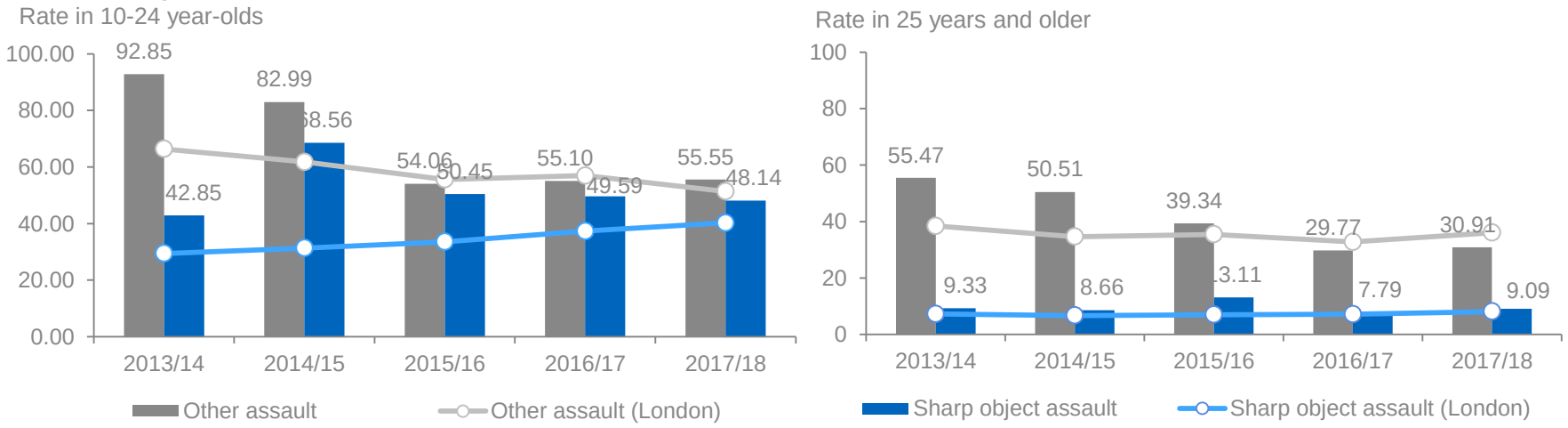
EPIDEMIOLOGY: EMERGENCY ADMISSIONS

Some incidents of SYV will result in hospital admission. These may have come from ambulance services or they may have presented directly to A&E and been admitted – a cohort that may not have been captured in police or LAS datasets. Emergency admissions exclude incidents of SYV (e.g. knife assaults) that are either not serious enough to merit hospital admission, or that result in immediate homicide.

Southwark has a high number of emergency admissions for assault compared to London, particularly for assault with a sharp object (ASO). The rate of admissions in Southwark has been consistently higher than the London average, though the regional rate is increasing.

- Age-standardised rates of admissions due to ASO are over 5x higher in young people than in those aged ≥25

Figure 11: Rate of emergency admissions for assault with and without a sharp object in Southwark per 100,000, 2013/14 – 2017/18[1] with London comparator



Methodology: HES data from financial year 2013/14 to 2017/18 were analysed, looking at incidents that included a code for 'assault'. Rates for those aged 10 to 24 were compared with those aged 25 and over. These data were limited by capturing only those cases that required hospital admission, and will therefore not account for incidents which didn't attend A&E, only attended A&E or died before reaching hospital.

References

1. Hospital Episode Statistics (HES) internal data, 06/04/2013 – 31/03/2018

Emergency admissions for assault with a sharp object have not decreased in line with admissions for other assaults

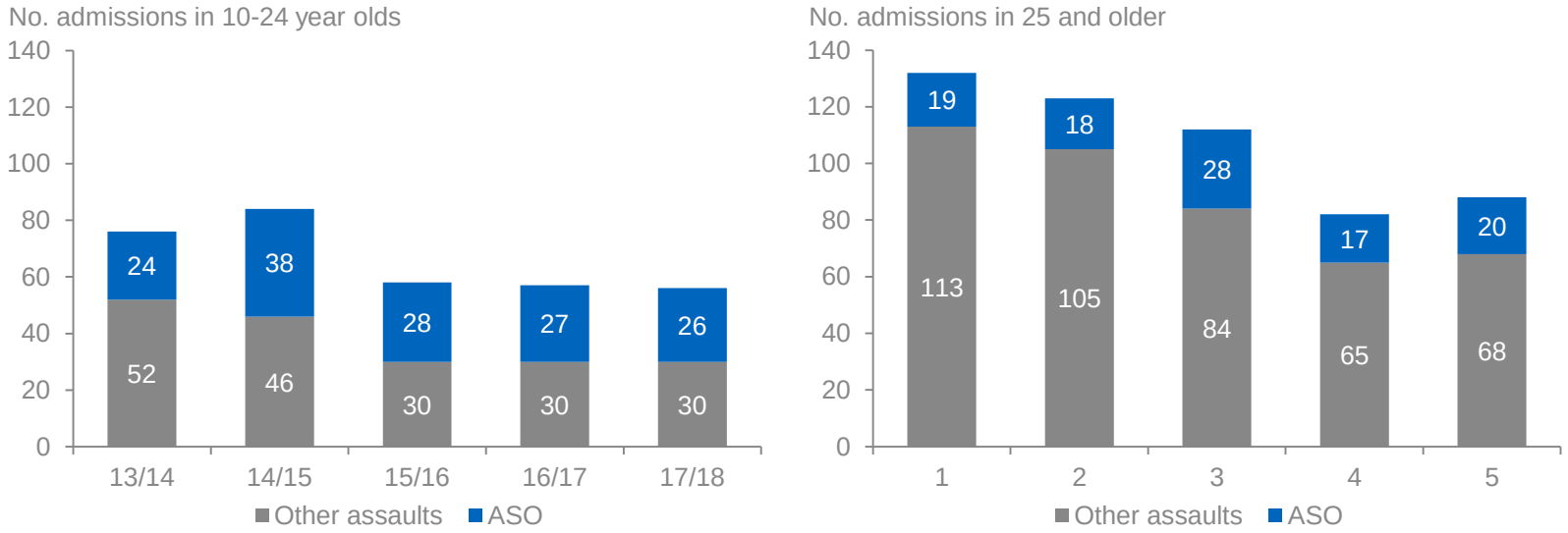
EPIDEMIOLOGY: EMERGENCY ADMISSIONS

While the overall number of emergency admissions for assault across all ages has decreased since 2013/14, the proportion of admissions due to ASO remains relatively stable. The majority of victims of ASO are adolescent.[1]

- Young people accounted for 40% of emergency admissions for assault overall in Southwark in 2017/18
- Fourty-six percent of these adolescent emergency admissions for assault in 2017/18 were for ASO, compared to only 23% in the adult population

Data on the absolute number of admissions for ASO (Figure 12) would suggest that the number of admissions for ASO involving young people has been relatively stable over the last five years.

Figure 12: Number of emergency admissions by proportion attributed to assault with and without a sharp object in Southwark, 2013/14 – 2017/18[1]



Methodology: HES data from financial year 2013/14 to 2017/18 were analysed, looking at incidents that included a code for 'assault'. Rates for those aged 10 to 24 were compared with those aged 25 and over. These data were limited by capturing only those cases that required hospital admission, and will therefore not account for incidents which didn't attend A&E, only attended A&E or died before reaching hospital.

References

1. Hospital Episode Statistics (HES) internal data, 06/04/2013 – 31/03/2018

The demographics of young people admitted for assault differs from the general adolescent population

EPIDEMIOLOGY: EMERGENCY ADMISSIONS

The most common reason for emergency admission for assault with a sharp object in young people is thoracic or abdominal injury.[1] These are likely to require surgical intervention.

The ethnic profile of young people admitted for assault is more ethnically diverse then the general adolescent population.

- Black and Other ethnic groups are particularly represented, suggesting further investigation into shared risk factors for involvement in violence to understand the inequality.

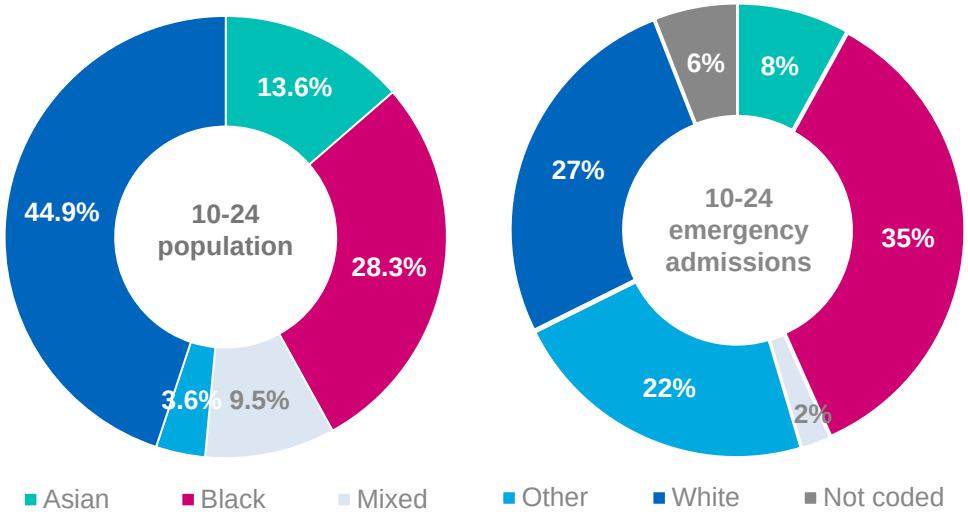
As with LAS call-outs, the majority (83%) of victims were male.

Most young people admitted were over the age of 16, however, <u>16% of victims</u> in 2017/18 were under 15 years old.

Seasonal and time trends also mimicked LAS call-outs.

- Peak admissions occurred over the summer months
- Highest rates of admission occurred over the weekend

Figure 13: Emergency admissions for assault by ethnicity in Southwark young people, 2013/14 – 2017/18[1]



Methodology: HES data from financial year 2013/14 to 2017/18 were analysed, looking at incidents that included a code for 'assault'. Rates for those aged 10 to 24 were compared with those aged 25 and over. These data were limited by capturing only those cases that required hospital admission, and will therefore not account for incidents which didn't attend A&E, only attended A&E or died before reaching hospital.

References

1. Hospital Episode Statistics (HES) internal data, 06/04/2013 – 31/03/2018

Southwark Council
southwark.gov.uk

Southwark has a high number of FTE to the youth justice system; these are largely young, BAME males

EPIDEMIOLOGY: FTE

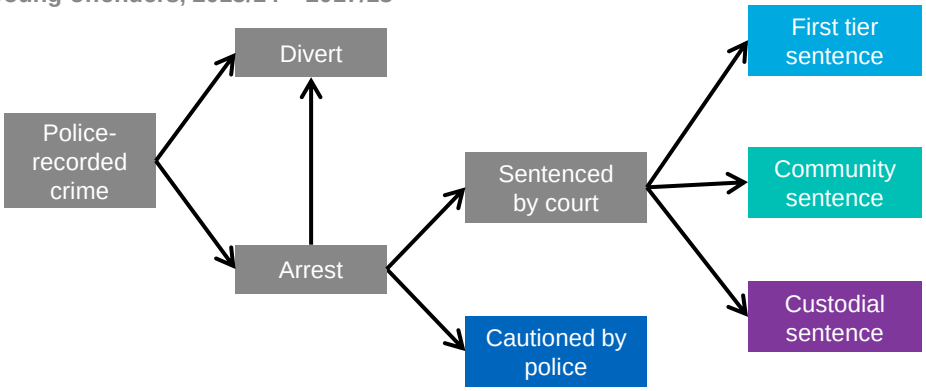
Young people aged 10-24 years who are found to have committed an offence will be supervised by either by the local youth offending service (YOS) (18 and under) or adult probation services (over 18s). Local authority-level data are not publically available for adult offenders. Therefore all subsequent slides pertain to those 18 and under only.

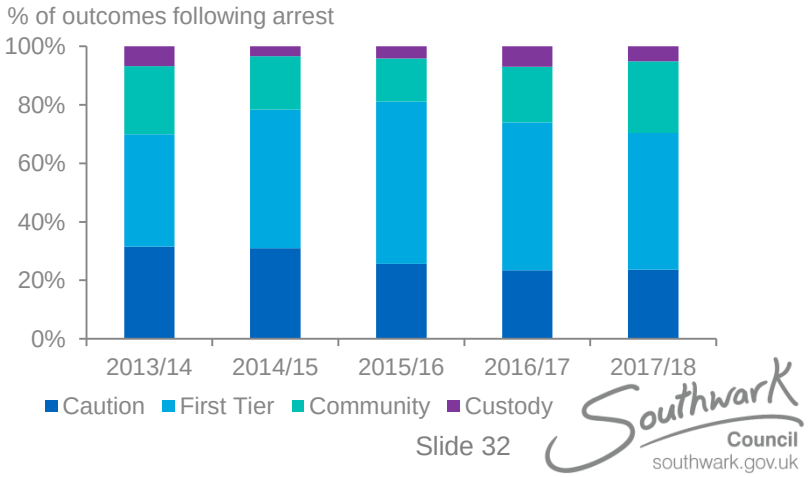
For young people who have committed an offence, there are a range of outcomes available. These should be both proportionate to the crime and effective at reducing re-offending.[1]

- Most offences are dealt with using an out-of-court disposal method
  - For minor offences, a youth caution / conditional caution is employed, or a 'first tier' penalty (discharge, fine, or deferred sentence)
  - More serious offences may require use of a community sentence (youth rehabilitation order), which sets additional limits and requirements on the young person's actions
- In only the most severe cases of offence is a young person served a custodial sentence

Cautions, first tier, community, and custodial sentences all result in the young person receiving a criminal record and being recorded as a 'first-time entrant' (FTE) into the youth justice system.

Figure 14: Youth sentencing pathway in England and outcomes among Southwark young offenders, 2013/14 – 2017/18[1]



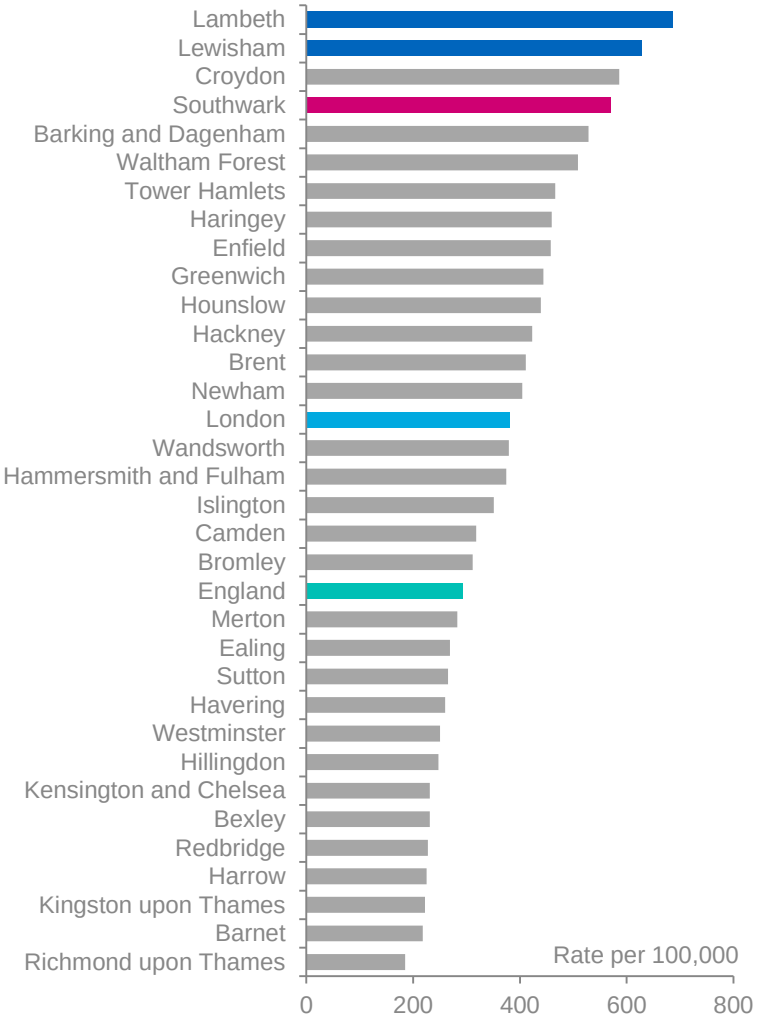


References
1. Ministry of Justice and YJB for England and Wales (2019) Youth Justice statistics

Southwark has a high number of FTE to the youth justice system; these are largely young, BAME males

EPIDEMIOLOGY: FTE

Figure 15: Rate of first-time entrants to the youth justice system in Southwark per 100,000, 2017[1]



Southwark has the fifth highest number of first-time entrants to the youth justice system (n=232 10-17 year olds in 2017/18) and the fourth highest rate of FTE (569.7 per 100,000) among all London local authorities.

More recent local data, however, indicate the rate of FTE has reduced and is now at its lowest rate ever (401 per 100,000).

FTE in Southwark are largely:[2]

- Male: on average 89% of FTE from 2013/14 – 2017/18
- BAME: on average 69.5% of FTE from 2013/14-2017/18
- Aged 15-17: on average 80% of FTE from 2013/14 – 2017/18

References
1. PHE Fingertips (2017) Public Health Outcomes Framework: Wider determinants of health
2. Ministry of Justice and YJB for England and Wales (2019) Youth Justice statistics: 2017 to 2018

Southwark has low rates of re-offending and of offences per re-offender

EPIDEMIOLOGY: REPEAT OFFENDERS / REPEAT VICTIMS

Despite high levels of FTE, Southwark has lower rates of re-offending* than the London and England average.

- About 45% of young people re-offend in the year following their conviction or release from custody
- Southwark also has the second lowest number of offences per re-offender within our statistical family group (1.48 per re-offender)
- The latter is largely reflective of the work of the Southwark youth offending service to divert young people away from re-offending
- An in-depth analysis of re-offending is currently underway by the Southwark YOS

An analysis of local emergency admissions data revealed low but not insignificant numbers of young people admitted more than once over the last five years.

- Of the 331 young people admitted to hospital for assault between 2013-2018, eight were re-admitted within that period; six were re-admitted due to knife assault
- The average length of time between admissions was 315 days
- In light of the interplay between victims and perpetrators of violence, low numbers of re-admissions for assault suggests positive outcomes following treatment. However, it cannot account for young people repeatedly involved in violence but not making it to hospital, either due to decease or less serious wounding

*Re-offending is measured as a new offence 12 months after conviction or release from custody, that also results in a substantive outcome (i.e. cautions, first tier, community, and custodial sentences)

References
1. Southwark Youth Offending Service internal data
2. Hospital Episode Statistics (HES) internal data, 06/04/2013 – 31/03/2018

Southwark is home to high-risk peer groups recognised nationally; their rivalries are frequently publicised

EPIDEMIOLOGY: GANGS

Southwark has a historical presence of gangs and high-risk peer groups in the borough who are involved in crime and violence.

- These groups have a national profile and have been linked to serious assaults and homicides
- Gang rivalry is frequently publicised through public (e.g. YouTube) and semi-private (e.g. SnapChat) channels

As of July 2018, the Metropolitan Police Service gang matrix contained 68 Southwark young people, 13 of which habitually carry a knife.

- An additional 37 Southwark young people not in the gang matrix are also considered habitual knife carriers and 9 to habitually carry a firearm

References
1. Metropolitan Police Service internal data, January 2016 – July 2018

Violence tends to be concentrated in a small number of LSOA, many of which are among the most deprived

EPIDEMIOLOGY: SUMMARY

Data for 2017/18 indicate that incidents of violence and ambulance call-outs to victims were concentrated largely in the centre and North-East of the borough, which include some of Southwark's most deprived communities and also areas of urban nightlife.

This may suggest an association between deprivation and involvement in violence as both a perpetrator and a victim.

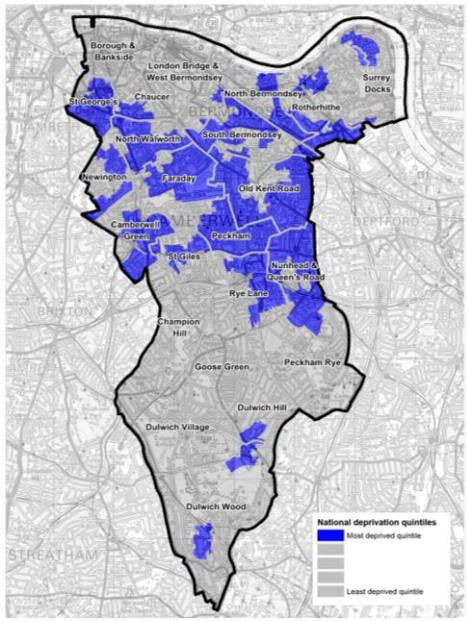


Figure 16: Indices of deprivation, 2015

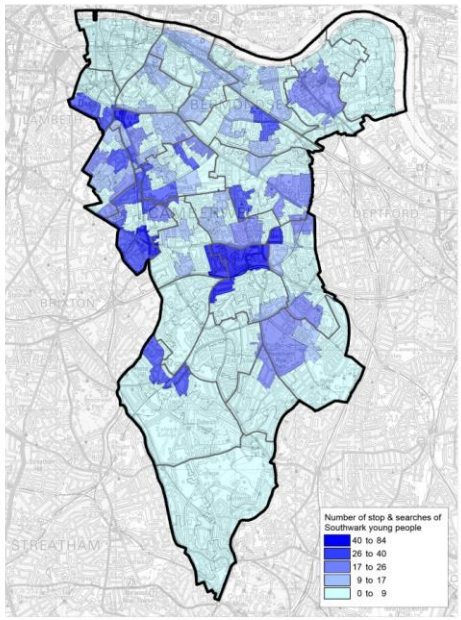


Figure 17: Stop & searches of young people for points and blades and firearms, 2017-18

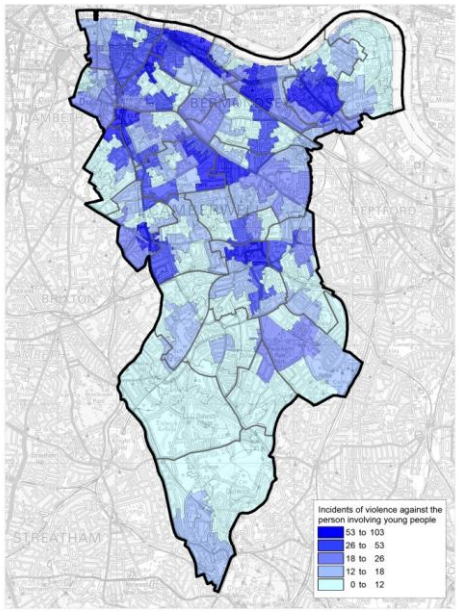


Figure 18: Incidents of violence against the person involving young people, 2017-18

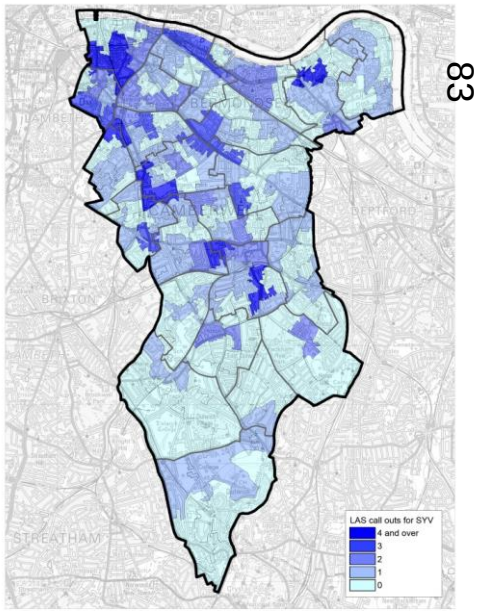


Figure 19: LAS call-outs for assault involving young people, 2017-18

References
1. Department for Communities and Local Government
2. Metropolitan Police Service internal data, January 2016 – July 2018

SYV in Southwark increasingly involves a sharp object and the age profile of those involved is getting younger

EPIDEMIOLOGY: SUMMARY

Demography

- Southwark has a large population of young people aged 10-24 years. Our adolescents are more deprived and more diverse than the general Southwark population.
- These conditions need to be considered when looking at risk of involvement in violence and they mean that interventions that work elsewhere in England or London, may need to be tailored locally.

Police data

- Southwark has the third highest number of stop & searches among London local authorities. Stop & searches disproportionally affect young people, males, and those of minority ethnic groups. In 14-20% of instances of stop & searches of Southwark young people, further action is taken.
- Violence against the person is the most common offence committed by young offenders in Southwark. Incidents of VAP involving Southwark YP have seen little change over the past three years but use of an offensive weapon has increased dramatically.

Health data

- There have been no major fluctuations in the overall number of LAS call-outs to young victims of assault over the last three years. However, the age profile of victims is increasingly younger.
- Emergency admissions for assault with a sharp object have not reduced in line with assaults overall and are over 5x higher in young people than in those aged over 25 years.

YOS data

- Despite high levels of first-time entrants to the youth justice system, Southwark has a low rate of re-offending compared to other London local authorities. Young people involved in the criminal justice system tend to be young males of BAME ethnicity.

Epidemiologic review suggests that incidents of assault involving young people have not dramatically increased of late, however, we are increasingly seeing involvement of a sharp object and of younger children. Black males are disproportionately represented in each dataset where ethnicity is available.

The data in this JSNA only reveal part of the picture of SYV; more is needed to develop a full understanding

EPIDEMIOLOGY: CAVEATS

While extensive efforts were made to collect data from a range of sources, it was not possible to include all datasets relevant to SYV and its root causes.

As outlined in the aims & objectives of this report, the scope of this JSNA is limited to SYV. The following datasets have not been included in this analysis but are expected to be covered by the forthcoming work on community harm and exploitation.

- Data pertaining to drugs, including exploitation, county lines-related convictions, convictions for possession or intent to supply, and others
- Data on robberies, which may or may not be drug-related
- Outcomes data for young people involved in pupil referral units or other forms of alternative provision

Furthermore, data are only available for young people in contact with services and therefore there will be many incidents that have not yet been brought to our attention through stop & searches or police/health-recorded incidents. Quantitative data on the degree of involvement and impact on women and girls in particular is less available.

References
1. Metropolitan Police Service internal data. Crime data dashboard
2. S Ibbotson (2015) Public health matters: preventing the disease of violence
3. Hobart V and Lindfield L (2018) Serious youth violence in London: developing a public health approach to violence prevention and reduction. Interim findings

CONTENTS

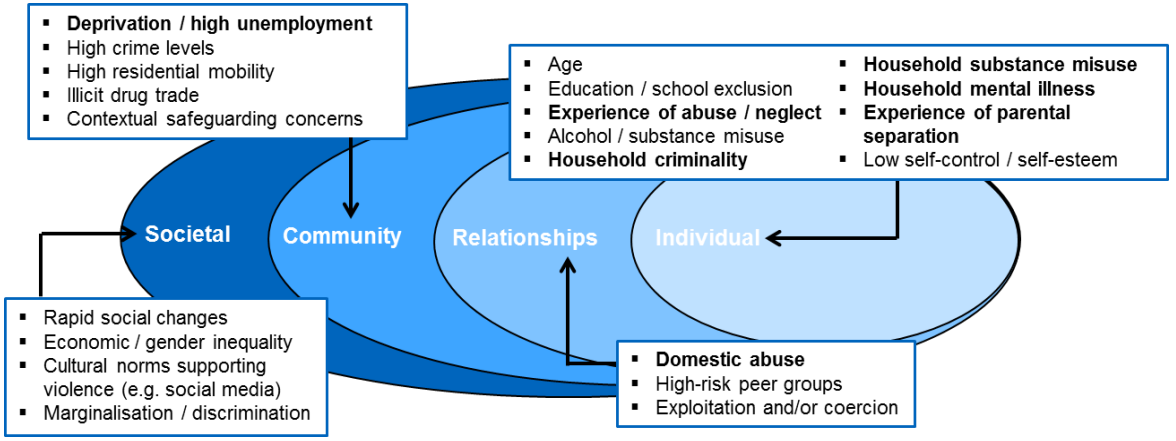
Risk factors prevalent among young offenders may shed light on where prevention and support should be focused

RISK FACTORS

As introduced on slide 8, there are numerous risk factors and vulnerabilities for involvement in violence, spanning individual, interpersonal, community, and societal domains.

There is considerable overlap between these factors and many are intrinsically linked.

Deprivation in particular tends to cluster with other risk factors, such as adverse childhood experiences. This in turn can make the development of protective factors to overcome adversity, more challenging.



It would not have been possible to discuss every risk factors in detail. Therefore a decision was made to focus on risk factors most commonly identified among Southwark young offenders:[1]

- Adverse childhood experiences
- Being a looked-after child, child in need status or subject to a child protection plan
- Having a special education need or disability
- Excluded / attendance issues at school
- Mental / physical health concerns

While we cannot say conclusively these are risk factors and not consequences of involvement in violence, they do build a picture of the vulnerabilities of this cohort and where we might focus our offers of prevention and support.

Moreover, it is important to note that data are only available on young people engaged in services. There are likely to be a number of vulnerable young people at risk of becoming involved in violence for which we have no data.

References
1. Southwark Youth Offending Service. Snapshot data of young people assessed using Asset Plus from October 2017 – September 2018

An estimated 9-10% of children aged 0-4 years in Southwark experience 4+ ACEs

RISK FACTORS: ACEs

Adverse childhood experiences (ACEs) are being increasingly recognised for their impact on life outcomes and behaviours.

ACEs are common: about half of all adults in England have experienced at least one. However, it is the multiplicity of ACEs that is most concerning and most strongly associated with poor outcomes and risk behaviour.

Exposure to ACEs leads to an accumulation of trauma, which in turn may affect neurodevelopment an vulnerability.[1]

This can manifest in behavioural issues, poor mental health, emotional dysregulation, lessened empathy, and increased anti-social behaviour.

Compared to people with no ACEs, those with 4+ are:[2,3]

- 7x more likely to be involved in violence
- 11x more likely to be incarcerated
- 4x more likely to have low levels of mental wellbeing
- 11x more likely to have smoked cannabis
- 5x more likely to use illicit drugs

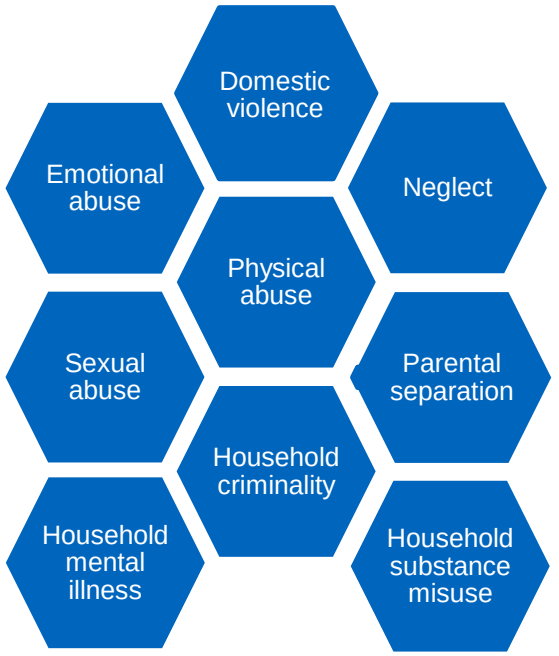


Figure 19: Adverse childhood experiences[2-6]

Data on ACEs are limited but national estimates and a 2018 review of health visiting case notes suggest that **9-10% of Southwark children aged 0-4 years experience 4+ ACEs.**

References

1. Kowalski MA Adverse childhood experiences and justice-involved youth: the effect of trauma and programming on different recidivistic outcomes
2. YoungMinds (2018) Addressing Adversity
3. Felitti VJ, Anda RF, Nordenberg D, *et al*. Relationship of childhood abuse and Household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med 1998;14(4):245-58
4. Public Health Wales. (2015). Welsh Adverse Childhood Experiences (ACE) Study
5. SAMHSA. Adverse childhood experiences. Available from: https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences
6. Hughes K, Bellis MA, Hardcastle KA, *et al.* The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. Lancet 2017;2(8):e356-e366.

The prevalence of ACEs is higher in the YOS cohort than the general Southwark population

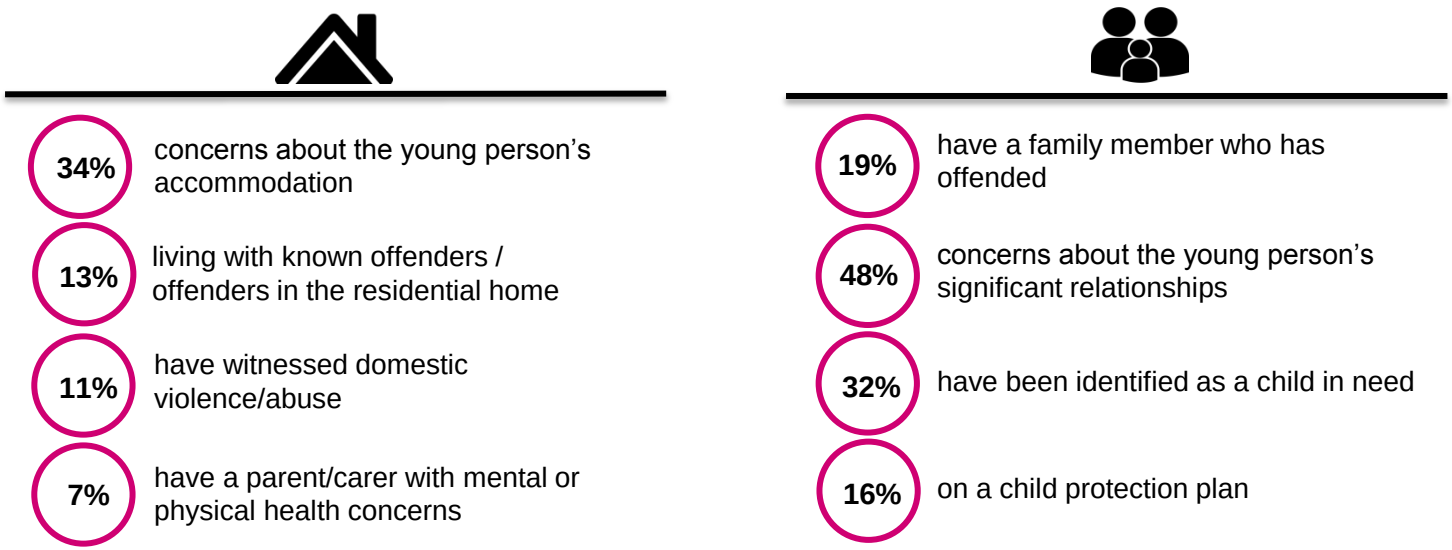
RISK FACTORS: ACEs

A review of the cohort of young people (n=259) assessed by the Southwark Youth Offending Service (YOS) over one year revealed a high prevalence of ACEs.*

- 72% of young people had at least one ACE, with 30% having experienced 4 or more.
- There was no discernible association between the number of ACEs and the age, ethnicity, or gender of the young person

The profile of ACEs among Southwark young offenders reveals concerns around the family/home environment and findings further support the need to identify and support families and children in difficult circumstances at an early stage.

Figure 20: Profile of ACEs in a snapshot cohort from the Southwark youth offending service[1]



*ACEs included: ever/current child protection plan / child in need, known victim or witness of abuse, concerns about accommodation (including household criminality), concerns about parental supervision, concerns about behaviour within the household, concerns about significant relationships, CSE concerns.

References

1. Southwark Youth Offending Service. Snapshot data of young people assessed using Asset Plus from October 2017 – September 2018.

Looked-after children have a high prevalence of ACEs and are among our most vulnerable children

RISK FACTORS: LAC

Children in care are those under 18 years who are looked after by the local authority. They have often suffered adverse childhood experiences and are among the most vulnerable in our society.

