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Children and Young People Select Committee Agenda

Wednesday, 14 September 2016
7.00 pm,
Committee Room 2
Civic Suite
Lewisham Town Hall
London SE6 4RU

For more information contact: Katie Wood (Tel: 020 8314 9446)

This meeting is an open meeting and all items on the agenda may be audio recorded and/or filmed.

Part 1

Members of the public are welcome to attend committee meetings. However, occasionally, committees may have to consider some business in private. Copies of agendas, minutes and reports are available on request in Braille, in large print, on audio tape, on computer disk or in other languages.

Children and Young People Select Committee Members

Members of the committee, listed below, are summoned to attend the meeting to be held on Wednesday, 14 September 2016.

Barry Quirk, Chief Executive
Tuesday, 6 September 2016

Councillor Hilary Moore (Chair)	
Councillor Luke Sorba (Vice-Chair)	
Councillor Chris Barnham	
Councillor Andre Bourne	
Councillor David Britton	
Councillor Simon Hooks	
Councillor Liz Johnston-Franklin	
Councillor Helen Klier	
Councillor Jacq Paschoud	
Councillor Alan Till	
Sharon Archibald (Parent Governor Representative)	
Mark Saunders (Parent Governor Representative)	
Gail Exon	Church Representative
Monsignor N Rothon	Church Representative
Kevin Mantle (Parent Governor Representative)	Parent Governor representative for special schools
Councillor Alan Hall (ex-Officio)	
Councillor Gareth Siddorn (ex-Officio)	

MINUTES OF THE CHILDREN AND YOUNG PEOPLE SELECT COMMITTEE

Wednesday, 13 July 2016 at 7.00 pm

PRESENT: Councillors Hilary Moore (Chair), Luke Sorba (Vice-Chair), Chris Barnham, Andre Bourne, David Britton, Simon Hooks, Liz Johnston-Franklin, Jacq Paschoud, Mark Saunders (Parent Governor Representative), Gail Exon (Church Representative), Monsignor N Rothon (Church Representative) and Kevin Mantle (Parent Governor representative for special schools)

APOLOGIES: Councillors Helen Klier, Alan Till and Sharon Archibald

ALSO PRESENT: Councillor Paul Maslin (Cabinet Member for Children and Young People), Paul Aladenika (Service Group Manager, Policy Development and Analytical Insight), Timothy Andrew (Interim Overview and Scrutiny Manager), Stephen Kitchman (Director of Children's Social Care), Katherine Manchester (Project Manager), Claudia Smith, Warwick Tomsett (Head of Targeted Services and Joint Commissioning), Sara Williams (Executive Director, Children and Young People) and Katie Wood (Scrutiny Manager)

1. Minutes of the meeting held on 8 June 2016

1.1 RESOLVED:

That the minutes of the meeting held on the 8 June be agreed as an accurate record of proceedings and the Chair be authorised to sign them.

2. Declarations of interest

Councillor Jacq Paschoud declared a personal interest in item 4 as she was a trustee of the Ravensbourne Project.

Kevin Mantel declared a personal interest in item 4 as he was a Parent Governor at Brent Knoll School, a committee member of Signal Family Support and he worked for the Government Equalities Office.

3. Children's Social Care Ofsted Action Plan

3.1 Stephen Kitchman, Director of Children's Social Care introduced the report to the Committee. Following questions and challenge from members of the Committee, the following key points were highlighted:

- Members of the Committee requested confirmation that the new deadlines around the review of the referral and assessment process and agreeing the new Early Help Strategy would be met. The Committee was informed that the new deadlines would be met and

they reflected the emphasis on assuring the quality of new processes and strategies. The new Multi-Agency Safeguarding Hub (MASH) was on target for being in place by 1 October.

- Following questions on the nature of the delays regarding return interviews; Members of the Committee were informed that better options had been identified and Children's Social Care was now working with the Commissioning team and had identified a partner organisation that in addition to the interview would provide analysis, match funding opportunities and other on-going work. The delay in delivery timescale was therefore worth the improved service that would be provided.
- Revising some of the deadlines reflected the fact that the best possible service delivery was more important than meeting the original dates and timeframes. The revised deadlines were realistic and would be met. It was important to focus on outcomes.
- Members of the Committee highlighted concerns that sickness by one member of staff had an effect on many of the actions and questioned capacity and resilience in the team. The Committee was informed that work was being done to address this and increase capacity by improving the structure of quality assurance teams and other organisational structure changes. The changes to the MASH would also help to build resilience to the teams.

3.2 Councillor Johnston-Franklin and Councillor Paschoud addressed the Committee regarding their recent visit to frontline staff in Children's Social Care.

- They had been impressed by how hard the teams were working, their knowledge, expertise and commitment to the borough, and the quality of partnership working.
- They were however concerned regarding the physical environment and working conditions.
- Social worker recruitment and retention could be a potential area for the Children and Young People Select Committee to consider in the future.

3.3 In response to their comments the Director of Children's Social Care made the following comments to the Committee:

- Staff had been very pleased to have the visit from Councillors and the opportunity to discuss their work.
- Improving the working environment and improvements to IT capabilities were being introduced and the importance of this to staff was recognised and noted.
- The Director of Children's Social Care would be happy to extend the invite to visit frontline staff to any other members of the Children and Young People Select Committee.
- Members of the Committee were invited to visit Kaleidoscope Lewisham on 7 September 2016 to meet frontline staff and increase their understanding of the work being done.

3.4 **RESOLVED:**

That the report be noted.

That an invite be sent round to members of the committee to visit Kaleidoscope Lewisham on 7 September 2016 to meet frontline staff.

4. Update on implementation of SEND Strategy

4.1 Warwick Tomsett, Head of Targeted Services and Joint Commissioning introduced the report to the Committee, Claudia Smith, Interim Service Manager was also in attendance. In response to questions and challenge by members of the Committee, the following key points were highlighted:

- The work being done by the Short Breaks Service in partnership with Contact A Family to signpost families to information and support, drew on information from previous studies as part of the research. There would be a consultation process including an online questionnaire which was due to be commenced in Autumn 2016.
- 14-18 year olds made up 45% of young people with Special Educational Needs (SEN) or an Education and Healthcare Plan (EHCP) who were educated outside the borough. The numbers were reducing slightly. The reasons for young people being educated outside the borough included a lack of specialist placements within the borough for some conditions such as High Functioning Autism Spectrum Disorders (ASD).
- Lewisham had the highest numbers of children diagnosed with ASD of any London borough. There was an internal review due to be commenced looking at reasons for this including: how referrals were made and carried out; what support was available to families; and comparisons with other boroughs. Views would be sought from parents and carers.
- Service pressures for supporting young people with ASD included the impact on the Education Support Team and on Health Services for the diagnosis and support.
- A business case was currently being prepared for a 14-25 Transition Pathway Team to establish a new transition pathway. The aim is to have robust processes that start early and include the right opportunities for young people as they become adults.
- The diagnosis of SEN including ASD and Multiple Learning Difficulties were made by Multi-Agency Panels as part of a robust assessment system.

4.2 **RESOLVED:**

That the report be noted.

5. Early Help Strategy

5.1 Stephen Kitchman introduced the report to the Committee, Katherine Manchester, Project Manager was also in attendance. During the presentation to Committee, the following key points were highlighted:

- The Early Help Strategy was set to be completed by September 2016. It consists of four different strands of work: children's workforce development; the MASH and Referral and assessment process; early help commissioning and delivery; and early help module, Common Assessment Framework (CAF) and Team Around Child and Team Around Family.

5.2 Following question and challenge from members of the committee the following key points were highlighted.

- Persistent absence rates in Lewisham were a major concern and a priority for school improvement work alongside improving attainment. The Welfare and Attendance Team had been reorganised and improvements made to the service level agreement with schools. The council had also run an attendance conference which had been very well attended by Lewisham teachers and Heads.
- There was a difference between the approach to attendance taken at primary and at secondary level and the amount of support young people received. This could be looked at to develop a more personal approach at secondary.
- The new referral process had been welcomed by dedicated safeguarding leads at schools. The new proposals would provide a streamlined referral tool.
- Lewisham had high levels of domestic violence and this was a big priority for the Safeguarding Lewisham Partnership. The Athena Service in Lewisham provided support and advice to Lewisham residents experiencing domestic violence and other forms of gender-based violence. Comparative statistics with other London boroughs on children's social care cases where domestic violence was a feature would be provided to the Committee.
- Budget reductions at the London Borough of Lewisham had not affected the tracking of non-attendance at schools. It was individual schools' obligation and responsibility to track absences. The Councils obligations were on the school improvement and legal side.
- To date, Head Teachers had not highlighted any post-Brexit hate crimes or incidences at Lewisham schools. Schools were required to report any incidences of racism and this was monitored closely by the Council.

5.3 **RESOLVED:**

That the report be noted.

That additional statistics comparing the London Borough of Lewisham with other London boroughs on the number of children's social care cases where domestic violence is a factor, be provided to the Committee.

6. Safeguarding Services 6-month report

6.1 Stephen Kitchman, introduced the report to the Committee highlighting that it provided a six-monthly overview of safeguarding and child protection services. Following questions and challenge from members of the Committee, the following key points were highlighted:

- The target number for numbers of children on child protection plans (CPP) was reviewed annually following analysis. Some performance indicators were set by the Government others were set locally.
- Neglect was the most common cause for children being on Child Protection Plans. The Early Help Strategy looked to identify those at risk at the earliest possible point such as from poor attendance at school and provide intervention to support children and families.
- The Early Help Strategy gave Children's Centres a more central role in supporting families and being part of the Family Intervention Programme. The number of families being worked with had not reduced as a result of savings being made to Children's Centre's Budgets.

6.2 **RESOLVED:**

That the report be noted.

7. Child Sexual Exploitation Update

7.1 Stephen Kitchman, introduced the report to the Committee, following questions and challenge from members of the Committee the following key points were highlighted:

- There was support for current and historic victims of child sexual exploitation in Lewisham. A Child Sexual Exploitation Officer in Lewisham provided dedicated support to young people. Social workers were trained in how to advise victims. Lewisham was part of the London-wide coordinated, multi-agency Child House Model which was funded by MOPAC (Mayor's Office for Policing and Crime). This was designed to develop and coordinate services ensuring there was the best possible support and service for victims.
- There were high numbers of looked after children who were victims of CSE. Part of this was due to the fact that if CSE was discovered or suspected it was often necessary to remove a child and the child would therefore become looked after. It was important to continually assess risks and risky behaviour of all young people at risk of sexual exploitation.