The prevalence of behavioural or emotional problems in this group is estimated to be as high as 72%.[1]

- As of 31 March 2018, there were 491 looked after children in Southwark. The local rate of entry into care per 10,000 children (76) is much higher than that of London (49), England (64) or our South East London neighbours[2]
- These children have higher rates of depression, anxiety, conduct disorders, and ADHD[3]

Some looked-after children will have been the subject of a Child Protection Plan (CPP).

- A CPP is drawn up by the local authority, bringing together relevant multi-agency carers to ensure the child is safe and to promote their health and development
- In 2017/18, there were 347 children in Southwark with a CPP[4]
- For just over 50% of cases, the most common latest category of abuse was emotional abuse (51%), followed by neglect (35%), roughly mirroring the national picture (38% and 48%, respectively)[4]

Previous abuse and disrupted relationships with caregivers mean looked-after children are at risk of exploitation and gang-affiliation.[5]

- About a third of young people seen by Southwark YOS are estimated to be a child in need and around 15% are on a child protection plan[6]
- National evidence suggests about a third of children in custody have been looked-after[7]

References

1. Sempik, J. et al. Emotional and behavioural difficulties of children and young people at entry into care. Clinical Child Psychology and Psychiatry, 2008;13 (2), pp. 221-233
2. DfE (2018) Children looked after in England including adoption: 2017 to 2018
3. Children and Young People. Southwark and Lambeth's JSNA. Southwark Council: London, 2015
4. DfE (2016) Official Statistics: Characteristics of children in need: 2017 to 2018
5. Sands C (2018) Child Criminal Exploitation: county lines gangs, child trafficking & modern slavery defences for children
6. Southwark Youth Offending Service. Snapshot data of young people assessed using Asset Plus from October 2017 – September 2018
7. Southwark Council (2016) Children in care and care leavers strategy 2016-2019

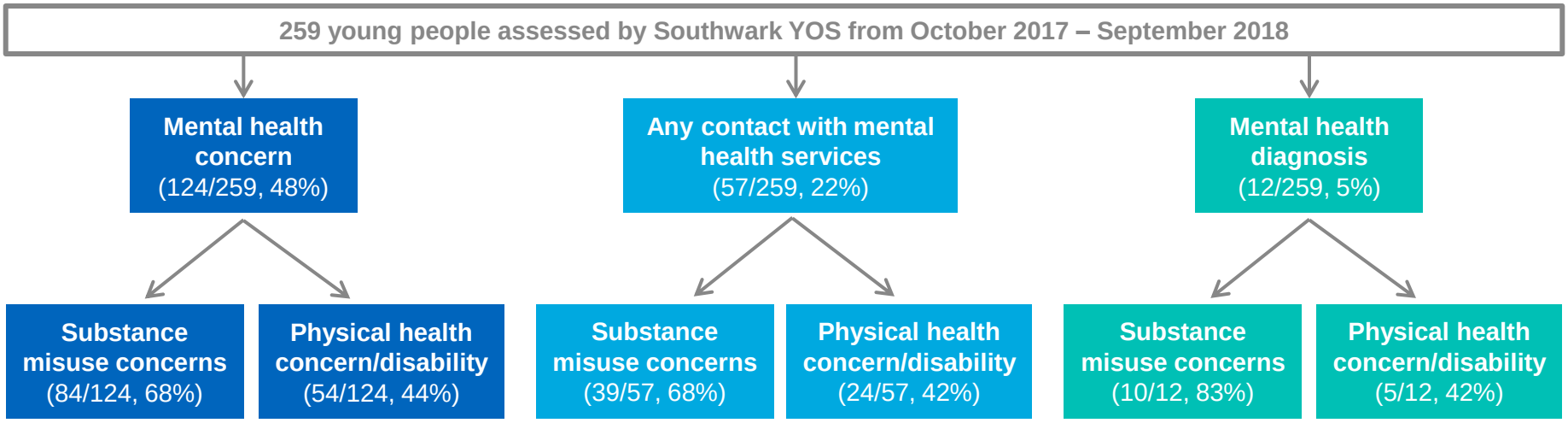
Young people with poor mental health and wellbeing are vulnerable to exploitation and involvement in crime

RISK FACTORS: MENTAL WELLBEING

There are shared risk factors between poor mental wellbeing and involvement in crime and gangs: low self-esteem, neglect, exclusion, social disadvantage, among others.[1]

- Young people may be attracted to higher-risk peer groups who offer support and a sense of belonging to those without strong relationships of their own
- Involvement in higher-risk peer groups typically begins in early adolescence, a particularly vulnerable period for development, self-identity, and mental wellbeing

Mental health concerns are prominent among young people assessed by the Southwark YOS, though we cannot confirm a causal link.[2] These young people are also likely to present with physical health needs and substance misuse concerns.



References
1. PHE (2015) The mental health needs of gang-affiliated young people
2. Southwark Youth Offending Service. Snapshot data of young people assessed using Asset Plus from October 2017 – September 2018

Children with special needs are more likely to experience poor mental health and exhibit difficult behaviours

RISK GROUPS: SEND

Children and young people with special educational needs and disabilities (SEND)* are more likely to develop poor mental health.[1-4] They are also more likely to exhibit behaviours that increase their risk of school exclusion and involvement in violence.

- Speech, language, and communication need can impact on a young person's ability to express themselves and in understanding and respecting social norms of communication
- Social, emotional, and mental health difficulties can manifest in a variety of ways, including becoming withdrawn as well as displaying challenging, disruptive or disturbing behaviour

Young people with SEND are also at risk of being exploited as part of gang or criminal activity.[5]

In Southwark, 8145 children were identified as having SEND in 2017.[2]

- While this number has decreased since 2011, it remains higher than the London and national average
- These children are more likely to be:


Black Caribbean


More deprived


Social or behavioural need (Autism, ADHD, Asperger's)

- The latest figures for more complex children requiring Education, Health and Care Plans reveal an increase over recent years, due to a rising population[2]

Speech, language and communication difficulties and special educational needs are prevalent (estimated between 25-50%) among young offenders in Southwark.[6]

*According to the SEND Code of Practice[1], a child has Special Educational Needs and Disabilities if '*they have a learning difficulty or disability, which requires special educational provision to be made for him or her.'* A number of broad categories of need are identified in the SEND Code of Practice, including: communication and interaction, cognition and learning, social, mental and emotional health, sensory and/or physical need.

References

1. Department for Education, 2015. Special educational needs and disability code of practice: 0 to 25 years.
2. Children & Young People with Special Educational Needs and Disabilities. Southwark JSNA. Southwark Council: London, 2018
3. Jacobs M, Downie H, Kidd G, *et al*. Mental health services for children and adolescents with learning disabilities: a review of research on experiences of service users and providers. British Journal of Learning Disabilities 2016;44(3):225-232
4. Emerson E and Hatton C. Mental health of children and adolescents with intellectual disabilities in Britain. British Journal of Psychiatry (2007);191:493-9
5. Home Office (2018) Criminal exploitation of children and vulnerable adults: County Lines guidance
6. Southwark Youth Offending Service. Snapshot data of young people assessed using Asset Plus from October 2017 – September 2018.

Formal school exclusions have been increasing; outcomes for this vulnerable cohort are generally poor

RISK FACTORS: EXCLUSIONS

Young people having severe difficulties in school may face exclusion, fixed-period (temporary) or permanent. Exclusion is a serious punishment with longer-term impacts on health and educational outcomes.

Excluded young people are a very vulnerable cohort. Exclusion is associated with poor mental and physical health, anti-social behaviour and crime.[1-3]

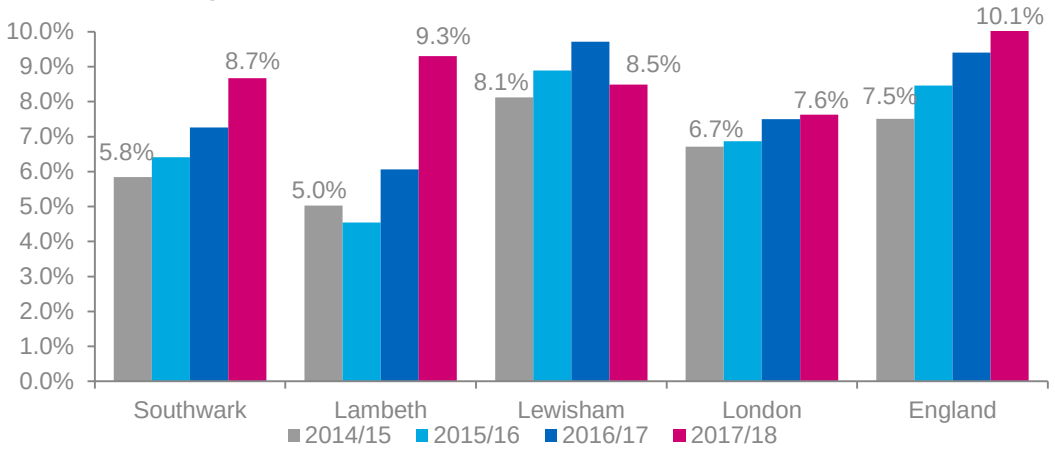
- Excluded students are more likely to be deprived, male, BAME, and have a SEND, suggesting a multiplicity of risk and an overlap in vulnerability to involvement in violence
- Vulnerable young people excluded and/or in alternative provision education may be more susceptible to exploitation and recruitment by criminals and gangs

Southwark has a higher rate of primary school fixed-period exclusion than London, England, and Lambeth and Lewisham: 1.47 per 100 students in 2017/18. For the first time in four years, there were two permanent exclusions among primary students in Southwark.[4]

The rates of fixed-term and permanent exclusion in Southwark secondary schools have increased steadily since 2014/15. In 2017/18, 47 pupils were permanently excluded in Southwark.[4]

Notably, these figures only include exclusions recorded formally and do not account for informal exclusions, including managed moves, and forced home schooling.

Figure 21: Secondary school fixed-period exclusions as a percentage of head count in January 2014/15 – 2017/18[4]



References

1. Pirrie A, Macleod G, Cullen MA, McCluskey G. What happens to pupils permanently excluded from special schools and pupil referral units in England? British Educational Research Journal 2011;37(3):519-38
2. Lereya T and Deighton J (2019) Learning from HeadStart: the relationship between mental health and school attainment, attendance and exclusions in young people aged 11-14. London: EBPU
3. Timpson E (2019) Timpson Review of School Exclusion
4. DfE (2018) Permanent and fixed period exclusions in England 2017 to 2018

Formal school exclusions have been increasing; outcomes for this vulnerable cohort are generally poor

RISK FACTORS: EXCLUSIONS

The rate of fixed-period exclusion is highest in special schools (per 100), though there have been dramatic reductions since 2014/15 (Table 2).[1]

In light of the association between school exclusion and crime, It is unsurprising that about 20% of young people at the Southwark YOS are not in education, training or employment.[2]

Table 2: Special schools fixed-period exclusions as a percentage of head count in January[1]

Area	14/15	15/16	16/17	18/19
Southwark	**43.28**	**25.37**	**17.72**	**10.27**
Lambeth	17.12	9.45	10.92	7.02
Lewisham	41.39	21.93	28.82	11.25
London	13.49	13.34	15.51	14.14
England	13.54	12.53	13.03	12.34

Students who are excluded may return to mainstream education after a period of time, or may move to a pupil referral unit. There is one pupil referral unit in the borough: Southwark Inclusive Learning Service (SILS).

- As of January 2018, there were 81 pupils enrolled at SILS[1]
- Young people in our PRU are consistently more deprived than other local students, with 42% of students at SILS eligible for free school meals in 2018[1]

Children and young people at risk of exclusion from mainstream school or who require behaviour support can attend alternative provision at Summerhouse (primary) or Phoenix Place (secondary, females only).

Persistent disruptive behaviour is the leading cause nationally for fixed-term exclusions and the third leading reason in Southwark.[1]

- While recognising that schools must balance uninterrupted learning environments with supporting children with conduct difficulties, disruptive behaviour may be a manifestation of difficulties in the home or in interpersonal relationships, or SEND[3-5]

References

1. DfE (2019) Schools, pupils, and their characteristics
2. Southwark Youth Offending Service. Snapshot data of young people assessed using Asset Plus from October 2017 – September 2018.
3. Royal College of Psychiatrists (2017) Behavioural problems and conduct disorder: for parents, carers and anyone working with young people
4. Department for Education, 2015. Special educational needs and disability code of practice: 0 to 25 years.
5. Timpson E (2019) Timpson Review of School Exclusion

CONTENTS

The impacts of youth violence reverberate through to communities and society

IMPACT

As with risk and protective factors for violence, the impacts of SYV are numerous and affect individuals, relationships, communities, and even societies.

It would not be possible to cover in depth the breadth of impacts. This report will instead focus on one-two examples at each level of impact.

Individual: mental health and wellbeing

Relationships: unhealthy, exploitative relationships

Community: community wellbeing and physical health

Society: worsening inequalities and multiple disadvantage

Serious youth violence can be both a driver and an outcome of poor mental health

IMPACT: MENTAL HEALTH

While poor mental health is a risk factor for involvement in SYV, violence in turn has severe impacts on mental health and wellbeing, particularly in relation to trauma.

- Victims and perpetrators of violence have reported symptoms of post-traumatic stress disorder
- Young people may be living in a normalised state of hypervigilance, fear, and oversensitivity
- There are severe impacts on quality of life: young people have reported taking precautions such as changing their bus route and avoiding certain areas to keep themselves safe

A heightened sense of fear among those still involved or exposed to violence tends to surpass fear of police and increase the likelihood of re-offending, for example through knife carrying.

The near universal prevalence and use of social media by young people increases the likelihood that traumatic events will be captured and disseminated more widely, exposing a larger audience to the trauma. The ability to record and replay events may also re-expose and re-traumatise young people.

Professionals should acknowledge that anti-social behaviour and violence may be manifestations of trauma and suppressed anxiety and depression, and support appropriately.

References
1. PHE (2015) The mental health needs of gang-affiliated young people
2. Southwark YOS (2018) Trauma informed weapons awareness programme – an interim evaluation summary of the delivery of a knife crime prevention programme in schools
3. Youth Violence Commission (2017) Evidence session: public health, mental health and youth violence
4. Ramshaw N, Charleton B, Dawson P. MOPAC Evidence and Insight: Youth Voice Survey 2018

A young person involved in SYV has likely been or is at risk of being exploited by organised criminals

IMPACT: EXPLOITATION

Young people involved in violence and crime are at risk of engaging in unhealthy, exploitative relationships with gangs and others involved in criminal activity. Exploitation is also, in many instances, a precursor / gateway or even risk factor to becoming involved in violence.

Many young people are thought to be exploited as part of county lines activity: the supply of class A drugs (largely cocaine and heroin) from urban hubs to rural locations.[1] This business model is fluid and thrives on the exploitation of vulnerable children and adults.

- Young people in poverty, experiencing family breakdown or involvement of social care services, or those excluded from mainstream services are frequently targeted by country lines offenders
- London Metropolitan Police report the highest number of county lines in operation of all police forces nationally
- The majority of referrals made nationally for county lines involved young people aged 15-17 years

Offender(s) tends to build a relationship with the young person, sometimes over social media → Vulnerabilities and economic opportunity are exploited and the young person may be coerced into doing a small task → Young person becomes indebted to the offender(s) → An economic imperative is thus created for the young person to continue to be exploited

Notably, county lines activity also depends on the exploitation of vulnerable adults, including through taking over properties for use as a base for drug dealing and taking (known as ‘cuckooing’), and other older adolescent cohorts including university students.

Young women may be exploited using romantic relationships and are at particular risk of sexual exploitation; nearly a third (27%) of females assessed by the Southwark YOS were deemed at risk.[2]

To date, males represent almost all (91%) of victims nationally, however, involvement of females is likely to be underrepresented. Historical gender bias in law enforcement may lead to less females being suspected of criminal involvement.

References
1. National Crime Agency. Intelligence Assessment (2019) County lines drug supply, vulnerability and harm, 2018
2. Southwark Youth Offending Service. Snapshot data of young people assessed using Asset Plus from October 2017 – September 2018

Violence may affect the communal sense of safety and wellbeing, and impact on healthy behaviours

IMPACT: COMMUNITY

Violence, including youth violence, has significant impacts on the wider community.

Mental wellbeing and cohesion

The emotional and mental wellbeing of those in the local community may be affected, even if they are not directly involved in violence themselves.

- People can become fearful or lose their sense of safety in public places. As a result, they may be hesitant to enjoy the environment and local space
- Areas can become labelled as 'unsafe' and avoided, building a tolerance for violence in that area and a marginalisation of those involved or living nearby
- Without appropriate prevention and intervention, spaces can become dominated by anti-social behaviour space

Community wellbeing (how thriving and supportive a community is) is also impacted by violence.

- This is particularly challenging for communities with low resilience and/or protective factors, such as more deprived or disengaged communities and those that lack a sense of social cohesion

Physical health and wellbeing

When the local environment and community is not perceived as safe, measures designed to encourage healthy lifestyles may be foregone.

- For example, parks, recreation centres, and areas for exercise and socialising may be avoided for fear of violence

Poor health and wellbeing outcomes may contribute to enduring inequalities in socio-economic attainment.

References

1. NHS Confederation, DH, Home Office, and PHE (2014) Violence and health and wellbeing boards: a practical guide for health and wellbeing boards
2. Lawrence R and Hobart V (2018) '4b Public Health Approach to Serious Youth Violence in London' *Violence Reduction Unit Partnership Reference Group 26 November 2018.* Greater London Authority, London

Serious youth violence may widen inequalities in Southwark and contribute to multiple disadvantage

IMPACT: SOCIETY

Southwark is an inner-London borough of wide inequalities.

- While there has been significant regeneration in recent years, there remain clusters of high deprivation

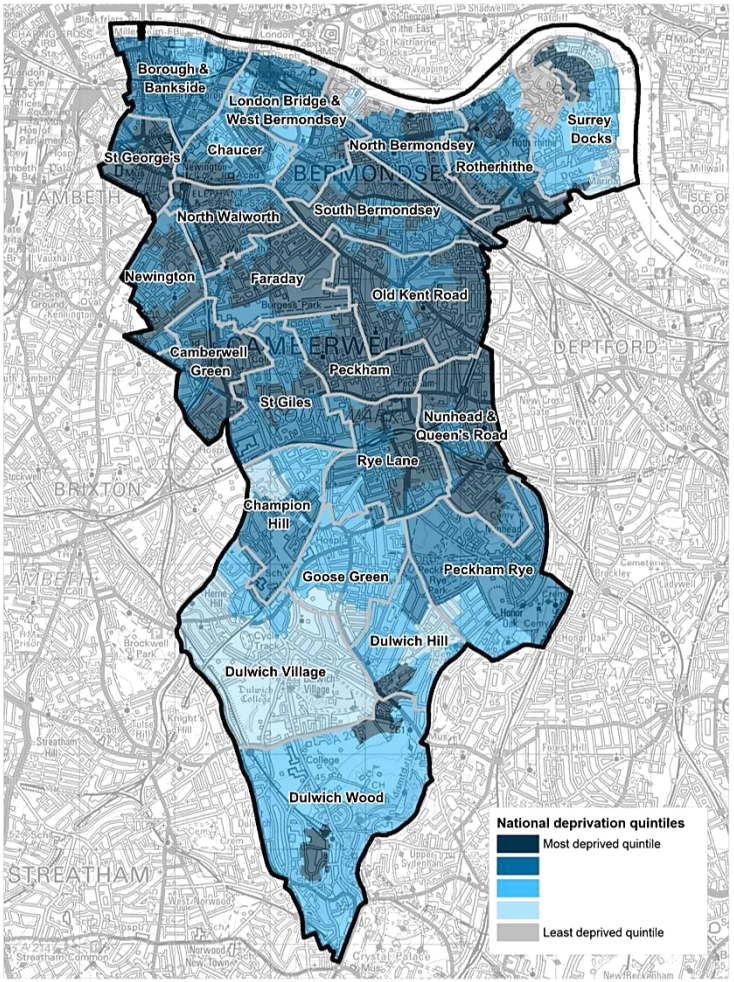
There are stark differences between corporate London Bridge and leafy Dulwich, and some areas in the middle belt of the borough that are ranked within the highest levels of deprivation nationally.

- The borough is transitioning to a region of two extremes, mirroring the London picture
- This may lead to tension and discrimination between areas at each end of the spectrum

Over time and with growing inequalities, these clusters may experience multiple and accumulating disadvantage.

- Cycles of poverty, poor educational attainment and employment may self-perpetuate
- This in turn significantly affects health and wellbeing and life outcomes

Therefore, tackling youth violence cannot be purely enforcement-led. Rather, it requires a mixture of interventions where both welfare, wellbeing, and enforcement are used together in a proportionate way.



Indices of Deprivation 2015

Data source: Department for Communities & Local Government
Southwark Public Health Department I People & Health Intelligence I publichealth@southwark.gov.uk
July 2017.

References

1. GLA (2018) The London Health Inequalities Strategy
2. Bullock R and Parker R (2014) A historical review of the concept of severe and multiple disadvantage and of responses to it. A discussion paper for Lankelly Chase
3. The Marmot Review (2010) Fair Society, Healthy Lives

CONTENTS

Youth violence prevention requires a multi-agency response that tackles the wider determinants

LOCAL RESPONSE

Given the breadth of risk factors for youth violence, a multi-faceted and multi-agency response at the societal, community, and individual level is needed.

Support should also be made available at all three levels of prevention:

1. Primary prevention: preventing the development of risk factors for violence e.g. by reducing adverse childhood experiences or supporting vulnerable parents/families to build self-efficacy
2. Secondary prevention: preventing violence before it occurs for example through community policing strategies or diversion programmes
3. Tertiary prevention: reducing the long term impact of violence, such as rehabilitation and reintegration of offenders and support for victims

There are a plethora of activities ongoing in Southwark to tackle youth violence and we are a heterogeneous borough made up of a number of different agencies.

- The stakeholder and partnership environment is complex and involves national, regional, and local collaborators

Given the number of interventions and services that intersect with youth violence prevention, it was not possible to evaluate each in depth for its reach or effectiveness. Rather, the following slides are intended to provide an outline of and introduction to key local programmes and initiatives to prevent violence at all three levels of prevention and across all four levels of risk (individual → society).

Preventing youth violence requires a societal shift towards inclusivity and respect

LOCAL RESPONSE: SOCIETY

Prevention of SYV should address the broad societal, cultural and economic factors that help create a climate in which violence is encouraged or uninhibited, e.g. marginalisation and/or discrimination on the basis of ethnicity or immigration status, and the pervasive influence of social media.

Prevention strategies focus on reducing socio-economic exclusion, increasing gender equality, and reducing homophobia and racism.

Schools provide a number of universal programmes on gender equality and inclusivity through PSHE and SRE lessons.

- ‘Great men value women’ is a workshop available to secondary schools that challenges them to think critically about gender stereotypes and cultural expectations. The normalisation of certain negative behaviours may lead to an expectation of hypermasculinity and a risk of sexual exploitation for young girls

In July 2018, the Home Office launched a series of PSHE lessons on knife crime (#knifefree) for all secondary school students

- These aim to help reduce knife crime by challenging the myths and communicating the realities of knife carrying in young people
- The intention is to prevent young people from deciding to carry a knife
- It is likely, however, that uptake of these lessons varies across schools

Note: all services and programmes are current as of September 2019

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LOCAL RESPONSE: SOCIETY

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Prevention strategies focus on reducing socio-economic exclusion, increasing gender equality, and reducing homophobia and racism.

The Mayor of London developed a toolkit to accompany their media campaign 'London Needs You Alive."

- LNYA aspires for young people to value their lives and to foster positive aspirations
- The toolkit includes lesson plans and training on how to discuss and address violence with young people

The Government's draft guidance for relationships and health education in schools (to be implemented September 2020) includes topics around staying safe online, which will teach children and young people how to use technology safely and respectfully.

Operation Sceptre is an on-going series of intensified action against knife crime by the police services in London and across England.

- Officers ran targeted stop and searches, weapons sweeps, and test purchases of knives from retailers
- They also focused on habitual knife carriers and targeted police enforcement to hotspot areas

Note: all services and programmes are current as of September 2019

Developing a strong sense of community can foster local engagement and prevent involvement in violence

LOCAL RESPONSE: COMMUNITIES

Schools, workplaces, and neighbourhoods can play a role in identifying the characteristics of settings that are associated with becoming victims or perpetrators of violence.

Prevention strategies impact the social and physical environment – e.g. by reducing social isolation, improving the physical environment, and improving local economic and housing opportunities.

The Council has a role to play in planning and developing the physical space of the community.

- Trading Standards and the Licensing team mitigate the availability of potentially risky premises such as off-licences or gambling venues
- CCTV is deployed at key locations throughout the borough and help to monitor public spaces, detect crime, and direct services to incidents
- The availability, quality, and safety of community spaces such as parks is important in providing young people with an opportunity to play and spend time outdoors and can be influenced locally by Planning and Regeneration teams
- Recognising that safety while traveling is a major concern for local communities, the Council is working alongside the police, local businesses, and the Southwark young advisors to establish safer routes through the borough and safe places for young people to seek safety and support if they feel threatened

The Joint Enforcement Team community wardens operate throughout Southwark to prevent crime, reduce antisocial behaviour, and build links with the community.

- Community wardens provide a visible, reassuring presence. They work closely with the Metropolitan Police Service and members of the public to perform weapons sweeps
- They also work with schools and help organise community or sporting events. These activities develop and strengthen our sense of community and our engagement locally

Note: all services and programmes are current as of September 2019

Developing a strong sense of community can foster local engagement and prevent involvement in violence

LOCAL RESPONSE: COMMUNITIES

Schools, workplaces, and neighbourhoods can play a role in identifying the characteristics of settings that are associated with becoming victims or perpetrators of violence.

Prevention strategies impact the social and physical environment – e.g. by reducing social isolation, improving the physical environment, and improving local economic and housing opportunities.

Young Advisors is a national charity who train community leaders how to engage young people in community life. Southwark's local chapter has a 'StreetBase team' whose priority is to engage youth and signpost to positive activities and opportunities to help prevent offending behaviour.

- The Young Advisors themselves are resident young people who gain the respect of those they're trying to engage and can relate to the challenging and often violent surroundings
- They work with young people who engage or are at-risk of engaging in anti-social behaviour but who are not already involved in mainstream youth services

Local faith groups play a critical role in fostering a sense of community and belonging.

- Work is ongoing to try to engage with these communities and work to together to tackle youth violence, including hosting a faith leaders conference to co-develop solutions to SYV

Note: all services and programmes are current as of September 2019

Healthy interpersonal relationships can positively influence behaviour and experiences

LOCAL RESPONSE: RELATIONSHIPS

A person's peers, partners and family members influence their behaviour and contribute to their experience of violence as both a victim and perpetrator.

Prevention strategies include parenting or family-focused prevention programs, mentoring and peer programs designed to reduce conflict.

A number of local services seek to mitigate adverse childhood experiences which may later increase a young person's risk of involvement in violence.

- Parental Mental Health is a service for parents with mental health difficulties and with young children. Their support can help improve parent-child relationships
- Southwark Advocacy and Support Service provide therapeutic support for children and young people who have experienced domestic abuse

Social care provide support to families in difficult times and link directly into children's centres and schools. However, most of these programmes are 'traded' services purchased by schools and in some cases, the threshold for treatment does not reflect local need.

- The Specialist Family Focus team provides intensive support to resolve family crisis
- The Functional Family Therapy team support children and families where there is challenging
- behaviour in two or more settings (home/school/community)
- Early Help CAMHS team provide early intervention to those with mental health issues due to home and/or school-based problems, and those with mild-moderate mental health issues
- The multi-agency safeguarding hub (MASH) brings together a team of multi-disciplinary professionals to deal with safeguarding concerns about children and families

Note: all services and programmes are current as of September 2019

Healthy interpersonal relationships can positively influence behaviour and experiences

LOCAL RESPONSE: RELATIONSHIPS

A person's peers, partners and family members influence their behaviour and contribute to their experience of violence as both a victim and perpetrator.

Prevention strategies include parenting or family-focused prevention programs, mentoring and peer programs designed to reduce conflict.

Schools have a role in promoting safe and healthy relationships as part of their SRE lessons. These can help support young people to identify coercive and unequal relationships.

- 'Safe, Healthy & Equal Relationships' (SHER) is an two-day peer educator programme run by Participation People that promotes awareness of healthy relationships
- The 'Esteem' programme delivers lessons on building healthy self-esteem, critical thinking around peer pressure, and understanding healthy relationships
- However, these programmes are not universally offered across schools

The Southwark Youth Offending Service (YOS) has a range of offers for young people who have been involved in crime, including peer-led work on emotional intelligence run by Peer Navigators. They are based at the YOS and at hubs across the borough.

Growing Against Violence is a London charity that provides school-based sessions in Southwark on refusal skills and negative peer pressure ('Friends and Friendly').

Note: all services and programmes are current as of September 2019

A person's individual risk factors for violence can be overcome by appropriate support and engagement

LOCAL RESPONSE: INDIVIDUALS

Finally, a person has individual factors that increase the likelihood of becoming a victim or perpetrator of youth violence, e.g. age, education, substance use, or history of abuse.

Prevention strategies promote attitudes, beliefs, and behaviours that strengthen resilience and promote protective factors against involvement in violence, e.g. supporting school engagement.

The environment in which a child grows up plays an important role in their development of risk factors for violence.

- Health visitors and midwifery services are well-placed to identify adverse experiences or risk factors in childhood that may increase a child's chance of involvement in violence. They also provide targeted support for families with complex needs (e.g. substance misuse, domestic violence)
- For teenage mothers under 20 expecting their first birth, the Family Nurse Partnership provides support for young parents to make positive lifestyle choices and build their self-efficacy, as well as promote parental attachment and a child's healthy development
- Parents and Communities Together (PACT) are a local, community-led support network bringing together parents, carers, community and faith groups, maternity services, and children's centres. PACT empower and support parents to increase their own confidence parenting, develop social capital and supportive relationships, improve parental wellbeing, and improve outcomes for infants in social, emotional, and language development

When children reach school, they are universally given lessons aimed at promoting healthy attitudes and behaviours that may prevent involvement in violence or high-risk peer groups.

- Resilience training is provided through PSHE lessons e.g. Head-First , who train school staff to deliver evidence-based lessons on mental wellbeing and resilience, as well as offer mental health first-aid training
- Programmes explicitly tackling violence, however, are inconsistent

Note: all services and programmes are current as of September 2019

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LOCAL RESPONSE: INDIVIDUALS

Finally, a person has individual factors that increase the likelihood of becoming a victim or perpetrator of youth violence, e.g. age, education, substance use, or history of abuse.

Prevention strategies promote attitudes, beliefs, and behaviours that strengthen resilience and promote protective factors against involvement in violence, e.g. supporting school engagement.

Young people may struggle with their health and wellbeing during adolescence. Preventing the development of unhealthy behaviours can help to reduce risk factors for involvement in violence as well as reduce the risk of vulnerability and exploitation.

- Southwark Public Health commission an integrated service for young people ('Healthy Young People'). This provides support/advice for substance misuse, sexual health, relationships, and wellbeing
- The charity 'Faces in Focus' provides counselling for young people dealing with anger, loneliness, and problems at school or in the family

Some young people are not in mainstream schools and may benefit from additional support to engage with education.

- Southwark's pupil referral unit (SILS) aspires to offer a safe, inclusive place to learn for students who have excluded or are unable to attend a mainstream school. These young people often have behavioural difficulties and may be more vulnerable to violence involvement
- COVO – Connecting Voices works with children unable to attend mainstream schools who have emotional and social difficulties, to reengage with their education
- 'Stand Up Southwark' works with disadvantaged children to empower them and build resilience. It encourages them to overcome emotional factors that are barriers to success and educational attainment
- Southwark Choices works with young people not in education, employment or training to re-engage and train for future opportunities

Note: all services and programmes are current as of September 2019

A person's individual risk factors for violence can be overcome by appropriate support and engagement

LOCAL RESPONSE: INDIVIDUALS

Finally, a person has individual factors that increase the likelihood of becoming a victim or perpetrator of youth violence, e.g. age, education, substance use, or history of abuse.

Prevention strategies promote attitudes, beliefs, and behaviours that strengthen resilience and promote protective factors against involvement in violence, e.g. supporting school engagement.

When a child or young person is involved in violence, they are sent to the Southwark Youth Offending Service (YOS) where they have the opportunity to receive peer- and professional-led support.

- Peer Navigators are based at the YOS and at hubs across the borough. Successful 'graduates' of the YOS, they are trained by the charity YouthInk in emotional intelligence and trauma support for their peers who have been involved in violence
- The trauma-informed weapons awareness programme works with high-risk and 2nd-time offenders of knife crime to explore the reasons for carrying a weapon and to develop alternative strategies for keeping safe

In many cases, there is overlap between victims and perpetrators of violence. To prevent the cyclical nature of violence, victims also need support.

- Young victims who attend A&E may receive violence reduction interventions by Redthread (King's College Hospital) or Oasis Youth Support (St Thomas' Hospital)
- Southwark emergency rehousing victims of violent enterprise (SERVE) provides safe accommodation and mentoring for those at risk of gang-affiliated violence and crime
- Southwark anti-violence unit (SAVU) provides multi-agency support for young people at risk of gang-related activity or violence, such as education and training, substance misuse, and health. Their work aims to reduce the risk of harm to those involved and to their local communities
- The YOS also offers restorative justice with the victims of some crimes

Note: all services and programmes are current as of September 2019

CONTENTS

Surveys of young people youth reveal violence is prolific across England and London

COMMUNITY & STAKEHOLDER VIEWS

Direct engagement was not undertaken as part of this JSNA as it is intended to be read alongside community and stakeholder engagement by the Southwark Youth Violence Panel and the Southwark Extended Learning Review. However, surveys of young people nationally and locally have been included.

The national Youth Violence Commission conduced the Safer Lives Survey of over 2,200 young people aged 8-24 years in early 2018.

- Exposure to violence was prolific amongst those surveyed. Over 70% of young people reported being exposed to serious violence in real life at least once a month. Upon inclusion of social and traditional media, this number rose to 90%. Younger respondents (ages 8-19) experienced the most serious violence
- Police were not reported as a primary source of support when faced with possible victimisation. Less than half of respondents said they would ask police for advice if they were worried about becoming a victim of crime, highlighting the importance of community partners as alternative first points of contact for young people

The Mayor's Office for Policing and Crime hosted the online Youth Voice Survey also in 2018. This captured the views of nearly 8,000 young people in London.

- About 1-in-10 young people reported being the victim of a crime in the last year while a quarter said they knew someone who had carried a knife
- 74% respondents said they felt safe in the local area in which they live, though feelings of safety diminished by age: 79% of 11 year olds compared to 61% of 16 year olds

The 2016 school survey asked pupils about negative behaviours they had experienced in their relationships.

- Almost a quarter (23%) of secondary pupils surveyed had experienced at least one negative behaviour with a current or previous partner. Negative behaviours included checking their phone, jealousy when spending time with friends, and pressuring to do sexual things
- The prevalence of coercive behaviours in Southwark adolescents highlights the importance of school-based lessons on healthy relationships, and the need to work with young people to recognise and address these behaviours

References

1. Youth Violence Commission (2018) Interim Report
2. Ramshaw N, Charleton B, Dawson P. MOPAC Evidence and Insight: Youth Voice Survey 2018
3. Schools Health Education Unit (SHEU). Supporting the Health and Wellbeing of Children and Young People in Southwark. Health & Wellbeing Related Behaviour Survey 2016

CONTENTS

Preventing violence should begin by addressing the root causes, including the context in which young people live

SUMMARY & KEY FINDINGS

Violence is a complex and a symptom of wider and underlying issues. Prevention should begin by addressing the root causes.

- Youth violence is a pertinent issue in Southwark, where we have historically prominent and high-profile gangs, recognised county lines drug supply, and the fourth highest volume of youth knife crime among all London boroughs. This is occurring against a backdrop of rapid regeneration and widening inequalities in the borough

The places and environments in which our adolescents are born, grow, and live play a crucial role in their health and development, and their risk for becoming vulnerable to exploitation and violence. Data suggest that Southwark has a large population of potentially vulnerable children:

- Young people (aged 10-24 years) are both more deprived and more diverse than the general population of Southwark
- Local estimates of adverse childhood experiences suggest there are more children with $\geq$ 4 ACEs locally than the national average
- The rate of entry into care as a looked-after child is substantially greater in Southwark than in London or England
- More Southwark children are identified as having a special educational need or disability than in London or England
- Southwark has a higher rate of primary school fixed-period exclusion, secondary school fixed-period exclusion, and secondary school permanent exclusion than the London average

Preventing violence should begin by addressing the root causes, including the context in which young people live

SUMMARY & KEY FINDINGS

Data from Metropolitan Police Services and London Ambulance Services indicate that incidents of violence involving an offensive weapon and/or assault with a sharp object have not reduced in line with other assaults. Moreover, young people involved are of an increasingly younger age.

- These incidents tend to concentrate in the centre and North-East of the borough, which include some of Southwark's most deprived communities and also areas of urban nightlife

The impacts of serious youth violence are numerous and reverberate through to communities and society.

- Young people involved in violence as victims or perpetrators have experience trauma and likely post-traumatic stress disorder. This not only has longer-term impacts on their health and wellbeing but may also manifest in anti-social or violent behaviour. Services and settings need to understand the impact trauma has and how to identify and support affected adolescents
- Communities' sense of safety and wellbeing is affected by violence in the area. Without appropriate prevention, intervention, and support, spaces can become dominated by anti-social behaviour and labelled as 'unsafe'. This in turn affects the use and enjoyment of public spaces

There are a plethora of activities ongoing locally to prevent SYV and mitigate its effects, though the landscape of partnership working is vast and complex.

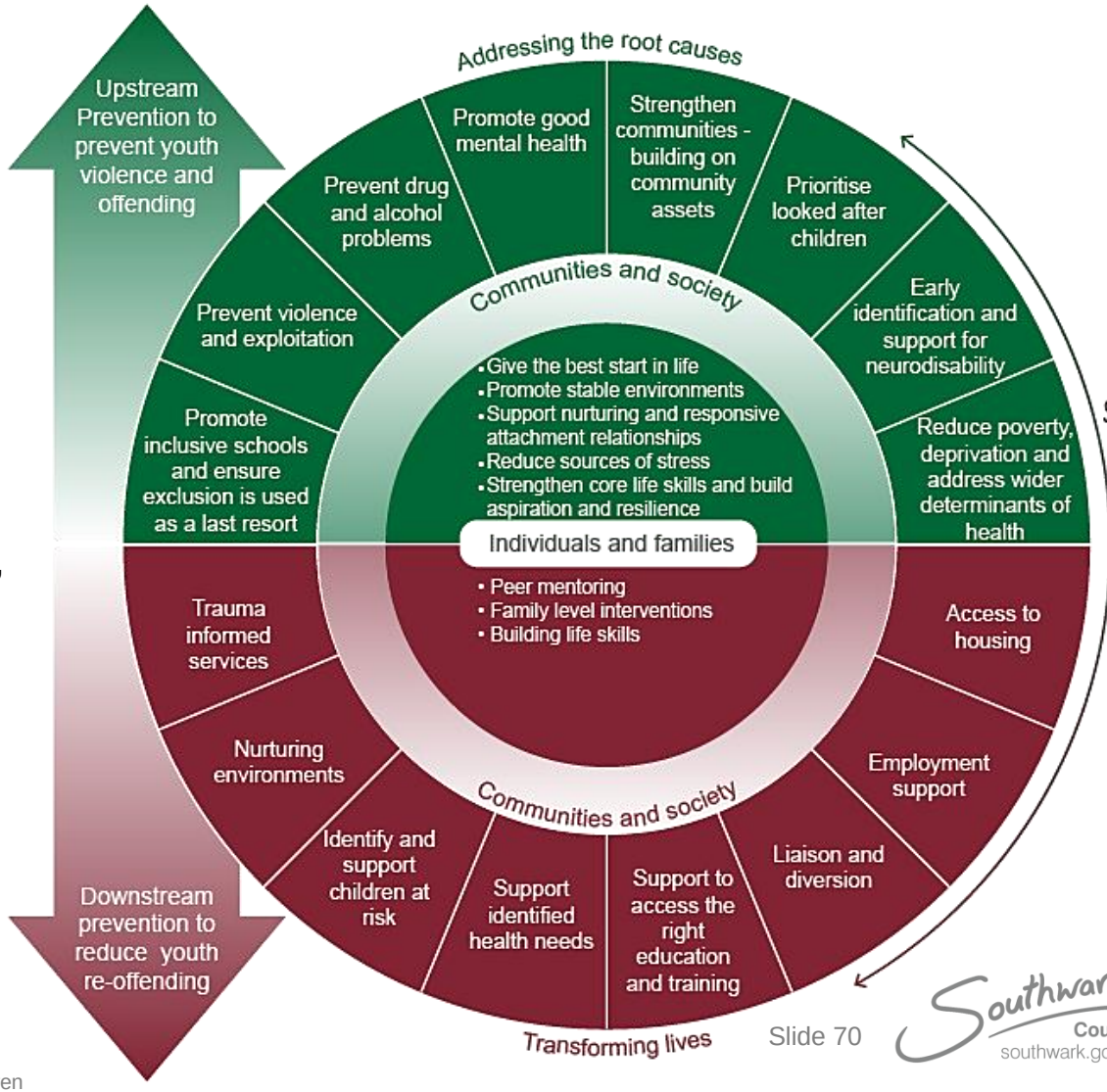
This JSNA consolidates a number of recommendations from the literature, informed by local epidemiology

RECOMMENDATIONS & NEXT STEPS

Public Health England's (PHE) recent report on reducing offending and reoffending[1] includes a framework for prevention.

The following recommendations are derived from the literature and epidemiology in this report, the Southwark Extended Learning Review, and the Southwark Youth Violence Panel.

These have been organised under the themes identified by PHE, where the theme was within the scope of this JSNA.



References
1. Public Health England (2019) Collaborative approaches to preventing offending and re-offending by children

Recommendations (1 of 7)

RECOMMENDATIONS & NEXT STEPS

Theme(s)	Recommendation	Suggested owner
ADDRESSING THE ROOT CAUSES		
Promote inclusive schools / Trauma-informed services	Undertake an in-depth review of school exclusions (formal and informal), managed moves and home schooling in Southwark to understand the profile of young people affected and explore the impact on wider vulnerability	Children's Services
	Work with schools to embed a trauma-informed approach (e.g. attachment, regulation and competency) and ACE-awareness, which recognises that disruptive behaviour may be a manifestation of trauma, and clarify support available for those young people	CYP & EI steering group
Prevent exploitation	Undertake needs assessment of vulnerability and violence to develop a fuller picture of vulnerability in the borough	Community Safety
	[See identification and support of children at risk]	N/A
Prevent drug & alcohol problems	Continue to work with schools and school nursing to develop modern and relevant PSHE lessons that promote healthy behaviours	Education / Public Health
	Continue to promote and improve uptake of Healthy Young People (HYP) within schools and youth settings to improve access for young people to substance misuse support services	Public Health
	Further examine the use and impact of cannabis in Southwark adolescents to explore links with exploitation, and trauma and wellbeing	Community Safety

Recommendations (2 of 7)

RECOMMENDATIONS & NEXT STEPS

Theme(s)	Recommendation	Suggested owner
Strengthen communities	Ensure communities and VCS groups are included in the steering group to take forward the recommendations from this JSNA, the Extended Learning Review, and Youth Violence Panel	LA
Promote good mental health	Support whole-settings approaches to promoting mental wellbeing	LA & CCG
	Support schools (including alternative provision) and school nursing to develop curricula on mental wellbeing and early identification	Public Health
	Develop workstream for the Council on children and young people's mental wellbeing and early intervention, coordinating interventions across children's settings (e.g. children's centres, schools, PRU, etc.)	CYP & EI steering group
	Explore the role of social media in violence, including in inciting violence and transmitting and replaying traumatic events	LA & MPS
	Increase understanding within the Council, CCG, and the community of the impact of ACEs and ways to improve family wellbeing	LA & CCG
	Review support available to parents whose mental health needs do not meet the threshold for clinical support	Children's & Adult's Services / Public Health / CCG

Recommendations (3 of 7)

RECOMMENDATIONS & NEXT STEPS

Theme(s)	Recommendation	Suggested owner
LAC	Review offer of support to care leavers at this critical transition point	Children's & Adult's Services
Relationships / Family-level interventions	Review current offer of support available to parents of children of all ages and their families, in a range of settings	Children's Services / Public Health
	Work with schools to develop RSE that is inclusive of vulnerability and exploitation, and of coercive relationships	Public Health / Education
Core life skills	Continue to work with schools and school nursing to develop modern and relevant PSHE lessons that emphasise and support emotional awareness	Public Health / Education

Recommendations (4 of 7)

RECOMMENDATIONS & NEXT STEPS

Theme(s)	Recommendation	Suggested owner
TRANSFORMING LIVES		
Liaison & diversion	Continue to explore and take up opportunities to trial diversion programmes locally	Youth Offending Service
Support access to education & training	Review support for young people transitioning to secondary education and/or between mainstream and alternative provision	Children's Services / Education
Support identified health needs	Continue to promote and improve uptake of Healthy Young People (HYP) within schools and youth settings to improve access for young people to substance misuse and sexual health support services	Public Health
	Review parental health offers and pathways into support, including access to parental mental health and adult substance misuse services	CYP MH Steering Group / Children's Services
	Ensuring strong links between young people's services and young people in alternative provision or being home-schooled	Education / All

Recommendations (5 of 7)

RECOMMENDATIONS & NEXT STEPS

Theme(s)	Recommendation	Suggested owner
Identify and support children at risk	Ensure schools have clear safeguarding pathways and are able to identify and appropriately refer at-risk children	Children's Services / Education
	Ensure a common language around safeguarding is used by parents, schools, and services so that parents are able to identify when a child is at risk / vulnerable and to understand where and how to seek support	Children's Services / Education
	Work with schools to develop RSE that is inclusive of vulnerability and exploitation, and of coercive relationships	Public Health
	Continue with Keeping Families Strong approach, ensuring sustainability and empowerment of families	Children's & Adult's Services
Peer mentoring	Continue to support peer mentoring initiatives, particularly as part of rehabilitation	YOS

Recommendations (6 of 7)

RECOMMENDATIONS & NEXT STEPS

Theme(s)	Recommendation	Suggested owner
CROSS-CUTTING RECOMMENDATIONS		
Coordination	Develop clear governance pathways for SYV work streams across the Council, as per the Southwark Extended Learning review	Southwark Safeguarding Children's Board
	Develop a directory of services and interventions in place to prevent youth violence (primary, secondary, and tertiary prevention), including Council and VCS initiatives. This directory should be made publically available to improve the accessibility of referrals and should be used as the support offer underpinning the forthcoming community harm and exploitation hub	Community Safety / All
Collaboration	Establish/identify a steering group to take forward recommendations from this JSNA and from the Southwark Extended Learning Review and Youth Violence Panel, ensuring the group is inclusive of a wide range of Council department as well as members from the VCS	ELR board / All
	Encourage steering group members to embed an identification of vulnerable children and young people into all policies	All
	Continue with the wide range of activities currently ongoing to provide early intervention, prevent youth violence, and support those affected	All

Recommendations (7 of 7)

RECOMMENDATIONS & NEXT STEPS

Theme(s)	Recommendation	Suggested owner
CROSS-CUTTING RECOMMENDATIONS		
Data sharing	Continue to improve data sharing amongst departments involved in serious youth violence and vulnerability, to ensure a shared, complete vision for the borough	All
Dissemination	Develop a communication plan to disseminate the findings of this report more widely alongside reports on the Community Crime and Exploitation Hub and narrative of vulnerability, which will be presented to Cabinet in December 2019	Public Health / Community Safety

Find out more at
southwark.gov.uk/JSNA

Healthcare Public Health Team

Southwark Public Health

Agenda Item 10

Item No.	Classification:	Date:	Meeting Name:
10.	Open	18 November 2019	Health and Wellbeing Board
Report title:		Bridges to Health and Wellbeing	
Ward(s) or groups affected:		All	
From:		Sam Hepplewhite, Director of Integrated Commissioning, NHS Southwark CCG Genette Laws, Director of Commissioning, Southwark Council	

RECOMMENDATION

1. That the Health and Wellbeing Board note this report.

BACKGROUND INFORMATION

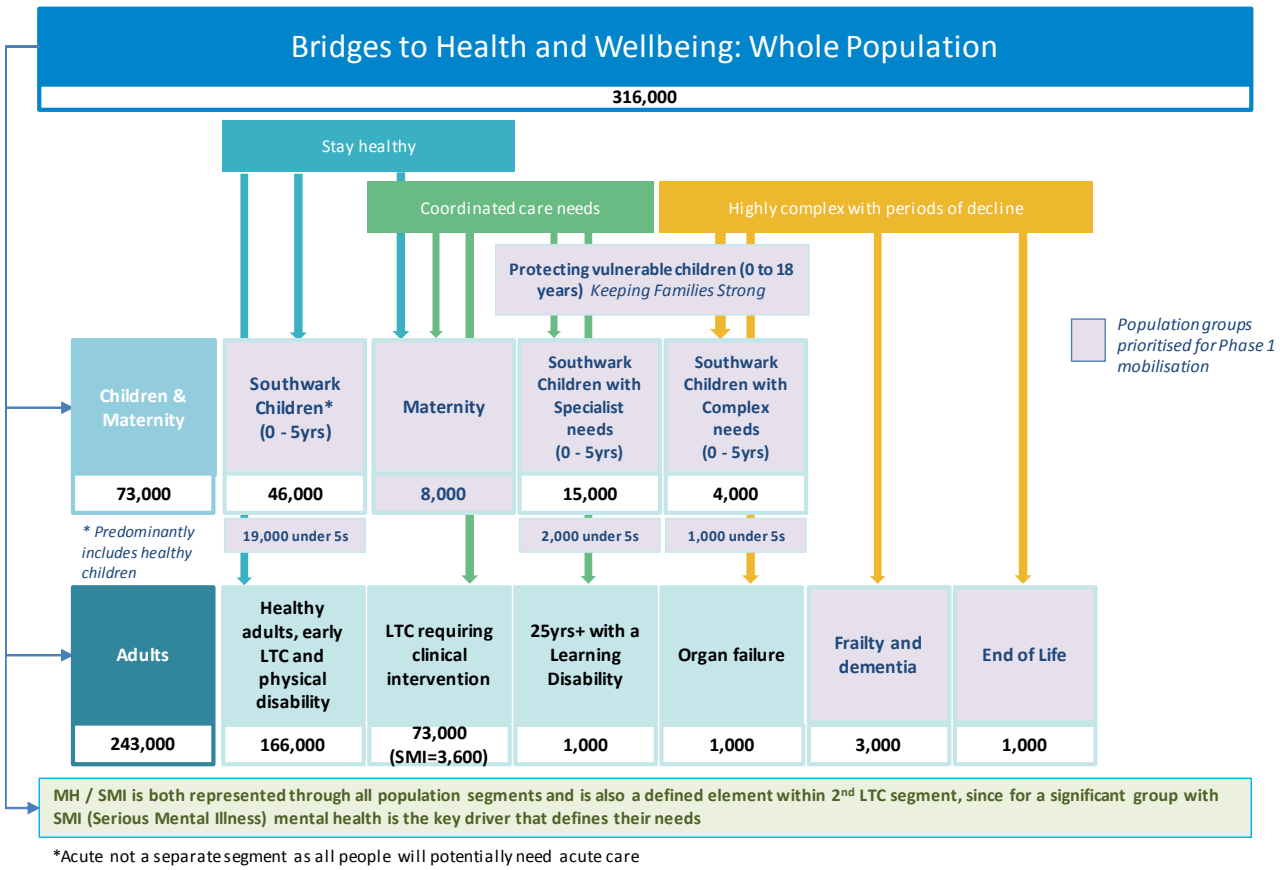
2. Southwark Bridges to Health and Wellbeing is the framework that Southwark CCG and Council commissioners have agreed to use to develop their approach to population based commissioning for outcomes. It seeks to address the issues identified in Southwark's Five Year Forward View, which recognised that we tend to have fragmented commissioning arrangements which are focused on services rather than outcomes, and which do not always incentivise providers to collaborate or invest in prevention and early intervention. The approach has been agreed by Partnership Southwark as underpinning the overall approach to place based service integration and the focus on improving outcomes will feed into all workstreams.

3. The Southwark model adapts an established approach to population based commissioning for health outcomes (Bridges to Health) by widening the scope to Health and Wellbeing, reflecting our desire to not just look at health and care but also the wider determinants such as housing, education and employment.

4. The approach involves segmenting the population into groups with similar patterns of needs as set out bin figure 1 below. For each population segment an agreed set of outcomes and related proxy measures is produced. Providers and commissioners and other stakeholders then come together to consider how new collaborative approaches can help improve those outcomes, taking into account the collective resources available and opportunities for rationalisation through integration, early intervention and prevention.

5. The methodology is a person centred approach aiming to look at how the whole persons needs and ensuring personal objectives are met, rather than different health, care and social needs being assessed and met separately by agencies acting in a sometimes uncoordinated way.

6. **Figure 1: The population segments to which we will apply the Bridges to Health and Wellbeing approach are set out below:**



7. After careful development of the agreed model - which is recognised as a whole population approach – the Joint Commissioning Strategy Committee selected two key population groups to test the methodology in phase 1:

- **Adults:** Frailty, Dementia and End of Life
- **Children and Young People:**
  Maternity and all children (up to 5 years) including those with Specialist or Complex needs and,
  Protecting vulnerable children (0 to 18 years) – Keeping Families Strong

KEY ISSUES FOR CONSIDERATION

Progress on phase 1 priority areas

8. The Bridges to Health and Wellbeing workstream has been incorporated into the overall Partnership Southwark programme and progress is being made in implementing the phase 1 priority areas, although this is still at a developmental stage.

9. The aim is to have developed an agreed set of key outcomes for each population segment by the end of 2019/20. This will be used to provide a foundation for

collaborative work between commissioners, providers and the voluntary sector to make progress on improving those outcomes for the population of Southwark.

Children and Young People (CYP)

10. Within Partnership Southwark there is a specific CYP workstream with an agreed project scope based on taking forward the Bridges to Health and Wellbeing approach.

11. The CYP Commissioning Development Group, which had supported the development of the Bridges to Health and Wellbeing model in a CYP context, was stepped down in July, recognising that a broader group combining front line service providers, commissioners and other stakeholders was required to take forward the implementation. The inaugural meeting of the Southwark Children and Young People Partnership (SCYPP) set up for this purpose was held on 19th September 2019. The meeting was well attended by those involved in the commissioning and provision of services for children, including health, social care and education, and those with a key indirect role such as Housing and Leisure services. The meeting split into facilitated workshop tables focussing on different stages of childhood, identifying what needs to change to improve outcomes. Discussions focussed on outcomes including school readiness, childhood obesity, emotional wellbeing, challenging behaviour and transition to adolescence. A common theme emerging from the groups was the importance of joint working and data sharing to improve targeting of early interventions.

12. A Core Delivery Team has also been established which drives forward the work between bi-monthly SCYPP meetings. The product of the workshop is being processed by the team to articulate priority actions and a work plan that will be discussed and agreed at next SCYPP meeting in November. This will also inform the finalisation of the priority outcomes which are current expressed as:

    - **Connections** – creating effective partnerships, around CYP and families, between public bodies and the community assets that exist in Southwark.
    - **Mental wellbeing** – including maternal mental wellbeing
    - **School readiness/attendance** – focused on reducing inequalities in school readiness and increasing school attainment for vulnerable children
    - **Healthy weight** (in pregnancy, birth weight for babies, child healthy weight).
    - **Families** are supportive units for vulnerable CYP
    - **Feeling safe within the family and within the community**

13. Case studies have been developed as a reference point for testing how proposals may make a real difference to young people.

14. A life course approach will be taken, looking at key issues and transitions from pregnancy and under 5s, primary school, secondary school and young adults.

Adults

15. The initial focus is on improving outcomes for people with dementia, frailty and at the end of life.

16. An outcomes workshop was held on 11 July at which a range of commissioners, service providers and voluntary sector organisations discussed the evolving outcomes framework and helped prioritise particular outcomes and associated

measures. The workshop was facilitated with support from subject matter experts who took on board the workshop findings to develop a shortlist of 20 measures that relate to key outcome domains, and personalised I/we statements that have previously arisen from consultation with the public.

17. Following further discussion and refinement a proposed outcomes scorecard has been developed that was endorsed at the Partnership Southwark Leadership Team in November.

Key measures in the draft adults outcomes framework

Ref	Overarching outcome theme	Outcome	I/We Statement	Outcome proxy measure
1.1	Healthy population	Increase the number of years lived in self-assessed good health (male)	I am able to live the life I want and get the support I need to do that	Healthy Life expectancy at birth (i) male *Source: PHOF*
1.2	Healthy population	Increase the number of years lived in self-assessed good health (female)	I am able to live the life I want and get the support I need to do that	Healthy Life expectancy at birth (ii) female *Source: PHOF*
2	Better experience of care	More Older People die in the place of their choice	I can die peacefully and free from pain in my own room without being admitted to hospital, if that is what I choose.	a) Proportion of deaths **inside** a hospital setting b) Death in usual place of residence *(PHE EOL care profiles)*
3	Healthy population	Ensure Older People have fewer and less serious falls	We Live Healthier lives	Rate of emergency hospital admissions for injuries due to falls in persons aged 65+ per 100,000 population (age-sex standardised) *Source IAF NHSE*
4.1	Healthy population	Detect dementia earlier	We Live Healthier lives	Improvement in diagnosis rate for people with dementia *Source IAF*

Ref	Overarching outcome theme	Outcome	I/We Statement	Outcome proxy measure
4.2	Better experience of care	Improve dementia care	We have quality care	Increase in percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months *Source QOF (Gpcontract)*
5.1	Better experience of care	Improve the care we receive at home and in the community so we can prevent unnecessary hospital stays	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 and "I live independently"	Reduction in Emergency readmissions within 30 days of discharge from hospital *(source NHSOF 3b)*
5.2	Better experience of care	Improve the care we receive at home and in the community so we can prevent unnecessary hospital stays	We have quality care	Reduction in unplanned admissions to hospital from care homes *source: extensivist pilot*
5.3	Better experience of care	Improve the care we receive at home and in the community so we can prevent unnecessary hospital stays	We have quality care	Reduce length of stay for patients in hospital for 21 days and over *(NHSE length of stay dashboard)*
6	Empowered and active communities	Improve the care and support we receive at home	We have quality care	Rate of permanent admissions to care homes of people over 65 per 100,000 (*ASCOF 2a part 2)*
7	Empowered and active communities	Improve the support to maximise independence	We recover and stay well	Increase in percentage of clients completing Rehabilitation and Reablement where the sequel to service was either no ongoing support or support of a lower level (%) *(ASCOF 2D)*

Ref	Overarching outcome theme	Outcome	I/We Statement	Outcome proxy measure
8	Empowered and active communities	Improve our wellbeing	Our Quality of Life will improve	Enhancing quality of life (QoL) for people with care and support needs. Domains are: control, dignity, personal care, food & nutrition, safety, occupation, social participation, accommodation. (A*SCOF (1A) overarching measure from national User Survey).*
9	Empowered and active communities	Improve carer wellbeing	We recover and stay well	Enhancing quality of life for people who are carers. Carer reported quality of life over 6 domains. *Source:ASCOF 1D national survey*
10	Healthy population	Improve the management of medicines for older people	"I had regular, comprehensive reviews of my medicines." "I was as involved as I wanted to be in decisions about my medicines – whether they were needed, and which one to choose."	Structured Medication Reviews. To use approach per PCN specification 2020/21.
11	Empowered and active communities	Reduce isolation and feelings of loneliness and improve our wellbeing and sense of belonging	"I have as much social contact / social support as would like/ I feel part of the community"	To develop Vol Sector Hub access measures with new contract monitoring arrangements 2020/21

Ref	Overarching outcome theme	Outcome	I/We Statement	Outcome proxy measure
12	Empowered and active communities	Improve the achievement of the outcomes that matter to people in their care plan	I have regular reviews of my care and treatment, and of my care and support plan. National Voices (narrative for person centred coordinated care) "I am supported to make decisions as best as I am able about my daily life."	Increase in proportion of people with recorded achievement of All or Some of their personal goals, following their care plan review

18. The final outcomes framework will inform and help align a number of current workstreams impacting on this population segment, which will focus on how these specific outcomes can be improved through collaborative working.

19. A number of the proxy measures will be further refined over time to better align with the outcome. For example, the measure “earlier detection of dementia” that is currently available is the dementia diagnosis rate. This will be refined to better capture early detection.

Policy Implications

20. The Bridges to Health and Wellbeing approach described in this report will inform the place based approach to integrated commissioning and provision of services to be overseen by the Southwark Place Based Board following the formation of the South East London Clinical Commissioning Group in 2020/21.

Community Impact Statement

21. The Bridges to Health and Wellbeing model seeks to improve outcomes for the whole community in Southwark by supporting services to take an integrated approach that meets the “whole” needs of key population segments. The model also includes a particular focus on improving outcomes for those with the worst outcomes and inequalities for whom traditional approaches have had insufficient impact.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Bridges to Health and Wellbeing documentation	160 Tooley Street SE1 2QH	Adrian Ward Programme Manager Partnership Commissioning Team, Southwark Council and CCG 020 7525 3345

AUDIT TRAIL

Lead Officers	Sam Hepplewhite, Director of Integrated Commissioning, NHS Southwark CCG Genette Laws, Director of Commissioning, Southwark Council		
Report Author	Adrian Ward, Partnership Commissioning Team		
Version	Final		
Dated	8 November 2019		
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			8 November 2019

Agenda Item 11

Item No. 11.	Classification: Open	Date: 18 November 2019	Meeting Name: Health and Wellbeing Board
Report title:		Health and Wellbeing Board Governance Review – Update on review and feedback from facilitated workshop	
Ward(s) or groups affected:		N/a	
From:		Strategic Director of Place and Wellbeing	

RECOMMENDATIONS

1. That the health and wellbeing board note the refresh of the governance review that is now being undertaken in light of changes taking place in the NHS.

2. That the facilitator feedback from the Health and Wellbeing Board facilitated workshop held on 15 April 2019 be noted.

BACKGROUND INFORMATION

3. The Health and Wellbeing Board agreed at its meeting on 30 July 2018 to undertake a review of the health and wellbeing board governance arrangements to ensure continued fitness for purpose and an opportunity to deliver better alignment between the Council and the CCG. This initiative arose from work undertaken by the Integrated Planning and Delivery Group (12 month task and finish group) which was set up to explore opportunities for integration across health and care in Southwark.

4. In agreeing to the governance review the health and wellbeing board established a Strategic Board, to be lead by Professor Kevin Fenton to identify individuals or organisations to undertake the review.

5. The Strategic Board met on 14 November 2018 to discuss the review and agree next steps. Present at the meeting were Doreen Forrester Brown, Director of Law and Democracy, Stephen Gaskell, Head of Chief Executive's Office, Ross Graves, Managing Director of the CCG, Jay Stickland, Director of Adult Social Care, Caroline Gilmartin, the then Director of Integrated Commissioning, Tim Jones, Departmental Finance Manager, Kieran Swann, Head of Governance and Assurance (CCG), Everton Roberts, Principal Constitutional Officer and Patricia Rowe, Executive Assistant to the Strategic Director of Place and Wellbeing.

6. Arising from that meeting was the arrangement of the Local Government Association facilitated workshop to enable external input for a clearer understanding of where the Board was positioned in respect of its current arrangements, factoring in experience of other local authorities with a view to the findings being used to inform the review direction.

7. The LGA facilitated workshop was held on 15 April 2019 and was attended by the majority of boards. A summary of the feedback from the facilitator is attached as Appendix 1. The intention was for the findings to be discussed at the last board meeting however the item was not ready for the agenda.

KEY ISSUES FOR CONSIDERATION

8. At the last health and wellbeing board meeting in June the Accountable Officer for NHS Bexley, Bromley, Greenwich, Southwark, and Lewisham Clinical Commissioning Groups reported on changes taking place in the NHS and across CCGs, including the amalgamation of the South East London CCGs and the creation of place based boards and local care partnerships, the governance arrangements for which are still being developed. These developments will inevitably impact on the future role of the health and wellbeing board and the environment in which it operates. The board is therefore asked to note that the review of the board will now be undertaken factoring in the developments and changes taking place in the NHS and across the CCG, some of which will take effect from 1 April 2020.

9. A progress update on the creation of the South East London Integrated Care System and local plans being developed for Southwark is contained elsewhere on the agenda. The update sets out more detail of the changes taking place.

Facilitated Workshop

10. The information gathered from the workshop will be used to inform future developments in the areas highlighted in the feedback, following a fine tuning of the actions identified and comments of board partners.

Review – Next steps

11. The strategic board tasked with overseeing the review will be meeting in November / December to consider further how to take the review forward in light of the changing landscape.

Policy implications

12. In 2016, the CCG and the Council agreed the Southwark Five Year Forward View for improving health and social care outcomes across the borough. The Council Plan which was approved by Cabinet on the 26 June 2018 details the Fairer Future Promises and the ambition for a healthier Southwark, achieving the best start in life where your background does not determine your health outcomes.

13. Taken together, these provide the local policy framework in which the senior leadership of the Council and CCG has agreed to greater integration between health and social care. Any proposed changes to current policy in light of changes taking place in the NHS will be considered by the council and the CCGs governing bodies at the appropriate stage in the process.

Community impact statement

14. The Public Sector Equality Duty requires that public authorities must have 'due regard' to the need to eliminate unlawful discrimination, harassment and victimisation as well as advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not.

15. It is essential when decisions are made that they take into account the public sector equality duty as set out in S149 of the Equality Act 2010. Any organisation

which the council engages to deliver a review in the future will have a detailed understanding of the PSED and undertake the review in line with the general duty under the act and the council's approach to equality.

Legal implications

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

Financial implications

17. There are no specific financial implications arising from this report.

Consultation

18. Consultation has taken place between key officers in the Council and the CCG.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Health and Wellbeing Board Agenda and Minutes – 30 July 2018	160 Tooley Street London SE1 2QH	Everton Roberts 020 7525 7221
Link: http://moderngov.southwark.gov.uk/ieListDocuments.aspx?CId=365&MId=6155&Ver=4		

APPENDICES

No.	Title
Appendix 1	Feedback from LGA Facilitated Workshop

AUDIT TRAIL

Lead Officer	Professor Kevin Fenton, Strategic Director of Place and Wellbeing		
Report Author	Everton Roberts, Principal Constitutional Officer		
Version	Final		
Dated	7 November 2019		
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			7 November 2019

APPENDIX 1

Southwark Facilitated Workshop – 15 April 2019 (Facilitator Feedback)

Attendance

Name	Title	Representing
Councillor Peter John	Leader of the Council (chair of the board)	Council **Table 1**
Catherine Negus	Healthwatch Southwark	Local Healthwatch **Table 1**
Dr Jonty Heaversedge	Chair of NHS Southwark CCG (Vice-Chair of the H&WB)	NHS Southwark CCG **Table 1**
Councillor Jasmine Ali	Cabinet Member for Children, Schools and Adult Care	Council **Table 1**
Dr Yvonneke Roe	Clinical Lead for Prevention and Early Action	NHS Southwark CCG **Table 2**
David Quirke-Thornton	Strategic Director of Children's and Adults' Services	Council **Table 2**
Genette Laws (officer – non board member)	Director of Commissioning	Council **Table 2**
Sam Hepplewhite (officer – non board member)	Director of Integrated Commissioning	NHS Southwark CCG **Table 2**
Paul Rymer	Chief Executive, Community Southwark	Voluntary Sector **Table 3**
Councillor David Noakes	Opposition spokesperson for Health	Council **Table 3**
Angela Dawe (non board member)	Joint Director for Integrated Care	Guy's and St Thomas' NHS Foundation Trust **Table 3**
Stephen Gaskell (officer- non board member	Head of Chief Executive's Office	Council **Table 4**
Tim Jones (officer – non board member	Departmental Finance Manager	Council **Table 4**
Professor Kevin Fenton	Strategic Director of Place and Wellbeing (Director of Public Health)	Council **Table 4**
Everton Roberts (officer – non board member	Principal Constitutional Officer	Council 020 7525 7221

Summary

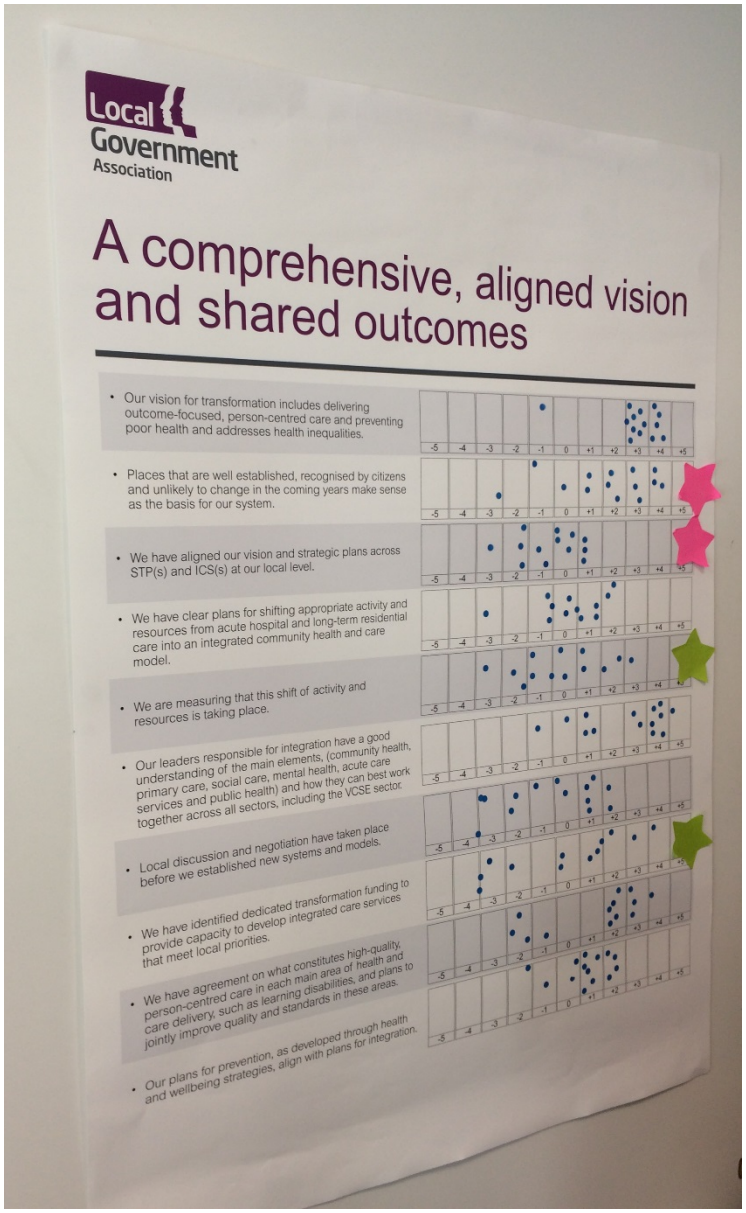
Actions plan

ACT	**1. Review the HWB role** - Review membership - Refresh and purpose - Develop protocols and arrangements for risk - Be clear on decision making and governance **2. Require Organisational Development** - To develop skills for collaborative leadership - For workforce generally on integrated environment **3. Agree metrics for measuring shift of activity** **4. Develop an integrated workforce plan** - Needs to 'knit' together existing plans before coming to HWB - HWB sets strategic vision e.g. 'Never been a better time to come and work in Southwark' - Focus on health and wellbeing for staff, and impact on retention
SPONSOR	**1. Resident engagement through public sense check/evaluation** **2. Digital and shared records** - Working through technical barriers, engagement with patients, extending to VCS **3. Integrated approach to assessments and care plans** **4. Integrated information and advice** **5. Positive engagement with the STP** **6. Dependencies and subsidiaries** **7. Places recognised**
WATCH	**1. Align vision and strategic plans** **2. Dedicated transformation funding**
OUT OF SCOPE	**1. South East London level developments e.g. digital** **2. Explore other issues which may be 'happening elsewhere'**