- Work was being done to ensure that intervention was as early as possible and ensuring that processes were as speedy as possible to support victims. Any prosecution would involve the Crown Prosecution Service.

7.2 **RESOLVED:**

That the report be noted.

8. Select Committee work programme

8.1 Katie Wood, Scrutiny Manager, introduced the report to the Committee and highlighted the reports which were due to be presented at the Committee's next meeting.

8.2 **RESOLVED:**

That the report be noted.

9. Referrals to Mayor and Cabinet

9.1 **RESOLVED:**

There were no referrals to Mayor and Cabinet.

The meeting ended at 8.40 pm

Chair:

Date:

Committee	Children and Young People Select Committee	**Item No.**	2
Title	Declarations of Interest		
Wards			
Contributors	Chief Executive		
Class	Part 1	**Date**	14 September 2016

Declaration of interests

Members are asked to declare any personal interest they have in any item on the agenda.

1 Personal interests

There are three types of personal interest referred to in the Council's Member Code of Conduct :-

(1) Disclosable pecuniary interests
(2) Other registerable interests
(3) Non-registerable interests

2 Disclosable pecuniary interests are defined by regulation as:-

(a) Employment, trade, profession or vocation of a relevant person* for profit or gain

(b) Sponsorship –payment or provision of any other financial benefit (other than by the Council) within the 12 months prior to giving notice for inclusion in the register in respect of expenses incurred by you in carrying out duties as a member or towards your election expenses (including payment or financial benefit from a Trade Union).

(c) Undischarged contracts between a relevant person* (or a firm in which they are a partner or a body corporate in which they are a director, or in the securities of which they have a beneficial interest) and the Council for goods, services or works.

(d) Beneficial interests in land in the borough.

(e) Licence to occupy land in the borough for one month or more.

(f) Corporate tenancies – any tenancy, where to the member's knowledge, the Council is landlord and the tenant is a firm in which the relevant person* is a partner, a body corporate in which they are a director, or in the securities of which they have a beneficial interest.

(g) Beneficial interest in securities of a body where:-

(a) that body to the member's knowledge has a place of business or land in the borough; and

(b) either

(i) the total nominal value of the securities exceeds £25,000 or 1/100 of the total issued share capital of that body; or

(ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person* has a beneficial interest exceeds 1/100 of the total issued share capital of that class.

*A relevant person is the member, their spouse or civil partner, or a person with whom they live as spouse or civil partner.

(3) Other registerable interests

The Lewisham Member Code of Conduct requires members also to register the following interests:-

(a) Membership or position of control or management in a body to which you were appointed or nominated by the Council

(b) Any body exercising functions of a public nature or directed to charitable purposes , or whose principal purposes include the influence of public opinion or policy, including any political party

(c) Any person from whom you have received a gift or hospitality with an estimated value of at least £25

(4) Non registerable interests

Occasions may arise when a matter under consideration would or would be likely to affect the wellbeing of a member, their family, friend or close associate more than it would affect the wellbeing of those in the local area generally, but which is not required to be registered in the Register of Members' Interests (for example a matter concerning the closure of a school at which a Member's child attends).

(5) Declaration and Impact of interest on member's participation

(a) Where a member has any registerable interest in a matter and they are present at a meeting at which that matter is to be discussed, they must declare the nature of the interest at the earliest opportunity and in any event before the matter is considered. The declaration will be recorded in the minutes of the meeting. If the matter is a disclosable pecuniary interest the member must take not part in consideration of the matter and withdraw from the room before it is considered. They must not seek improperly to influence the decision in any way. **Failure to declare such an interest which has not already been entered in the Register of Members' Interests, or participation where such an interest exists, is liable to prosecution and on conviction carries a fine of up to £5000**

(b) Where a member has a registerable interest which falls short of a disclosable pecuniary interest they must still declare the nature of the interest to the

meeting at the earliest opportunity and in any event before the matter is considered, but they may stay in the room, participate in consideration of the matter and vote on it unless paragraph (c) below applies.

(c) Where a member has a registerable interest which falls short of a disclosable pecuniary interest, the member must consider whether a reasonable member of the public in possession of the facts would think that their interest is so significant that it would be likely to impair the member's judgement of the public interest. If so, the member must withdraw and take no part in consideration of the matter nor seek to influence the outcome improperly.

(d) If a non-registerable interest arises which affects the wellbeing of a member, their, family, friend or close associate more than it would affect those in the local area generally, then the provisions relating to the declarations of interest and withdrawal apply as if it were a registerable interest.

(e) Decisions relating to declarations of interests are for the member's personal judgement, though in cases of doubt they may wish to seek the advice of the Monitoring Officer.

(6) Sensitive information

There are special provisions relating to sensitive interests. These are interests the disclosure of which would be likely to expose the member to risk of violence or intimidation where the Monitoring Officer has agreed that such interest need not be registered. Members with such an interest are referred to the Code and advised to seek advice from the Monitoring Officer in advance.

(7) Exempt categories

There are exemptions to these provisions allowing members to participate in decisions notwithstanding interests that would otherwise prevent them doing so. These include:-

(a) Housing – holding a tenancy or lease with the Council unless the matter relates to your particular tenancy or lease; (subject to arrears exception)
(b) School meals, school transport and travelling expenses; if you are a parent or guardian of a child in full time education, or a school governor unless the matter relates particularly to the school your child attends or of which you are a governor;
(c) Statutory sick pay; if you are in receipt
(d) Allowances, payment or indemnity for members
(e) Ceremonial honours for members
(f) Setting Council Tax or precept (subject to arrears exception)

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Children and Young People Select Committee		
Report Title	**Public Health savings consultation**	
Ward	**All**	**Item No. 4**
Contributors	**Executive Director for Community Services** **Executive Director for Children and Young People**	
Class	**Part 1**	**Date: 14/9/16**

1. Summary and Purpose of the Report

1.1 The purpose of this report is to ask the Children and Young People Select Committee (The Committee) to review the report attached as Appendix 1 for Mayor & Cabinet on September 28th 2016.

1.2 The report in Appendix 1 outlines the consultation conducted as outlined in the report to Mayor & Cabinet on July 13th 2016, and activity for proposals to realise savings as agreed by Mayor and Cabinet. The activity outlined in this report delivers the required level of savings for Staying Healthy and Sexual Health services. The proposals for Health Visiting and School Nursing, in response to consultation, now deliver a reduced level of savings. This leaves the overall proposals delivering only £4.4m of the required £4.7m savings. Further proposals will be developed to deliver the remaining £300,000 saving.

1.3 A final 'Staying Healthy' stakeholder event is being conducted on September 1st. Officers are meeting with Lewisham Clinical Commissioning Group's governing body on the 8th of September. The report in Appendix 1 may be adapted to reflect feedback from these forums and from the Committee.

2. Recommendations

2.1 The Committee is recommended to review, note and comment upon the consultation activity and proposals for savings relating to health visiting and school nursing, 'staying healthy' (preventative health), and sexual health services in the report attached as Appendix 1.

3. Legal Implications

3.1 There are no specific legal implications arising from this report which is prepared as part of the ongoing consultation process relating to the proposals contained in the attached report.

4. Financial Implications

4.1 The financial implications are as laid out in section 10 of the report attached as appendix 1.

5. Crime and Disorder Act Implications

5.1 There are no crime and disorder implications.

6. Equalities Implications and human rights

6.1 The equalities and human rights implications are as laid out in section 14 of the report attached as appendix 1.

7. Environmental Implications

7.1 There are no environmental implications.

8. Conclusion

8.1 The report in Appendix 1 outlines the consultation conducted as proposed in the report to Mayor & Cabinet on July 13th 2016, and describes activity for proposals to realise savings as agreed by Mayor and Cabinet. The report seeks Mayor & Cabinet approval to conduct this consultation activity.

8.2 The activity in the report in Appendix 1 delivers the required level of savings for Staying Healthy and Sexual Health services. The proposals for Health Visiting and School Nursing, in response to consultation, now deliver a reduced level of savings. This leaves the overall proposals delivering only £4.4m of the required £4.7m savings. Further proposals will be developed to deliver the remaining £300,000 saving.

8.3 The Committee is recommended to review, note and comment upon the consultation activity and proposals for savings relating to health visiting and school nursing, 'staying healthy' (preventative health), and sexual health services in the report attached as Appendix 1.

MAYOR AND CABINET		
Report Title	**Public Health savings**	
Key decision	**Yes**	**Item No.**
Ward	**All**	
Contributors	**Executive Director for Community Services**	
Class		**Date: 28/9/16**

1. **Summary and Purpose of the Report**

The purpose of the report is to appraise Mayor & Cabinet of the outcome of the consultation agreed by Mayor & Cabinet on the 13th of July for Staying Healthy, Sexual Health, Health Visiting and School Nursing services.

This report seeks approval for a range of activity to realise the savings agreed by Mayor & Cabinet on September 30th 2015, and to balance the reduction to the Public Health grant announced in the 2015 spending review.

The activity outlined in this report delivers the required level of savings for Staying Healthy and Sexual Health services. The proposals for Health Visiting and School Nursing, in response to consultation, now deliver a reduced level of savings. This leaves the overall proposals delivering only £4.4m of the required £4.7m savings. Further proposals will be developed to deliver the remaining £300,000 saving.

2. Structure of the Report

2.1 The report is structured as follows:
Section 3 sets out the recommendations.
Section 4 sets out the policy context
Section 5 sets out the background
Section 6 preventative health (Staying Healthy) services
Section 7 health visiting and school nursing
Section 8 sexual health services
Section 9 sets out procurement arrangements
Section 10 sets out the financial implications
Section 11 sets out the legal implications
Section 12 sets out the crime and disorder implications
Section 13 sets out the equalities implications
Section 14 sets out the environmental implications

Appendix 1 Lewisham's 9 health and wellbeing priorities
Appendix 2 2016-17 allocation of the Public Health grant
Appendix 3 the Public Health Outcomes Framework
Appendix 4 Public Health England's grant reduction letter to local authorities
Appendix 5 Equalities Analysis for Staying Healthy services
Appendix 6 Equalities Analysis for Health visiting and School Nursing
Appendix 7 Equalities Analysis for Sexual Health
Appendix 8 final stakeholder event summary **TO FOLLOW**
Appendix 9 Uengage health visiting and school nursing public responses
Appendix 10 Uengage health visiting and school nursing stakeholder responses
Appendix 11 Health Impact Assessment for Staying Healthy services

3. Recommendations

3.1 Mayor and Cabinet is recommended to:

- Approve the proposals for 'staying healthy' services outlined below following consultation as agreed by Mayor & Cabinet on the 13th of July 2016.
- Delegate authority to the Executive Director for Resources and Regeneration to approve procurement activity to deliver proposals for Staying Healthy services.
- Approve proposals for health visiting and school nursing services outlined below following consultation as agreed by Mayor & Cabinet on the 13th of July 2016.
- Approve competitive tenders for Health Visiting and School Nursing.
- Note the consultation outcome and proposals for sexual health services outlined below as agreed by Mayor & Cabinet on the 13th of July 2016. Mayor and Cabinet(contracts) 21st October 2015 delegated authority to the Executive Director for Resources and Regeneration to approve the procurement activity to deliver the proposals for Sexual Health.