Notes:

Discussion and poster self-assessment

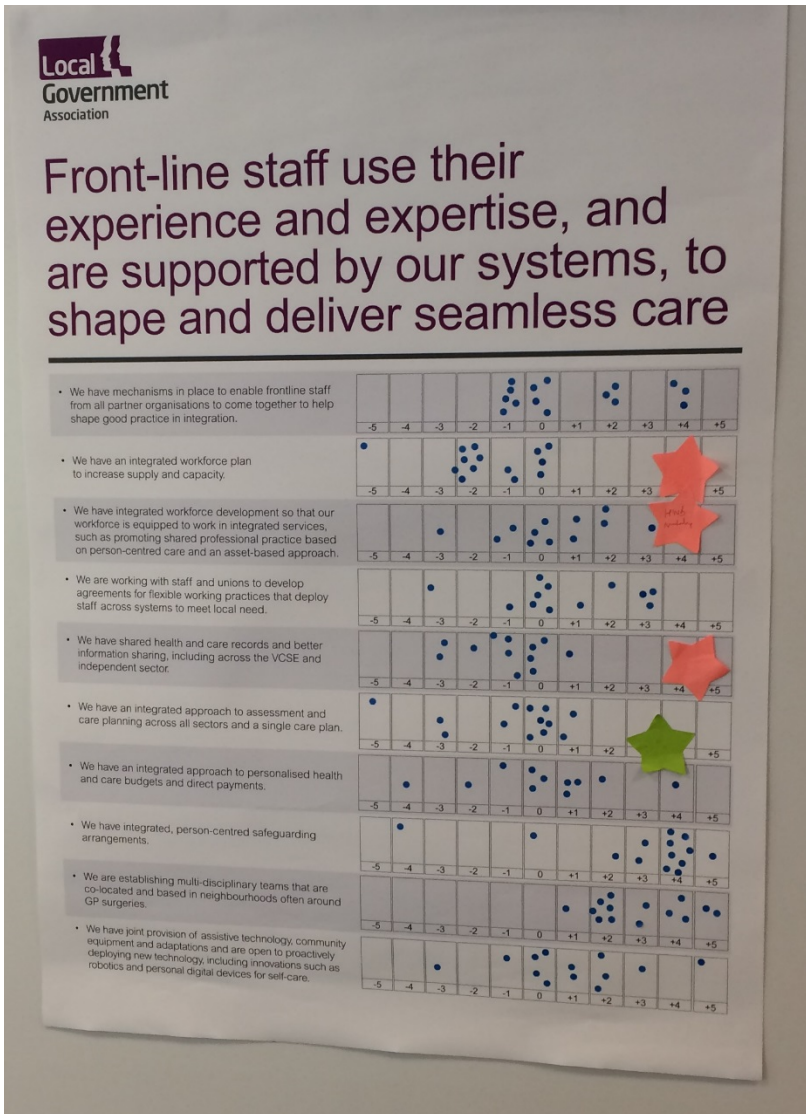
Poster #1



- Question what sits at Southwark level, or South East London level?
- Different interpretations of place – boundaries require constant review
    - Tension between place and population – what is the difference, something which could be explored.
    - Frontline staff delivering services in place and neighbourhoods
        - Identify with their teams and communities
        - Pride of place
        - Residents identity
- Some of the questions posed delegates to question where they should place their dot, as they were unaware if happening or not. Is this unawareness an issue, or not? To be filter through action planning (what does the board do - act, sponsor, watch, or is it out of scope)

- Can see Southwark in STP/ICS plans, but not sure how much Southwark feeds into plan
    - Top-down
    - How does Southwark influence the STP?
- Clear ambitions for shift in activity, but based around institutions and activity
    - Challenges (external)
    - Planning for shift in activity limited
    - Aspiration for the long-term
- Measuring shift of activity in pockets, not necessarily sharing with one another
    - No shared metrics
    - Good DTOC figures may mean pressures do not exist in Southwark as elsewhere to develop a clear plan
    - JHWBS – priorities, measured bi-annually
- Good examples in Southwark, despite local government funding cuts but not necessarily due to the HWB e.g. hubs, innovation
- Self-assessment is a snapshot in time, and expect to come closer together over time
- Posters show that the vision clear, but less aligned on outcomes/measures
- Things happening in individual organisations are so effective, may not be the pressure to join-up, but does not mean should not
- Does the money focus on the day-to-day delivery, rather than the transformational?
    - But now transformation is business as usual
    - Need to develop a shared understanding if there is or isn't capacity for transformation, and have a conversation to reflect on how capacity is used

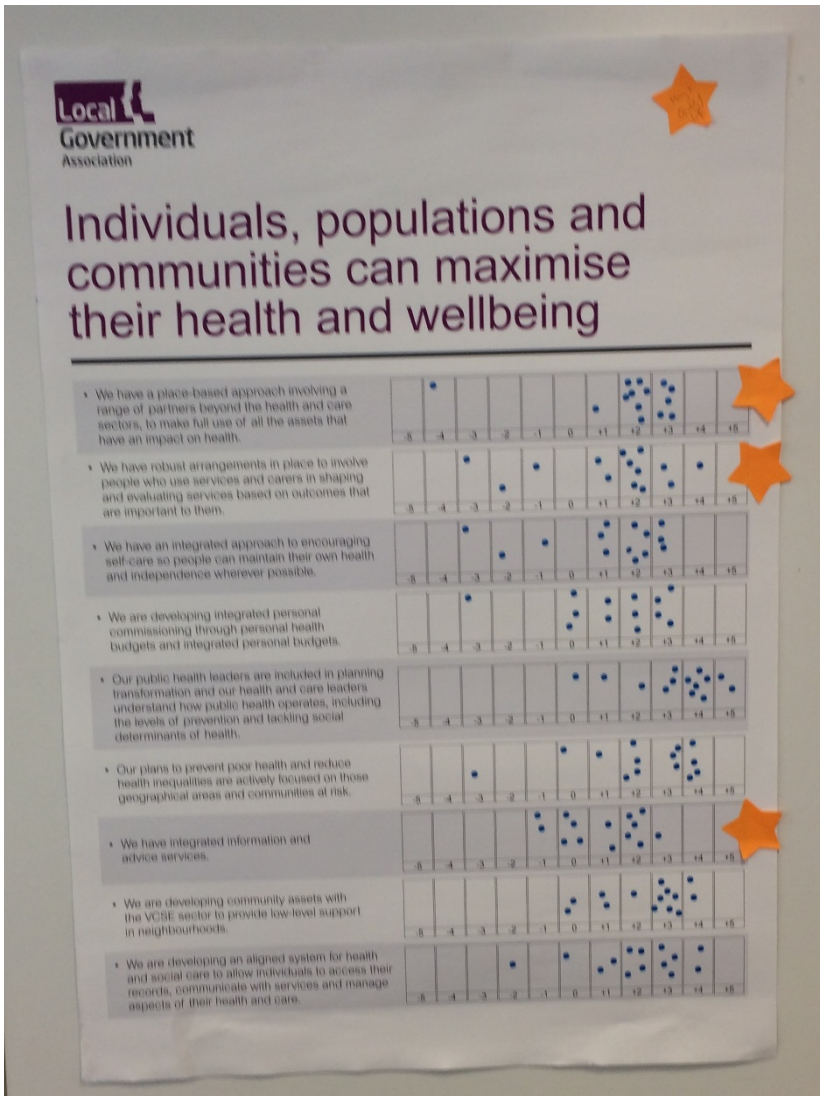
Poster #2



- Some teams e.g. safeguarding coming together working collectively, but not necessarily systematic, but on the journey there. Difficult to generalise.
- Review required of HWB
    - Membership (Guy's and St. Thomas' not on HWB)?
    - Deficit of knowledge and awareness for HWB.
    - Disconnect between board, and what is going on on the ground
        - Assurance mechanisms, rather than knowing in detail
- Workforce
    - Teams coming together, feels like organic process
    - No integrated workforce plan – could develop
        - Recognise difficulty with workforce plans - inherently hard to do write
    - Recruitment and retention
        - Health and wellbeing of front line staffed
- Shared health and care records and information sharing
    - In progress with a plan
    - Sharing health data with social care, but not voluntary sector

        - Involvement of community voice through citizens jury
            - Respectful and cautious approach, building trust
        - Voluntary sector is the next step
    - Moving towards user visibility of data and how they wish to share
    - What is the role for big data?
    - Working with health professionals about why it is important to share data
    - Need to continue to prioritise despite successful progress
- Integrated approach to assessment and care planning, and single care plan
    - Does a single agreed way of assessing need to be developed?
    - Currently different models which are not necessarily in conflict, but stand alone
    - Resident experience should be the priority
- GP contracting could risk good progress made in neighbourhoods
    - Communication needs to continue to be collaborative with
    - National contacting could undermine (PCN)
- Technology
    - Closely linked to workforce and impact upon retention
    - Could be considered further

Poster #3



- In having a place-based approach, could the role of housing be more prominent to the board?
- Is there space between system leader's perception and residents'
    - Is there an exercise required to test residents' views?
- Integrated information and advice services to differing degrees
    - E.g. Children and Young People, and Adults

Poster 4

- Organisational development required to understand the direction of travel in terms of integrating. For both leaders and staff to develop collaborative leadership and an integrated environment
- Principle of subsidiarity well understood, need to maintain whilst change happens
- Where does the HWB sit in Southwark's governance arrangements
    - E.g. how does the HWB and 'partnership Southwark' interrelate?
    - Role of oversight and decision making, ensuring efficiency of decision making
- Shared protocols and arrangements
    - Different interpretations between council and CCG
        - Lack shared protocols and agreements, but have strong individual ones
        - Some may be for SE London level

Action plan:

ACT (require engagement of all partners and will not happen without strong, shared focus):

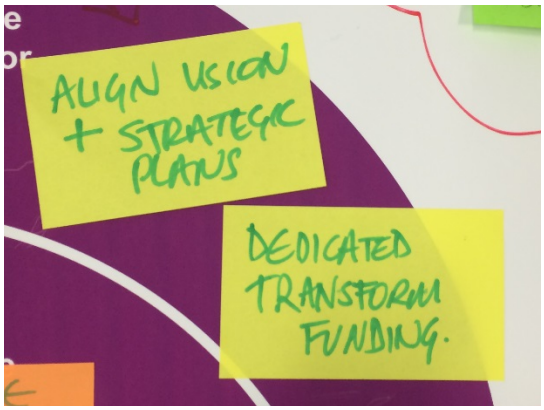
1. Review the HWB role
    a. Review membership
        i. Refresh and purpose
    b. Develop protocols and arrangements for risk
    c. Be clear on decision making and governance
2. Require Organisational Development
    a. To develop skills for collaborative leadership
    b. For workforce generally on integrated environment
3. Agree metrics for measuring shift of activity
4. Develop an integrated workforce plan
    a. Needs to 'knit' together existing plans before coming to HWB
    b. HWB sets strategic vision e.g. 'Never been a better time to come and work in Southwark'
    c. Focus on health and wellbeing for staff, and impact on retention

SPONSOR (are being or will be delivered through existing action plans)

1. Resident engagement through public sense check/evaluation
2. Digital and shared records
    - Working through technical barriers, engagement with patients, extending to VCS
3. Integrated approach to assessments and care plans
4. Integrated information and advice
5. Positive engagement with the STP
6. Dependencies and subsidiaries
7. Places recognised

WATCH (responsibility of one or two partners and/or already underway):

1. Align vision and strategic plans
2. Dedicated transformation funding



OUT OF SCOPE

1. South East London level developments e.g. digital
2. Explore other issues which may be 'happening elsewhere'

ACTION: develop agenda setting and work plan for HWB

Agenda Item 13

Item No. 13.	Classification: Open	Date: 18 November 2019	Meeting Name: Health and Wellbeing Board
Report title:		Better Care Fund 2019/20	
Ward(s) or groups affected:		All	
From:		Sam Hepplewhite, Director of Integrated Commissioning, NHS Southwark CCG Genette Laws, Director of Commissioning, Southwark Council	

RECOMMENDATION

1. That the Health and Wellbeing Board

   - note the Better Care Fund template 2019/20 submitted to NHS England for assurance on 27 September.

   - note the performance on key BCF targets during 2019/20

BACKGROUND INFORMATION

2. The Better Care Fund (BCF) was first established in 2015/16 as a national policy initiative to drive forward the integration of health and social care services by requiring local councils and CCGs to agree a pooled budget and an associated BCF plan for community based health and care services.

3. The Better Care Fund Plan needs to be agreed by the council, the Southwark NHS Clinical Commissioning Group (CCG) and the Health and Wellbeing Board prior to national submission for approval by NHS England.

4. An update on the BCF planning process and approach to finalising the plan was reported to the Health and Wellbeing Board on June 26, noting the substantial delay by NHS England in issuing national planning requirements for 2019/20. To meet the compressed timescales the Board agreed that the approval of the plan for submission would be undertaken on a delegated basis by the chair on behalf of the board, following sign off by both the accountable officer of the CCG and the strategic director of the Council. It was agreed the plan would be circulated to Board members at the time and would then be reported to the next scheduled meeting.

5. Planning guidance was issued in July and the planning template was completed in line with the approach outlined in the June BCF report. The Chair of the Health and Wellbeing Board approved the BCF plan for submission on 27 September following agreement by the Council and CCG. The plan is currently undergoing national assurance with approval to the plan expected in mid-November, which will enable the formal pooled budget to be established.

KEY ISSUES FOR CONSIDERATION

BCF allocation and growth since 2018/19

6. The final BCF Plan template is attached in appendix 1.

7. The value of the 2019/20 BCF and funding sources, showing growth from 2018/29 is set out below:

BCF pooled budget total			
Funding Sources	**18/19**	**19/20**	**growth**
a) Disabled Facilities Grant	£1,377,165	£1,486,043	£108,878
b) Minimum CCG Contribution	£21,449,545	£22,654,606	£1,205,061
c) IBCF grant	£12,584,184	£15,751,933	£3,167,749
d) Winter Pressures Grant	£0	£1,570,648	£1,570,648
Total	£35,410,895	£41,463,230	£6,052,335

8. As set out in the June report to the Board, the agreed strategy had been to essentially roll forward 2018/19 budgets to provide stability for services given the delay in clarifying national BCF arrangements. Decisions on use of growth were based on joint agreement about priority areas, with a particular focus on investments that will improve performance on the key target to reduce delayed transfers of care, on which Southwark has experienced significant growth over the last year.

9. With the exception of the higher than expected inflation in the CCG minimum contribution (see b below), the growth had been anticipated in budget planning processes for 2019/20.

Notes on growth items:

a) **Disabled Facilities Grant**: For the Disabled Facilities Grant (DFG) growth of £108k it has been agreed with Housing this is to be used on issuing home improvement grants in line with DFG requirements, and to increase the speed of assessments for housing adaptations through additional occupational therapy input.

b) **CCG minimum contribution:** There is £1.2m uplift in the CCG minimum contribution, shared proportionally between Social Care and CCG commissioned services for which there are set minimum investment levels. This reflects an uplift of 5.7% in line with overall CCG budget growth. This was announced in July and is substantially more than the CCG planned for (on the basis of national planning advice) in the planning round in January 2019 (£380k) which was based on a 1.8% uplift. This initially created a funding gap which was recognised by NHSE. To obtain the additional funding for the full Social Care element of the additional uplift (£570k) the CCG applied for a grant from NHSE for which a condition is that it will be used to help deliver the social care related aspects of NHS Long Term Plan implementation. This grant has been approved. For the CCG additional funding uplift (£250k) no funding is available, and CCGs have been advised to bring existing budgets for relevant CCG commissioned community based health services into the BCF to meet the minimum requirement.

c) **Improved Better Care Fund Grant:** £3.1m growth is in the council's Improved Better Care Fund grant which is ringfenced for council adult social services.

d) **Winter Pressures Grant:** this £1.5m growth relates to the winter pressures council grant, also ring fenced for social care services. Last year this sum was paid directly to councils at short notice in November without a requirement for it to be pooled into the BCF. It is specifically used to fund services required to discharge people from hospital.

Decisions on use of growth

10. The table below sets out the use of growth agreed at the September 16th Health and Social Care Partnership Board reflected in the BCF template attached in annex 1:

Area	Growth	Application	Amount	Note
1. DFG	£108,878	1.1 Agreement to use to fund OT and additional DFG capital spend to increase timeliness of adaptations process	£108,878	
2 BCF minimum contribution inflation	£1,205,061	a) Core growth 1.79% (£383,947):		
		2.1 Neuro-rehab growth (CCG):	£8,677	Agreed on transfer from council to CCG lead commissioner
		2.2 Mental Health Discharge worker (council):	£50,000	
		2.3 Mental Health Social Worker Complex Cases (Council)	£60,000	
		2.4 Mental Health Placement Broker (Council)	£50,000	
		2.5 Housing worker for hospital discharge (council)	£50,000	
		2.6 Discharge to assess – cost pressure for social services (council). PART 1	£64,957	PART 2 funded from additional growth grant below. (2.8) Total £260,000
		2.7 Discharge to assess cost pressure for CCG:	£100,313	CCG share of core inflation
		Sub-total	£383,947	
		b) Additional growth to 5.7% (£821,114):		Nb. Treated separately as different conditions apply
		1. Use of grant for Social Services inflation uplift (£570,414):		CCG grant agreed
		2.8) Discharge to assess PART 2 (part 1 in 2.6)	£195,043	Total £260,000 Part 1 and 2.
		2.9) Staffing Pressures (Council staff)	£300,000	Additional funding for potential increase in costs for social work

Area	Growth	Application	Amount	Note
				and OT staff
		2.10) Pooled budget for complex joint discharges	£75,371	Added to 5.2 gives total of £175,371
		2. CCG increase (£250,700)		Unfunded growth
		2.11). Enhanced Rapid Response and at home Community Health service	£250,700	Existing budget to be bought into BCF. Current spend on these services exceeds the BCF contribution.
		Sub-total	£821,114	
		Total	*£1,205,061*	
Area	**Growth**	**Application**	**Amount**	**Note**
3. IBCF (all council social services)	£3,167,749	Agreed:		
		3.1 Sustaining quality in home care by paying a fair price for care and complying with the SECC	£368,000	
		3.2 Rebuilding Southwark's nursing home market by investing in high quality and local nursing care homes and supporting social care providers generally	£1,800,000	
		3.3 Reablement and Intermediate care including bed based care model	£999,749	
		Total	**£3,167,749**	
4. Winter Pressures Grant (all council social services)	£1,570,648	4.1 **Winter Pressure grant plan:** Provider Cost Pressures (approx. 5%): 4.1.a OP Residential – £400,000 4.1b OP Nursing – £300,000 4.1c OP Homecare £870,648	**£1,570,648**	
Total	**£6,052,335**		**£6,052,335**	

Redirected funding from reduction in current schemes:

11. In addition to the above growth in the BCF, a sum of £264,000 was released by adjustments to existing budgets:

Area	Growth	Application	Amount	Note
redirected funding	£264,000 (joint)	To be agreed		
		5.1 joint contingency for potential growth in community equipment costs	£164,000	
		5.2 Pooled budget for joint S117 discharges	£100,000	Combined with 2.1 gives £175k
		Total	**£264,000**	

Application of funding: revised BCF budgets 2019/20:

The full 2019/20 BCF budget after growth is set out below.

ref	Scheme	Budget holder	2019/20
	Theme 1: Hospital Discharge – I get the support I need to leave hospital and settle back at home		
1	Hospital discharge	LA	£1,790,453
2	Reablement	LA	£1,936,738
3	Neuro rehab team	CCG	£197,886
4	Shared budget for complex joint discharge	LA/CCG	£176,120
5	Discharge to Assess – council costs	LA	£260,000
6	Discharge to Assess – CCG costs	CCG	£100,313
7	Night Owls - overnight intensive homecare	LA	£224,000
8	Housing worker – discharge team	LA	£50,000
9	Contingency – council staff	LA	£300,000
10	Intermediate Care	LA	£1,137,563
	Sub-total – hospital discharge		**£6,173,073**
	Theme 2: Admissions avoidance - I get support that reduces the need to be in hospital		
11	Community Health Enhanced Rapid Response /@home	CCG	£,4,216,105
12	Care home pharmacist	CCG	£47,095
13	Enhanced Primary Care Access - 7 day services	CCG	£743,000
14	Self -management for long terms conditions	CCG	£307,000
	Sub-total		**£5,313,200**
	Theme 3: Community support and maintenance - I am helped to live in my community		
15	Home care quality improvement	LA	£1,900,000
16	Dementia - Enhanced neighbourhood support	LA	£184,177
17	End of life care	LA	£152,905
18	Disabled Facilities Grant	LA	£1,486,043
19	Protect Adult Social Care - Residential Care	LA	£2,010,619
	Sub-total		**£5,733,735**
	Theme 4: Prevention: I can access resources in the community that help me and my carers		
20	Voluntary sector preventative services	LA	£1,248,251
21	Voluntary sector carers work	LA	£400,000
22	Carers strategy	LA	£450,000
23	Telecare	LA	£566,000
24	Community equipment: council cost	LA	£400,000
25	Community equipment: joint contingency for 19/20	LA/CCG	£164,000
	Sub-total		**£3,228,251**
	Theme 5: Mental Health and Learning Disability – I get the support I need to leave hospital and settle back at home		
26	Mental Health Reablement	LA	£151,632
27	Community mental health services	LA	£655,000
28	Mental Health discharge worker	LA	£50,000
29	Mental Health Broker	LA	£50,000
30	Mental Health Complex Cases worker	LA	£60,000
31	Psychiatric Liaison (AMHPs and reablement)	LA	£300,000
32	Mental Health – personal budgets	LA	£600,000
33	Learning Disabilities – personal budgets	LA	£211,000
34	Enhanced Psychological Support for those with LD (£29k	CCG	£239,000

	Local Authority, £210k CCG)	/LA	
	Sub-total		**£2,316,632**
	Care Act funding and Service Development and change Management		
35	Care Act Funding	LA	£1,000,000
36	Service development and change management	CCG/LA	£375,758
	Sub-total		**£1,375,758**
	Total (Core BCF)		**£24,140,649**
	Improved Better Care Fund grant (iBCF)		
37	Sustaining quality in home care	LA	£10,327,850
38	Re-ablement and intermediate care including step down accommodation	LA	£999,749
39	Improving and Investing in local nursing care	LA	£4,174,334
40	Transformation fund	LA	£250,000
	Sub-Total iBCF		**£15,751,933**
	Winter Pressures Grant		
41	Residential care for older people	LA	£400,000
42	Nursing care for older People	LA	£300,000
43	Home care for older people	LA	£870,648
	Sub-total Winter Pressures Grant		**£1,570,648**
	Grand Total BCF		**£41,632,230**

Balance of spend from CCG minimum contribution

12. The balance of spending from the CCG contribution minimum to the pooled budget between Council services and CCG commissioned community health schemes is in line with the required ring fenced minimum for each type of spend. For Southwark this is as follows.

Required Spend from CCG contribution	Minimum Required Spend	Planned Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£6,437,797	£6,633,466
Adult Social Care services spend from the minimum CCG allocations	£15,730,051	£16,616,328

13. All spend from Council contribution is ringfenced for Council adults social care or Housing Disabled Facilities Grant related spend.

The Better Care Fund framework in 2020/21

14. As reported to the Board in June, it was originally advised that a new framework replacing the BCF would be produced for 2020/21. However, it has been confirmed that the BCF will continue into 2020/21 with the CCG contribution inflated in real terms by 3.4% (£770k) and that iBCF grant funding will be continuing at current levels. This assurance is useful for high level planning purposes, but to enable detailed planning the BCF policy framework and planning guidance for 2020/21 is required.

Delivery on key BCF targets 2019/20

15. Close monitoring of the BCF is undertaken through national quarterly monitoring returns and internal monitoring which is overseen by the Health and Social Care

Partnership Board on behalf of the Health and Wellbeing Board. There are 4 key targets associated with the BCF discussed below:

16. **Delayed transfers of care:** The BCF funds a range of services that promote safe and timely discharge from hospital. Until 9 months ago Southwark maintained strong performance on this target. However, since then performance has declined and has not met the target NHSE set for Southwark.

Days delayed	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
BCF Target	449	449	434	449	434	449	449	405	449	333	344	333	344	344
Actual	341	283	369	403	525	410	571	737	766	577	608	736	558	653

17. Performance on this measure is subject to close monitoring. An analysis of the reasons for the growth in delays has been undertaken informing an action plan to address the growth and restore good performance. A range of key issues have been identified including;

- Delays relating to shortage of capacity in the nursing care home market are the main reason for recent growth. Steps are being taken to increase local supply but the impact of this is likely to be medium to long term only. Enhanced intermediate care step down beds are being commissioned to help address the pressure in the short term.
- Residential care home delays are the second biggest cause of delays. Extra investment in home care, residential care and intermediate care care, including step down flats is intended to reduce this pressure.
- Delays caused by patient choice in hospital are the third highest reason for the growth. This is being tackled by working with the trusts to ensure full implementation of the revised patient choice policy.

18. It should be noted that the majority of delays relate to NHS issues rather than social care. e.g. 512 NHS delayed days in August, as compared to 141 council delays.

19. The BCF Plan sets out in more detail the actions being taken to address the growth in delays.

20. **Non-elective admissions:** The target for non-elective admissions to hospital was exceeded by 7.4% in 2018/19 and 2019/20 targets have been uplifted in agreement with NHS England to reflect expected demand. Targets are currently being met for 2019/20.

21. **Admissions to care homes:** A key objective of BCF funded services is to support people to live safely and independently in their own home, and there are a range of investments in home care and other community support services to help deliver that outcomes. Targets have been uplifted reflecting the increase in demand experienced during 2018/19. The target is being met in 2019/20 to date with 76 admissions against a target of 86.

22. **Reablement:** The BCF funds reablement services that aim to restore people's independence. Latest quarterly figures show that 157 out of 184 (85%) people discharged from hospital with a reablement service during Q2 were still at home

in 91 days without having been readmitted to hospital or a care home. This is in line with the target.

Policy Implications

23. The document "2019-20 Better Care Fund: Policy Framework" published by the Department of Health and Department of Communities and Local Government on 11 April 2017 sets out the purpose of the BCF in terms of driving forward the national integration agenda. The BCF plan reflects local policy on integration as set out in the Southwark Five Year Forward View and is consistent with the national framework.

Community Impact Statement

24. The BCF plan protects current services funded through the core BCF which provide essential support for people with health and social care needs. This has benefit to all people with protected characteristics, particularly services provided for older people, and people with disabilities and mental health problems. The BCF also funds a range of voluntary sector services promoting community resilience. The iBCF funding is also used to protect current levels of home care and nursing care funded through the council general fund but for which current budgets are insufficient to meet current activity levels.

25. Other beneficiaries of this investment are the homecare workforce who have been paid the London living wage since April 2018 under Southwark's ethical care charter. This workforce has a high proportion of women and those from the black and minority ethnic communities.

SUPPLEMENTARY ADVICE FROM OFFICERS

Southwark Council

Strategic Director of Finance and Governance (44TJ201920)

26. This report recommends the approval of the Better Care Fund plan for 2019-20. The plan includes the rollover of the majority of pre-existing schemes, plus the addition of growth monies for 2019-20 totalling approximately £6m.

27. These income streams (BCF, iBCF & Winter Pressures) now fund in excess of £30m of the Council's Adult Social Care budgets, including a mixture of 'traditional' social care provision such as nursing care and home care and joint projects with the CCG to reduce delayed transfers of care. Given that the council and CCG have been jointly incurring expenditure in relation to these schemes since 1st April 2019 it is disappointing that central government delays mean that plans for the year are only submitted in late September. The recent Spending Round has confirmed that existing social care funding will continue into 2020-21, including a proposed 3.4% uplift in the BCF. Whilst this is a welcome development, longer term certainty is required if councils and CCGs are to be expected to develop and sustain meaningful transformation.

28. The proposals contained within this report can be fully funded within existing resources in 2019-20, however health and social care colleagues must continue to make plans that meet the needs of the borough whilst recognizing the continuing uncertainty of these funding streams.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Better Care Fund documentation	160 Tooley Street SE1 2QH	Adrian Ward Programme Manager Partnership Commissioning Team, Southwark Council and CCG 020 7525 3345

APPENDICES

No.	Title
Appendix A	Better Care Fund Plan template 2019/20

AUDIT TRAIL

Lead Officers	Sam Hepplewhite, Director of Integrated Commissioning, NHS Southwark CCG Genette Laws, Director of Commissioning, Southwark Council	
Report Author	Adrian Ward, Partnership Commissioning Team	
Version	Final	
Dated	8 November 2019	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Law and Democracy	Yes	No (not required)
Strategic Director of Finance and Governance	Yes	Yes
Cabinet Member	No	No
Date final report sent to Constitutional Team		8 November 2019

Better Care Fund 2019/20 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.
3. The checker column will appear 'Red' and contain the word 'No' if the information has not been completed. Clicking on the corresponding 'Cell Reference' column will link to the incomplete cell for completion. Once completed the checker column will change to 'Green' and contain the word 'Yes'
4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to
6. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net
3. Please note that in line with fair processing of personal data we collect email addresses to communicate with key individuals from the local areas for various purposes relating to the delivery of the BCF plans including plan development, assurance, approval and provision of support.
We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

4. Strategic Narrative (click to go to sheet)

This section of the template should set out the agreed approach locally to integration of health & social care. The narratives should focus on updating existing plans, and changes since integration plans were set out until 2020 rather than reiterating them and can be short. Word limits have been applied to each section and these are indicated on the

1. Approach to integrating care around the person. This should set out your approach to integrating health and social care around the people, particularly those with long term health and care needs. This should highlight developments
2 i. Approach to integrating services at HWB level (including any arrangements at neighbourhood level where relevant). This should set out the agreed approach and services that will be commissioned through the BCF. Where schemes are new or approaches locally have changed, you should set out a short rationale.
2 ii. DFG and wider services. This should describe your approach to integration and joint commissioning/delivery with wider services. In all cases this should include housing, and a short narrative on use of the DFG to support people with care needs to remain independent through adaptations or other capital expenditure on their homes. This should include
3. How your BCF plan and other local plans align with the wider system and support integrated approaches. Examples may include the read across to the STP (Sustainability Transformation Partnerships) or ICS (Integrated Care Systems) plan(s) for your area and any other relevant strategies.

You can attach (in the e-mail) visuals and illustrations to aid understanding if this will assist assurers in understanding

5. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's Better Care Fund (BCF) plan and pooled budget for 2019/20. On selected the HWB from the Cover page, this sheet will be pre-populated with the minimum CCG contributions to the BCF, DFG (Disabled Facilities Grant), iBCF (improved Better Care Fund) and Winter Pressures allocations to be pooled within the BCF. These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from Local Authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be utilised to include any relevant carry-overs from the
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact England.bettercaresupport@nhs.net

6. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and utilised to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Condition 2
The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.
On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is free text field to include a brief headline description of the scheme being planned.
4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available at the end of the table (follow the link to the description section at the top of the main expenditure table).
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
5. Planned Outputs
- The BCF Planning requirements document requires areas to set out planned outputs for certain scheme types (those which lend themselves to delivery of discrete units of delivery) to help to better understand and account for the activity funded through the BCF.
- The Planned Outputs fields will only be editable if one of the relevant scheme types is selected. Please select a relevant
6. Metric Impact
- This field is collecting information on the metrics that a chem will impact on (rather than the actual planned impact on the metric)
- For the schemes being planned please select from the drop-down options of 'High-Medium-Low-n/a' to provide an indicative level of impact on the four BCF metrics. Where the scheme impacts multiple metrics, this can be expressed by selecting the appropriate level from the drop down for each of the metrics. For example, a discharge to assess scheme might have a medium impact on Delayed Transfers of Care and permanent admissions to residential care. Where the
7. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
8. Commissioner:
- Identify the commissioning entity for the scheme based on who commissions the scheme from the provider. If there is a single commissioner, please select the option from the drop-down list.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns alongside.
9. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

10. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop-down list
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the
11. Expenditure (£) 2019/20:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
12. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2019/20 and will inform the understanding of planned spend for the iBCF and Winter Funding grants.

7. HICM (click to go to sheet)

National condition four of the BCF requires that areas continue to make progress in implementing the High Impact Change model for managing transfers of care and continue to work towards the centrally set expectations for reducing DToC. In the planning template, you should provide:

- An assessment of your current level of implementation against each of the 8 elements of the model – from a drop-
- Your planned level of implementation by the end March 2020 – again from a drop-down list

A narrative that sets out the approach to implementing the model further. The Narrative section in the HICM tab sets out furthe

8. Metrics (click to go to sheet)

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2019/20. The BCF requires plans to be agreed for the four metrics. This should build on planned and

1. Non-Elective Admissions (NEA) metric planning:

- BCF plans as in previous years mirror the latest CCG Operating Plans for the NEA metric. Therefore, this metric is not collected via this template.

2. Residential Admissions (RES) planning:

- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from ONS subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
- Please include a brief narrative associated with this metric plan

3. Reablement (REA) planning:

- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.
- Please include a brief narrative associated with this metric plan

4. Delayed Transfers of Care (DToC) planning:

- The expectations for this metric from 2018/19 are retained for 2019/20 and these are prepopulated.
- Please include a brief narrative associated with this metric plan.
- This narrative should include details of the plan, agreed between the local authority and the CCG for using the Winter Pressures grant to manage pressures on the system over Winter.

9. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2019/20 for further details.

The Key Lines of Enquiry (KLOE) underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

10. CCG-HWB Mapping (click to go to sheet)

The final sheet provides details of the CCG - HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity figures.