4. Policy Context

4.1 The services within this paper meet the two key principles of the Lewisham's Sustainable Community Strategy 2008-2020:

- Reducing inequality – narrowing the gap in outcomes for citizens
- Delivering together efficiently, effectively and equitably – ensuring that all citizens have appropriate access to and choice of high-quality local services

4.2 These services also contribute to the following priority outcomes:

- Safer – where people feel safe and live free from crime, antisocial behaviour and abuse
- Empowered and responsible – where people are actively involved in their local area and contribute to supportive communities
- Healthy, active and enjoyable – where people can actively participate in maintaining and improving their health and well-being

4.3 The services in this report support the council's corporate priorities of:

- Community Leadership and empowerment- developing opportunities for the active participation and engagement of people in the life of the community
- Caring for adults and older people- working with health services to support older people and adults in need of care
- Active, healthy citizens- leisure, sporting, learning and creative activities for everyone

4.4 The Health and Well Being Strategy 2012/22 has been developed by Lewisham's Health and Wellbeing Board (HWB) and sets out the improvements and changes that the board, in partnership with others, will focus on to achieve the board's vision of achieving a healthier and happier future for all. Sexual health, preventing the uptake

of smoking among children and young people and reducing the numbers of people smoking, reducing alcohol harm and promoting healthy weight are all priorities identified in the Health and Well Being Strategy.

4.5 Sexual Health is an important public health priority at both a national and local level. Lewisham continues to experience high demand and need for sexual health services reflected as high rates of teenage pregnancy, abortion and sexually transmitted infections.

4.6 Although smoking prevalence has reduced there are higher rates of smoking in Lewisham than London and England. More than 1 in 5 of the adult Lewisham population are smokers and 1 in 4 people in routine and manual occupations still smoke. There are currently about 50,000 adult smokers in Lewisham with a high proportion who are heavily dependent, such as pregnant women, people with long term conditions and people with mental health problems. Smoking is a contributory factor to the main causes of death in Lewisham and it is the single largest factor associated with health inequalities. Smoking is responsible for half the difference in life expectancy between Lewisham's richest and poorest residents.
Forty eight percent of Lewisham school children said they lived in a household with a smoker[1] and Lewisham's asthma admission rates for children are significantly higher than England.

Lewisham has a higher proportion of smoking related hospital admissions and early deaths due to smoking. Babies and children exposed to a smoky atmosphere are more likely to need hospital care in the first year of life. Passive smoking can put children at an increased risk of sudden infant death syndrome (SIDS), developing asthma or having asthma attacks when the condition is already present, middle ear infection, and coughs and colds. In households where mothers smoke, for example, young children have a 72% increased risk of respiratory illnesses.

The estimated local societal cost of smoking for Lewisham is £73.4m each year, and passive smoking costs a further £1m annually, including £9m on healthcare and £4m on social care directly attributable to smoking.

4.6.1 Lewisham's Children and Young People's Strategic Partnership vision is: "Together with families, we will improve the lives and life chances of the children and young people in Lewisham". This is achieved through a focus upon closing the gaps in outcomes achieved by our children and young people and agreement to ensure that children's and families' needs are prevented from escalating and are instead lowered. The ideal is for all children and young people to require only universal services and where further support is needed this should be identified and provided as early as possible.

4.6.2 Reported obesity rates among adults in Lewisham show a steady upward trend with 60% of adults with excess weight (obese and overweight) in 2014. This equates to 53,000 people with a BMI above 30 (obese) and 137,500 people with a BMI above 25 (excess weight). Estimated prevalence of morbid obesity (BMI above 40) is 2.5% (5000 people). Nationally obesity is projected to increase from 29% in 2015 to 32%

[1] School Health Education Unit survey

in 2020 and 41% in 2035, with prevalence projected to rise most markedly from the lowest income groups. If current trends continue 72% of the adult population would be predicted to be overweight or obese by 2035.

4.6.3 In Lewisham childhood obesity rates remain significantly higher than the England rate with a quarter of children in Reception (age 4-5) and over a third of children in Year 6 (age 10-11) being overweight or obese. Maternal obesity is a risk factor for childhood obesity and nearly half of women are overweight or obese at their booking appointment. It is estimated that there are over 8,500 children at risk of obesity in Lewisham with over 900 children identified each year through the National Child Measurement programme.

4.12 Obesity prevalence is associated with socioeconomic status with a higher level of obesity found among more deprived groups.

5. Background

5.1 The Health and Social Care Act (2012) transferred the bulk of public health functions to local authorities. The Council is responsible for delivering public health outcomes through commissioning and building partnerships within the borough, region and city.

5.2 **I**n September 2015 Mayor & Cabinet approved £2m of savings by 17/18.In the Spending Review and Autumn Statement 2015 the government announced cuts to public health services. For Lewisham this has resulted in a grant reduction of £2.7m by 2017/18. The Council therefore needs to save £4.7m by 1 April 2017.

5.3 At its meeting on 26 November 2014, Council agreed to set up a time limited Public Health Working Group to operate until the end of February 2015 to consider the proposals to change public health services being proposed as part of the Council's budget process for 2015/16. This contributed to the Council's debate about the future of public health services in Lewisham and reported in February 2015.

5.4 In order to deliver the savings as outlined above, officers have conducted extensive consultation on service redesign proposals leading to recommendations for Mayor & Cabinet as outlined in this report.

5.5 The activity outlined in this report delivers the required level of savings for Staying Healthy and Sexual Health services. The proposals for Health Visiting and School Nursing, in response to consultation, now deliver a reduced level of savings. This leaves the overall proposals delivering only £4.4m of the required £4.7m savings, with the Council therefore needing to find a £300,000 saving elsewhere in its budget.

5.6 The outcome of the consultation conducted and detailed service redesign recommendations are laid out below for:

- Staying Healthy services
- Health Visiting and School Nursing services
- Sexual Health services

6 Staying Healthy services

6.1 **Overview of current services:** The Council currently commissions a range of services to support behaviour change in residents at high risk of ill health and reduce health inequalities, including smoking, eating, physical activity and wellbeing. These are delivered in partnership with local healthcare and voluntary sector providers, and have a total value of £2.3m. These services are in addition to broader policies which promote health such as those relating to the environment and the regulation of supply.

6.1.1 The Lewisham Stop Smoking service is an addiction treatment service, which assists dependent smokers to quit and is delivered by Lewisham and Greenwich Healthcare Trust (LGT) for £461,000 per annum with a further £240,000 of medication costs. Last year 1297 people quit smoking through a combination of a specialist team and primary care provision through GPs and pharmacies. The primary role of the Stop Smoking Service is to deliver high quality, evidence-based stop smoking interventions to dependent smokers living in Lewisham. This includes a more intensive service for highly dependent smokers provided through group and one to one sessions, and support for moderately dependent smokers through GPs & pharmacies including a hub based model in each neighbourhood. This service is primarily targeted at heavily dependent smokers, including pregnant smokers, smokers with mental health problems and smokers with long term conditions. This service has recently been redesigned due to a 30% reduction in funding from the Council in 2015/16.

6.1.2 The Community Health Improvement Service is delivered by Lewisham and Greenwich Trust (LGT) for £571,518 per annum to provide a range of health promotion activities targeted at those with poorer health outcomes**.** In 2015/16 CHIS provided behaviour change and healthy lifestyle support through: a lifestyle hub delivering motivational interventions and referrals to 950 people identified as at risk following an NHS Health check; Health Trainers providing one to one and group motivational interviewing and lifestyle coach support to 250 people and the Healthy Walks programme, which trains walk leaders, develops, promotes and ensures regular health walks to increase participation and uptake of physical activity (200 new walkers per annum and just under 600 regular walkers). It also engages, develops and empowers communities through community development for health improvement and neighbourhood based activities including outreach, participatory budgeting/small grants, networks, negotiating and developing referral pathways into preventative lifestyle activities and interventions, and linking providers of preventative initiatives with community groups (reaching at least 500 people per year).

6.1.3 The £450,000 per annum NHS Health Check programme is commissioned to identify 40-74 year olds with a high risk of developing cardiovascular and other conditions. This includes direct commissioning of health checks provided by GPs, pharmacies and To Health (outreach); a call/recall system (every 5 years) and IT. This is a mandatory programme, assessing risk and facilitating early intervention. About 6,000 Health checks were conducted in Lewisham last year.

6.1.4 The Breastfeeding Network project manages the community breastfeeding groups and provision of a breastfeeding peer support service for £48,895 per annum. This

includes training 24 new breastfeeding peer supporters and providing on-going supervision to all active volunteer peer supporters (around 30). The peer supporters support mothers attending the community breastfeeding groups and on the postnatal ward (total 1200 hours of volunteer time per annum). The community breastfeeding groups support 900 new women a year.

6.1.5 MyTime Active deliver a children's weight management programme (MEND) for £230,000 per annum. The service delivers a range of age-specific evidence-based family interventions for 375 overweight and obese children. The service includes specialist support (dietician, psychologist and physical activity specialist) for obese children with co-morbidities or with complex needs (180 children per annum). The service also delivers a range of bespoke workforce training sessions (100 staff per annum). The children's weight management service supports the mandatory National Child Measurement Programme which identifies that Lewisham has consistently high prevalence of childhood obesity.

6.1.6 Weightwatchers deliver 795 adult weight management interventions at a cost of £42,930 per annum. This entitles individuals that are overweight or obese (BMI of 28 or more) to attend 12 weeks of Weight Watchers meetings and access 16 weeks online support free of charge. The service has shown successful outcomes with 54% of clients completing the programme and 91% successfully losing weight.

6.2 **Consultation process:** The Council consulted the public, service users and stakeholders from July to September as agreed by Mayor & Cabinet on the 13th of July 2016 in the following ways:

- The Council conducted online engagement through Uengage with the public and users of the different services
- The Council consulted with fellow health commissioners on each proposal area for savings. Officers attended the Clinical Commissioning Group's clinical directors, governing body and membership forum.
- The Council consulted healthcare partners and expert stakeholders through Uengage, GP neighbourhood forums and an engagement event
- The Council worked with Healthwatch Lewisham and consulted existing neighbourhood health forums.