Better Care Fund 2019/20 Template

2. Cover

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS

Version 1.2

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2019/20.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Southwark
Completed by:	adrian.ward3@nhs.net
E-mail:	adrian.ward3@nhs.net
Contact number:	2075253345
Who signed off the report on behalf of the Health and Wellbeing Board:	Cllr Peter John (Health and Wellbeing Board (chair)
Will the HWB sign-off the plan after the submission date?	No
If yes, please indicate the date when the HWB meeting is scheduled:	

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Peter	John	Peter.john@southwark.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Andrew	Bland	andrewbland@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		n/a	n/a	na@nhs.net
	Local Authority Chief Executive		Eleanor	Kelly	Eleanor.kelly@southwark.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		David	Quirke-Thornton	David.Quirke-Thornton@southwark.gov.
	Better Care Fund Lead Official		Adrian	Ward	adrian.ward3@nhs.net
	LA Section 151 Officer		Duncan	Whitfield	Duncan.whitfield@southwark.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->	Director of Adult Social Care		Jay	Stickland	jay.stickland@southwark.gov.uk
	Director of Commissioning, Children and Families		Genette	Laws	genette.laws@southwark.gov.uk
	Director of Integrated Commissioning, CCG		Sam	Hepplewhite	sam.hepplewhite@nhs.net

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Complete:
2. Cover	Yes
4. Strategic Narrative	Yes
5. Income	Yes
6. Expenditure	Yes
7. HICM	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

<< Link to the Guidance sheet

Checklist

2. Cover

^^ Link back to top

	Cell Reference	Checker
Health & Wellbeing Board	D13	Yes
Completed by:	D15	Yes
E-mail:	D17	Yes
Contact number:	D19	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	D21	Yes
Will the HWB sign-off the plan after the submission date?	D23	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	D24	Yes
Area Assurance Contact Details - Role:	C27 : C36	Yes
Area Assurance Contact Details - First name:	F27 : F36	Yes
Area Assurance Contact Details - Surname:	G27 : G36	Yes
Area Assurance Contact Details - E-mail:	H27 : H36	Yes

Sheet Complete	Yes

4. Strategic Narrative

^^ Link back to top

	Cell Reference	Checker
A) Person-centred outcomes:	B20	Yes
B) (i) Your approach to integrated services at HWB level (and neighbourhood where applicable):	B31	Yes
B) (ii) Your approach to integration with wider services (e.g. Housing):	B37	Yes
C) System level alignment:	B44	Yes

Sheet Complete	Yes

5. Income

^^ Link back to top

	Cell Reference	Checker
Are any additional LA Contributions being made in 2019/20?	C39	Yes
Additional Local Authority	B42 : B44	Yes
Additional LA Contribution	C42 : C44	Yes
Additional LA Contribution Narrative	D42 : D44	Yes
Are any additional CCG Contributions being made in 2019/20?	C59	Yes
Additional CCGs	B62 : B71	Yes
Additional CCG Contribution	C62 : C71	Yes
Additional CCG Contribution Narrative	D62 : D71	Yes

Sheet Complete	Yes

6. Expenditure ^^ Link back to top

	Cell Reference	Checker
Scheme ID:	B22 : B271	Yes
Scheme Name:	C22 : C271	Yes
Brief Description of Scheme:	D22 : D271	Yes
Scheme Type:	E22 : E271	Yes
Sub Types:	F22 : F271	Yes
Specify if scheme type is Other:	G22 : G271	Yes
Planned Output:	H22 : H271	Yes
Planned Output Unit Estimate:	I22 : I271	Yes
Impact: Non-Elective Admissions:	J22 : J271	Yes
Impact: Delayed Transfers of Care:	K22 : K271	Yes
Impact: Residential Admissions:	L22 : L271	Yes
Impact: Reablement:	M22 : M271	Yes
Area of Spend:	N22 : N271	Yes
Specify if area of spend is Other:	O22 : O271	Yes
Commissioner:	P22 : P271	Yes
Joint Commissioner %:	Q22 : Q271	Yes
Provider:	S22 : S271	Yes
Source of Funding:	T22 : T271	Yes
Expenditure:	U22 : U271	Yes
New/Existing Scheme:	V22 : V271	Yes

Sheet Complete	Yes

7. HICM ^^ Link back to top

	Cell Reference	Checker
Priorities for embedding elements of the HCIM for Managing Transfers of Care locally:	B11	Yes
Chg 1) Early discharge planning - Current Level:	D15	Yes
Chg 2) Systems to monitor patient flow - Current Level:	D16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Current Level:	D17	Yes
Chg 4) Home first / discharge to assess - Current Level:	D18	Yes
Chg 5) Seven-day service - Current Level:	D19	Yes
Chg 6) Trusted assessors - Current Level:	D20	Yes
Chg 7) Focus on choice - Current Level:	D21	Yes
Chg 8) Enhancing health in care homes - Current Level:	D22	Yes
Chg 1) Early discharge planning - Planned Level:	E15	Yes
Chg 2) Systems to monitor patient flow - Planned Level:	E16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Planned Level:	E17	Yes
Chg 4) Home first / discharge to assess - Planned Level:	E18	Yes
Chg 5) Seven-day service - Planned Level:	E19	Yes
Chg 6) Trusted assessors - Planned Level:	E20	Yes
Chg 7) Focus on choice - Planned Level:	E21	Yes
Chg 8) Enhancing health in care homes - Planned Level:	E22	Yes
Chg 1) Early discharge planning - Reasons:	F15	Yes
Chg 2) Systems to monitor patient flow - Reasons:	F16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Reasons:	F17	Yes
Chg 4) Home first / discharge to assess - Reasons:	F18	Yes
Chg 5) Seven-day service - Reasons:	F19	Yes
Chg 6) Trusted assessors - Reasons:	F20	Yes
Chg 7) Focus on choice - Reasons:	F21	Yes
Chg 8) Enhancing health in care homes - Reasons:	F22	Yes

Sheet Complete	Yes

8. Metrics

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	Cell Reference	Checker
Non-Elective Admissions: Overview Narrative:	E10	Yes
Delayed Transfers of Care: Overview Narrative:	E17	Yes
Residential Admissions Numerator:	F27	Yes
Residential Admissions: Overview Narrative:	G26	Yes
Reablement Numerator:	F39	Yes
Reablement Denominator:	F40	Yes
Reablement: Overview Narrative:	G38	Yes

Sheet Complete	Yes

9. Planning Requirements

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	Cell Reference	Checker
PR1: NC1: Jointly agreed plan - Plan to Meet	F8	Yes
PR2: NC1: Jointly agreed plan - Plan to Meet	F9	Yes
PR3: NC1: Jointly agreed plan - Plan to Meet	F10	Yes
PR4: NC2: Social Care Maintenance - Plan to Meet	F11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Plan to Meet	F12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Plan to Meet	F13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F15	Yes
PR9: Metrics - Plan to Meet	F16	Yes
PR1: NC1: Jointly agreed plan - Actions in place if not	H8	Yes
PR2: NC1: Jointly agreed plan - Actions in place if not	H9	Yes
PR3: NC1: Jointly agreed plan - Actions in place if not	H10	Yes
PR4: NC2: Social Care Maintenance - Actions in place if not	H11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Actions in place if not	H12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Actions in place if not	H13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H15	Yes
PR9: Metrics - Actions in place if not	H16	Yes
PR1: NC1: Jointly agreed plan - Timeframe if not met	I8	Yes
PR2: NC1: Jointly agreed plan - Timeframe if not met	I9	Yes
PR3: NC1: Jointly agreed plan - Timeframe if not met	I10	Yes
PR4: NC2: Social Care Maintenance - Timeframe if not met	I11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Timeframe if not met	I12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Timeframe if not met	I13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I15	Yes
PR9: Metrics - Timeframe if not met	I16	Yes

Sheet Complete	Yes

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Better Care Fund 2019/20 Template

3. Summary

Selected Health and Wellbeing Board: Southwark

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£1,486,043	£1,486,043	£0
Minimum CCG Contribution	£22,654,606	£22,654,606	£0
iBCF	£15,751,933	£15,751,933	£0
Winter Pressures Grant	£1,570,648	£1,570,648	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£41,463,230	£41,463,230	£0

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£6,437,797
Planned spend	£6,633,466

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£15,730,051
Planned spend	£16,616,328

Scheme Types

Assistive Technologies and Equipment	£1,130,000
Care Act Implementation Related Duties	£1,000,000
Carers Services	£850,000
Community Based Schemes	£2,142,727
DFG Related Schemes	£1,486,043
Enablers for Integration	£625,758
HICM for Managing Transfer of Care	£2,726,886
Home Care or Domiciliary Care	£13,322,498
Housing Related Schemes	£50,000
Integrated Care Planning and Navigation	£337,082
Intermediate Care Services	£8,848,041
Personalised Budgeting and Commissioning	£811,000
Personalised Care at Home	£0
Prevention / Early Intervention	£1,248,251
Residential Placements	£4,874,334
Other	£2,010,610
Total	£41,463,230

HICM >>

		Planned level of maturity for 2019/2020
Chg 1	Early discharge planning	Established
Chg 2	Systems to monitor patient flow	Established
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Mature
Chg 4	Home first / discharge to assess	Mature
Chg 5	Seven-day service	Established
Chg 6	Trusted assessors	Established
Chg 7	Focus on choice	Established
Chg 8	Enhancing health in care homes	Established

Metrics >>

Non-Elective Admissions	Go to Better Care Exchange >>
Delayed Transfer of Care	

Residential Admissions

		19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	642.7394212

Reablement

		19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	0.849702381

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
	PR8	Yes
Metrics	PR9	Yes

Better Care Fund 2019/20 Template

4. Strategic Narrative

Selected Health and Wellbeing Board: Southwark

Please outline your approach towards integration of health & social care:

When providing your responses to the below sections, please highlight any learning from the previous planning round (2017-2019) and cover any priorities for reducing health inequalities under the Equality Act 2010.

Please note that there are 4 responses required below, for questions: A), B(i), B(ii) and C)

Link to B) (i)
Link to B) (ii)
Link to C)

A) Person-centred outcomes Your approach to integrating care around the person, this may include (but is not limited to): - Prevention and self-care - Promoting choice and independence	
Remaining Word Limit:	647

At the heart of Southwark's approach to integration is the recognised need set out in our Five Year Forward View to improve outcomes by ensuring people's overall needs are addressed in a more holistic way. This means different providers and commissioners of health, social care and other services working in a co-ordinated way around individual and population needs. This includes organising our collective resources in a way that allows for a shift in focus towards prevention and ensuring that people and their families and carers are actively involved in co-developing and co-delivering personalised outcomes in their care plans. The neighbourhood model being developed by Partnership Southwark is based on people being firmly at the centre of a network of local services and support focussed on working better together and empowering people to improve their health and wellbeingindividual outcomes. Support for carers is integral to this strategy and the BCF continues to provide resources specifically for carers services.
Partnership Southwark has also adopted an approach to joint commissioning for population health and wellbeing outcomes using “Southwark "Bridges to Health and Wellbeing". Central to this approach is the development of population and person- centred outcomes that act as the focus for service providers to work together with commissioners to better integrate and streamline services and improve outcomes that matter to people.
A summary of the Partnership Southwark approach to integration, and our key priorities and objectives, which underpin BCFs 2019/20 plans is set out in the following document link : https://www.southwarkccg.nhs.uk/our-plans/partnership-southwark/Pages/default.aspx.

Personal budgets: All social care services are provided through personal budgets based on personalised care plans and outcomes, with the aim of maximising choice and independence. The CCG will continue to expand its existing offer of personal health budgets in CHC and Mental Health. Alongside South East London CCGs Southwark will also be working towards a consistent approach to Personal Wheelchair Budgets. The CCG’s plan is to have 275 personal health budgets in place by the end of the year an increase of 55%. The neighbourhood model includes a care co-ordination approach which will enable greater alignment of health and social care personal budgets.

Self-care and prevention: Self-care is promoted with funding from the BCF for Self-Management UK and Walking Away from Diabetes to provide self-management workshops for people with long term conditions. The BCF provides substantial resources for prevention, including £1.1m for voluntary sector organisations providing preventative services which will be organised in a hub model. This is aligned with the BCF funded social prescribing initiatives currently underway - which will be expanded substantially within the PCN model and through the development of a more coordinated and robust model of social prescribing within Partnership Southwark. In addition a number of the social care services funded via the BCF have clear evidence based preventative value, such as telecare, community equipment and home care which all play a key role in, for example, falls prevention.

Contribution to Equalities Act requirements: The BCF funds services that provide a range of essential personalised support for people with health and social care needs. This has important benefits for people with protected characteristics under the Equalities Act, many of whom receive these services, in particular older people, people with disabilities and people with mental health problems. Other beneficiaries of this investment are the homecare workforce who have been paid the London living wage since April 2018 as a result of BCF investment in our ethical home care policy. This workforce is mainly made up of women and those from the black and minority ethnic communities. Diabetes is a focus of our equalities priorities locally during 2019/20, and funding for self-management of diabetes is included in the BCF.

Contribution to health inequalities: The Partnership Southwark vision clearly states that the level oftackling health inequalities within Southwark is a key driving force for ourthe vision. Community- based health and care services funded through the BCF provides essential support for an older population that generally has poor health outcomes and multiple long term conditions. Promoting the health and wellbeing of this cohort population helps to prevent or delay the need for more intensive services and improve outcomes such as healthy life expectancy. The neighbourhood approach set out in thebeing implemented through Partnership Southwark vision will provide a further opportunity for local care networksservices and teams working within and across our neighbourhood footprints to address specific local health and social inequalities issues.

Changes since the previous BCF plan: The local integration landscape has developed considerably since the last plan, with Partnership Southwark providing more mature partnership structures, including greater involvement of key providersa formal commissioner and provider alliance arrangement and the involvement of organisations beyond health and social care, to enable the delivery of the BCF vision. The range of schemes invested in in 2018/19 has rolled forward largely unchanged to 2019/20 following positive evaluation. The £6.1m BCF growth in 2019/20 is being focussed on supporting the development of hospital discharge support including discharge to assess, increased reablement including step down beds, and additional investment in home care and care homes.

B) HWB level

(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):
- Joint commissioning arrangements
- Alignment with primary care services (including PCNs (Primary Care Networks))
- Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)

^^ Link back to top

Remaining Word Limit:	151

The Partnership Southwark strategic outline case provides a comprehensive overview of the plan for integrating services at HWB level from 2019/20 onwards, providing a strengthened delivery platform for the vision for integration previously set out in the BCF and the Southwark Five Year Forward View.

Joint Commissioning arrangements: Southwark has had a Partnership Commissioning Team in place for 3 year which leads on the development of integrated commissioning and reports to the Directors of Commissioning of the Council and the CCG. Commissioning Development Groups were established for client groups, reporting to an overarching Joint Strategy Commissioning Committee. This structure is now being reviewed during 2019/20, taking into account the progress made to date and the changing CCG commissioning landscape. It is envisaged that the commissioning team will become part of a wider integrated place based team within Partnership Southwark, and the Commissioning Development Groups are already evolving into joint groups with commissioners and providers focussed on delivering transformation through the Partnership Southwark workstreams. This will take forward the initial work undertaken on joint commissioning for population outcomes with providers within the partnership. During 2019/20 this outcomes approach (Bridges to Health and Wellbeing in Southwark) is being piloted for the population segment covering frailty, dementia and end of life care, with which there is a strong overlap with BCF funded services.

Alignment with primary care services: The Partnership Southwark work programme will be the vehicle for the further integration of place based health and care services, and as a priority will build on our previous development of Local Care Networks to develop a new neighbourhood model. A central component of this is the Primary Care Networks as the building block for this approach, enabling closer multi-disciplinary working and more proactive and preventative care across range of health and care services. The Better Care Fund provides funding for our two local GP federations for social prescribing, pharmacy in care homes and enhanced primary care access across our primary care networks.

Alignment of services and the approach to partnership with the voluntary and community sector: Operational integration will be guided by the outcomes framework and alliances of providers will be supported to collaborate to improve outcomes through Partnership Southwark. The voluntary sector are key partners in the development of the outcomes framework and the redesign of services, and are involved with the pilot work on developing the outcomes based approach to joint commissioning. The BCF provides £1.1m funding to the voluntary sector to provide a range of preventative services which will be organised in a hub model, aligned with the social prescribing initiatives currently underway which will be expanded within the PCN model also funded by the BCF.

A successful example of improved integrated working in Southwark that illustrates our approach is the integration of Enhanced Rapid Response, Supported Discharge, Reablement including the ASC reablement care provider contract and the urgent social work response (all BCF funded). This has been successfully integrated forming a single joint team, Intermediate Care Southwark, which provides a simplified and co-ordinated urgent response system, and is bedding in further in 2019/20 with plans for further integration between community health and social care being developed. The approach has been provider led with commissioner involvement on the board. It involved creating a new team under a single manager with 178 employees and an annual budget of £5.5m. A key benefit has been the rationalisation and simplification of numerous complex referral processes into a streamlined approach. The programme of change was intensive including separate workstreams for; shared leadership & management; creating the pathway, workflows & teams; developing the workforce, working culture & staff engagement; shared performance management; premises and IT. The learning from this process has been captured and disseminated, including through a workshop for Joint Commissioning Strategy Committee, and taken on board in the Partnership Southwark change management approach.

(ii) Your approach to integration with wider services (e.g. Housing), this should include:
- Your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the (Regulatory Reform Order 2002)

^^ Link back to top

Remaining Word Limit:	240

The Partnership Southwark model of neighbourhood networks clearly identifies a wide range of statutory and voluntary services as part of the person centred network of support services that have a role in helping people achieve their outcomes. Housing is key within this, which is especially important in Southwark given the high levels of social housing, particularly amongst older people. Housing are involved in our outcomes based commissioning workstreams, as are other council services such as leisure and libraries.

The use of the full Disabled Facilities Grant (DFG) has been agreed by the BCF Planning Group with housing services and will be fully deployed to enable individuals to adapt their housing to meet their needs. Adult Social Care and Housing have worked in collaboration to strengthen pathways for DFG's, and further develop the prevention agenda by ensuring that where possible and practical services are linked through pathways and referral routes to achieve better outcomes such as increased opportunity for independence.

Housing have made a number of changes to the way DFG's are delivered to reduce unnecessary delays and help to improve the service. These changes include:

• Changing the way work is tendered to contractors. Work programmes have been put in place where contractors receive a higher number of works to complete within an agreed timescale
• By combing the initial assessment visit to complete the Test of Resources and the DFG application pack
• By working closely with ASC Occupational Therapy (OT) team, design/plans for adaptations are agreed within 5 days
• There are plans to employ a Senior Occupational Therapist to work alongside the Housing team to help increase the number of OT assessments completed, improve communication/queries with adaptations on site and build stronger links with ASC and Health colleagues
• A framework agreement is being considered with a Stairlift provider to offer better value for money, reduce timescales for installations and provide a storage/reclining service for the council
• As part of improving partnership working and promoting the availability of the DFG, meetings have taken place with GP Practice Managers across Southwark
• A fast track system has been put in place to ensure cases assessed as urgent or end of life are prioritised
• The Housing team have been trained in falls prevention and provide advice, support and practical help when visiting older, frail and vulnerable people to help prevent the risk of falls and potential hospitalisation

By working jointly, teams across, Housing, Health and ASC have continued to make improvements to the way people can return home safely following hospital treatment. This has improved accessibility to DFG's for major adaptations and also the use of the Southwark Handyperson Service who deliver services to often the most vulnerable people to support independent living. Under the Regulatory Reform Order flexibilities Southwark also provide a range of small repairs grants and loans to help vulnerable people carry out repairs and improvements to their homes as well as adaptations funded through DFG's.

There is also a strong link between housing and adults social care with regards to the BCF funded telecare services which the Housing department provides.

The BCF in 2019/20 is providing additional resources to have a housing advice officer working within the hospital discharge teams with the objective of addressing housing related delays as effectively as possible.

C) System level alignment, for example this may include (but is not limited to):	
- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans - A brief description of joint governance arrangements for the BCF plan	^^ Link back to top
Remaining Word Limit:	562

The vision set out in the BCF plan aligns strongly with the wider integration landscape in Southwark as follows:

ICS plans and place based delivery: Partnership Southwark will be a key vehicle for delivering integrated place based care within the overall Integrated Care System of South East London. The strategic outline case for Partnership Southwark was agreed in March 2019 and describes a vision and plans for integrated community based care that aligns with and build on the vision set out in the BCF plan for 2017/19. Providers and commissioners will collaborate to deliver improved outcomes for the population through an approach for which the stated aims are to:
• Make best use of the Southwark pound to deliver improvements in health and wellbeing outcomes for local people • Be inclusive, and wider than health and care organisations so that we can tackle the causes of health inequalities and prevent illness • Ensure every part of the health and care landscape is clearly focused on common goals of supporting self-management, keeping everyone well, providing resilient high-quality services, meeting individual and population-level needs, and making it easier for people to access the information, advice, care and support they need.• Support resilient and sustainable general practice, including enabling practices to work together within Primary Care Networks, and with other local health and care providers, through our neighbourhood model.• View health, social care, housing, VCS organisations, education and employment as equal value/partners when working towards a healthier Southwark.• Equip people to manage their own conditions, take part in activities that will help keep them well and to support others in their community. Initial Priorities to deliver this vision are to: • Work with local people and frontline staff to co-design and develop Southwark's neighbourhood model to better join up care and support within the community, and respond to the health and wellbeing needs of local populations. • Formalise collaborative alliance arrangements enabling system partners (initially Southwark CCG, GSTT, SLAM, GP federations, and Adult Social Care) to deliver integrated primary and community-based health and care; working closely with communities and other agencies involved in delivering care to Southwark residents.• Join-up strategic commissioning between the Council and CCG which, over time, will move towards a population-based approach to commissioning for outcomes using Bridges to Health and Wellbeing segmentation framework

South East London plan for implementation of NHS Long Term Plan: There is also a close alignment between the objectives of the BCF and the South East London plan for the NHS Long Term Plan, in particular its focus on:• Transformed out of hospital care and fully integrated community based care • Increase the capacity and responsiveness of community and intermediate care services • Expanded community MDTs aligned with new PCNs • Support to people in care homes • Supporting people to age well • Reducing pressures on emergency hospital services • Cutting delays in patients able to go home; through enhancing primary and community care • People will get more control over their own health and more personalised care when they need it • NHS Comprehensive Model of Personalised Care • Social prescribing to widen the range of support available • Accelerate the roll out of personal health budgets • Personalise care to improve end of life care

The BCF also provides funding to support social services involvement in neighbourhood care co-ordination and other multi-disciplinary team work in line with NHS Long Term Plan priorities. Substantial growth in funding for reablement in 2019/20 will also provide resources to enable the new reablement and rapid response targets within the long term plan to be met by Intermediate Care Southwark.

STP: As set out in the 2017/19 BCF plan, the South East London STP has a key overarching objective of developing consistent and high quality community based care which aligns with the Southwark BCF vision.

Governance arrangements for the BCF Plan: The Health and Social Care Partnership Board, which oversees the governance and monitoring of all joint funding arrangements, oversees the development and monitoring of the BCF Plan. A sub-group of the Board has been set up – the BCF Planning Group – which meets monthly to undertake the more detailed discussions required to oversee BCF planning and delivery. This group includes the Director of Adult Social Care, Directors of Commissioning and senior finance leads from the council and the CCG. When the draft plan has been developed it is agreed through the respective governance mechanisms of the CCG and Council before being signed off by both parties and the Health and Wellbeing Board. Following assurance by NHSE the full BCF agreement and associated scheme schedules are set out in a section 75 agreement signed by both parties. Council and CCG internal governance around budget and performance monitoring apply to schemes for which each organisation is the lead commissioner. It is of note that both Council and CCG internal audits of BCF governance arrangements in the past 12 months provided positive assurance that controls are robust. Note: The BCF planning process was subject to a Health and Wellbeing Board report in June 2019 at which the approach being taken was set out. It was agreed by the board that the plan could be signed off by the chair under delegated powers, with the final plan tabled at the subsequent meeting of the board.

Better Care Fund 2019/20 Template

5. Income

Selected Health and Wellbeing Board: Southwark

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Southwark	£1,486,043
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£1,486,043**

iBCF Contribution	Contribution
Southwark	£15,751,933
Total iBCF Contribution	**£15,751,933**

Winter Pressures Grant	Contribution
Southwark	£1,570,648
Total Winter Pressures Grant Contribution	**£1,570,648**

Are any additional LA Contributions being made in 2019/20? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Southwark CCG	£22,654,606
Total Minimum CCG Contribution	**£22,654,606**

Are any additional CCG Contributions being made in 2019/20? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Total Addition CCG Contribution	**£0**	
Total CCG Contribution	**£22,654,606**	

	2019/20
Total BCF Pooled Budget	**£41,463,230**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2019/20 Template

6. Expenditure

Selected Health and Wellbeing Board: Southwark

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£1,486,043	£1,486,043	£0
Minimum CCG Contribution	£22,654,606	£22,654,606	£0
iBCF	£15,751,933	£15,751,933	£0
Winter Pressures Grant	£1,570,648	£1,570,648	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£41,463,230	£41,463,230	**£0**

Required Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£6,437,797	£6,633,466	£0
Adult Social Care services spend from the minimum CCG allocations	£15,730,051	£16,616,328	£0

Link to Scheme Type description

						Planned Outputs		Metric Impact				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Hospital Discharge	Hospital discharge team including Community Support Team, weekend team & brokerage	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				High	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,790,453	Existing
2	Reablement	Reablement - previous reablement grant and additional funding	Intermediate Care Services	Reablement/Rehabilitation Services		Hours of Care	99,319.0	High	High	High	High	Social Care		LA			Private Sector	Minimum CCG Contribution	£1,936,738	Existing
3	Neuro-rehab team	Support workers for GSTT community neuro-rehab team (previously commisoned by council)	Intermediate Care Services	Reablement/Rehabilitation Services		Packages	300.0	Medium	High	High	High	Community Health		CCG			Private Sector	Minimum CCG Contribution	£197,886	Existing
4	Intermediate care	Supported discharge team and Intermediate care packages	Intermediate Care Services	Reablement/Rehabilitation Services		Hours of Care	58,336.0	High	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,137,563	Existing
5	Community Equipment	ICES contract - council costs	Assistive Technologies and Equipment	Community Based Equipment				High	High	High	High	Social Care		LA			Private Sector	Minimum CCG Contribution	£400,000	Existing
6	Community equipment - ICES contingency	Budget to meet potential cost pressures over winter period	Assistive Technologies and Equipment	Community Based Equipment				High	High	High	High	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum CCG Contribution	£164,000	New
7	Admissions avoidance - ERR and @home	Community health services enhanced rapid response and @home service, including 7 day services funding including 2019/20 growth	Intermediate Care Services	Rapid / Crisis Response				High	High	High	Medium	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£4,216,105	Existing
8	Enhanced primary care access	Enhanced primary care access - additional 7 day appointments at 2 sites - contribution to total cost	Community Based Schemes					High	Medium	Medium	Medium	Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£743,000	Existing
9	Self-management	Self-management for people with long term conditions.	Community Based Schemes					High	Low	Medium	Medium	Primary Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£307,000	Existing
10	Care home pharmacist	Care home pharmacy support	Community Based Schemes					Medium	Low	Not applicable	Not applicable	Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£47,095	Existing
11	Home care	Home care quality improvement (core BCF)	Home Care or Domiciliary Care			Hours of Care	111,764.0	High	High	High	Medium	Social Care		LA			Private Sector	Minimum CCG Contribution	£1,900,000	Existing
12	Disabled Facilities Grant	Disabled Facilities Grant including growth for additional OT to speed up process	DFG Related Schemes	Adaptations				Medium	High	High	Medium	Social Care		LA			Local Authority	DFG	£1,486,043	Existing
13	Voluntary Sector Hub	Range of voluntary sector support services providing preventative support on a hub referral model	Prevention / Early Intervention	Social Prescribing				Medium	Medium	High	Medium	Social Care		Joint	27.0%	73.0%	Charity / Voluntary Sector	Minimum CCG Contribution	£1,248,251	Existing
14	Shared budegt for joint discharges	A joint budegt to facilitate discharge of joint (non-CHC) cases at risk of delay in advance of S117 funding agreement	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				High	High	High	Medium	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum CCG Contribution	£176,120	New
15	Carers	Voluntary sector support for carers (Southwark Carers)	Carers Services	Respite Services				High	High	High	High	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£400,000	Existing
16	Carers	Carer Assessments	Carers Services	Carer Advice and Support				High	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£450,000	Existing

17	Telecare	Telecare including pendant alarms and other assistive technology and SMART response service	Assistive Technologies and Equipment	Telecare				High	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£566,000	Existing
18	Nightowls	Overnight intensive home care to assist discharge (downsize 2019/20)	Home Care or Domiciliary Care			Hours of Care	13,215.0	High	High	High	Medium	Social Care		Joint	50.0%	50.0%	Private Sector	Minimum CCG Contribution	£224,000	Existing
19	Mental health reablement	Restoring independence for people so no long term service required	Community Based Schemes					Medium	Medium	Medium	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£151,632	Existing
20	Psychiatric liason	Psychiatric Liaison, AMHP and reablement support	Intermediate Care Services	Rapid / Crisis Response				High	Medium	Medium	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£300,000	Existing
21	Community Mental Health Services	Community mental health services (Move on Support Team etc)	Community Based Schemes					High	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£655,000	Existing
22	Mental Health discharge worker	To ensure safe and timely discharges from Southwark psychiatric inpatient wards	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge				Low	High	Medium	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£50,000	New
23	Mental health Complex Cases worker	Specialist mental health social worker providing outreach to help prevent hospital admission	Intermediate Care Services	Rapid / Crisis Response				High	Low	High	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£60,000	New
24	Mental health Personal Budgets	Personal budgets for people with mental health services	Personalised Budgeting and Commissioning	Other	social care personal budget			High	Medium	High	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£600,000	Existing
25	Learning disability Personal Budgets	Personal budgets for people with learning disabilities	Personalised Budgeting and Commissioning	Other	social care personal budget			High	Medium	High	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£211,000	Existing
26	Enhanced Intervention Services	MDT providing enhanced psycholgical support for people with learning disabilities and challenging behaviour	Community Based Schemes					Medium	Medium	High	Low	Mental Health		Joint	90.0%	10.0%	NHS Mental Health Provider	Minimum CCG Contribution	£239,000	Existing
27	Protecting social care	Contribution to previous year saving target to prevent service reduction	Other		protecting adult social care			Medium	Medium	Medium	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£2,010,610	Existing
28	Care Act Funding	General funding for Care Act duties, amount in line with guidance	Care Act Implementation Related Duties	Other	Range of Care Act duties inc carers			Medium	Medium	Medium	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,000,000	Existing
29	Service development (50% council element)	Funding for the Partnership Commissioning team, BCF management and consultancy for integration projects	Enablers for Integration	Integrated commissioning models				Medium	Medium	Medium	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£187,879	Existing
30	Service development (50% CCG element)	Funding for the Partnership Commissioning team, BCF management and consultancy for integration projects	Enablers for Integration	Integrated commissioning models				Medium	Medium	Medium	Medium	Community Health		CCG			CCG	Minimum CCG Contribution	£187,879	Existing
31	Housing worker - hospital discharge	Housing officer working with hospital discharge teams to help avoid housing related delays	Housing Related Schemes					Medium	High	High	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£50,000	new
32	Mental health placement broker	New broker for mental health placements to obtain quicker access to appropriate placements and improve VFM	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				Medium	High	High	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£50,000	new
33	Dementia navigators	Voluntary sector support for people with dementia to navigate and access services	Integrated Care Planning and Navigation	Care Coordination				High	High	High	Medium	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£184,177	Existing
34	End of Life Care	Funding for social work input into co-ordinating end of life care.	Integrated Care Planning and Navigation	Care Coordination				High	High	High	Low	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£152,905	Existing
35	Council assessment and care management contingency	Additional funding for assessment and care management (including OT) to meet a range of potential pressures including costs associated with NHS Long Term Plan delivery.	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge Teams				High	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£300,000	New
36	iBCF funding plans - sustaining quality in home care	iBCF funding plans - sustaining quality in home care - including 19/20 IBCF growth	Home Care or Domiciliary Care			Hours of Care	607,520.0	High	High	High	Medium	Social Care		LA			Private Sector	iBCF	£10,327,850	Existing
37	iBCF funding plans - Improving and investing in local nursing care homes	iBCF funding plans - Improving and investing in local nursing care homes - - including 19/20 IBCF growth	Residential Placements	Nursing Home		Placements	6,832.0	High	High	Not applicable	Not applicable	Social Care		LA			Private Sector	iBCF	£4,174,334	Existing
38	iBCF funding plans - Transformation fund to improve the health, wellbeing and resilience of	iBCF funding plans - Transformation fund to improve the health, wellbeing and resilience of vulnerable service users	Enablers for Integration	Integrated models of provision				Medium	Medium	Medium	Medium	Social Care		LA			Local Authority	iBCF	£250,000	Existing
39	IBCF Reablement and Intermedaite bed based care	IBCF Reablement and Intermediate bed based care - new for 19/20	Intermediate Care Services	Bed Based - Step Up/Down		No. of beds	1,538.0	High	High	High	High	Social Care		LA			Private Sector	iBCF	£999,749	New

40	Discharge to assess - CCG costs	Funding for CCG costs relating to Discharge to Assess pathway	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Medium	High	High	High	Community Health		CCG			Private Sector	Minimum CCG Contribution	£100,313	New
41	Discharge to assess - council costs	Funding for Council costs relating to Discharge to Assess pathway	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Medium	High	High	High	Social Care		LA			Private Sector	Minimum CCG Contribution	£260,000	New
42	Winter Pressures Grant (1)	Residential Care Home placements for older people (weeks)	Residential Placements	Care Home		Placements	751.0	Medium	High	Not applicable	Not applicable	Social Care		LA			Private Sector	Winter Pressures	£400,000	New
43	Winter Pressures Grant (2)	Nursing Care Home placements for older people (weeks)	Residential Placements	Nursing Home		Placements	491.0	Medium	High	Not applicable	Not applicable	Social Care		LA			Private Sector	Winter Pressures Grant	£300,000	New
44	Winter Pressures Grant (3)	Home Care for older people	Home Care or Domiciliary Care			Hours of Care	51,226.0	High	High	High	High	Social Care		LA			Private Sector	Winter Pressures Grant	£870,648	New

^^ Link back up

Scheme Type	Description	Sub Type
Assistive Technologies and Equipment	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Digital participation services).	Telecare Wellness Services Digital Participation Services Community Based Equipment Other
Care Act Implementation Related Duties	Funding planned towards the implementation of Care Act related duties.	Deprivation of Liberty Safeguards (DoLS) Other
Carers Services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. This also includes the implementation of the Care Act as a sub-type.	Carer Advice and Support Respite Services Other
Community Based Schemes	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood level (eg: Integrated Neighbourhood Teams)	
DFG Related Schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.	Adaptations Other

Enablers for Integration	Schemes that build and develop the enabling foundations of health and social care integration encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.	
High Impact Change Model for Managing Transfer of Care	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM as such, is included in this section.	Chg 1. Early Discharge Planning Chg 2. Systems to Monitor Patient Flow Chg 3. Multi-Disciplinary/Multi-Agency Discharge Teams Chg 4. Home First / Discharge to Access Chg 5. Seven-Day Services Chg 6. Trusted Assessors Chg 7. Focus on Choice Chg 8. Enhancing Health in Care Homes Other - 'Red Bag' scheme Other approaches
Home Care or Domiciliary Care	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.	
Housing Related Schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	

Integrated Care Planning and Navigation	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches like Single Point of Access (SPoA) and linking people to community assets. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams and the HICM for managing discharges, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.	Care Coordination Single Point of Access Care Planning, Assessment and Review Other
Intermediate Care Services	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.	Bed Based - Step Up/Down Rapid / Crisis Response Reablement/Rehabilitation Services Other

Personalised Budgeting and Commissioning	Various person centred approaches to commissioning and budgeting.	Personal Health Budgets Integrated Personalised Commissioning Direct Payments Other
Personalised Care at Home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.	
Prevention / Early Intervention	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.	Social Prescribing Risk Stratification Choice Policy Other
Residential Placements	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.	Supported Living Learning Disability Extra Care Care Home Nursing Home Other
Other	Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.	

^^ Link back up

Better Care Fund 2019/20 Template

7. High Impact Change Model

Selected Health and Wellbeing Board: Southwark

Explain your priorities for embedding elements of the High Impact Change Model for Managing Transfers of Care locally, including:
- Current performance issues to be addressed
- The changes that you are looking to embed further - including any changes in the context of commitments to reablement and Enhanced Health in Care Homes in the NHS Long-Term Plan
- Anticipated improvements from this work

The Lambeth and Southwark Transfers of Care Group (including commissioners, social services, community health and local trusts) oversees a programme of improvement on patient flow, delayed transfers and long length of stay, including progress against the High Impact Changes Model. The group updated the assessment and maturity levels and priority actions during the BCF planning process.
The current focus is on understanding and addressing the increases in delayed transfers of care experienced across the local system since October 2018. These are predominantly due to a high rate of Nursing Care delays caused by lack of local capacity (lack of care homes capacity in London has been recognised as a key concern by CQC) and delays relating to patient choice, residential care and housing. With regards to the 8 high impact change areas there are a number of improvements we wish to develop and embed further as follows;

a) Early discharge planning - to further improve current arrangements we will seek to enhance primary care involvement in pre-admission discharge planning for elective patients as part of the Partnership Southwark integrated neighbourhood working model workstream and the developing Primary Care Networks.
b) Systems to monitor patient flow - there are identified areas for development to further improve whole system demand and capacity management and related IT/IS systems. This will be subject to a new task and finish group.
c) Home first/ discharge to assess - we have advanced plans that we need to implement for commissioning additional bed based reablement which will provide additional capacity for discharge to assess in more complex cases (funded by the iBCF grant) and will continue to refine and embed the agreed discharge to assess pathway to ensure desired outcomes are achieved.
d) Patient choice - a robust policy has been agreed and fully embedding the policy with all key staff and ensuring early communication of choice policy to patients and families remains a priority. Further work on improving information leaflets for staff and patients to be undertaken.
e) Trusted Assessor - work will continue with care homes on fully implementing policy with all homes we regularly commission from
f) Enhancing Health in Care Homes - further supporting care homes to develop the capacity to deliver on objectives, in particular addressing avoidable ambulance call outs.