6.3 **Consultation outcome and recommendations**: The outcome of the consultation process outlined above informed the health impact assessment (HIA) attached as Appendix 11, And Equalities Analysis Assessment attached as Appendix 5. These informed the development of the final proposals below. Officers recommend delivery of the required savings of £800k through a combination of re-commissioning, redesign and decommissioning of services across the areas outlined below. These proposals have been drawn up with an emphasis on effectiveness in terms of outcome and increased alignment between services and pathways to reduce costs.

6.4 **Savings from the Stop Smoking Service (£120,000)**

6.4.1 To deliver this saving the Council will negotiate with the current provider (LGT) to continue to deliver the service within a reduced cost envelope. This will include a

reduction in the value of the block contract with LGT, a reduction in management costs, and in prescribing costs which will form approximately 50% of the saving. Should the Council be unable to deliver the required saving through this negotiation the service will be put out to tender with a reduced value.

6.4.2 The Council's consultation with stakeholders identified the Stop Smoking Service as a priority evidence-based service, with 53% of respondents to the online survey ranking the service as their highest priority. This is reflected in the relatively small disinvestment in the service.

6.4.3 The Council's public consultation showed the highest support for a mixed model of delivery incorporating face-to face and digital support (on-line and phone or text messaging (30%). There was also significant support for face-to-face (27%) and group (25%) support.

6.4.4 Consequently the council will focus the redesign on:

- a greater use of digital support for less heavily dependent smokers
- face to face support, including groups, from specialists for heavily dependent smokers such as pregnant women, smokers with mental health problems and/or long term medical conditions
- more efficient and effective prescribing of stop smoking medication

6.4.5 The Council's EAA (Appendix 5) shows that a reduction in service capacity could impact adversely on high-risk groups such as pregnant women, smokers with mental health problems and those with long-term medical conditions. This impact will be mitigated by the redesign's focus on ensuring face to face support for these groups is retained.

6.4.6 The greater quit-rate the specialist team achieve amongst men and black African communities through face-to-face support may mean a reduction in this element of the service adversely impacts on these groups. This will be mitigated by all patients entering the service having an initial face-to-face assessment to determine the appropriate channel for support. Male and black African smokers who fall under the heavily dependent category will be supported through face to face interventions rather than digital support.

6.5 Savings from the Community Health Improvement Service (CHIS): (£451,448)

6.5.1 To deliver this saving the Council will cease commissioning CHIS. The decision to decommission CHIS was taken following examination of impacts and mitigation, and given the level of savings required officers decided that reinvesting £120,000 meant that impacts could be mitigated more effectively than from savings elsewhere.

6.5.2 CHIS currently provides:

- the Lewisham Lifestyle Hub (LLH) which manages all referrals to lifestyle services and delivers motivational interventions to those identified as at risk following an NHS Health check. LLH had 957 referrals last year.
- Health Trainers providing one to one and group motivational interviewing and lifestyle coach support to 250 people

- Community development for health improvement and neighbourhood based activities including outreach, participatory budgeting/small grants, networks, negotiating and developing referral pathways into preventative lifestyle activities and interventions, and linking providers of preventative initiatives with community groups
- the Healthy Walks programme, which trains walk leaders, develops, promotes and ensures regular health walks to increase participation and uptake of physical activity (200 new walkers per annum and just under 600 regular walkers)

6.5.3 **Lewisham Lifestyle Hub**

The HIA states that there is 'no peer-reviewed evidence identified in this HIA that examined the effectiveness of a hub model like LLH improving health outcomes. An external evaluation of the LLH noted that the motivational interviewing for those having an NHS Health Check was extremely valuable'. This element will form part of any future NHS Healthchecks delivery.

The EAA identifies that the LLH element of CHIS achieves good reach to BME groups, particularly Black African and Caribbean groups. As such the removal of the LLH has the potential to impact negatively on these groups. However the only referral pathway to LLH is the NHS Health check programme, and the reach of this programme will be retained. The overall impact of the change will be mitigated by proposed changes to NHS Health Checks delivery to include motivational interviewing and general advice about lifestyle behaviour change and onward referrals.

6.5.4 **Health trainers**

The HIA (Appendix 11) states that 'an evidence review for this component of CHIS was performed in November 2015. The review found that for health trainers, high grade evidence on their impact is in short supply, but available studies indicate that they may lead to short-term improvements in some health related behaviours. However, there is no evidence that they bring about sustained behaviour change, and wider community impacts remain unclear'.

The EAA (Appendix 5) states that 45% of the users of health trainers were Black African or black Caribbean and 75% of users were women, so these populations could potentially be disproportionately affected by the removal of the health trainer programme as. Overall respondents to both the public and stakeholders' consultations felt the changes were likely to have a negative impact.

Removal of the health trainer programme will be mitigated by the community nutrition and physical activity service delivered by Greenwich Community Development Agency (GCDA), an additional investment of £15,000 to expand the existing weight management offer, and the new (National Diabetes Prevention Programme) service commissioned by NHS England for people identified with a high risk of developing diabetes. Black Caribbean and black African populations are at increased risk of diabetes and therefore are likely to be well represented in the new national diabetes prevention programme. The community development approach of the community nutrition and physical activity service will target black African and black Caribbean communities.

Consultation with professional stakeholders identified the importance of retaining a choice of provider; consequently the mitigating expansion of the existing weight management offer will include a choice of provider.

The demographic uptake of these services will be monitored to ensure proportionate representation of black African, black Caribbean communities and women.

6.5.5 **Community Development (CD)**

With reference to the latest CHIS Annual report and monitoring data the EAA was unable to readily assess the potential equalities impact of the CD work of CHIS, although historical and verbal reports confirm that the CD work of CHIS was very effective at reaching BME and more deprived communities. These groups could potentially be disproportionately affected by any reduction Overall respondents to both the public and stakeholders' consultations felt the changes were likely to have a negative impact.

The EAA states that the CD work of CHIS does not supply sufficient demographic data to assess the potential equalities impact, although overall respondents to both the public and stakeholders' consultations felt the changes were likely to have a negative impact.

The removal of the CD element of CHIS will be mitigated by the Council investing £70,000 to £100,000 to support grants in all 4 neighbourhoods for activities that promote healthy eating, increase physical activity, mental wellbeing, sexual health, and raise awareness of the risks of smoking and alcohol consumption. Community groups will be supported by GCDA in delivery of projects supported through the grants. The Council will address the lack of data on equalities impacts through ensuring its mitigating investment in grants requires sufficient data to assess these impacts in the future.

The Council's mitigating investment in grants will retain the Participatory Budgeting model that has also worked in the successful Well Bellingham initiative and will continue to target those groups with poorer health outcomes such as BME and people with disabilities. This will be linked with Community Connections and emerging neighbourhood care networks, and aligned with the community nutrition and physical activity pathways delivered by GCDA. This is also match funding for the 'Well Communities' Big Lottery bid, which could potentially bring in an additional £180k investment per year for 3 years to support community development and wellbeing.

6.5.6 **Healthy Walks**

The Healthy Walks programme was the 2nd most popular Staying Healthy service from the Uengage public survey. A number of passionate responses to the consultation emphasised the reach and value of the programme. The EAA states that the programme in Lewisham has been able to engage with a significantly higher percentage of participants with long term health conditions or disabilities, as well as with BME groups compared to other Walking for Health schemes nationally and those based in London. The programme will continue to be commissioned, and will

continue to train walk leaders and develop, promote and ensure regular healthy walks in each of the four Neighbourhoods in order to help increase the participation and uptake of physical activity levels. It will be re-procured and aligned with other physical activity community development initiatives in the borough.

6.6 Savings from the children's weight management service (£100,00)

6.6.1 The Council will cease commissioning the provider of the existing service. This will be mitigated by investing £130,000 in the new contract for school nursing, to ensure weight management is a core function of the service.

6.6.2 The EAA identified potential negative equalities impacts of children with complex needs receiving the same offer as other children in the new service, which the Council will seek to mitigate through specifying strong pathways to other areas of the redesigned health visiting and school nursing services. The incorporation of the service into school nursing may help to mitigate this negative health impact by maintaining close links with children with complex needs to provide some additional support where required.

6.6.3 The EAA identified potential positive impact for age, the integration the service into school nursing may mean better follow up of those in overweight/obese groups requiring MEND since the National Child Measurement Programme (NCMP) takes place in schools. However, since there will be reduced capacity of the service to provide additional support to children, this may offset any new benefit for young people overall.

6.6.4 The professionals consultation of Staying Healthy services expressed concern of a potential equalities impact of any reduction in overall service capacity as a result of changes most notably that childhood obesity affects those of lower socio-economic status the most, and that any reduction in capacity of the service would increase health inequalities.

6.6.5 Close monitoring of service use and health outcome data following the introduction of the proposed changes, particularly to capture demographic data for service users will be vital to identify if any negative impacts are realised and to work to mitigate them when/if they arise.

6.6.7 Detailed plans and consultation for the redesign of school nursing services are contained in Section 8 of this report.

6.7 Savings from the breastfeeding support service (£49,000)

6.7.1 The Council will cease commissioning the provider of the existing service. This will be mitigated by ensuring breastfeeding peer support and support to existing groups is a specified function of the new health visiting service

6.7.2 The EAA identified that the existing service is under-utilised by younger mothers, so these changes present an opportunity for a positive equalities impact in that regard.

6.7.3 Detailed plans and consultation for the redesigned health visiting service are contained in Section 8 of this report.

6.8 Savings from the NHS Health Checks programme (£70,000)

6.8.1 The Council will recommission this mandatory programme as an integrated pathway, delivering savings through reducing interface costs as well as focusing on better targeting of high risk groups and follow-up referrals for those identified as at risk.

6.8.2 The new service will specify delivery across primary care to ensure coverage on a neighbourhood and population level and will seek to target those most at risk of developing cardiovascular disease (CVD)It will include specific interventions for those identified at greatest CVD risk.

6.8.3 Respondents to the public consultation identified NHS Health checks as their most preferred Staying Healthy service, with respondents to the professional consultation ranking it as their 2nd most preferred service.. Professionals did emphasise the potential benefits of early identification, and emphasised the importance of the usage of point of care blood testing to identify high risk individuals. Effective communication with GP practices was highlighted as a way to ensure best practice pathways are followed including clinical follow-up and referrals to lifestyle services for all individuals identified at high CVD risk

6.8.4 In line with the recent reconfiguration of GP practices into a federated organisation, the Council will seek to negotiate a single contract for delivering the whole NHS Health Check service pathway as an initial 18-21 month pilot. This will include provision of the service in community pharmacies as well as GP practices. Following feedback from professionals this will include point of care blood testing.