It is expected that these improvements will contribute to a significant reduction in delayed transfers restoring Southwark's previous strong performance, in particular through reductions in the category of patient choice. However, the greatest improvements are expected to come from those aspects of our action plan focussing on nursing and residential delays for which the recent growth relates to market capacity rather than discharge planning arrangement. The expansion of reablement step down beds will also be key to reducing rates.

		Please enter current position of maturity	Please enter the maturity level planned to be reached by March 2020	If the planned maturity level for 2019/20 is below established, please state reasons behind that?
Chg 1	Early discharge planning	Established	Established	
Chg 2	Systems to monitor patient flow	Plans in place	Established	
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Established	Mature	
Chg 4	Home first / discharge to assess	Established	Mature	
Chg 5	Seven-day service	Established	Established	
Chg 6	Trusted assessors	Plans in place	Established	
Chg 7	Focus on choice	Plans in place	Established	
Chg 8	Enhancing health in care homes	Established	Established	

Better Care Fund 2019/20 Template

8. Metrics

Selected Health and Wellbeing Board: Southwark

8.1 Non-Elective Admissions

	19/20 Plan	Overview Narrative	
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.	In South East London, based on the significant NEL growth in 18/19, the Integrated Contracts and Delivery Team (ICDT) have submitted an expected growth of 3.4% non-elective admissions across SEL. In Southwark CCG this is a 5.1% increase or 1345 non-elective admissions. The SEL ICDT local team for Southwark attends the regular KCH Emergency Pathway Steering Group and Joint Management Board (UTC/Hurley) meetings to provide assistance and assure the Trust is delivering their plans. The System Improvement Plan focuses on: Clinically led front door streaming and admissions avoidance, increased utilisation of same day emergency care models operating 7 days a week to reduce non-elective admissions and increase same day care, including a comprehensive frailty assessment and acute frailty mode. Southwark CCG continues to provide quick access to GP appointments for KCH A&E to stream patients to appropriate services who don't have urgent care needs. At present KCH is not fully utilising available slots, ongoing work is being done with the A&E team to improve. KCH launched a new SDEC unit on 1st July and have seen 415 patients to date with only 36 converting into an admission. The unit was modelled on capacity of 32 per day which has not been reached, phase 2 will explore opening access to General Practice direct referrals. SEL ICDT are working with LAS and system partners to maximise alternative care pathways from the point of clinical triage, this reduce the need for an ambulance conveyance, support demand management and admission avoidance plans, whilst continuing to secure improved LAS response and handover times. In July 2019, the new 111 Integrated Urgent Care service was formally signed off and fully mobilised, overall performance of the service continues to improve and the service transitions into business as usual. The new service has moved from a 'hear and refer' model of care to a 'hear and treat' model of care. Clinicians have access to book patients into GP Extended Access Hubs, Out of Hours GP services and Urgent Treatment Centres and in SEL ICDT are working with LAS and GP Practices to allow direct booking into Primary Care. We are anticipating that downstream A&E departments will see a reduction in attendances. Standardising our out of hospital provision (recognising this is a multi year objective) with a 2019/20 focus on: optimised access to GP extended access from A&E, admission avoidance services for GPs, LAS and A&E, services that target high intensity users and that manage patients with multiple long term conditions, targeted support to Care Homes, full access to Discharge to Assess pathways to include bridging capacity, community based alternatives for key conditions and a review of therapy services to ensure therapists are placed at all required stages of the U&EC in and out of hospital pathway. In Quarter 1, BCF funded community health admissions avoidance services (enhanced rapid response and @home services) had accepted 1107 referrals as an alternative to hospital care. Work is underway with the @Home service to increase access to the service for LAS 999 crews, the LAS 999 Clinical Hub and the 111 IUC service. This will allow more patients to be directed to the service avoiding a hospital attendance. The BCF also provides funding for the enhanced primary care access services which provided 13,075 additional utlised appointments in Q1.	**Please set out the overall plan in the HWB area for reducing Non-Elective Admissions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

Plans are yet to be finalised and signed-off so are subject to change; **for the latest version of the NEA CCG operating plans at your HWB footprint please contact your local Better Care Manager (BCM)** in the first instance or write in to the support inbox: ENGLAND.bettercaresupport@nhs.net

8.2 Delayed Transfers of Care

19/20 Plan	Overview Narrative

Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	11.1	Following a sustained period of strong performance on delayed transfers of care during the period of the last plan Southwark has experienced a deterioration in performance linked to a combination of factors including nursing and residential capacity, patient choices delays and housing and homelessness issues increasing the rate of NHS attributed delays. Social Care delays have increased to a lesser extent from a very low baseline. It is a high priority to restore good performance and this is subject to an action plan reported to board level. The key focus areas of this plan are: • Investing £3.1m iBCF growth in reablement, home care quality and nursing care capacity • Ensuring High Impact Changes effectively implemented through the Lambeth and Southwark Transfers of Care Group • Improved operational management of real time delays - Weekly senior escalation teleconferences across the Trusts and Adult Social Care on unresolved delays issues •Monthly escalation and discussion at systems leaders transfer of care group to ensure this remains a system priority and gets ownership across partners • Choice – revised discharge protocol full implementation • Intermediate Care provision - business case for increased bed based intermediate care to address identified gap in provision approved from iBCF • Availability of nursing care provision – commissioning strategy for in-borough nursing care provision to be increased including for people with complex needs and EMI and purchasing of additional beds in the neighbouring boroughs • Residential Care assessment delays to be addressed through expanded trusted assessor scheme • Data recording and assurance, including enhanced monitoring and analysis of published data and reviewing pre-publication data to challenge mis-attributed delays • Agreed protocol with Housing to ensure avoidable delays on homelessness and strategies to reduce other housing related delays related to repairs and adaptations The agreed winter pressures plan, incorporating CCG funding as well as BCF funding, sets out the areas of investment planned to reduce anticipated pressures on patient flow based on learning from previous winter plans. This includes extra resources for the commissioning of residential care, nursing care and home care. Although it is anticipated that the actions will improve performance it is not expected that the nationally set target will be delivered in the short term due to local system pressures and capacity issues.	**Please set out the overall plan in the HWB area for reducing Delayed Transfers of Care to meet expectations set for your area. This should include any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric. Include in this, your agreed plan for using the Winter Pressures grant funding to support the local health and care system to manage demand pressures on the NHS, with particular reference to seasonal winter pressures.**

Please note that the plan figure for Greater Manchester has been combined, for HWBs in Greater Manchester please comment on individuals HWBs rather than Greater Manchester as a whole.
Please note that due to the merger of Bournemouth, Christchurch and Poole to a new Local Authority will mean that planning information from 2018/19 will not reflect the present geographies.

8.3 Residential Admissions

		18/19 Plan	19/20 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	470	643	The care home admissions target has been rebased taking into account actual levels of demand experienced during 2017/18 and 2018/19 with a view to containing current levels of growth. The 2018/19 plan was based on 2015/16, a low baseline year which is now no longer considered comparable given the significant annual increase in older people with dementia requiring care home support. To minimise the number of people needing to be admitted to care homes the BCF will be funding increased bed based intermediate step down options in 2019/20, funded from iBCF growth and plans are in place for extra care expansion. In the longer term this is expected to reduce total care home admissions. The majority of BCF funded services contribute directly or indirectly to the objective of supporting people in their own home for as long as possible, delaying or avoiding the need for more intensive support. Additional growth for home care is funded in the current plan, aimed at driving up the quality of care at home. Partnership Southwark neighbourhood model workstream includes multi-agency care co-ordination with the aim of helping people in their own homes, avoiding admission to hospital and care homes.
	Numerator	124	172	
	Denominator	26,367	26,760	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2016 based Sub-National Population Projections for Local Authorities in England; https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2016basedprojections

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

8.4 Reablement

		18/19 Plan	19/20 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	88.8%	85.0%	In 2018/19 the rate achieved was 85%. This is considered to be an appropriate target taking into account the high needs levels of service users. The BCF plan for 2019/20 includes substantial growth for Intermediate Care Southwark (including our integrated Rehabilitation & Reablement and Urgent Response Teams) as a way of ensuring reablement outcomes are maximised and also assisting to prevent hospital admissions and facilitate timely transfers of care. Bed based options will be expanded which should impact positively on performance and outcomes for service users, including a reduction in long term residential placements. There is also a focus on the extent to which service users require long term care following reablement, including establishing firmer move on pathways after Reablement including the Southwark Resource Centre and Community Rehab and Falls Service and ensuring service users are linked into voluntary supports.
	Numerator	533	571	
	Denominator	600	672	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

Better Care Fund 2019/20 Template

9. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Southwark

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	**Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted?** Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Do the governance arrangements described support collaboration and integrated care? Where the strategic narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure, metric and HICM sections of the plan been submitted for each HWB concerned?	Yes			
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that covers:** - Person centred care, including approaches to delivering joint assessments, promoting choice, independence and personalised care? - A clear approach at HWB level for integrating services that supports the overall approach to integrated care and confirmation that the approach supports delivery at the interface between health and social care? - A description of how the local BCF plan and other integration plans e.g. STP/ICSs align? - Is there a description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? This should include confirmation that equality impacts of the local BCF plan have been considered, a description of local priorities related to health inequality and equality that the BCF plan will contribute to addressing. Has the plan summarised any changes from the previous planning period? And noted (where appropriate) any lessons learnt?	Yes	Links to Partnership Southwark documentation - see summary at https://www.southwarkccg.nhs.uk/our-plans/partnership-southwark/Pages/default.aspx .		
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home. In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Yes			
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Yes			
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Yes			
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	**Is there a plan for implementing the High Impact Change Model for managing transfers of care?**	**Does the BCF plan demonstrate a continued plan in place for implementing the High Impact Change Model for Managing Transfers of Care?** Has the area confirmed the current level of implementation and the planned level at March 2020 for all eight changes? Is there an accompanying overall narrative setting out the priorities and approach for ongoing implementation of the HICM? Does the level of ambition set out for implementing the HICM changes correspond to performance challenges in the system? If the current level of implementation is below established for any of the HICM changes, has the plan included a clear explanation and set of actions towards establishing the change as soon as possible in 2019-20?	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Have the planned schemes been assigned to the metrics they are aiming to make an impact on? Expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (tick-box) Is there an agreed plan for use of the Winter Pressures grant that sets out how the money will be used to address expected demand pressures on the Health system over Winter? **Has funding for the following from the CCG contribution been identified for the area?** - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Yes			
	PR8	**Indication of outputs for specified scheme types**	Has the area set out the outputs corresponding to the planned scheme types (Note that this is only for where any of the specified set of scheme types requiring outputs are planned)? (auto-validated)	Yes			
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric? Is there a proportionate range of scheme types and spend included in the expenditure section of the plan to support delivery of the metric ambitions for each of the metrics? Do the narrative plans for each metric set out clear and ambitious approaches to delivering improvements? **Have stretching metrics been agreed locally for:** - Metric 2: Long term admission to residential and nursing care homes - Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement	Yes			

CCG to Health and Well-Being Board Mapping for 2019/20

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	90.7%	87.4%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	6.9%	8.3%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.4%	0.6%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.5%	3.5%
E09000002	Barking and Dagenham	08W	NHS Waltham Forest CCG	0.1%	0.1%
E09000003	Barnet	07M	NHS Barnet CCG	91.1%	92.1%
E09000003	Barnet	07P	NHS Brent CCG	2.0%	1.8%
E09000003	Barnet	07R	NHS Camden CCG	1.0%	0.7%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000003	Barnet	07X	NHS Enfield CCG	3.0%	2.4%
E09000003	Barnet	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000003	Barnet	08D	NHS Haringey CCG	2.2%	1.6%
E09000003	Barnet	08E	NHS Harrow CCG	1.2%	0.8%
E09000003	Barnet	06N	NHS Herts Valleys CCG	0.0%	0.1%
E09000003	Barnet	08H	NHS Islington CCG	0.2%	0.1%
E09000003	Barnet	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.6%	98.1%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.4%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.4%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11E	NHS Bath and North East Somerset CCG	93.5%	98.3%
E06000022	Bath and North East Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.9%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	99N	NHS Wiltshire CCG	0.1%	0.3%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.7%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	04G	NHS Nene CCG	0.2%	0.6%
E09000004	Bexley	07N	NHS Bexley CCG	93.4%	89.8%
E09000004	Bexley	07Q	NHS Bromley CCG	0.1%	0.1%
E09000004	Bexley	09J	NHS Dartford, Gravesham and Swanley CCG	1.4%	1.5%
E09000004	Bexley	08A	NHS Greenwich CCG	7.2%	8.4%
E09000004	Bexley	08L	NHS Lewisham CCG	0.1%	0.1%
E08000025	Birmingham	15E	NHS Birmingham and Solihull CCG	78.4%	81.7%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05J	NHS Redditch and Bromsgrove CCG	3.1%	0.4%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	39.2%	17.8%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	88.9%	95.8%
E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.7%	1.7%
E06000009	Blackpool	00R	NHS Blackpool CCG	86.4%	97.6%
E06000009	Blackpool	02M	NHS Fylde & Wyre CCG	2.1%	2.4%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.5%
E08000001	Bolton	00V	NHS Bury CCG	1.5%	1.0%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%
E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%
E06000058	Bournemouth, Christchurch and Poole	11J	NHS Dorset CCG	52.4%	99.7%
E06000058	Bournemouth, Christchurch and Poole	11A	NHS West Hampshire CCG	0.2%	0.3%
E06000036	Bracknell Forest	15A	NHS Berkshire West CCG	0.5%	2.0%
E06000036	Bracknell Forest	15D	NHS East Berkshire CCG	26.1%	96.9%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.0%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.2%	0.1%
E08000032	Bradford	02N	NHS Airedale, Wharfdale and Craven CCG	67.2%	18.4%
E08000032	Bradford	02W	NHS Bradford City CCG	98.9%	23.9%
E08000032	Bradford	02R	NHS Bradford Districts CCG	98.0%	56.3%
E08000032	Bradford	02T	NHS Calderdale CCG	0.2%	0.0%
E08000032	Bradford	15F	NHS Leeds CCG	0.9%	1.4%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.2%	0.0%
E09000005	Brent	07M	NHS Barnet CCG	2.3%	2.4%
E09000005	Brent	07P	NHS Brent CCG	89.7%	86.4%
E09000005	Brent	07R	NHS Camden CCG	3.9%	2.8%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.3%	0.7%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	0.6%	0.4%
E09000005	Brent	08E	NHS Harrow CCG	5.9%	4.0%
E09000005	Brent	08Y	NHS West London (K&C & QPP) CCG	4.3%	2.7%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.9%	99.7%
E06000043	Brighton and Hove	09G	NHS Coastal West Sussex CCG	0.1%	0.2%
E06000043	Brighton and Hove	99K	NHS High Weald Lewes Havens CCG	0.3%	0.1%
E06000023	Bristol, City of	11E	NHS Bath and North East Somerset CCG	0.1%	0.0%
E06000023	Bristol, City of	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	49.3%	100.0%
E09000006	Bromley	07N	NHS Bexley CCG	0.2%	0.1%
E09000006	Bromley	07Q	NHS Bromley CCG	94.6%	95.1%
E09000006	Bromley	07V	NHS Croydon CCG	1.2%	1.4%
E09000006	Bromley	08A	NHS Greenwich CCG	1.4%	1.2%
E09000006	Bromley	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000006	Bromley	08K	NHS Lambeth CCG	0.1%	0.2%
E09000006	Bromley	08L	NHS Lewisham CCG	1.9%	1.8%
E09000006	Bromley	99J	NHS West Kent CCG	0.1%	0.2%

E10000002	Buckinghamshire	06F	NHS Bedfordshire CCG	0.6%	0.5%
E10000002	Buckinghamshire	14Y	NHS Buckinghamshire CCG	94.4%	94.9%
E10000002	Buckinghamshire	15D	NHS East Berkshire CCG	1.4%	1.2%
E10000002	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E10000002	Buckinghamshire	08G	NHS Hillingdon CCG	0.7%	0.4%
E10000002	Buckinghamshire	04F	NHS Milton Keynes CCG	1.3%	0.7%
E10000002	Buckinghamshire	04G	NHS Nene CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.6%	0.7%
E08000002	Bury	00T	NHS Bolton CCG	0.8%	1.2%
E08000002	Bury	00V	NHS Bury CCG	94.0%	94.3%
E08000002	Bury	01A	NHS East Lancashire CCG	0.0%	0.2%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	14L	NHS Manchester CCG	0.6%	2.0%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.9%
E08000033	Calderdale	02R	NHS Bradford Districts CCG	0.4%	0.6%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.4%	98.9%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.3%	0.3%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.7%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	71.8%	96.7%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.8%	0.7%
E10000003	Cambridgeshire	99D	NHS South Lincolnshire CCG	0.3%	0.0%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07J	NHS West Norfolk CCG	1.6%	0.4%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	4.0%	1.4%
E09000007	Camden	07M	NHS Barnet CCG	0.2%	0.3%
E09000007	Camden	07P	NHS Brent CCG	1.3%	1.9%
E09000007	Camden	07R	NHS Camden CCG	83.9%	88.9%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	5.6%	4.8%
E09000007	Camden	08C	NHS Hammersmith and Fulham CCG	0.4%	0.3%
E09000007	Camden	08D	NHS Haringey CCG	0.5%	0.6%
E09000007	Camden	08H	NHS Islington CCG	3.2%	3.0%
E09000007	Camden	08Y	NHS West London (K&C & QPP) CCG	0.3%	0.2%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.6%	95.0%
E06000056	Central Bedfordshire	14Y	NHS Buckinghamshire CCG	0.8%	1.5%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.9%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.3%	1.9%
E06000056	Central Bedfordshire	04F	NHS Milton Keynes CCG	0.1%	0.1%
E06000049	Cheshire East	15M	NHS Derby and Derbyshire CCG	0.1%	0.3%
E06000049	Cheshire East	01C	NHS Eastern Cheshire CCG	96.4%	50.2%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.1%	0.6%
E06000049	Cheshire East	01R	NHS South Cheshire CCG	98.6%	45.8%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.2%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02D	NHS Vale Royal CCG	0.6%	0.2%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	02F	NHS West Cheshire CCG	1.9%	1.2%
E06000050	Cheshire West and Chester	01C	NHS Eastern Cheshire CCG	1.2%	0.7%
E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	01R	NHS South Cheshire CCG	0.5%	0.2%
E06000050	Cheshire West and Chester	02D	NHS Vale Royal CCG	99.4%	29.5%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	02F	NHS West Cheshire CCG	96.9%	69.1%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.3%
E09000001	City of London	07R	NHS Camden CCG	0.2%	7.0%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.1%	2.5%
E09000001	City of London	07T	NHS City and Hackney CCG	1.8%	70.4%
E09000001	City of London	08C	NHS Hammersmith and Fulham CCG	0.0%	1.2%
E09000001	City of London	08H	NHS Islington CCG	0.1%	3.6%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.4%	15.0%
E09000001	City of London	08Y	NHS West London (K&C & QPP) CCG	0.0%	0.2%
E06000052	Cornwall & Scilly	15N	NHS Devon CCG	0.3%	0.6%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000047	County Durham	00D	NHS Durham Dales, Easington and Sedgefield CCG	97.0%	52.4%
E06000047	County Durham	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.0%
E06000047	County Durham	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.1%	0.0%
E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	00J	NHS North Durham CCG	96.7%	46.3%
E06000047	County Durham	00P	NHS Sunderland CCG	1.2%	0.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.5%	99.8%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.4%	0.2%
E09000008	Croydon	07Q	NHS Bromley CCG	1.6%	1.3%
E09000008	Croydon	07V	NHS Croydon CCG	95.3%	93.2%
E09000008	Croydon	09L	NHS East Surrey CCG	2.9%	1.3%
E09000008	Croydon	08C	NHS Hammersmith and Fulham CCG	0.2%	0.0%
E09000008	Croydon	08K	NHS Lambeth CCG	3.0%	3.0%
E09000008	Croydon	08R	NHS Merton CCG	0.8%	0.4%
E09000008	Croydon	08T	NHS Sutton CCG	0.8%	0.4%
E09000008	Croydon	08X	NHS Wandsworth CCG	0.5%	0.5%

E10000006	Cumbria	01K	NHS Morecambe Bay CCG	54.0%	36.6%
E10000006	Cumbria	01H	NHS North Cumbria CCG	99.9%	63.4%
E06000005	Darlington	00C	NHS Darlington CCG	98.2%	96.1%
E06000005	Darlington	00D	NHS Durham Dales, Easington and Sedgefield CCG	1.2%	3.2%
E06000005	Darlington	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.2%
E06000005	Darlington	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.6%
E06000015	Derby	15M	NHS Derby and Derbyshire CCG	26.5%	100.0%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	15M	NHS Derby and Derbyshire CCG	70.9%	92.6%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	7.9%	1.4%
E10000007	Derbyshire	01C	NHS Eastern Cheshire CCG	0.3%	0.0%
E10000007	Derbyshire	04E	NHS Mansfield and Ashfield CCG	2.1%	0.5%
E10000007	Derbyshire	04L	NHS Nottingham North and East CCG	0.3%	0.0%
E10000007	Derbyshire	04M	NHS Nottingham West CCG	5.1%	0.6%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.4%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	13.9%	4.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.5%	0.2%
E10000008	Devon	15N	NHS Devon CCG	65.7%	99.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.3%	0.3%
E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.5%	0.6%
E08000017	Doncaster	02X	NHS Doncaster CCG	96.8%	97.8%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.2%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.2%
E06000059	Dorset	11J	NHS Dorset CCG	46.0%	95.6%
E06000059	Dorset	11X	NHS Somerset CCG	0.6%	0.9%
E06000059	Dorset	11A	NHS West Hampshire CCG	1.7%	2.5%
E06000059	Dorset	99N	NHS Wiltshire CCG	0.7%	1.0%
E08000027	Dudley	15E	NHS Birmingham and Solihull CCG	0.1%	0.6%
E08000027	Dudley	05C	NHS Dudley CCG	93.3%	90.7%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	3.9%	6.9%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.8%	1.5%
E08000027	Dudley	06D	NHS Wyre Forest CCG	0.8%	0.3%
E09000009	Ealing	07P	NHS Brent CCG	1.8%	1.6%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000009	Ealing	07W	NHS Ealing CCG	86.9%	90.4%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.5%	3.1%
E09000009	Ealing	08E	NHS Harrow CCG	0.4%	0.3%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.7%	0.5%
E09000009	Ealing	07Y	NHS Hounslow CCG	4.7%	3.5%
E09000009	Ealing	08Y	NHS West London (K&C & QPP) CCG	0.7%	0.4%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.3%	85.1%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	9.2%	7.9%
E06000011	East Riding of Yorkshire	03M	NHS Scarborough and Ryedale CCG	0.7%	0.2%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.6%	6.8%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.0%	0.6%
E10000011	East Sussex	09F	NHS Eastbourne, Hailsham and Seaford CCG	100.0%	34.7%
E10000011	East Sussex	09P	NHS Hastings and Rother CCG	99.7%	33.3%
E10000011	East Sussex	99K	NHS High Weald Lewes Havens CCG	98.1%	29.6%
E10000011	East Sussex	09X	NHS Horsham and Mid Sussex CCG	2.8%	1.2%
E10000011	East Sussex	99J	NHS West Kent CCG	0.8%	0.7%
E09000010	Enfield	07M	NHS Barnet CCG	1.0%	1.2%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E09000010	Enfield	07X	NHS Enfield CCG	95.2%	90.9%
E09000010	Enfield	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000010	Enfield	08D	NHS Haringey CCG	7.7%	6.9%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%
E09000010	Enfield	08H	NHS Islington CCG	0.2%	0.1%
E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.1%	0.0%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.2%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.2%	11.5%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.6%	0.6%
E10000012	Essex	08F	NHS Havering CCG	0.3%	0.0%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.5%
E10000012	Essex	06T	NHS North East Essex CCG	98.6%	22.7%
E10000012	Essex	08N	NHS Redbridge CCG	2.9%	0.6%
E10000012	Essex	99G	NHS Southend CCG	3.3%	0.4%
E10000012	Essex	07G	NHS Thurrock CCG	1.4%	0.2%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	07H	NHS West Essex CCG	97.1%	19.8%
E10000012	Essex	07K	NHS West Suffolk CCG	2.3%	0.4%

E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	38.5%	97.7%
E08000037	Gateshead	00J	NHS North Durham CCG	0.9%	1.2%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.8%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E08000037	Gateshead	00P	NHS Sunderland CCG	0.0%	0.1%
E10000013	Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.1%	0.1%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.6%	98.6%
E10000013	Gloucestershire	05F	NHS Herefordshire CCG	0.5%	0.1%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.6%	0.2%
E10000013	Gloucestershire	05T	NHS South Worcestershire CCG	1.1%	0.5%
E10000013	Gloucestershire	99N	NHS Wiltshire CCG	0.2%	0.2%
E09000011	Greenwich	07N	NHS Bexley CCG	5.1%	4.2%
E09000011	Greenwich	07Q	NHS Bromley CCG	1.1%	1.3%
E09000011	Greenwich	08A	NHS Greenwich CCG	89.2%	89.3%
E09000011	Greenwich	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000011	Greenwich	08L	NHS Lewisham CCG	4.4%	4.9%
E09000011	Greenwich	08Q	NHS Southwark CCG	0.1%	0.1%
E09000012	Hackney	07R	NHS Camden CCG	0.7%	0.7%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.2%	93.8%
E09000012	Hackney	08C	NHS Hammersmith and Fulham CCG	0.5%	0.4%
E09000012	Hackney	08D	NHS Haringey CCG	0.6%	0.7%
E09000012	Hackney	08H	NHS Islington CCG	4.6%	3.7%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.5%	0.6%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.5%
E06000006	Halton	01J	NHS Knowsley CCG	0.2%	0.3%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E06000006	Halton	02E	NHS Warrington CCG	0.7%	1.1%
E06000006	Halton	02F	NHS West Cheshire CCG	0.6%	1.1%
E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07R	NHS Camden CCG	0.1%	0.1%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.5%	2.5%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.6%	1.1%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	82.8%	87.6%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.7%
E09000013	Hammersmith and Fulham	08X	NHS Wandsworth CCG	0.2%	0.3%
E09000013	Hammersmith and Fulham	08Y	NHS West London (K&C & QPP) CCG	6.5%	7.2%
E10000014	Hampshire	15A	NHS Berkshire West CCG	1.7%	0.6%
E10000014	Hampshire	09G	NHS Coastal West Sussex CCG	0.2%	0.1%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	15D	NHS East Berkshire CCG	0.2%	0.0%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.5%	14.3%
E10000014	Hampshire	09N	NHS Guildford and Waverley CCG	2.9%	0.5%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.5%	12.4%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.2%	15.9%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.4%	0.7%
E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.6%	14.6%
E10000014	Hampshire	10X	NHS Southampton CCG	5.1%	1.0%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.8%	0.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.1%
E10000014	Hampshire	99N	NHS Wiltshire CCG	1.3%	0.4%
E09000014	Haringey	07M	NHS Barnet CCG	1.0%	1.4%
E09000014	Haringey	07R	NHS Camden CCG	0.6%	0.6%
E09000014	Haringey	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.1%	3.2%
E09000014	Haringey	07X	NHS Enfield CCG	1.3%	1.4%
E09000014	Haringey	08C	NHS Hammersmith and Fulham CCG	0.4%	0.3%
E09000014	Haringey	08D	NHS Haringey CCG	87.7%	91.0%
E09000014	Haringey	08H	NHS Islington CCG	2.5%	2.1%
E09000015	Harrow	07M	NHS Barnet CCG	4.3%	6.4%
E09000015	Harrow	07P	NHS Brent CCG	3.6%	4.8%
E09000015	Harrow	07W	NHS Ealing CCG	1.3%	2.1%
E09000015	Harrow	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000015	Harrow	08E	NHS Harrow CCG	89.7%	84.1%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.5%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.8%	2.0%
E09000015	Harrow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%

E06000001	Hartlepool	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.6%
E06000001	Hartlepool	00K	NHS Hartlepool and Stockton-On-Tees CCG	32.4%	99.4%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	3.5%	2.9%
E09000016	Havering	08F	NHS Havering CCG	91.7%	96.2%
E09000016	Havering	08M	NHS Newham CCG	0.1%	0.2%
E09000016	Havering	08N	NHS Redbridge CCG	0.6%	0.7%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.0%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	0.9%
E06000019	Herefordshire, County of	05F	NHS Herefordshire CCG	98.2%	97.3%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	05T	NHS South Worcestershire CCG	0.8%	1.3%
E10000015	Hertfordshire	07M	NHS Barnet CCG	0.2%	0.0%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000015	Hertfordshire	14Y	NHS Buckinghamshire CCG	0.2%	0.1%
E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	97.0%	46.5%
E10000015	Hertfordshire	07X	NHS Enfield CCG	0.5%	0.1%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.6%	0.1%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.0%	50.7%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.2%	0.6%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.8%	0.2%
E09000017	Hillingdon	14Y	NHS Buckinghamshire CCG	0.0%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.2%	6.9%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.2%	1.8%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.3%	89.8%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.1%	1.0%
E09000018	Hounslow	07W	NHS Ealing CCG	5.4%	7.4%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.2%	0.9%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.2%	87.1%
E09000018	Hounslow	09Y	NHS North West Surrey CCG	0.3%	0.4%
E09000018	Hounslow	08P	NHS Richmond CCG	5.7%	3.8%
E09000018	Hounslow	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07R	NHS Camden CCG	4.9%	5.4%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.5%	0.5%
E09000019	Islington	07T	NHS City and Hackney CCG	3.4%	4.2%
E09000019	Islington	08C	NHS Hammersmith and Fulham CCG	0.5%	0.5%
E09000019	Islington	08D	NHS Haringey CCG	1.2%	1.5%
E09000019	Islington	08H	NHS Islington CCG	89.1%	87.9%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	07R	NHS Camden CCG	0.2%	0.3%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.0%	5.4%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	1.2%	1.7%
E09000020	Kensington and Chelsea	08Y	NHS West London (K&C & QPP) CCG	63.9%	92.5%
E10000016	Kent	09C	NHS Ashford CCG	100.0%	8.3%
E10000016	Kent	07N	NHS Bexley CCG	1.3%	0.2%
E10000016	Kent	07Q	NHS Bromley CCG	0.9%	0.2%
E10000016	Kent	09E	NHS Canterbury and Coastal CCG	100.0%	14.1%
E10000016	Kent	09J	NHS Dartford, Gravesham and Swanley CCG	98.3%	16.5%
E10000016	Kent	09L	NHS East Surrey CCG	0.1%	0.0%
E10000016	Kent	08A	NHS Greenwich CCG	0.2%	0.0%
E10000016	Kent	09P	NHS Hastings and Rother CCG	0.3%	0.0%
E10000016	Kent	99K	NHS High Weald Lewes Havens CCG	0.6%	0.0%
E10000016	Kent	09W	NHS Medway CCG	6.1%	1.1%
E10000016	Kent	10A	NHS South Kent Coast CCG	100.0%	12.9%
E10000016	Kent	10D	NHS Swale CCG	99.8%	7.1%
E10000016	Kent	10E	NHS Thanet CCG	100.0%	9.1%
E10000016	Kent	99J	NHS West Kent CCG	98.7%	30.4%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.4%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	90.8%	98.6%
E09000021	Kingston upon Thames	08J	NHS Kingston CCG	86.9%	95.9%
E09000021	Kingston upon Thames	08R	NHS Merton CCG	1.1%	1.3%
E09000021	Kingston upon Thames	08P	NHS Richmond CCG	0.7%	0.8%
E09000021	Kingston upon Thames	99H	NHS Surrey Downs CCG	0.7%	1.2%
E09000021	Kingston upon Thames	08T	NHS Sutton CCG	0.1%	0.1%
E09000021	Kingston upon Thames	08X	NHS Wandsworth CCG	0.3%	0.7%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02R	NHS Bradford Districts CCG	1.0%	0.7%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.4%	0.7%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.6%	54.7%
E08000034	Kirklees	15F	NHS Leeds CCG	0.1%	0.3%
E08000034	Kirklees	03J	NHS North Kirklees CCG	98.9%	42.4%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.5%	1.3%

E08000011	Knowsley	01F	NHS Halton CCG	1.0%	0.8%
E08000011	Knowsley	01J	NHS Knowsley CCG	86.8%	88.2%
E08000011	Knowsley	99A	NHS Liverpool CCG	2.4%	8.0%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.1%	0.1%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.8%
E09000022	Lambeth	07R	NHS Camden CCG	0.2%	0.1%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	0.9%	0.6%
E09000022	Lambeth	07V	NHS Croydon CCG	0.7%	0.8%
E09000022	Lambeth	08C	NHS Hammersmith and Fulham CCG	0.6%	0.4%
E09000022	Lambeth	08K	NHS Lambeth CCG	85.5%	92.2%
E09000022	Lambeth	08R	NHS Merton CCG	1.0%	0.6%
E09000022	Lambeth	08Q	NHS Southwark CCG	1.9%	1.6%
E09000022	Lambeth	08X	NHS Wandsworth CCG	3.5%	3.7%
E09000022	Lambeth	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.0%
E10000017	Lancashire	02N	NHS Airedale, Wharfdale and Craven CCG	0.2%	0.0%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.1%	1.5%
E10000017	Lancashire	00R	NHS Blackpool CCG	13.6%	1.9%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01A	NHS East Lancashire CCG	99.0%	30.0%
E10000017	Lancashire	02M	NHS Fylde & Wyre CCG	97.9%	13.8%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	16.6%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.9%	0.2%
E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Morecambe Bay CCG	44.1%	12.1%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.2%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.5%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	96.9%	8.7%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.7%	0.2%
E08000035	Leeds	02N	NHS Airedale, Wharfdale and Craven CCG	0.1%	0.0%
E08000035	Leeds	02W	NHS Bradford City CCG	1.1%	0.2%
E08000035	Leeds	02R	NHS Bradford Districts CCG	0.5%	0.2%
E08000035	Leeds	15F	NHS Leeds CCG	97.7%	98.8%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.6%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.4%	0.6%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	2.1%	1.8%
E06000016	Leicester	04C	NHS Leicester City CCG	92.8%	95.5%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.8%	2.7%
E10000018	Leicestershire	03V	NHS Corby CCG	0.5%	0.0%
E10000018	Leicestershire	15M	NHS Derby and Derbyshire CCG	0.4%	0.6%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.5%	39.8%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.2%	4.1%
E10000018	Leicestershire	04N	NHS Rushcliffe CCG	5.4%	1.0%
E10000018	Leicestershire	04Q	NHS South West Lincolnshire CCG	5.6%	1.1%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	53.1%
E09000023	Lewisham	07Q	NHS Bromley CCG	1.4%	1.5%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000023	Lewisham	08A	NHS Greenwich CCG	2.1%	1.9%
E09000023	Lewisham	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000023	Lewisham	08K	NHS Lambeth CCG	0.3%	0.4%
E09000023	Lewisham	08L	NHS Lewisham CCG	91.5%	92.0%
E09000023	Lewisham	08Q	NHS Southwark CCG	3.9%	3.9%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.3%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.2%	0.1%
E10000019	Lincolnshire	03T	NHS Lincolnshire East CCG	99.2%	32.0%
E10000019	Lincolnshire	04D	NHS Lincolnshire West CCG	98.6%	29.9%
E10000019	Lincolnshire	04H	NHS Newark & Sherwood CCG	2.4%	0.4%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	4.9%	1.1%
E10000019	Lincolnshire	99D	NHS South Lincolnshire CCG	90.8%	19.6%
E10000019	Lincolnshire	04Q	NHS South West Lincolnshire CCG	93.3%	16.1%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.5%	2.7%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.4%	96.3%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.3%	1.0%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.3%	4.5%
E06000032	Luton	06P	NHS Luton CCG	97.3%	95.5%
E08000003	Manchester	00V	NHS Bury CCG	0.4%	0.1%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	14L	NHS Manchester CCG	90.9%	95.6%
E08000003	Manchester	00Y	NHS Oldham CCG	0.9%	0.4%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01W	NHS Stockport CCG	1.7%	0.8%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	4.0%	1.6%