6.8.5 Following an evaluation of the pilot, the Council will reprocure using the learning from the pilot. The service will include a call and recall system. Using GP patient registers as a basis for the call and recall will enable better targeting of at-risk groups, as well as better alignment with GP clinical follow up. The pathway will also offer follow up brief advice and onward referrals.

6.8.6 If the Council is unable to agree a satisfactory price and model for the pilot, the Council will undertake a procurement exercise.

6.9 Savings Table

The table below outlines the Staying Healthy areas where savings are planned, and where the council continues to invest. Although savings have been delivered in all areas, the council retains significant investment in the mandatory NHS Healthchecks programme and in smoking cessation, as well as retaining investment in health improvement, obesity and physical activity:

STAYING HEALTHY SAVINGS AREAS	16-17 Budget	savings identified	17-18 budget or reinvestment
Obesity & Physical activity			
UNICEF BABY FRIENDLY	£1,000	£0	£1,000
IMPLEMENTATION OF UNIVERSAL VITAMIN D SCHEME	£20,300	£0	£20,300
BREASTFEEDING SUPPORT	£49,000	£49,000	£0
WEIGHT MANAGEMENT: ADULTS	£99,000	£0	£99,000
HEALTHIER CATERING COMMITMENTS	£12,000	£0	£12,000
HEALTH IMPROVEMENT TRAINING	£5,000	£5,000	£0
WEIGHT MANAGEMENT: CHILDREN	£235,100	£100,000	£135,100
SUBTOTAL	**£421,400**	**£154,000**	**£267,400**
Smoking			
STOP SMOKING SERVICE & PRESCRIBING	£698,494	£120,000	£578,494
TOBACCO CONTROL AND ILLEGAL SALES	£10,000	£5,000	£5,000
SUBTOTAL	**£708,494**	**£125,000**	**£583,494**
Health improvement			
WELL LONDON	£30,000	£0	£30,000
COMMUNITY PA & NUTRITION	£120,000	£0	£120,000
CHIS	£571,518	£451,448	£120,070
SUBTOTAL	**£721,518**	**£451,448**	**£270,070**
NHS Health Checks			
CALL/RECALL NHS HEALTH CHECKS	£34,000	£0	£34,000
NHS HEALTH CHECK PROVIDERS	£270,728	£50,000	£220,728
IT PROVIDERS	£63,000	£0	£63,000
NHS HEALTH CHECK CLINICAL RESOURCES	£82,000	£20,000	£62,000
SUBTOTALS	**£449,728**	**£70,000**	**£379,728**
TOTAL	**£2,301,140**	**£800,448**	**£1,500,692**

7 Health visiting and school nursing

7.1 Savings identified

The Council will deliver savings of £1.7m through a combination of re-commissioning and redesign of the health visiting service and the school aged nursing service. These proposals have been drawn up with an emphasis on effectiveness of outcomes, increased integration of services for children and young people, and a reduction in management and administration costs.

(i) **Savings from the school aged nursing service**
The proposed redesign will deliver savings of £510,915 (2017-18) and an additional £15,057 (2018-19 onwards).
(ii) **Savings from health visiting**
The proposed redesign will deliver savings of £1,203,813 (2017-18 onwards).

CHILDREN AND YOUNG PEOPLE'S SAVINGS	16-17 LA budget	Savings identified	17-18 LA budget
HEALTH VISITING SERVICE	£7,350,000	£1,203,813	£6,146,187
SCHOOL AGED NURSING SERVICE	£1,750,000	£510,915	£890,827*
TEENAGE HEALTH AND WELLBEING SERVICE	N/A	N/A	£348,258**
TOTAL	**£9,100,000**	**£1,714,728**	**£7,385,272**

* An additional £130,000 will be added to this budget to pay for the new integrated weight management service.
** There will be additional funding for this new service to finance substance misuse, sexual health and mental health support.

7.2 Overview of current services

7.2.1 Lewisham's Children and Young People joint commissioning team has undertaken a review of universal and targeted services and pathways for children, young people and their families. The focus of this review has been on public health nursing services (health visiting and school nursing) and how these services work with children's centres:

7.2.2 **Health visiting** - provides help and support for families with children aged 0 to 5 years on parenting, health and development issues. Health visitors offer five health and development reviews to every child aged up to 2½ years in line with the Healthy Child Programme. Additional targeted support is provided for vulnerable families.

The current service costs £7.35m per annum and is provided by LGT. The service is funded by the central government public health grant which has been cut. For this reason, the budget for this service will need to be reduced from 2017-18.

7.2.3 **School nursing -** provides advice and support for school aged children including specific support for children with chronic conditions and complex needs, safeguarding and immunisation. The service is also responsible for the delivery of a health screening service for primary school children which consists of a school entry health check, vision and hearing screening, and height and weight checks through the National Child Measurement Programme in Reception and Year 6.

The current service costs £1.75m per annum and is provided by LGT. The service is funded by the central government public health grant which has been cut. For this reason, the budget for this service will need to be reduced from 2017-18. An additional £229,000 is provided by NHS England for school-age immunisations and this funding will continue in 2017-18.

7.2.4 In addition, Lewisham's **children's centres** provide a wide range of activities and services for children and families to support the health and welfare of children, and to reduce inequalities in child development and school readiness. Services are for children and young people aged 0 to 19 years, with most services aimed at the early years (0 to 5 years). Children's centres are provided in 16 sites in Lewisham.

The current service costs £1.8m per annum and is commissioned from two area-based providers and five schools. Children's centres are funded by the local

authority. The budget for children's centres was cut in 2011 and 2014, and further financial reductions to this service are not proposed.

7.3 **Background**

The following factors have prompted a review of services:

7.3.1 **Reductions in central government funding** of local authorities which mean the council needs to find £4.7m of savings from public health funded services by 2017-18.

7.3.2 **Changing demand for children's services in Lewisham** - there will be a slight decrease in the population of children aged 0-4 years in 2015 and 2016. Slight declines are also projected for 2017 and 2018.[2] However, there has been an increase in the number of children and families identified as vulnerable. Currently there are 2,000 children on the health visiting targeted caseload and 400 children subject to child protection plans in Lewisham.

7.3.3 **The Council's current contracts** - for school nursing, health visiting and children's centres end in March 2017, and therefore the procurement process needs to start in the autumn 2016 to ensure new contracts are in place for April 2017.

There are also key opportunities for change:

7.3.4 **Changes to commissioning and statutory arrangements for health visiting** – from 1st October 2015 responsibility for commissioning health visiting services passed from CCGs to local authorities. The transfer was made on a 'lift and shift' basis with local authorities mandated to deliver the five health reviews. From April 2017, this mandation will be lifted (unless new legislation is passed) enabling authorities to review the effectiveness of current pathways and to specify a service which is relevant for their local populations.

7.3.5 **Early help offer** - the Council has reviewed its early help pathway in response to recent recommendations made by Ofsted. A new Early Help strategy is being developed which will promote a single point of access for referrals for children and families, a new targeted family support service, and more joined up pathways for parents requiring additional support.

7.3.6 **Neighbourhood network model** – Lewisham CCG, with the local authority, is currently reviewing the way in which they provide services to identify opportunities to deliver more health services in community settings via neighbourhood care network models. This model brings together work already underway through the Sustainable Transformation Plan, One Public Estate, and the integration of adult social care and health. The Children and Young People's Strategic Partnership has been considering how this model would work for children, building on the children's centre model. This would ensure that where possible, services are co-located together and that access to other local services is clear to families, young people and professionals.

7.4 Phase 1 initial review and consultation: January to June 2016

7.4.1 To inform the recommissioning process, officers from CYP commissioning, Early Intervention and Public Health undertook an initial review of current services between

[2] Lewisham Council Childcare Sufficiency Assessment. August 2016.

January 2016 and June 2016. The aim of this review was to clarify current service delivery models and costs including key pressures, impact and effectiveness of interventions. Officers also aimed to engage partners and service users in shaping a new model for more integrated services for children and young people.

Phase 1 methods
The following consultation activities were carried out in phase 1:

7.4.2 *Staff and stakeholder involvement*
- Engagement through meetings and three half-day workshops with service managers and staff from current services on models and opportunities for change.
- Engagement with key stakeholders (including Councillors, schools, voluntary sector, LGT, and SLAM) through the CYP Strategic Partnership Board and the Joint Commissioning Group.
- Activity Based Costing exercises for health visiting, school nursing and children's centres services.
- A public health led review of national evidence on the effectiveness of public health interventions.

7.4.3 *Service user involvement*
Direct service user consultation with parents and young people. This consisted of a six-week online survey for parents and a six-week online survey for young people and interviews with parents in children's centres. The surveys and interviews asked questions about current services and expectations for future services. The surveys were cascaded to service users via health visitors and schools, Lewisham Youth Service, HealthWatch Lewisham, Young Mayor's and Advisors, Mummy's Gin Fund, and Voluntary Action Lewisham.

7.4.4 *Learning from other local authorities*
Information exchange with neighbouring local authorities who are also redesigning their health visiting and school nursing services, including visits with our existing provider to Hackney, and participation in two workshops on the future of 0 to 5 years' services organised by the London Councils.

7.4.5 **Phase 1 key findings**
Service mapping - all three services provide valuable support and advice to parents and carers during the critical period of early child development. In addition, all three services provide families in need of extra support through targeted Early Help services. Together these services provide:

- A universal service – including screening, immunisations, expert advice on child health and development and parenting
- Early identification of need in a range of settings: home (health visiting), community (children's centres) & school (school nursing)
- Targeted support for families, preventing escalation of need to social care.
- Spaces for parents and children to meet and develop in a safe environment and spaces for professionals to come together to deliver services jointly.
- Support for children with chronic conditions and complex need and parenting interventions (i.e. disability care plans)
- A core safeguarding function for our most vulnerable young people.