E06000035	Medway	09J	NHS Dartford, Gravesham and Swanley CCG	0.2%	0.2%
E06000035	Medway	09W	NHS Medway CCG	93.9%	99.5%
E06000035	Medway	10D	NHS Swale CCG	0.2%	0.0%
E06000035	Medway	99J	NHS West Kent CCG	0.2%	0.3%
E09000024	Merton	07V	NHS Croydon CCG	0.5%	0.9%
E09000024	Merton	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000024	Merton	08J	NHS Kingston CCG	3.4%	2.9%
E09000024	Merton	08K	NHS Lambeth CCG	1.0%	1.7%
E09000024	Merton	08R	NHS Merton CCG	87.7%	80.9%
E09000024	Merton	08T	NHS Sutton CCG	3.3%	2.6%
E09000024	Merton	08X	NHS Wandsworth CCG	6.6%	10.8%
E06000002	Middlesbrough	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.2%	0.2%
E06000002	Middlesbrough	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.3%
E06000002	Middlesbrough	00M	NHS South Tees CCG	52.3%	99.5%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.2%
E06000042	Milton Keynes	04G	NHS Nene CCG	0.6%	1.3%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	58.9%	95.2%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	5.9%	4.0%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.8%	0.8%
E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.5%	0.3%
E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.0%
E09000025	Newham	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000025	Newham	08M	NHS Newham CCG	96.6%	97.3%
E09000025	Newham	08N	NHS Redbridge CCG	0.3%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.2%	0.2%
E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.4%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.7%	0.7%
E10000020	Norfolk	06M	NHS Great Yarmouth and Waveney CCG	47.7%	12.2%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000020	Norfolk	06V	NHS North Norfolk CCG	100.0%	18.6%
E10000020	Norfolk	06W	NHS Norwich CCG	100.0%	25.2%
E10000020	Norfolk	99D	NHS South Lincolnshire CCG	0.2%	0.0%
E10000020	Norfolk	06Y	NHS South Norfolk CCG	98.9%	24.1%
E10000020	Norfolk	07J	NHS West Norfolk CCG	98.4%	18.5%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.6%	0.7%
E06000012	North East Lincolnshire	03T	NHS Lincolnshire East CCG	0.8%	1.2%
E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.6%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.2%	0.2%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.2%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.1%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.1%
E06000013	North Lincolnshire	04D	NHS Lincolnshire West CCG	1.0%	1.3%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	94.9%	96.9%
E06000024	North Somerset	11E	NHS Bath and North East Somerset CCG	1.6%	1.5%
E06000024	North Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	21.8%	98.3%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.6%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.2%	96.3%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E10000023	North Yorkshire	02N	NHS Airedale, Wharfdale and Craven CCG	32.5%	8.3%
E10000023	North Yorkshire	00C	NHS Darlington CCG	1.3%	0.2%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.1%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.4%	0.7%
E10000023	North Yorkshire	03D	NHS Hambleton, Richmondshire and Whitby CCG	98.3%	22.8%
E10000023	North Yorkshire	03E	NHS Harrogate and Rural District CCG	99.8%	26.2%
E10000023	North Yorkshire	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.1%
E10000023	North Yorkshire	15F	NHS Leeds CCG	0.9%	1.3%
E10000023	North Yorkshire	01K	NHS Morecambe Bay CCG	1.9%	1.0%
E10000023	North Yorkshire	03M	NHS Scarborough and Ryedale CCG	99.3%	19.2%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.6%	18.8%
E10000023	North Yorkshire	03R	NHS Wakefield CCG	2.0%	1.2%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.6%	1.9%
E10000021	Northamptonshire	03V	NHS Corby CCG	99.2%	9.8%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	2.0%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.1%	1.2%
E10000021	Northamptonshire	04G	NHS Nene CCG	98.8%	84.9%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.1%	1.0%
E10000021	Northamptonshire	99D	NHS South Lincolnshire CCG	0.9%	0.2%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.5%
E06000057	Northumberland	01H	NHS North Cumbria CCG	0.1%	0.1%
E06000057	Northumberland	00J	NHS North Durham CCG	0.2%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	0.9%	0.6%
E06000057	Northumberland	00L	NHS Northumberland CCG	97.9%	98.7%

E06000018	Nottingham	04K	NHS Nottingham City CCG	89.9%	95.4%
E06000018	Nottingham	04L	NHS Nottingham North and East CCG	4.6%	2.0%
E06000018	Nottingham	04M	NHS Nottingham West CCG	4.1%	1.1%
E06000018	Nottingham	04N	NHS Rushcliffe CCG	4.3%	1.5%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	97.1%	13.5%
E10000024	Nottinghamshire	15M	NHS Derby and Derbyshire CCG	1.5%	1.8%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.6%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	04D	NHS Lincolnshire West CCG	0.4%	0.1%
E10000024	Nottinghamshire	04E	NHS Mansfield and Ashfield CCG	97.9%	22.5%
E10000024	Nottinghamshire	04H	NHS Newark & Sherwood CCG	97.6%	15.6%
E10000024	Nottinghamshire	04K	NHS Nottingham City CCG	10.1%	4.6%
E10000024	Nottinghamshire	04L	NHS Nottingham North and East CCG	95.1%	17.2%
E10000024	Nottinghamshire	04M	NHS Nottingham West CCG	90.8%	10.2%
E10000024	Nottinghamshire	04N	NHS Rushcliffe CCG	90.3%	13.6%
E10000024	Nottinghamshire	04Q	NHS South West Lincolnshire CCG	0.7%	0.1%
E10000024	Nottinghamshire	04V	NHS West Leicestershire CCG	0.1%	0.0%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.5%	1.4%
E08000004	Oldham	14L	NHS Manchester CCG	0.8%	2.1%
E08000004	Oldham	00Y	NHS Oldham CCG	94.5%	96.3%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E10000025	Oxfordshire	15A	NHS Berkshire West CCG	0.5%	0.3%
E10000025	Oxfordshire	14Y	NHS Buckinghamshire CCG	2.4%	1.8%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	04G	NHS Nene CCG	0.1%	0.1%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.4%	96.5%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.6%	0.2%
E10000025	Oxfordshire	12D	NHS Swindon CCG	2.7%	0.9%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	23.0%	96.3%
E06000031	Peterborough	99D	NHS South Lincolnshire CCG	5.1%	3.7%
E06000026	Plymouth	15N	NHS Devon CCG	22.1%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.5%	1.4%
E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.6%	98.4%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.2%	0.2%
E06000038	Reading	15A	NHS Berkshire West CCG	35.3%	99.4%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.2%	0.6%
E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	4.9%	3.3%
E09000026	Redbridge	08C	NHS Hammersmith and Fulham CCG	0.1%	0.1%
E09000026	Redbridge	08F	NHS Havering CCG	0.8%	0.7%
E09000026	Redbridge	08M	NHS Newham CCG	1.4%	1.7%
E09000026	Redbridge	08N	NHS Redbridge CCG	92.3%	89.4%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.3%	3.1%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.7%
E06000003	Redcar and Cleveland	03D	NHS Hambleton, Richmondshire and Whitby CCG	1.1%	1.1%
E06000003	Redcar and Cleveland	00M	NHS South Tees CCG	47.3%	98.9%
E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.5%	0.5%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	4.9%	7.0%
E09000027	Richmond upon Thames	08J	NHS Kingston CCG	1.6%	1.5%
E09000027	Richmond upon Thames	08P	NHS Richmond CCG	91.7%	90.3%
E09000027	Richmond upon Thames	99H	NHS Surrey Downs CCG	0.0%	0.1%
E09000027	Richmond upon Thames	08X	NHS Wandsworth CCG	0.4%	0.7%
E08000005	Rochdale	00V	NHS Bury CCG	0.7%	0.6%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.5%	96.6%
E08000005	Rochdale	14L	NHS Manchester CCG	0.6%	1.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.9%	1.0%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.3%	3.1%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	1.0%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.1%	1.2%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.8%	1.7%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.3%
E06000017	Rutland	03V	NHS Corby CCG	0.2%	0.5%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	9.9%	86.3%
E06000017	Rutland	99D	NHS South Lincolnshire CCG	2.6%	11.5%
E06000017	Rutland	04Q	NHS South West Lincolnshire CCG	0.4%	1.4%
E08000006	Salford	00T	NHS Bolton CCG	0.2%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.8%	1.4%
E08000006	Salford	14L	NHS Manchester CCG	1.1%	2.5%
E08000006	Salford	01G	NHS Salford CCG	94.1%	94.6%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.2%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.1%
E08000028	Sandwell	15E	NHS Birmingham and Solihull CCG	1.9%	7.0%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.7%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	55.1%	88.6%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.7%	1.3%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000014	Sefton	01J	NHS Knowsley CCG	1.8%	1.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.3%
E08000014	Sefton	01T	NHS South Sefton CCG	96.0%	51.6%
E08000014	Sefton	01V	NHS Southport and Formby CCG	96.8%	41.9%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.3%	0.1%

E08000019	Sheffield	02P	NHS Barnsley CCG	0.8%	0.4%
E08000019	Sheffield	15M	NHS Derby and Derbyshire CCG	0.2%	0.4%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.4%	0.2%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.5%	99.1%
E06000051	Shropshire	05F	NHS Herefordshire CCG	0.4%	0.3%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.5%	0.3%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.7%	95.4%
E06000051	Shropshire	01R	NHS South Cheshire CCG	0.4%	0.3%
E06000051	Shropshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.2%	0.9%
E06000051	Shropshire	05T	NHS South Worcestershire CCG	1.0%	1.0%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.3%	1.4%
E06000051	Shropshire	02F	NHS West Cheshire CCG	0.1%	0.1%
E06000051	Shropshire	06D	NHS Wyre Forest CCG	0.8%	0.3%
E06000039	Slough	14Y	NHS Buckinghamshire CCG	1.8%	6.2%
E06000039	Slough	07W	NHS Ealing CCG	0.0%	0.1%
E06000039	Slough	15D	NHS East Berkshire CCG	33.8%	93.4%
E06000039	Slough	08G	NHS Hillingdon CCG	0.0%	0.1%
E06000039	Slough	07Y	NHS Hounslow CCG	0.0%	0.1%
E06000039	Slough	09Y	NHS North West Surrey CCG	0.0%	0.1%
E08000029	Solihull	15E	NHS Birmingham and Solihull CCG	17.0%	98.9%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05J	NHS Redditch and Bromsgrove CCG	0.4%	0.3%
E08000029	Solihull	05L	NHS Sandwell and West Birmingham CCG	0.0%	0.1%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.4%	0.4%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E10000027	Somerset	11E	NHS Bath and North East Somerset CCG	3.1%	1.1%
E10000027	Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.3%
E10000027	Somerset	15N	NHS Devon CCG	0.2%	0.5%
E10000027	Somerset	11J	NHS Dorset CCG	0.5%	0.7%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.3%
E10000027	Somerset	99N	NHS Wiltshire CCG	0.1%	0.1%
E06000025	South Gloucestershire	11E	NHS Bath and North East Somerset CCG	0.8%	0.6%
E06000025	South Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	28.2%	97.5%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.8%	1.8%
E06000025	South Gloucestershire	99N	NHS Wiltshire CCG	0.0%	0.1%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.2%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.2%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E06000045	Southampton	10X	NHS Southampton CCG	94.9%	99.5%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.5%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.8%	4.7%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.7%	95.3%
E09000028	Southwark	07R	NHS Camden CCG	0.3%	0.3%
E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.5%	1.6%
E09000028	Southwark	08C	NHS Hammersmith and Fulham CCG	0.7%	0.5%
E09000028	Southwark	08K	NHS Lambeth CCG	6.6%	7.7%
E09000028	Southwark	08L	NHS Lewisham CCG	2.1%	2.0%
E09000028	Southwark	08Q	NHS Southwark CCG	94.1%	87.9%
E09000028	Southwark	08X	NHS Wandsworth CCG	0.1%	0.1%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.1%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.6%	2.3%
E08000013	St. Helens	01X	NHS St Helens CCG	91.2%	96.3%
E08000013	St. Helens	02E	NHS Warrington CCG	0.1%	0.1%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.7%	1.2%
E10000028	Staffordshire	15E	NHS Birmingham and Solihull CCG	0.3%	0.4%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.3%	14.9%
E10000028	Staffordshire	15M	NHS Derby and Derbyshire CCG	0.5%	0.5%
E10000028	Staffordshire	05C	NHS Dudley CCG	1.4%	0.5%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	92.1%	14.7%
E10000028	Staffordshire	01C	NHS Eastern Cheshire CCG	0.6%	0.1%
E10000028	Staffordshire	05G	NHS North Staffordshire CCG	95.1%	23.4%
E10000028	Staffordshire	05N	NHS Shropshire CCG	1.0%	0.3%
E10000028	Staffordshire	01R	NHS South Cheshire CCG	0.5%	0.1%
E10000028	Staffordshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	96.2%	23.6%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.5%	16.7%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	8.8%	2.9%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%
E10000028	Staffordshire	05Y	NHS Walsall CCG	1.6%	0.5%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.1%	0.2%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.6%	0.8%
E10000028	Staffordshire	06D	NHS Wyre Forest CCG	0.2%	0.0%
E08000007	Stockport	01C	NHS Eastern Cheshire CCG	1.6%	1.1%
E08000007	Stockport	14L	NHS Manchester CCG	1.1%	2.2%
E08000007	Stockport	01W	NHS Stockport CCG	94.9%	96.5%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E06000004	Stockton-on-Tees	00C	NHS Darlington CCG	0.4%	0.2%
E06000004	Stockton-on-Tees	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.4%	0.6%
E06000004	Stockton-on-Tees	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.1%
E06000004	Stockton-on-Tees	00K	NHS Hartlepool and Stockton-On-Tees CCG	66.9%	98.4%
E06000004	Stockton-on-Tees	00M	NHS South Tees CCG	0.4%	0.7%

E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.3%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.5%	0.3%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	91.2%	97.1%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.2%
E10000029	Suffolk	06M	NHS Great Yarmouth and Waveney CCG	52.3%	16.3%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.9%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.4%	0.6%
E10000029	Suffolk	06Y	NHS South Norfolk CCG	1.1%	0.3%
E10000029	Suffolk	07H	NHS West Essex CCG	0.1%	0.0%
E10000029	Suffolk	07K	NHS West Suffolk CCG	91.1%	29.7%
E08000024	Sunderland	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.9%	0.9%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.9%
E08000024	Sunderland	00J	NHS North Durham CCG	2.2%	1.9%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.5%	0.3%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	96.0%
E10000030	Surrey	07Q	NHS Bromley CCG	0.4%	0.1%
E10000030	Surrey	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000030	Surrey	09H	NHS Crawley CCG	6.6%	0.7%
E10000030	Surrey	07V	NHS Croydon CCG	1.3%	0.4%
E10000030	Surrey	15D	NHS East Berkshire CCG	3.4%	1.2%
E10000030	Surrey	09L	NHS East Surrey CCG	96.6%	14.1%
E10000030	Surrey	09N	NHS Guildford and Waverley CCG	94.0%	16.9%
E10000030	Surrey	09X	NHS Horsham and Mid Sussex CCG	1.5%	0.3%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.7%	0.2%
E10000030	Surrey	08J	NHS Kingston CCG	4.5%	0.7%
E10000030	Surrey	08R	NHS Merton CCG	0.3%	0.0%
E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	23.0%	4.2%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	09Y	NHS North West Surrey CCG	99.4%	29.5%
E10000030	Surrey	08P	NHS Richmond CCG	0.7%	0.1%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	99H	NHS Surrey Downs CCG	97.4%	23.8%
E10000030	Surrey	10C	NHS Surrey Heath CCG	98.9%	7.6%
E10000030	Surrey	08T	NHS Sutton CCG	1.2%	0.2%
E10000030	Surrey	99J	NHS West Kent CCG	0.2%	0.0%
E09000029	Sutton	07V	NHS Croydon CCG	1.0%	1.9%
E09000029	Sutton	08J	NHS Kingston CCG	3.5%	3.4%
E09000029	Sutton	08K	NHS Lambeth CCG	0.1%	0.2%
E09000029	Sutton	08R	NHS Merton CCG	6.3%	6.7%
E09000029	Sutton	99H	NHS Surrey Downs CCG	1.3%	1.9%
E09000029	Sutton	08T	NHS Sutton CCG	94.7%	85.6%
E09000029	Sutton	08X	NHS Wandsworth CCG	0.2%	0.3%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.0%	0.2%
E06000030	Swindon	12D	NHS Swindon CCG	96.0%	98.2%
E06000030	Swindon	99N	NHS Wiltshire CCG	0.7%	1.5%
E08000008	Tameside	14L	NHS Manchester CCG	2.2%	5.8%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.9%
E08000008	Tameside	01W	NHS Stockport CCG	1.8%	2.3%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.2%	88.0%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.8%	2.9%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.7%	97.1%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.3%	0.3%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.3%
E06000034	Thurrock	08F	NHS Havering CCG	0.2%	0.4%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.5%	99.0%
E06000027	Torbay	15N	NHS Devon CCG	11.7%	100.0%
E09000030	Tower Hamlets	07R	NHS Camden CCG	1.1%	0.9%
E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.5%	0.3%
E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	0.9%	0.9%
E09000030	Tower Hamlets	08C	NHS Hammersmith and Fulham CCG	0.8%	0.5%
E09000030	Tower Hamlets	08H	NHS Islington CCG	0.2%	0.1%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.2%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.9%	96.9%
E08000009	Trafford	14L	NHS Manchester CCG	2.7%	7.0%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.1%
E08000009	Trafford	02A	NHS Trafford CCG	95.7%	92.7%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%
E08000036	Wakefield	02P	NHS Barnsley CCG	0.9%	0.6%
E08000036	Wakefield	15F	NHS Leeds CCG	0.4%	1.0%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.5%	98.0%
E08000030	Walsall	15E	NHS Birmingham and Solihull CCG	1.1%	4.8%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.7%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.6%	3.1%
E08000030	Walsall	05Y	NHS Walsall CCG	92.8%	90.4%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.4%	1.4%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.4%	0.4%
E09000031	Waltham Forest	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000031	Waltham Forest	08D	NHS Haringey CCG	0.1%	0.1%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.3%	1.7%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.4%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.3%	96.1%

E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	0.9%	0.6%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	1.0%	0.6%
E09000032	Wandsworth	08J	NHS Kingston CCG	0.1%	0.0%
E09000032	Wandsworth	08K	NHS Lambeth CCG	3.2%	3.5%
E09000032	Wandsworth	08R	NHS Merton CCG	2.8%	1.6%
E09000032	Wandsworth	08P	NHS Richmond CCG	1.3%	0.7%
E09000032	Wandsworth	08X	NHS Wandsworth CCG	88.3%	92.6%
E09000032	Wandsworth	08Y	NHS West London (K&C & QPP) CCG	0.7%	0.4%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.2%	2.0%
E06000007	Warrington	02E	NHS Warrington CCG	97.6%	97.0%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.2%
E10000031	Warwickshire	15E	NHS Birmingham and Solihull CCG	0.2%	0.5%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.2%	21.5%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	04G	NHS Nene CCG	0.2%	0.2%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	05J	NHS Redditch and Bromsgrove CCG	0.7%	0.2%
E10000031	Warwickshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.1%	45.8%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.7%	30.7%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E06000037	West Berkshire	15A	NHS Berkshire West CCG	30.0%	97.6%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.7%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	99N	NHS Wiltshire CCG	0.1%	0.4%
E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.1%	0.4%
E10000032	West Sussex	09G	NHS Coastal West Sussex CCG	99.5%	57.5%
E10000032	West Sussex	09H	NHS Crawley CCG	93.4%	14.0%
E10000032	West Sussex	09L	NHS East Surrey CCG	0.3%	0.0%
E10000032	West Sussex	09N	NHS Guildford and Waverley CCG	3.1%	0.8%
E10000032	West Sussex	99K	NHS High Weald Lewes Havens CCG	1.1%	0.2%
E10000032	West Sussex	09X	NHS Horsham and Mid Sussex CCG	95.7%	25.9%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.1%	1.0%
E10000032	West Sussex	99H	NHS Surrey Downs CCG	0.6%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	2.0%
E09000033	Westminster	07R	NHS Camden CCG	3.0%	3.4%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	79.3%	71.3%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	0.6%	0.6%
E09000033	Westminster	08K	NHS Lambeth CCG	0.1%	0.2%
E09000033	Westminster	08Y	NHS West London (K&C & QPP) CCG	23.1%	22.6%
E08000010	Wigan	00T	NHS Bolton CCG	0.2%	0.1%
E08000010	Wigan	01G	NHS Salford CCG	0.8%	0.6%
E08000010	Wigan	01X	NHS St Helens CCG	3.8%	2.2%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.2%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.8%	1.0%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.7%
E06000054	Wiltshire	11E	NHS Bath and North East Somerset CCG	0.9%	0.4%
E06000054	Wiltshire	15A	NHS Berkshire West CCG	0.2%	0.2%
E06000054	Wiltshire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.5%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.3%	0.4%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.5%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.3%	0.4%
E06000054	Wiltshire	12D	NHS Swindon CCG	1.3%	0.6%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.2%
E06000054	Wiltshire	99N	NHS Wiltshire CCG	96.7%	96.8%
E06000040	Windsor and Maidenhead	15A	NHS Berkshire West CCG	0.4%	1.3%
E06000040	Windsor and Maidenhead	14Y	NHS Buckinghamshire CCG	0.3%	1.1%
E06000040	Windsor and Maidenhead	15D	NHS East Berkshire CCG	34.1%	96.9%
E06000040	Windsor and Maidenhead	09Y	NHS North West Surrey CCG	0.2%	0.5%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.2%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.1%	0.0%
E08000015	Wirral	02F	NHS West Cheshire CCG	0.4%	0.3%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.7%
E06000041	Wokingham	15A	NHS Berkshire West CCG	31.5%	97.0%
E06000041	Wokingham	15D	NHS East Berkshire CCG	1.0%	2.6%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.4%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.3%	1.5%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.1%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.8%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.4%	3.5%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	93.8%	93.4%
E10000034	Worcestershire	15E	NHS Birmingham and Solihull CCG	0.9%	2.0%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.7%	0.4%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	05F	NHS Herefordshire CCG	0.9%	0.3%
E10000034	Worcestershire	05J	NHS Redditch and Bromsgrove CCG	95.8%	27.7%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.3%	1.1%
E10000034	Worcestershire	05T	NHS South Worcestershire CCG	97.2%	49.3%
E10000034	Worcestershire	06D	NHS Wyre Forest CCG	98.3%	18.6%
E06000014	York	03E	NHS Harrogate and Rural District CCG	0.2%	0.1%
E06000014	York	03Q	NHS Vale of York CCG	60.2%	99.9%

Produced by NHS England using data from National Health Applications and Infrastructure Services (NHAIS) as supplied by NHS Digital.

Agenda Item 14

Item No. 14.	Classification: Open	Date: 18 November 2019	Meeting Name: Health and Wellbeing Board
Report title:		Response to Prevention Green Paper - Advancing our health- prevention in the 2020s	
Ward(s) or groups affected:		All wards	
From:		Professor Kevin Fenton, Director of Health and Wellbeing; Jin Lim, Deputy Director of Public Health Signe Norberg, Policy and Public Affairs Officer	

RECOMMENDATION

1. The Health and Wellbeing Board are invited to:

   - Note and consider the response to the Prevention Green Paper: *Advancing our health - Prevention in the 2020s* (Appendix 1).

BACKGROUND INFORMATION

2. The consultation on the Government *Green Paper on prevention: Advancing our health - Prevention in the 2020s* close 14th October 2019. The consultation paper highlighted the ambitions of having proactive, predictive, and personalised prevention. This means targeted support, tailored lifestyle advice, personalised care and greater protection against future threats. Views were sought on proposals to tackle the causes of preventable ill health in England in relation to the environment in which we live, the choices we make, and the services we receive.

KEY ISSUES FOR CONSIDERATION

3. The consultation asked 20 wide ranging questions (Appendix 1). While the focus on prevention is welcomed, the response highlights six areas requiring especial consideration by Government so that prevention ambitions can be truly embedded and realized in the health and social care and wider system.

   - **Wider determinants**: The significant impact of wider determinants on people's lives is recognised within the strategy, but there are no actions or commitments to mitigate this. Technology will undoubtedly transform, improve and create new services that will help change the way healthcare is accessed and used by patients, but it does not alter the socio-economic conditions and wider determinants of health that play a role in shaping a person's health and opportunities in life. Deprivation is a key driver of ill health across the country, and this needs to be further addressed within the strategy.

   - **Targeted interventions**: Whilst universal care is effective and important, the strategy does not fully acknowledge the importance of targeted interventions in ensuring the most vulnerable receive the care and support

they need. This is particularly important to recognise in the current climate of economic uncertainty, impacts of Brexit and cuts to health and social care budgets and the impacts of the reductions in public health budgets.

- **Childhood obesity**: It is encouraging to see that childhood obesity is highlighted in the Green Paper. However, there are already strong evidence based recommendations for actions from Chapter Two of the National Child Obesity Strategy that have not progressed beyond the consultation stage. Further clarity on how they will be taken forward by Govenment is urgently needed.

- **Healthy Start vouchers**: The weekly vouchers help low-income pregnant mothers and families with a child under 4 buy basic healthy foods, fruit and vegetables. When innovatively partnered with local businesses and markets, they also support and add value to the local economy. However, many eligible families still do not engage with the service and there are a number of improvements that need to be made in order to ensure higher uptake rates. It is estimated that between 2017 and 2018, nearly £135,000 worth of Healthy Start vouchers went unclaimed by eligible Southwark residents. Our response strongly requests that Government proceeds urgently with the consultation promised in Chapter 2 of the childhood obesity strategy.

- **Health in the planning and housing sector**: The strategy recognises that the scope of prevention is broad and incorporates a number of specialist fields. However the consultation fails to adequately highlight the importance of housing and planning in preventing ill-health. It should be recognised that the Government has made a number of positive changes to the housing sector in recent years by ensuring fair treatment of tenants and the creation of affordable housing. However, we would encourage the Government to consider how housing and planning can more fully participate in the prevention agenda through championing green-spaces, increasing accessibility to healthy food and ensuring individuals can access safe and affordable housing.

- **Funding is vital**: Without adequate long term funding, little progress can be made in any of these areas. The one-year Spending Review decision to allow a real-terms increase in public health grants is warmly received, but no details have been given on the precise nature of the increase, and the increase needs to extend beyond one year. The single year increase does not compensate for the estimated national reduction of approximately 25% in the public health grant over the last 5 years.[1] Alongside, it is estimated by the National Audit Office that nationally, general reductions in local authority budgets of almost a third (32.6%) since 2010/11, have led to falls in spending on wider local services that play an important role in supporting peoples' overall health and wellbeing.[2]

[1] https://www.kingsfund.org.uk/blog/2018/11/prevention-better-cure-except-when-it-comes-paying-it

[2] https://www.health.org.uk/news-and-comment/news/additional-%C2%A332bn-a-year-needed-to-reverse-impact-of-government-cuts-to-public-helath

Policy implications

4. The responses are currently being considered by Government. There is no clear timetable for the White Paper. As and when further Government proposals are made, their implications will be assessed for local policy.

5. Locally, we will continue to develop strong digital approaches with partners to make services more accessible and cost effective. Alongside the NHS digital programme, we are implementing major public health transformation approaches to key pubic health services such as health checks and sexual health.

6. We will also continue to embed a strong health in all policies approach across the Council. Our major Council strategies take an integrated approach to improving the health and wellbeing of Southwark's population. The New Southwark Plan provides a spatial planning and land use framework that includes supporting active travel, physical activity, affordable housing, increasing and protecting green space and growing opportunities and A5 (hot food take away) restrictions. Health improvement is also being integrated into the Housing Strategy and culture and health programmes. Additionally, the Council has recently adopted a healthier high streets framework. Southwark is also a changing borough and our social regeneration framework and charters aim to make regeneration work for everyone and ensure opportunities for health improvement are realised.

Resource implications

7. No further resource is required.

Legal implications

8. None.

Financial implications

9. None.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Consultation document: Advancing our health - prevention in the 2020s	Corporate Affairs	Signe Norberg
https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s		
Childhood obesity – A Plan for Action Chapter 2	Public Health Division	Rebecca Steele
https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action-chapter-2		

APPENDICES

No.	Title
Appendix 1	Response to Prevention Green Paper: Advancing our health: prevention in the 2020s

AUDIT TRAIL

Lead Officer	Professor Kevin Fenton, Strategic Director of Place and Wellbeing	
Report Author	Jin Lim, Deputy Director of Public Health Signe Norberg, Policy and Public Affairs Officer	
Version	Final	
Dated	1 Nov 2019	
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	Yes	NA
Date final report sent to Constitutional Team		7 November 2019

Advancing our health: prevention in the 2020s

Consultation response

This document sets out Southwark Council's response to the consultation on Advancing our health: prevention in the 2020s.

Summary

Southwark Council welcomes the government's strategy on prevention, *Advancing our health: prevention in the 2020s*. Prevention is crucial to improving the health of residents, preventing ill health and minimising cost to the healthcare system. The strategy marks a welcome shift towards preventing illness instead of merely treating it, and highlights a number of factors that can contribute towards ill health.

It is encouraging to see that there is an understanding that a new approach is needed for the wider health and care system, and that a range of public health areas are incorporated into the strategy. Commitments such as improving the NHS Health Checks programme will develop existing services and help identify areas for further action.

Southwark Council's consultation process has identified six key areas recommended for inclusion in the strategy in order to achieve the ambition of fully integrating prevention in the health and social care system.

1. **Wider determinants**: The significant impact of wider determinants on people's lives is recognised within the strategy, but there are no actions or commitments to mitigate this. Technology will undoubtedly transform, improve and create new services that will help change the way healthcare is accessed and used by patients, but it does not alter the socioeconomic conditions that play a role in influencing a person's health. Deprivation is a key driver of ill health across the country, and this needs to be further addressed within the strategy.

2. **Targeted interventions**: Whilst universal care is effective and important, the strategy doesn't fully acknowledge the importance of targeted interventions in ensuring the most vulnerable receive the care they need. This is particularly important to recognise in the current climate of economic uncertainty and cuts to health and social care budgets.

3. **Childhood obesity**: It is encouraging to see progress on the government's childhood obesity strategy. However, there are actions from chapter two that have not progressed beyond the consultation stage and further clarity on those is urgently needed.

4. **Healthy Start vouchers**: The voucher scheme can be a great way to ensure low-income families access fruit and vegetables. However, many eligible families still do not engage with the service and there are a number of improvements that need to be made in order to ensure higher uptake rates. One of these improvements would be for government to proceed with the consultation promised in Chapter 2 of the childhood obesity strategy.

5. **Health in the planning and housing sector**: The strategy recognises that the scope of prevention is broad and incorporates a number of specialist fields; however the consultation failed to adequately highlight the importance of housing and planning in preventing ill-health. It should be recognised that the government has made a number of positive changes to the housing sector in recent years by ensuring fair treatment of tenants and the creation of affordable housing. However, we would encourage the government to consider how housing and planning can more fully participate in the prevention agenda through championing green-spaces, increasing accessibility to healthy food and ensuring individuals can access safe and affordable housing.

6. **Funding is vital**: Without sufficient, long term funding, little progress can be made in any of these areas. The one-year Spending Review decision to allow a real-terms increase in public health grants is warmly received, but no details have been given on the precise nature of the increase, and the increase needs to extend beyond one year.

Consultation questions

Question 1: Which **health and social care policies** should be reviewed to improve the health of people living in poorer communities, or excluded groups?

There are a range of health and social care policies that can make a positive contribution to the lives of those living in poorer communities or excluded groups. Whilst other policies will be elaborated upon later in this response, Southwark Council would like to provide feedback on the following issues:

- **Social care green paper**: The long awaited green paper on social care needs to address the current staffing, budget and operational challenges within the social care sector. There should be a clear plan of how to ensure health and social care services work together to protect the most vulnerable members of society.

- **Recognising the role of deprivation**: All government health and social care policies need to be more explicit in recognising the impact of health inequalities on wellbeing and identify a set of actions to alleviate the impact of these.

- **Ensure policies are targeted**: Policies must be tailored to ensure the highest level of care is provided to all members of society, some of whom may require more targeted approaches to prevention.

- **Healthy Start vouchers consultation**: Healthy Start vouchers can be very positive for low income families in accessing healthy food, but uptake rates remain very low. Chapter two of the government's childhood obesity strategy recognises the need to examine ways to increase uptake, but there has been little progress on this.

It is equally crucial to recognise that these issues need to be examined in conjunction with other policy areas that impact poorer communities, such as housing and welfare. Without changes to an array of policies, the government is unlikely to significantly alter health outcomes for those that need it most. For further information on this, please consider our response on Questions 15 and 21.

Question 2: Do you have any ideas for how the **NHS Health Checks programme** could be improved?

At the moment, two in five people in Southwark who are invited to attend an NHS Health Check fail to book and complete a check. The findings in a national report from the Expert Scientific and Clinical Advisory Panel (ESCAP) on NHS Health Checks highlighted six major reasons why invitees do not attend an appointment. These included issues related to 'competing priorities' and 'convenience', alongside the restricted opportunity to attend a face-to-face check at certain providers and at certain times of the year. These reflect some of the challenges seen in Southwark.

To support greater uptake amongst those who do not respond to an invitation for a face-to-face check, Southwark developed a Digital Health Check tool which could be completed on a mobile device or tablet. During the pilot of this Digital Health Check (DHC) tool, over 3,000 SMS texts were sent to previously non-responding eligible patients. Of these, nearly one third of people invited by SMS visited the webpage, with around half going onto complete the online check. Over one in ten of those completing DHC were found to be at high risk of developing cardiovascular disease, and were therefore advised to book an appointment for a face-to-face check. However, local evidence suggests that residents in Southwark often find booking an appointment for a Health Check in GP surgeries to be a challenge. This is due to high call volumes directed to GP reception booking teams and the limited availability of appointments with healthcare professionals in busy surgeries.

It is not yet clear if the NHS Health Checks programme should target those with a high absolute risk of cardiovascular disease or those with an elevated relative or lifetime risk. The NHS Health Checks programme may be the best vehicle for delivering sustained behaviour change to adults in their 40s and 50s, and clear guidance is needed to define the role of the Health Checks programme in relation to both types of risk. Other risk factors for cardiovascular disease such as inactivity and alcohol should be included in any risk algorithm. Further investment is required by the government to have a fit for purpose risk algorithm that helps deliver a holistic NHS Health Check.

The public health mandate has skewed the delivery of the NHS Health Checks programme to focus on the assessment and communication of results. Care planning is often not considered to be part of the NHS Health Checks programme,

vastly reducing the impact of the service. The NHS Health Checks programme would function better if it delivered a high-quality, shared decision-making conversation which included referral to follow up clinics as well as lifestyle behaviour change services. Further work is required to ensure Health Checks are adequately funded to ensure comprehensive care.

To improve the NHS Health Checks programme, Southwark Council would recommend:

- **A national online option** to book an NHS Health Check without the need to call busy receptionists. Ideally this could be via the new NHS app that checks the eligibility of the patient for an NHS Health Check and allows them to book an appointment online.

- **Target those who are unlikely to respond**: As exemplified by the success of the Southwark Digital Health Check, it is important to directly target those at highest risk of not responding.

- The government should **explore the role of digital as a blended approach** across the whole NHS Health Checks care pathway - from identification, take up, assessment and care planning through to long-term behaviour change support. Delivery of these solutions nationally, working in partnership with local government is critical. Southwark would welcome working with the government to develop and test any solutions. We would encourage the open publication of all digital discovery and alpha work to date in line with the Government Digital Service (GDS) design principles and would further encourage all PHE and NHS digital developments to be open to all.