7.4.6 *Activity based costing exercise* - we conducted an activity based costing exercise for each service to identify the proportion of time spent on different activities, and the cost of these activities. Key findings were:

- The health visiting service caseload is split roughly 82% on the universal caseload, and 18% on the targeted (vulnerable) caseload. 20% of service time is spent on the five health reviews.
- A very high proportion of the health visiting budget is spent on management and administrative functions (approximately 58% excluding safeguarding related activities and follow ups on assessment results).
- There are various levels of integration between health visiting and children's centres. Partnership working tends to be based on individual relationships rather than organisational relationships and defined shared pathways.
- Some baby clinics are not well attended, others are very full – remodelling of provision would be sensible.
- There are areas of duplication between services – health visiting, maternity and children's centres.
- A high proportion of school nursing time (43%) is spent on safeguarding, particularly attendance at case conferences. School nurses have become the default health professional involved in all case conferences, even when they do not know the child previously. Immunisations also consumes a large amount of school nursing time.
- Health promotion – including one to one support for young people accounts for just 5% of school nursing time. The availability of this service for young people varies from school to school.

7.4.7 *Feedback from service users, stakeholders and other local authorities* – the main areas of comment were as follows:

- Parents value the help they receive from all three services. There was significant overlap between the role that parents felt health visiting and children's centres should play, with the additional emphasis on the role of children's centres in providing space for parents to meet.
- Parents felt there could be better use of children's centre buildings, to ensure that children's centres are in places where families want and need access to services.
- There is the potential for increased and more effective use of technology to support more efficient ways of working, and to increase access to services, particularly for young people.
- Young people report a wide range of needs for health and wellbeing support – primarily mental health, sexual health, and drugs and alcohol. There is a mismatch between demand for services and the ability of services to meet these needs. For example, there are long waiting times and high referral thresholds for CAMHS. There is lower than expected use of our young people's substance misuse service.
- New models are being developed in other local authority areas. All LAs are exploring ways of integrating services to make a more efficient use of funding, and a more joined up pathway for children and young people. Some LAs are decommissioning their children's centres and school nursing service.

7.5 New models

The consultation exercise in phase 1 provided valuable insight into current services and opportunities for change and enabled officers to design new models for school nursing and health visiting options for change. The focus of these models is on maximising outcomes, reducing efficiency and duplication of services, improving access to services, and creating more joined up support for children, young people and their families. This will enable the Council to generate cost savings from these services.

7.5.1 **Health visiting – proposed model**

	Current provision	Proposed changes
1.	Health visitors currently provide five mandatory health checks (reviews) for infants and toddlers. In Lewisham they provide two additional checks for some families at 3-4 months and 3.5 years. The government is consulting on changes to these mandatory health checks, which is likely to give Lewisham and other local authorities more flexibility to target additional checks at the most vulnerable families.	In future health visitors will provide checks during pregnancy only for women identified as vulnerable by maternity services. All other women will continue to have regular checks with GPs and midwives during their pregnancy. Health visitors will only offer additional checks at 3-4 months and 3½ years to families that are identified as vulnerable. *Rationale: eliminates duplication of services, while maintaining extra checks for vulnerable women, and is consistent with national guidance for a shared pathway with midwives and health visitors working together to deliver universal services and 'early intervention' for women and families. Few antenatal checks by health visitors are currently undertaken in Lewisham (only 13% of women).*[3]
2.	Health visitors carry out the five health checks (in pregnancy, new birth, 6-8 weeks, 7-11 months and 2-2½ years) in the family home, as well as in health centres and children's centres.	In future, vulnerable children will continue to have all their health checks in the home. For other children not assessed as vulnerable, two of these checks – the 7-11 month review and the 2-2½ years review – will be delivered in children's centres and in groups. All other checks will continue to be done in the home. *Rationale: more efficient use of health visitor time, promotes social interaction between parents and children, maintains home checks for vulnerable children and families.*
3.	Health visitors currently run baby clinics in children's centres, GP practices and health centres. Parents can take their babies to these clinics for weighing and advice from a health visitor.	In future, we will reduce the overall number of clinics delivered with the aim of them all being done in children's centres if buildings are accessible and acceptable to parents. We will also consider a new model for baby clinics which integrates group based breast feeding support, health education and parental weighing while continuing to ensure one to one access to a Health Visitor for advice. *Rationale: clinics are popular with parents, but some are not well attended. Parents spend a lot*

[3] Health visiting and midwifery partnership – pregnancy and early weeks. Public Health England and the Department of Health.

		of time in these clinics, and there is the scope to use them better for breastfeeding support, health promotion, and networking.
4.	Health visitors currently support 3 out of the 6 'breast feeding groups' in Lewisham, by giving advice on feeding, weaning, as well as mother and baby's health. These groups, and the provision of the volunteer breastfeeding peer supporters, are coordinated by the Breast Feeding Network.	In future, health visitor support for these groups will continue. We will transfer management of these groups to the health visiting service, supported by maternity services. Funding of this service will come from the health visiting budget. *Rationale: creates a more integrated service, and protects this service from future cuts.*
5.	A significant amount of the health visiting budget is spent on management and administrative functions (approximately 58% excluding safeguarding related activities and follow ups on assessment results).	In future, we will support our provider to deliver administrative activities more efficiently (such as through better use of technology) which would mean we could reduce the budget for administration. *Rationale: the proportion of budget spent on admin is high and higher than many other health visiting services. Other services have reduced their admin spend by smarter use of systems.*
6.	The health visiting service currently provides community clinics to deliver vaccinations to high risk babies that have not received the vaccination immediately after birth.	In future, this service might be delivered by a different team. However, clinics will still be community based. *Rationale: community clinics have in the past not had clear lines of funding. Funds have now been identified to pay for this service, by aligning the clinics with other child immunisation services.*

7.5.2 **School nursing – proposed model**

	Current provision	**Proposed changes**
1.	School nurses currently offer a health assessment to all children when they enter primary school with separate checks for vision, hearing. Nurses also do height and weight checks (National Child Measurement Programme) for reception and year 6 children.	In future, school nurses will provide a combined assessment for reception children consisting of a: • school entry health assessment. • National Child Measurement Programme (height and weight checks for reception and year 6 children). • hearing and vision screening. *Rationale: creates a more efficient service, and is easier for schools to organise clinics.*

2.	The school nursing service currently plays an important role in safeguarding and child protection.	Protecting vulnerable children will continue to be a priority and school nurses will still attend statutory meetings to support children and families when this is needed. In future school nurses will: • attend all initial case conferences but will only attend follow up reviews if the child has a health issue; • request that more case conferences and reviews take place in schools and at more suitable times of day; • continue to undertake health assessments for all children and young people aged 5-19 years when they become looked after or under the protection of the local authority. *Rationale: in Lewisham school nurses are required to attend all case conferences, reviews and core group meetings. This is a burden on the service, reduces school nurse time for other important health activities, and is not consistent with national guidance*.
3.	An organisation called MyTime Active currently deliver a weight management programme for children in Lewisham. This is separate to the school nursing service.	In future, our school nursing service will deliver an integrated weight management programme so that children who are overweight have access to better support. *Rationale: creates a more seamless service for children who are identified as overweight or obese.*
4.	The school nursing service currently supports the health and emotional wellbeing of children and young people through school drop-ins, appointments and health promotion work. However, school nurses have limited capacity to do this work.	In future, we will redesign this element of the service to create a new 'teenage health service'. This will be a targeted service for young people who are particularly vulnerable, but all young people will be able to use it: • be accessible from a number of venues in the borough as well as from schools. • offer online advice and face to face support for emotional wellbeing, alcohol and drugs misuse, and sexual health. • signpost and refer young people to more specialist services when required. *Rationale: teenagers will have access to a holistic health and wellbeing service which addresses the key risk factors for ill health. The current school nursing service does not have the capacity to provide this support and only has reach into schools. Many vulnerable young people are not in school.*
5.	School nurses provide support to children with long term conditions and	In future, school nurses will continue to provide some of this support. A dedicated nursing team,

	disabilities.	supported by the community paediatric team, will provide support for these children, for example by providing health assessments, helping develop individual care plans, and training school staff on how to look after children with long term conditions and disabilities in schools. *Rationale: we are redesigning our community nursing service and schools will in future have access to more expert help to support children with chronic conditions.*
6.	The school nursing service currently delivers immunisations to school age children.	Together with NHS England, we will continue to co-commission a school-based immunisation programme. However, we may deliver this through a different immunisation team not our school nursing service. *Rationale: new vaccines are added to the school-based immunisation programme each year and this places a burden on the school nursing service. Immunisation rates in Lewisham are not as high as they could be. We need to consider whether school nursing is best placed to provide this service.*

7.6 **Creating stronger links with children's centres – proposals**

7.6.1 Children's centres need to be recommissioned at the same time as health visiting and school nursing. This means there is an opportunity to ensure that proposals for new specifications for children's centres are aligned with proposals for health visiting and school nursing, and focus on increased integration of services for the benefit of families and children. The following initial proposals are being discussed with the current children's centre providers as well as the stakeholders engaged with through the health visitor and school aged nursing re-design:

7.6.2 Children's centres will have a clearer borough wide identity as "Children and Family Centres" which will provide a one stop shop for advice and support for families with young children.

7.6.3 All children's centres will have a consistent core menu of services and activities for families. There will be flexibility to add to this to meet local need.

7.6.4 Children's centres will be expected to provide increased support for families around employment, debt and employability skills.

7.6.5 Parenting skills programmes delivered by centres will need to be evidence-based, and better co-ordinated across the borough. These may be commissioned separately.

7.6.6 Better integration between the one to one family support work of children's centres, and the health visitor work with vulnerable families. This work may also be commissioned separately.

7.6.7 A hub and spoke model for children's centres will be retained and developed, with four area based hubs and outreach ('spoke') activities provided in schools, GP practices, community centres and libraries, building on some of the good examples that already exist, using locations that parents and families will use. This could mean not using some existing 'spokes', but developing new venues instead. Health visiting teams will be co-located with children's centres in area hubs as far as this is possible.

7.6.8 We will encourage increased integration between children's centres and other services working with families by:

- Ensuring that children's centres have a clear role in Lewisham's new Early Help strategy and Early Help pathway.
- Ensuring that there is a named senior health visitor and a named GP on children's centre management boards who will provide leadership for the closer integration of health visiting service with other services.
- Family Support will continue to be run from children's centres. However, it may be commissioned separately with the provider expected to demonstrate strong links to Lewisham's Troubled Families programme and to Health Visiting
- There will be joint referral pathways and multidisciplinary meetings with services to discuss families' needs for support and to agree intervention plans.

7.7 Phase 2 consultation on proposals: June to August 2016

7.7.1 Officers consulted on the proposals outlined above in a second phase from June to August 2016. The consultation consisted of:

- A meeting with the Young Mayor and advisors
- A workshop with commissioners and providers of sexual health, mental health and substance misuse services to shape the new Teenage Health Service
- Two workshops for children's centre providers and staff
- Presentations to each of the four GP neighbourhood forums
- Presentations to the CCG Membership Forum, the Clinical Directors' Senior Management Team, and a primary care workshop
- Presentations to the Primary Heads Forum and the Secondary Heads Forum
- Several meetings with the providers of current services and with maternity services

7.7.2 In addition, the Council ran two online U-engage consultations for five weeks from 18 July to 21 August 2016. The first survey was with the public and service users of the different services and asked for views on the proposed changes to services. The second survey was for health professionals and stakeholders and asked for views on the proposed changes, and the impact the proposals would be likely to have on service users and other professionals. Both consultations were promoted to professionals and service users through Healthwatch, youth services, children's centres, school nursing and health visiting, links on children's services pages and the main page of the Council website, the GP practice intranet, Lewisham life, and mailings to other health services and voluntary organisations. Officers also undertook visits to children's centres where they facilitated service user participation in the surveys.

7.8 Phase 2 consultation feedback

7.8.1 *Findings from meetings and workshops with stakeholders*

The main themes that emerged from discussions with GPs, headteachers and other stakeholders were:

- The need for more integrated services for families - GP practices, HV teams and children's centres, including co-location of services working with families where possible.
- GPs need more feedback from health visitors on the progress of families on targeted caseload.
- GPs value children's centres where they have good links but some GPs do not use the centres nor know where they are
- The NCMP (National Child Measurement Programme) could be delivered more efficiently with a different skill mix. Children should be weighed at 2 or 3 years as by reception age some children are already overweight.
- Experienced health visitors with strong relationships with GP practices are key to effective safeguarding.
- Some Lewisham families have high levels of need – the new model needs to have robust arrangements for safeguarding.
- There is concern about the potential risks of reducing funding for health visiting, and from changing the delivery of universal reviews. This may have an adverse effect on safeguarding and on the caseload of GPs. Universal reviews in the home are the mechanism for picking up "under the radar" problems.
- We need to be careful about changing the responsibilities of health visitors for universal provision. Some schools have very good relationships with health visitors and they would not want this to change
- There are opportunities with the redesign to strengthen public health outcomes – particularly around integrating weight management into health visiting and school nursing.
- Secondary schools felt that the school nursing service had improved in recent years and was more stable and responsive than in the past. Excellent examples were given of support for students, and some school nurses are greatly valued by their schools. However, it was felt that the quality of the service was variable with some school nurses not projecting a good image for health. It was felt that some school nurses were not able to respond to teenage mental health issues, and were not proactive in health promotion. Group-based work was sometimes poorly delivered.
- Links between GP practices and school nurses are weak. School nurses need to be part of the new neighbourhood model for general practice.
- There is strong interest in the proposed new Teenage Health and Wellbeing Service. This has the potential to offer more joined up care for risk behaviours that lead to ill health. The new service should be supported by good online resources.

7.8.2 *Formal response from NHS Lewisham*

The local authority received a formal response to the consultation from NHS Lewisham – the borough's Clinical Commissioning Group. The CCG response:

- Commended the approach undertaken by the local authority's CYP commissioning team to engage young people, parents and partners in shaping the new care models at an early stage.
- Supported the general direction of redesigning the advice, support and care provided by health visiting, school nursing and children's centres, as part of local Neighbourhood Care Networks.
- Understood the reasons for the proposals that Health Visitors will maintain focus more on the targeted caseload families, but registered some concerns about the proposals for the universal

caseload and the resultant risks for the rest of the population and how these risks will be mitigated. The CCG also asked that the impact of these changes in the transitional period on maternity services be properly assessed and monitored.

- Welcomed the opportunity to contribute further to the re-specification of new services through the involvement of the lead CCG Clinical Director for this area of work.

7.8.3 Findings from the U-engage consultations

7.8.4 *Responses to the public consultation*

There were 306 responses from the public and service users to the children and young people's consultation. Of these, 72% said they were Lewisham residents.

7.8.5 *Health visiting and children's centres*

- 301 people answered at least one of the questions in this section.
- 67% of respondents were using or had ever used a health visiting service.
- 61% had or currently used a children's centre. Of these, the main reasons for using a children's centre were to access play, music or other activities (36%), or to access health services (23%).
  In general, there were mixed responses to the health visiting proposals. More people opposed than supported the proposed changes to universal health checks and baby clinics. Some respondents felt that the proposals were positive, and would increase parental confidence and responsibility. Some pointed out the duplication of checks in different pathways. However, many service users and residents were concerned about the potential risks of making changes to universal health checks, such as delivering two of the checks through groups.

  The proposal to reduce the budget for administration was supported by fifty nine percent of respondents.

  Respondents did not want to see delivery sites for children's centres reduced, and did not agree that children's centres should be targeted more towards families with higher needs, implying that the universal services offered by children's centres is valued. There was support for co-location of children's centres with other health and education services (61% of respondents). Fifty two percent of respondents favoured integrating the family support service provided by children's centres with health visitor support for vulnerable families.

7.8.6 *School nursing*

- 259 people answered at least one of the questions in this section.
- 41% of respondents said that they or their children had ever used the school nursing service. 55% said that they or their children had not used the school nursing service. Respondents supported all proposals for changes to the school nursing service with 78% in favour of a. a combined health assessment for reception children, 83% in favour of weight management services to be integrated with school nursing service, 83% in support of a continuing role in protecting vulnerable children, 64% in support of a new teenage health service, and 55% supporting a dedicated nursing team, supported by community children's doctors, to provide support to children with long term conditions and disabilities

7.8.7 The table below provides a summary of responses to the public consultation. A full analysis, complete with feedback and comments, can be found in the Equalities Analysis Assessment in Appendix 6.

Table 1: Responses to the public consultation on changes to health visiting and school nursing

Responses

Consultation area	Proposed change	% Strongly agree or agree	% Strongly disagree or disagree	% Neither agree nor disagree
Health visiting	Deliver 7-11 months and 2-2.5 year checks for families not identified as vulnerable in groups at Children's Centres (CC).	35.57 %	48.66%	15.44%
Health visiting	Reduce the overall number of baby clinics delivered with the aim of them all being done in Children's Centres. Introduce parental weighing of babies at clinics (whilst continuing to provide access to a Health Visitor for advice).	29.83%	56.27%	13.22%
Health visiting	Only provide checks during pregnancy for women identified as vulnerable by maternity services (other women will continue to have access to GPs and midwives for health checks during their pregnancy). Only offer additional checks at 3-4 months and 3.5 years to families that are identified as vulnerable.	37.96%	46.10%	13.56%
Health visiting	Transfer management of Lewisham's breastfeeding groups to the health visiting service (supported by maternity services).	33.33%	31.29%	26.87%
Health visiting	Reduce the budget for administration by developing new ways of delivering this support (such as better use of technology).	58.53%	20.40%	17.39%
Health visiting	Develop a local dedicated immunisation team that will be able to provide community clinics to deliver BCG vaccinations to babies who have not received this after birth	55.22%	18.51%	21.89%
Children's centres	Offer the same services at fewer or different locations (such as an area based 'hub' supported by smaller sites, including the use of schools and community settings).	32.63%	44.56%	19.65%
Children's centres	Offer the same services, but targeted towards families with higher needs.	30.88%	46.32%	20.70%

Consultation area	Proposed change	% Strongly agree or agree	% Strongly disagree or disagree	% Neither agree nor disagree
Children's centres	Co-locate children's centres with other health and education services.	61.06%	13.68%	22.11%
Children's centres	Integrate the one-to-one family support service provided by Children's Centres with our health visitor support for vulnerable families.	52.48%	14.54%	22.70%
School nursing	Provide a combined assessment for reception children consisting of a school entry health assessment, National Child Measurement Programme (weight checks for reception and also for year 6 children) & hearing and vision screening.	78.26%	5.14%	12.65%
School nursing	Develop closer links between our weight management programme and our school nursing service so that children who are overweight have access to better support.	83.33%	3.17%	10.32%
School nursing	Require school nurses to attend ICPC and first core group meetings (subsequent attendances will be assessed according to the health needs of the individual child). Require school nurses to physically locate safeguarding leads in the new redesigned Multi-Agency Safeguarding Hub (MASH).	83.06%	7.26%	6.45%
School nursing	Create a dedicated 'teenage health service' which will be accessible from a number of venues in the borough as well as from schools, be provided by a mixture of health and non-health staff, offer online advice and one to one support about health and emotional wellbeing and risk behaviours e.g. alcohol or drugs misuse & sexual health and signpost and refer young people to other local services.	63.71%	20.16%	12.50%

Consultation area	Proposed change	% Strongly agree or agree	% Strongly disagree or disagree	% Neither agree nor disagree
School nursing	Create a dedicated nursing team, supported by community children's doctors, to provide support to children with long term conditions and disabilities (and train school staff on how to look after these children in schools).	55.33%	24.59%	16.39%
School nursing	Continue to provide immunisations in schools, but deliver these via a different immunisation team.	35.08%	27.42%	33.87%

7.8.8 *Responses to the professional consultation*

There were 72 responses from professionals and stakeholders to the children and young people's consultation. Of these 35% identified themselves as health visitors, 15% as school nurses, 17% as GPs, and 28% as "other health professionals".

7.8.9 *Health visiting and children's centres*

- 70 people answered at least one of the questions in this section.
- 75% of respondents had ever referred or regularly referred parents to children's centres. The main reason for referral was for the family support service (21.11%); 16% of referrals to children's centres were for advice on childcare and early years education.

Professionals were asked whether the proposed changes to health visiting would have a positive, neutral or negative effect on service users and on other professionals. The majority of respondents felt that the changes to universal health checks and baby clinics would be negative for service users. The anticipated impact on other professionals was thought to be mixed. There was wider support for the budget for administration to be reduced by developing new ways of delivering this support (53.03% thought a positive impact on professionals), and over half wanted a different immunisation team to health visiting to deliver community immunisation clinics.

Similar to the responses from service users, health professionals did not want to see delivery sites for children's centres reduced, and did not agree that children's centres should be targeted more towards families with higher needs. However, co-location of children's centres with other health and education services and integrating the family support service provided by children's centres with health visiting were proposals that were supported.

7.8.10 *School nursing*

- 63 people answered at least one of the questions in this section.

The proposed changes to school nursing were strongly supported with the proportion in favour of each proposal ranging from 44% to 72%, apart from the proposal on immunisations, which had 35% anticipating a positive impact on both service users, and 50% expecting a neutral impact

The table below provides a summary of responses to the public consultation. A full analysis, complete with feedback and comments, can be found in the Equalities Analysis Assessment in Appendix 1.