- Strengthening options to **commission services to alternative community providers** such as community pharmacists, leisure centres, opticians, dentists and local supermarkets. This would alleviate the burden of delivery of NHS Health Checks from the primary care sector. Community providers could be trained to refer to primary care where there is a clinical need, social prescribing services or healthy lifestyle behaviour change services, as appropriate. It would be important to support local government in testing these models of care, both from a process and impact perspective.

- The use of **intelligent risk prioritisation algorithms** which use existing medical record data to risk stratify eligible patients would improve the efficiency of the programme. It would allow resources to be moved from low to higher priority groups to improve outcomes and impact. This would depend on whether the NHS Health Checks will be used to identify those with a high 10-year absolute risk of developing cardiovascular disease, or whether the focus will move to primary prevention and modifying the behaviour of adults in their 40s and 50s to reduce their lifetime risk of developing non-communicable disease.

- Options to add **greater intrinsic value** to the programme should be explored, particularly for individuals that are either relatively ‘healthy’ or the ‘worried well’, who often report dissatisfaction with the relative simplicity of the check.

- Expanding the NHS health check to include **indicators for wider modifiable, non-communicable diseases and conditions** with a focus on lifestyle behaviour change support could improve the impact of the service.

- **A rewards or incentives programme** linked to attending and completing the NHS Health Check could support completers to improve or maintain a healthy lifestyle post-check. We would encourage the government to review the role of incentives as a behaviour change technique for healthy lifestyles. Southwark again would welcome being part of a pilot in this area.

Question 3: What ideas should the government consider to raise funds for helping people **stop smoking**?

Utilising revenue from proceeds of crime

The Proceeds of Crime Act 2002 gives officers the power to seize cash and recover assets such as cars and houses bought by criminals through the proceeds of their crime. Currently Southwark Trading Standards has a trained Financial Investigator (accredited by National Crime Agency) who assesses the proceeds of crime related to a criminal offence. Money is collected by the confiscation unit which is then transferred to the Home Office. This money is divided up accordingly: 50% to HM Treasury, 12.5% to the confiscation unit and 37.5% to the prosecuting organisation (Trading Standards). This is the arrangement within Southwark, but may not be the standard throughout England.

Good practice would be to:

- Increase the number of trained Financial Investigators so local authorities can receive proceeds of crime.
- Local authorities could share of the proceeds of crime would could then be directed toward initiatives such as stop smoking services.

Increase and hypothecate tobacco taxes

In light of increase in tobacco tax, the government could give a proportion of the tax on tobacco products to fund stop smoking services. The National Institute for Health and Care Excellence (NICE) estimates that for every pound invested in smoking cessation, £2.37 is generated in benefits.

Improve HMRC inspection capabilities

Over seven billion pounds is lost each year to tax evasion and avoidance. Collecting this money and investing it in prevention services, such as smoking, would make a huge difference to the health of people living in the UK.

Mandatory levy on gambling

Going beyond smoking, a mandatory levy on gambling would allow the government to tackle gambling addiction as well as a variety of other public health issues.

Question 4: How can we do more to support mothers to **breastfeed**?

Southwark Council is passionate about ensuring that mothers are supported to breastfeed, and aims to increase local levels of breastfeeding. At present, the local breastfeeding initiation rate is 89.5%. The Council and Guy's and St Thomas' NHS Foundation Trust have achieved level one accreditation as part of the UNICEF UK Baby Friendly Initiative and is working toward achieving level two. This internationally recognised standard enables public health services to better support families with feeding and bonding. As part of this work, the council is promoting breastfeeding by inviting local venues to participate in the 'Breastfeeding Welcome Scheme', which encourages mothers to breastfeed within their venue. The council also supports breastfeeding cafes, where mothers can feed in a supportive environment.

In our work to increase breastfeeding uptake rates locally, we have found that the following measures are crucial and need to be considered at a national level:

- Whilst it is unlawful to discriminate against a woman because she is breastfeeding a child, breastfeeding remains stigmatised in certain settings and communities. The government must ensure **all venues and workplaces across the country encourage and provide the right environments to support mothers to breastfeed**.
- The government should ensure that all mothers receive support to breastfeed through guaranteeing all health visitors and midwives receive appropriate **training**. In addition, **sufficient funding** is needed to ensure that midwives and health visitors have sufficient time to support mothers to breastfeed.
- There needs to be **consistent and positive messaging** regarding breastfeeding. For example, packs for new or expecting mothers should not contain goods or materials that could discourage breastfeeding.

Question 5: How can we better support families with children aged 0 to 5 years to **eat well**?

It is good that this green paper recognises the **wider determinants** of health within early years such as acknowledging the impact of parental conflict and family income on a child's health and development. However, it is not clear how these wider determinants will be addressed and it is recommended that this is more explicitly explored in the final strategy. In regard to eating well, it is vital to ensure comprehensive care across the early years by releasing sufficient funding for core universal services, such as Health Visiting and Children's Centres. The services can provide a number of interventions to improve the health of families and their children, particularly in relation to healthy eating.

To support families with children aged 0 to 5 years to eat well, Southwark Council would recommend the following:

- Parents play a key part in ensuring children eat well, but there are a range of reasons why this may be challenging. There needs to be **clear information** available to parents on what constitutes a good diet. There are confusing marketing messages on what constitutes healthy food that appear to conflict with official guidance, particularly in relation to children's food. It is therefore important to ensure **clear and easy to understand food labelling**, particularly on children's food. This should be supported by educational campaigns and wider parental support. This could be enacted by health visitors as well as cooking and nutritional support groups. There is also potential to incorporate such messages in NHS and Public Health England campaigns.

- **Income** significantly impacts how well a family can eat. National data suggests that households earning below £15,860 per annum after housing costs need to spend 42% of their household income on food to meet the government's nutritional guidelines, as set out in the Eatwell Plate. For example, a four-person family would need to spend £103.17 per week to meet the Eatwell guidelines, making a healthy diet unaffordable for many.

- **Food insecurity** can negatively influence a family's ability to eat healthily. Nationally, 52% of households with children are unable to afford a 'socially acceptable diet' as defined by the Minimum Income Standard. This refers to a diet which is healthy and allows social participation (e.g. inviting guests for dinner or eating out occasionally for a celebration). This needs to be addressed in order to ensure greater food security for the most vulnerable families.

- The scarcity of **time** can also play a part in poor diet choices for families. The UK Time Use Survey found that low income families have less free time during the weekend than higher occupational groups. Therefore, these groups may be unable to plan meals in advance or take time to prepare more complex and nutritious meals. Thus, it should be remembered that interventions that do not require individual action are more likely to address health inequalities.

- There is no mention of the proposed **Healthy Start Vouchers Consultation** within the green paper. The voucher scheme is a good way of ensuring low-income families with young children can afford fruit and vegetables. To support the scheme, the government needs to make the application process simpler and ensure vouchers are widely promoted to families and professionals. In addition, there should be a review into the fiscal value of Healthy Start vouchers, as the current contribution level has not increased since the vouchers were first introduced despite rising living costs.

Question 6: How else can we help people reach and stay at a **healthier weight**?

Over the past years there has been considerable progress in attempting to address the national obesity crisis, and it is one of the council's key public health priorities. With some of the highest obesity levels in the country, we are working across the council and with local partners to deliver a range of initiatives that help encourage people to maintain a healthy weight.

We welcome the plans to extend the **Soft Drinks Industry Levy** to milk-based drinks. It is also important that low sugar and sugar-free drinks are cheaper and included in price promotions, rather than high sugar alternatives. This will not only support a number of national Sugar Smart campaigns, but will also financially incentivise customers to make healthier choices.

To build on the positive outcomes from the Soft Drinks Industry Levy, there are points that need to be addressed:

- Will schools continue to receive the **revenue** from the Sugar Drinks Industry Levy so that they can fund initiatives and interventions to promote a healthy weight? Long-term funding and increased clarity is needed for schools in order to help provide interventions that encourage long-term change.

- A stronger emphasis on the **socioeconomic factors** that impact the food and drink choices of individuals is required to more fully address the social inequalities associated with this issue.

- In order to establish healthy eating behaviours from a young age, it is important that **schools continue to support and provide healthy meals**. In Southwark, universal free meals are provided to all primary school children and the council is now extending this to nursery school classes. The council is supporting schools to improve the nutritional quality of meals where possible, but this would be made easier if meeting the School Food Standards was part of Ofsted inspections. The green paper makes very little reference to the role of schools in establishing healthy behaviours, not just in promoting healthy diets but also in encouraging physical

activity. For example, in Southwark we have a council-wide commitment to encourage all primary schools to do the 'Daily Mile' in order to increase physical activity.

- The council has welcomed the government's commitment to conduct a consultation on online and television **advertising** guidelines related to high fat, salt and sugar (HFSS) products; we are eagerly awaiting the outcome of this work. In the meantime, Southwark Council has introduced an advertising ban on HFSS for all council-owned advertising opportunities, in line with Transport for London's advertising policy. To further reduce the consumption of HFSS products the **use of cartoon and other characters** should not be included on food packets or offered as a gift within packaging.

- As part of the ban on HFSS product advertising, Southwark has also banned the promotion of alcoholic drinks to encourage a healthy lifestyle for residents. **Alcohol** has a considerable impact on people's health but is not adequately examined in the green paper.

- **The National Child Measurement Programme** (NCMP) also plays a vital part in helping us understand the health of children. To have the best impact possible, NCMP needs to be developed further. As a local authority, we recognise the need to share NCMP digitally, but we need further support to be able to do this. It is particularly important that NCMP data is shared with child weight management programmes, to increase the number of families receiving behavioural change support, and with GPs, so that families receive consistent messaging and support from healthcare professionals. There is a need for increased capacity within the programme to track children through their school journey, in order to gain more detailed knowledge of the factors that may impact their health. Under the current regime, there is no way to understand how a child's measurements might change between reception and year six.

- **Implementation of the consultations announced in the government's childhood obesity strategy**: In Chapter two, there were a range of measures that would significantly help people maintain a healthy weight such as consistent calorie labelling in the out-of-home sector, banning price promotions, 9pm watershed on TV advertising for HFSS products and similar protection for online advertising. Consultations for these initiatives have been completed, but no further action has resulted. **Clarification on how and when these policies would be adopted** would be welcomed.

- **Further healthy weight support for healthcare professionals**: Southwark Council is one of the first local authorities to develop a bespoke online healthy weight training programme for professionals across the borough. Interest and uptake by healthcare professionals in Southwark has far exceeded our expectations and participants have said that they found the training engaging and inspiring. We note recommendations from a recent report by the British Psychological Society on childhood obesity, which corroborates our local position. Specifically, that health professionals should be trained to talk about weight loss in a more supportive way and to avoid language and explanations that locate the 'problem' of obesity within individuals. The government should heed the recommendations of this report and expand healthy weight training across the country.

- The government should further highlight the **clear correlation between obesity and economic deprivation**. This paper does not identify how such wider determinants of health will be addressed to prevent more people becoming overweight. This is a fundamental weakness when trying to ensure that the next decade will offer individuals targeted support, tailored lifestyle advice and personalised care. The forthcoming roadmap, being developed by Dame Sally Davies, on how to achieve the government target of **halving childhood obesity by 2030** should be helpful in this regard, but as made clear in this response, it needs to acknowledge the key role of deprivation in this phenomenon.

- The government needs to prioritise **active travel**, focusing on encouraging uptake of walking and cycling. Currently, there are limited sources of national transport funding, with only £400m available each year. To reach a sustained behaviour shift amongst residents and to demonstrate to local authorities that this is a priority area, there needs to be more ambitious government action. This should include a refresh of the Cycling and Walking Investment Strategy. Measures such as school streets, 20mph roads, play streets and low emission neighbourhoods require further support from government to avoid a piecemeal provision across the country. All of this will help combat the rise of largely sedentary behaviour.

Question 7: Have you got examples or ideas that would help people do **more strength and balance exercises**?

One of the largest risks to older residents' health is the complications related to **falling and slipping**. 16,000 people in Southwark and Lambeth are at risk of falling, which equates to a third of the over 65 years population. In 2012/13 there were 13,039 falls related attendances and ambulance call outs by the registered population of Lambeth and Southwark, and 3,029 admissions into a hospital bed. This amounts to a whole system cost of £8.25 million per year. In 2017-18 in Southwark there were 1,283 Emergency hospital admissions for injuries due to falls in people age 65-79.

To help reduce these instances, SLIPS (Southwark & Lambeth Integrated Care Pathway for Older People with Falls) programme was initiated as an integrated falls service across health, social, voluntary and leisure sectors in Southwark and Lambeth. The service was evaluated between June 2013 and November 2015 and successfully showed improvement on all outcome measures including increasing people's confidence, improving their activities of daily living and independence levels. Of the 275 people triaged to be at risk of falls who participated over the 14 months of the project, 96.5% had no falls and of those who did fall, none required hospital care.

Implementing this programme in Southwark and Lambeth has had a number of positive outcomes for participants and the programme leads are currently working closely with Age UK's Safe and Independent Living (SAIL) programme to consider using it elsewhere. The programme will also be integrated into the council's Developing Social Prescribing model.

Beyond implementing similar services across the country, there are a number of other actions that would help people do more strength and balance exercises:

- There needs to be a greater emphasis and promotion of the **Chief Medical Officer's guidelines on physical activity**, especially for those aged 64 years and above.
- It is important to recognise that doing strength and balance exercises twice a week is not met by low intensity cardiovascular activities such as walking.
- All residents aged 60 years or above should be screened for risk of falls annually and referred and signposted to specialist services if needed.
- Strength and balance exercises should not be seen as only for the young or 'gym goers'. There are a number of ways to dispel this myth such as providing support services and educating people on simple ways to develop strength without going to the gym.

Question 8: Can you give any examples of **any local schemes that help people to do more strength and balance exercises**?

The council offers free swim and gym access to all residents in the borough on specific days (Fridays, Saturdays and Sundays), which helps build strength and balance for all residents. As of quarter one in 2019/20, our leisure centres have had over 39,000 visits. The council has further plans to make free swim and gym more flexible for residents and to offer free swimming lesson for all.

Founded in 2013, Silverfit is an exciting, rapidly expanding charity in Southwark, which is led by older people for older people. Silverfit's aim is to promote happier, healthier ageing through physical activity whilst at the same time combating social isolation. Their 'sandwich' formula of socialising/exercise/socialising for older people is unique, and is increasing activity levels and helping people make new friends, feel more confident and enjoy life as they age. They currently run sessions in parks around London for older people to meet, enjoy some exercise (everything from Nordic Walking and Pilates to Walking Football and Cheerleading) and have a chat in the café afterwards. Silverfit recently undertook a study on their members' views on exercise, and it found that most exercised to improve their physical health, feel good and improve mental health.

The council has also been working with five older adult community groups through an initiative called Oomph, which focuses on alleviating isolation and loneliness, empowering Southwark volunteers and staff to develop life-long employment skills and build confidence through exercise training. Participants admitted they would not normally participate in these kinds of activities, but have remarked how they feel more confident and keen to participate further. Instructors have seen large improvements in the mobility of participants after completion of the programme.

Southwark CCG commission an ESCAPE pain service delivered at Kings College and Dulwich Hospitals, which stands for *Enabling Self-management and Coping with arthritic Pain through Exercise.* It is run by physiotherapists for up to ten patients who meet twice a week for ten to twelve sessions. The programme includes a combination of education, self-management and coping advice with physical exercises. During the sessions, patients share experiences and take stock on changes in their conditions since the previous meeting, set and review goals and action plans, engage in themed discussions on topics such as managing pain, healthy eating, pacing activity and rest and agree exercises to do at home. 82% of patients completed this training. The Southwark Partnership has also recently been successful in achieving funding from The Healthy London Partnership and Innovation Unit that will allow us to develop some new innovations for residents that have been both diagnosed with MSK and depression or anxiety. Part of this will be to expand the current ESCAPE pain classes and sessions across Southwark. This will be done by developing a relationship with the MSK triage Hub (MCATS). The pilot project will start in October 2019 and run for 6 months until the end of March 2020.

Question 9: There are many factors affecting people's **mental health**. How can we support the things that are good for mental health and prevent the things that are bad for mental health, in addition to the mental health actions in the green paper?

This prevention green paper recognises that there are many factors affecting people's mental health, and although the paper highlighted the need to take urgent action to address some of these risk factors, **it is not clear what type of interventions will be implemented and how these would be funded**. This facet of the strategy needs more direction and clarity in order to sufficiently help support people's mental health and effectively prevent ill health.

Poverty, deprivation and debt have a detrimental effect on mental health, so any intervention aimed at reducing their impact would be helpful, but these need to be adequately funded. People, particularly the most vulnerable, need to be financially secure and have access to basic requirements, such as secure housing and healthy food. Examples of where the government could intervene include in the so-called 'gig economy' to ensure those employed on zero hour contracts can have basic income security, and to ensure that safe, quality homes are built at genuinely affordable rents.

In terms of what can be done to support things that are good for mental health, the evidence shows that a healthy prenatal and childhood environment, good social relationships, healthy lifestyle and good employment prospects are all protective factors for mental health. Frameworks akin to **'5 Ways to Wellbeing'** or the **'Wheel of Wellbeing'** could be used to steer community interventions.

Specific recommendations that will help support better mental health include:

- **Adequate funding for mental health and support services**, ensuring there is no postcode lottery in terms of mental health provision.
- Mandate **mental health first aid training for front line health and social care staff** so that individuals experiencing mental health crises are supported and effectively directed to appropriate mental health support services.
- Encourage community and voluntary sector (CVS) organisations working with individuals in debt to implement Mental Health First Aid training for all staff.
- Prevent public organisations from passing on individuals' details to private **debt collection** companies.
- **Targeted efforts** to reduce mental health inequalities, especially amongst BME populations, by launching culturally appropriate campaigns to de-stigmatise mental health issues and promote early intervention.
- Supporting people to 'give back' to their local communities through the promotion of **volunteering schemes** or to consider increasing their educational attainment through **adult learning programmes**, both of which can contribute to good mental health.
- Train workers within the **wellness and fitness industry** such as beauticians, hairdressers and fitness instructors, to talk about mental health. This could be similar to PHE and Treatwell's 'Life Saving Wax' initiative that aimed to encourage women to undergo cervical screening.

- The interaction between mental health and **digital technologies** is complex and does not have a singular outcome; it is recognised that digital technologies can both improve and worsen a person's mental wellbeing. However, it is important to recognise that they can provide part of the solution to the mental illness crisis by increasing access to mental wellbeing education and mental health support services. It is imperative that central government provide leadership and guidance in this arena, with particular focus on helping to develop and test digital interventions. Southwark would welcome being part of any pilot work.

Question 10: Have you got examples or ideas about **using technology** to prevent mental ill-health, and promote good mental health and wellbeing?

There are a range of opportunities for technology to be utilised. A few critical areas include:

- **Pre-natal and maternity**: Digitalise maternity and postnatal records to allow for more robust flagging and follow-up of women who are at risk of postnatal depression.

- **Young children**: Issue guidance on screen time limits for parents and teachers, including support on how to implement these and working with the digital marketplace to support this. This should accompany guidance for outdoor activity time.

- **Teenagers and adults:** Ensure that mental health services have clear navigable online access and self-referral routes, accompanied by clear information and advice written from a patient's point of view. Allow people to engage with services using online and text messaging as a first step.

- **Whole population**: Risk algorithms can be developed and implemented across health and social care records, identifying risk factors for poor mental health and wellbeing, and proactively flag individuals who may need preventative help. It is critical that shared intelligence protocols are in place between NHS, local government and key provider services. Electronic records should not just be limited to the NHS. The government have an important role in supporting this, and we recommend that a link is made with the Ministry of Housing, Communities & Local Government (MHCLG) local digital work.

- **Life stages**: It is important that digital technology targets and empowers the population to make positive lifestyle changes, for example by targeting people at transitions in life which make them more vulnerable to poor mental health. These include having a baby, moving into a new area and retirement. Targeting can be done by using high quality digital social marketing, with an online customer journey triaging to further support in the community as well as online.

Question 11: We recognise that **sleep deprivation** (not getting enough sleep) is bad for your health in several ways. What would help people get 7 to 9 hours of sleep a night?

Good sleep hygiene is important to ensure good health and we welcome its inclusion in the prevention green paper. In terms of helping people get seven to nine hours of sleep per night, it would be good to **embed good sleep hygiene practices in school curricula** (either within scientific subjects like biology, or as part of possible mental wellbeing programmes).

Employers should also take the lead in making their employees aware of the importance of sleep, in particular those who employ shift and night workers. Public Health England recently produced a 'Sleep toolkit' for employers that could be more widely advertised. The government could consider legislation that guarantees employees a 'right to disconnect' outside of work hours (as has recently been adopted in France).

In terms of the environmental factors that affect sleep, more emphasis could be put on the work of the local authorities environmental health teams. For example, Public Health and the Environmental Health team could work with licensing colleagues to ensure that **noise nuisance** generated by the night time economy is mitigated as much as possible by robust licensing policies.

Wider issues around the gig economy such as people working several jobs to keep their families afloat, not being paid a living wage, insecure tenancies, high rents, and poor housing standards all contribute to lack of sleep. A **truly liveable 'living wage'** should be considered when thinking about encouraging more sleep.

Question 12: Have you got examples or ideas for services or advice that could be delivered by **community pharmacies** to promote health?

Biometric measurements such as weight, height, blood pressure, blood cholesterol and blood glucose testing in community pharmacies would lessen the burden on GP surgeries and secondary care providers. These test results could be **digitally linked to a Digital NHS Health Check** in order to complete a remote NHS Health Check, for those where this would be the most appropriate delivery method.

Question 13: What should the role of water companies be in **water fluoridation schemes**?

Tooth decay remains the most common oral disease affecting children and young people in England and one of the most common reasons for their hospital admission; and yet, it is entirely preventable. Fluoride is a naturally occurring mineral that can help prevent tooth decay. While most commercial toothpastes contain fluoride, **inclusion of fluoride in the water supply** is an evidence-based population level intervention to reduce tooth decay not yet espoused universally in the UK. Water fluoridation schemes are already explicitly permitted by parliament and local authorities hold decision-making responsibilities; however, it is up to the Secretary of State for Health and Social Care to engage in agreements and partnerships with commercial water companies to make it happen.

Mainstreaming water fluoridation would require **a thorough communication plan** that focuses on tackling a number of false assertions about safety and efficacy, which can disproportionately affect public opinion. Any decision to move forward with water fluoridation would therefore need to be unilaterally agreed by water companies, so that a clear and consistent message comes from all professionals involved. Tooth decay has a significant socio-economic gradient and thus national fluoridation would reduce oral health inequalities.

Question 14: What would you like to see included in a call for evidence on **musculoskeletal (MSK) health**?

Trying to prevent an increase of MSK conditions is welcomed, and there are a number of areas that we believe should be included in a call for evidence on MSK:

- **A focus on the positive outcomes of doing strength work** when an individual is suffering from MSK-related ill health.
- **A review of GP coding of MSK problems.** Codes vary greatly making correct signposting and referring difficult, and results in an inability to accurately evaluate the incidence and prevalence of MSK-related illness.
- More evidence is required to assess the effectiveness of an adequately-funded **MSK service** in every local authority.
- **The relationship between MSK and mental health**: there is strong evidence to suggest that those suffering from MSK conditions will have a degree of poor mental health. This should be addressed by the strategy in order to encourage better prevention and treatment services for these individuals.
- Further guidance on how **evidence-based approaches** such as rapid-access physiotherapy, 'Escape Pain' initiatives and Joint Pain Advisor programmes can be delivered at scale, without the cost implications being prohibitive for employers.
- Consideration of **measures such as standing desks:** making them more affordable for smaller employers and encouraging workplace health schemes to recognise the importance of regular movement throughout the day.
- Further thought regarding initiatives for the **older population**, and whether these can be incorporated into a annual screening for 60+ year olds, as mentioned in Question 7.

Question 15: **What could the government do to help people live more healthily**: in homes and neighbourhoods, when going somewhere, in workplaces, in communities?

There are opportunities for significant government action in three areas - housing, planning, and work – all of which could help people live healthier lives.

In regard to housing, the introduction of the Homes Act 2018 (Fitness for Human Habitation) is welcomed. **Ensuring that all residential dwellings are suitable for living** could vastly improve health. There are ample opportunities for further action and we would encourage the government to examine this area further.

The Town and Country Planning Association has campaigned for the government to introduce a **Healthy Homes Bill**, which would ensure all new housing is built to an acceptable standard. The draft Bill contains ten principles, which set out what constitutes an acceptable home. These include:

1. Low risk of fire
2. Adequate living space
3. Access to natural light
4. Accessible housing as well as accessible and safe neighbourhoods.
5. Within walkable neighbourhoods with greenspace
6. Radical reductions in carbon dioxide emissions in line with the ambitions of the Climate Change Act 2008
7. Walkable access to green and play space
8. Increased resilience to a changing climate
9. Safe and secure, and will meet 'designing out crime standards'
10. Meet enhanced standards to prevent unacceptable noise pollution

Adequate housing insulation and other heat saving measures need to be included as well.

The physical environment is important in encouraging healthy behaviours and maintaining good health. Local authorities have some planning powers but **more explicit central government guidance on healthy environments would help create healthier communities**. For example, national guidance could make clear that there should not be an unhealthy concentration of A5 premises in an area. Implementing recommendations from the **'Putting Health into Place'** report should be helpful in achieving this.

The **Raynsford Review of Planning** identifies a number of recommendations that would serve the prevention agenda. The review identifies an amendment to Section 8 of the 2017 Neighbourhood Planning Act, which would place a legal duty on some strategic priorities. It suggests that the section should be changed to reflect the importance of people-centred policy and the interaction with health outcomes. In doing this, health can be incorporated more easily within the planning agenda.

Additionally, it is important that the government **supports and encourages longitudinal studies** to monitor and strengthen the evidence base for the prevention agenda and the creation of healthier places, such as a qualitative longitudinal study using Post-Occupancy Evaluation (POE) of neighbourhoods.

Another key area for examination is employment. Although the paper states that good work is good for health, **'good work'** is not clearly defined. In addition, it is not clear how employers can be encouraged to adopt healthier working practices. There are examples of good practice in this area such as The Mayor of London's Healthy Workplace Award and Good Work Standard, Scotland's Healthy Working Lives programme and the Better Health at Work Award in the North East of England. Although these are a promising start operating at a regional level, national leadership focused on this are would be welcomed.

In recognition of the significant sickness absence burden of mental ill-health and stress-related conditions, the **Health and Safety Executive's Management Standards on Work-Related Stress** is an example of good practice. Although there is an expectation that employers should ensure they are completing stress risk assessments, this is not universally implemented. Securing greater compliance with the management standards including making them statutory, whilst supporting smaller organisations to engage with them, should be considered.

An area not adequately addressed by the strategy is **low pay**. The Institute of Health Equity report, *Promoting good quality jobs to reduce health inequalities*, made a number of recommendations in recognition of the significant impact on health of low paid, low status and insecure jobs. These included ensuring an adequate level of pay for all workers, protection from physical hazards, improving job security, providing skills training, ensuring good work/life balance and greater involvement on the part of employees in decision-making.

The government could help people to live more healthy lives by considering the effect of low pay on health and wellbeing. Suggestions for change include:

- **A clearer focus on improving the quality of jobs**. This is an important consideration which should be explicit in employment support programmes – for example Work and Health Programme and JobCentre plus (JCP) job support.

- Ensure that there is **no weakening of health and safety and other employment protection regulations and legislation following Brexit**.

- Encourage and incentivise employers to **reduce the incidence of low pay** by adopting the Living Wage as set by the Living Wage Foundation's campaign and raising the minimum and National Living Wage levels.

- Take action to **end the use of unstable employment patterns**, including zero hours contracts.

- **Increased investment in health and safety infrastructure** so that the current levels of protection are available to all and consistently enforced.

Question 16: What is your priority for making England the best country in the world to **grow old** in, alongside the work of PHE and national partner organisations?

- Support people with staying in work
- Support people with training to change careers in later life
- Support people with caring for a loved one
- Improve homes to meet the needs of older people
- Improve neighbourhoods to meet the needs of older people
- Other:

Our priority is to make Southwark a place which provides homes and neighbourhoods that support people to live long, healthy, happy lives in their own communities. In 2015 Southwark Council joined the WHO Global Network and became London's first age-friendly borough. As well as **delivering extra care housing** and exploring other specialist housing options for older people, we are **adapting properties** to enable older residents and people with disabilities to live independently.

We are working in partnership with the Southwark CCG and the Community and Voluntary Sector to understand the opportunities to **improve social cohesion**. At the start of next year we will launch our local loneliness strategy which has been co-produced with local partners.

Across the borough, we are examining opportunities to secure suitable **housing** for our older residents. Home environments have an impact across the life course of health and wellbeing. We are therefore currently working on refreshing Southwark's housing strategy to 'encourage and support a mix of high quality homes, of different tenures, types sizes, which are accessible and respond to people's changing needs over time'.

Furthermore, research indicates that fuel poverty increases with age particularly amongst the over 75s and physical and mental ill health are affected. Southwark will be working in partnership with the CCG and the voluntary sector to **coordinate an approach to fuel poverty**. This includes working with the GLA-funded Fuel Poverty Partnership, who offer advice and refer fuel-poor households to support services including income maximisation, health, and energy efficiency schemes.

We also want to ensure that work addresses **the needs of older workers**. In particular we want to ensure that employers offer:

- A range of flexible and agile working options

- Support for those with caring responsibilities

- Line management which is age inclusive by ensuring that age bias is addressed and removed

- Ensuring training and development opportunities are available for all workers in a range of accessible formats

- Recruitment processes which are truly age-inclusive

Question 17: What government policies (outside of health and social care) do you think have the **biggest impact on people's mental and physical health**? Please describe a top 3.

The main government policies outside the health and social care sector that have the biggest impact on people's mental and physical health include:

1. Welfare reform to ensure adequate income
2. Housing and planning
3. Effective workplace regulation

A key driver of physical and mental ill health is the **inability to earn an adequate income**. People with a low income tend to have poor nutrition, are more likely to be overweight or obese, be time-poor and have worse mental health. One way to alleviate this excess burden of ill health is to introduce further welfare reform.

Southwark was a forerunner site for **Universal Credit (UC)** and whilst it is not yet fully in place across the country, it has had a significant impact on residents. Since its initiation, a significant number of claimants have fallen into rent arrears due to a delay in starting the programme and are still struggling to pay this back. This has had a significant effect on their health and mental wellbeing. According to Trussell Trust who surveyed users from 30 foodbanks across the UK in March 2018, 57% of respondents said that they had experienced mental or physical health issues as a result of the wait for their first payment. Additionally, we are opposed to the **current 'minimum' wage** which is often unable to meet basic living costs. The government should introduce a fair 'living' wage with a London weighting that provides a sustainable way to live well. Removing the two child cap on benefits and a review of sick and maternity pay would also serve to support this aim.

As referenced to in Question 15, **housing** has a significant impact on people's health. Homes need to be genuinely affordable, of high quality, adequately insulated and safe and suitable for human occupation. Introducing a Healthy Homes Bill and mandating increased housing standards in the private rented sector would be fruitful avenues to thoroughly ensuring we can prevent ill-health across the population.

Finally, as mentioned in Question 15, **workplace regulation and employment practices** are important. There should be a clear focus on improving the quality of jobs, appropriate employment practices (such as ending the use of zero hour contracts) and a salary which can sustain workers.

Generally, it is important to point out that that there needs to be **a coordinated attempt to embed the prevention agenda across all government departments and all policy areas**. Government policy should focus on delivering health benefits for people in all public spheres. In this way, the healthy choice can become the easy choice.

Question 18: How can we make **better use of existing assets** – across both the public and private sectors – to promote the prevention agenda?

Fundamentally, no single actor can deliver the prevention agenda alone. **Partnership working** is essential and a range of stakeholders need to be mobilised. National and local government can help by setting out ambitions and directions of travel, but often they need to mobilise other areas of society, including the business and voluntary sectors. Engaging a wide array of stakeholders will ensure a well-rounded implementation and a more comprehensive support system.

The second step is to ensure that **everyone is aware of the role they can play in preventing illness**. Every stakeholder, department, civil servant and third sector body needs to understand that prevention can be incorporated into their work. For example, developers can bear in mind best practice when creating healthy environments and when submitting a planning applications. Welfare officers can consider the health impact of policy and the role of the wider determinants of health in promoting wellbeing.

Health should be everyone's business and in Southwark we have attempted to deliver this in various ways:

- Public Health in Southwark is now part of the directorate of Wellbeing and Place, meaning planning, environment and health teams can work together to promote a healthy society within our borough.
- Southwark is soon establishing a Community and Wellbeing Group with housing providers to share examples of good practice and resources on how to approach health and wellbeing in housing across the borough.

- We are developing a Healthy High Street Framework to recognise the role of the high street in influencing the health of local communities.

- Taking a human-focused approach when exploring policy areas like transport to help encourage healthy behaviours such as active travel.

Question 19: What more can we do to **help local authorities and NHS bodies** work well together?

- **Guidance**: A key way to ensure local authorities and NHS bodies work in tandem is to provide guidance on best practice. Highlighting models or local areas where this is done particularly well is a helpful starting point for creating collaborations across teams.

- **Funding**: Partnership working can be effective and valuable, but it is challenging to implement new ways of working without sufficient funding to create new pathways, work patterns and forums to share and learn from one another. The funding needs to have the necessary flexibility to be invested in the areas that are most in need of effective partnership working.

- **Convening**: The government should exercise its ability to convene a range of stakeholders within local government, NHS, PHE and other health bodies to work together to form a vision of how these players can better work together to support the prevention agenda.

Question 20: What are the top 3 things you'd like to see covered in a future strategy on **sexual and reproductive health**?

Southwark Council published its joint Sexual Health Strategy with the London Boroughs of Lambeth and Lewisham in March 2019. The strategy identified a number of actions that will help increase testing and treatment for Sexually Transmitted Infections (STIs), empower residents to enjoy healthy sexual relationships and good reproductive health and continue work towards eradicating HIV transmissions and late diagnoses. We believe these are vital aims of any future national strategy on sexual and reproductive health.

In terms of specific items for a future strategy, we would recommend the following three things:

- **Comprehensive funding**: Adequate funding to meet the demand of sexual heath services, to prevent cost shifting and gaps in services between public health, CCGs and NHSE, as is currently the case. Schools also need funding to carry out Relationships and Sex Education (RSE), with targeted outreach and catch-up for those who are most disengaged in education (who are also most likely to become teenage parents).

- **Public awareness**: It is important to tackle the inequity of knowledge and access to the full range of contraception across England and between population groups. Incentivising GPs to see this as a priority would be recommended. National and targeted campaigns to tackle increases in unprotected sex, focussing on population groups with the poorest sexual health as well as the general public, would further aid in this endeavour and deliver positive health outcomes.

- **Specific efforts to tackle HIV stigma and fully funded rollout of Pre-Exposure Prophylaxis (PrEP)**: Southwark still has the second highest number of people diagnosed with HIV in UK and the third highest HIV prevalence rate in London. The council is working hard to ensure it can effectively prevent, diagnose and treat HIV, and we believe that there are a few specific asks that will aid this. The PrEP programme has delivered positive outcomes as part of the borough's participation in the NHS England PrEP IMPACT trial, and a fully funded rollout of the programme across the country would go a long way to fully eradicate HIV/AIDS and help people live healthy lives and prevent illness. Further more public education is required to eliminate the stigma that is unfortunately often associated with HIV and STIs.

Question 21: What **other areas** (in addition to those set out in this green paper) would you like future government policy on prevention to cover?

In addition to those already included in the prevention green paper, we recommend inclusion of the following policy areas:

- The importance of good quality affordable housing, suitable for human habitation.

- The interaction between planning and the creation of healthy environments that encourage healthy behaviours.
- The role of the workplace and employers.
- Robust embedding of the prevention agenda in all government departments and policy areas.
- Support for local government in implementing the Government Digital Services (GDS) framework and NHS digital service design standards, NHS technology code of conduct, and the GDS technology code of practice. Further support is also needed to meet the NICE evidence standards for digital health technology across the country.

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Dated: November 2019