Table 2: Responses to the stakeholder/professional public consultation on changes to health visiting and school nursing

Consultation area	Proposed change	% believing the proposed change would have a positive or neutral effect on service users	% believing the proposed change would have a negative effect on service users	% believing the proposed change would have a positive or neutral effect on other professionals	% believing the proposed change would have a negative effect on other professionals
Health visiting	Deliver 7-11 months and 2-2.5 year checks for families not identified as vulnerable in groups at Children's Centres (CC).	42.65%	57.35%	55.07%	44.93%
Health visiting	Reduce the overall number of baby clinics delivered with the aim of them all being done in Children's Centres. Introduce parental weighing of babies at clinics (whilst continuing to provide access to a Health Visitor for advice).	40.31%	59.70%	43.48%	56.52%
Health visiting	Only provide checks during pregnancy for women identified as vulnerable by maternity services (other women will continue to have access to GPs and midwives for health checks during their pregnancy). Only offer additional checks at 3-4 months and 3.5 years to families that are identified as vulnerable.	39.39%	60.61%	50%	50%
Health visiting	Transfer management of Lewisham's breastfeeding groups to the health visiting service (supported by maternity services).	71.21%	28.79%	71.64%	28.36%
Health visiting	Reduce the budget for administration by developing new ways of delivering this support (such as better use of technology).	76.93%	23.08%	71.21%	28.79%

Consultation area	Proposed change	% believing the proposed change would have a positive or neutral effect on service users	% believing the proposed change would have a negative effect on service users	% believing the proposed change would have a positive or neutral effect on other professionals	% believing the proposed change would have a negative effect on other professionals
Health visiting	Develop a local dedicated immunisation team that will be able to provide community clinics to deliver BCG vaccinations to babies who have not received this after birth	89.24%	10.77%	92.54%	7.46%
School nursing	Provide a combined assessment for reception children consisting of a school entry health assessment, National Child Measurement Programme (weight checks for reception and also for year 6 children) & hearing and vision screening.	91.80%	8.20%	93.45%	6.56%
School nursing	Develop closer links between our weight management programme and our school nursing service so that children who are overweight have access to better support.	93.65%	6.35%	95.24%	4.76%
School nursing	Require school nurses to attend ICPC and first core group meetings (subsequent attendances will be assessed according to the health needs of the individual child). Require school nurses to physically locate safeguarding leads in the new redesigned Multi-Agency Safeguarding Hub (MASH).	85.25%	14.75%	82.54%	17.46%

Consultation area	Proposed change	% believing the proposed change would have a positive or neutral effect on service users	% believing the proposed change would have a negative effect on service users	% believing the proposed change would have a positive or neutral effect on other professionals	% believing the proposed change would have a negative effect on other professionals
School nursing	Create a dedicated 'teenage health service' which will be accessible from a number of venues in the borough as well as from schools, be provided by a mixture of health and non-health staff, offer online advice and one to one support about health and emotional wellbeing and risk behaviours e.g. alcohol or drugs misuse & sexual health and signpost and refer young people to other local services.	76.27%	23.73%	78.69%	21.31%
School nursing	Create a dedicated nursing team, supported by community children's doctors, to provide support to children with long term conditions and disabilities (and train school staff on how to look after these children in schools).	83.33%	16.67%	77.04%	22.95%
School nursing	Continue to provide immunisations in schools, but deliver these via a different immunisation team.	85%	15%	80.64%	19.35%

Consultation area	Proposed change	% Strongly agree or agree	% Strongly disagree or disagree	% Neither agree nor disagree
Children's centres	Offer the same services at fewer or different locations (such as an area based 'hub' supported by smaller sites, including the use of schools and community settings).	35.38%	49.23%	13.85%

Children's centres	Offer the same services, but targeted towards families with higher needs.	34.92%	50.79%	14.29%
Children's centres	Co-locate children's centres with other health and education services.	68.25%	9.52%	22.22%
Children's centres	Integrate the one-to-one family support service provided by Children's Centres with our health visitor support for vulnerable families.	57.58%	25.76%	15.15%

7.9 **Equalities Analysis Assessment (EAA).**

A full EAA was undertaken to determine whether the proposed changes to public health nursing services in Lewisham were likely to have a positive, neutral or negative impact on different protected characteristics within the local community and to identify mitigating actions to address any disproportionately negative outcomes.

The overall assessment of available data and research, plus the findings from the consultation exercise, found that the proposed changes did not discriminate, although they may have a greater impact on particular protected characteristics, such as age, disability and ethnicity which will be addressed where possible in the development of detailed service specifications. As a result, no major amendments are required at this stage.

The EAA, including the Action Plan, will be reviewed regularly (every three months after the completion of the recommissioning process in April 2017) to ensure that equalities issues continue to be positively reflected in service delivery.

The full Equalities Impact Assessment can be found in Appendix 6.

7.10 **Mitigation of risks**

The consultation process has identified some risks, particularly around the proposed changes to health visiting. Commissioners will be taking the following actions in response to the risks identified:

7.10.1 *Further analysis and consideration of consultation comments:* the public, service users and stakeholders made many comments during the U-engage consultation – these offer valuable suggestions and insights into how services can be delivered in the future. The Young Mayors' advisors had useful insights into the planned new Teenage Health and Wellbeing Service.

7.10.2 *Health visitor antenatal check:* we will agree a work plan with Lewisham's maternity and health visiting services to develop a more integrated and collaborative approach to services, particularly around the antenatal pathway. Discussions have already begun with providers, and will continue with a focus on the potential benefits of more joined up approaches to antenatal and postnatal care. National guidance advises the

commissioning of joined up services for parents during pregnancy and the early weeks of life. The current maternity service has skilled midwives for dealing with vulnerable women and who coordinate with health visitors during the antenatal pathway. This pathway will be protected and improved.

7.10.3 *Delivery of two of the five health checks in groups*: we will work closely with health visitors, children's centres and GPs on how this is developed. We will ensure that there is a pathway for identifying children initially seen in groups to a separate assessment and follow up with a health professional when this is required. We will require providers to develop digital/online information, advice and guidance to support this change.

7.10.4 *Changes to baby clinics:* we will conduct a review of the usage of baby clinics to better locate clinics to meet demand. We will work with health visitors, the Maternity Services Liaison Committee, and the Breast Feeding Network, in order to design a new model for baby clinics which provides more inclusive support on a range of issues, while maintaining one to one access to a health visitor.

7.10.5 *Children's centres*: we are not proposing to reduce the number of delivery sites for children's centres. However there is an opportunity to review which sites are best suited to become 'hubs', and to make use of the best locations for 'spokes' – which may not be those currently used. We will ensure that children's centres continue to provide a comprehensive universal service as well as targeted services for families with higher needs.

7.10.6 We will involve the CCG clinical director for children and young people in the development of the new service specifications for health visiting, school nursing and children's centres.

7.10.7 *School nursing and safeguarding:* we will continue discussions with senior staff in Children's Social Care and school nursing with a view to developing an effective and safe school nursing safeguarding service for children in need.

7.10.8 *School immunisations:* we will continue to commission school nursing to provide immunisations in schools in 2017-18. However, this will be reviewed after one year, and immunisations might in future be delivered by a separate immunisation team as they are in many London boroughs.

7.10.9 In addition, we plan further consultation on our proposals over the next few months, including the following activities:

- An additional survey for Headteachers and school nursing staff around the changes to school nursing and the design of the new teenage health service.
- Further engagement with key stakeholders and professionals in order to develop proposals, and assess the potential for unidentified risks.
- A focus group with the young service users' panel of the current substance misuse service to test our proposals for changes to school nursing.
- Establishing a user panel of young people to develop the new Teenage Health Service.

7.11 **Timetable for further consultation and the procurement process**

Activity	Date
Recommissioning proposals for children's centres presented to Children and Young People's Select Committee	14 September 2016
Further engagement of key stakeholders to develop proposals.	Early September 2016
Final savings and redesign proposals presented to Mayor and Cabinet	28 September 2016
Development of draft specifications and tender documentation for new service models	September 2016
External tender process. Including possible competitive dialogue procedure for health visiting, the development of children's centre sites and for development of Teenage Health and Wellbeing Service.	October – December 2016
Tender evaluation and contract award	December 2016 – January 2017

8 Sexual Health

8.1 The sexual health elements of the consultation build on existing consultation and pre-consultation engagement that has been undertaken as part of the London Sexual Health Transformation Programme and SE London sexual health services transformation. The consultation also builds on the direction of service development outlined in the 2014 Lambeth, Southwark and Lewisham Sexual Health Strategy.

8.2 Whilst it is anticipated that there will be savings of £500,000 delivered through the proposals, the majority of this saving is through changes to the 'back office' payment systems rather than front line services. This saving will be from across the whole of sexual health system in London accessed by Lewisham residents rather than just local services.

8.3 Moving access to some sexual health services to online and pharmacy will also contribute to the £500,000.

8.4 Local sexual health proposals consulted on were:

- Increased use of home testing/self-sampling for sexually transmitted infections through an online service
- Increased and more comprehensive offer of contraception and STI testing services offered by community pharmacies and GPs
- Service user and public views on the provision of specific services for young people (under 25).

8.5 The sexual health service consultation included:

- Online survey for professionals
- Online survey for public
- Attendance by officers at 4 GP neighbourhood meetings
- Attendance by officers at Local Medical Committee meeting
- Attendance by officers at CCG membership forum
- Attendance by officers at Young Advisors meeting
- Attendance by officers CCG senior management team meeting
- Attendance by officers at Lewisham People's Day to discuss proposals and get feedback on existing services.

8.6 An equalities impact assessment (this differs from Lewisham's EAA template as it formed part of a joint approach with Southwark and Lambeth Councils) has been completed as summary of the findings is in the table below. Overall the impact of the changes proposed is expected to be positive as the changes are targeted at those groups with the greatest need for sexual health services. However, where there is insufficient information to assess the impact at present this will be collected in the future to enable an ongoing assessment of impact.

Protected Characteristics	Impact
age	Positive
disability	Positive
gender reassignment	Not known
pregnancy and maternity	Positive
race	Positive
religion or belief	Not known
sex	Positive
sexual orientation	Positive
marriage and civil partnership (only in respect of eliminating unlawful discrimination)	Not known

8.7 **Professional online survey**

8.7.1 In total 87 professionals completed the online survey in relation to sexual health.

8.7.2 Most of the feedback in relation to existing sexual health clinic provision was positive, however, long waits to be seen and clinics closing early was highlighted as feedback that professionals had received from patients. The importance of the additional level of anonymity the clinics provided was also mentioned. Around a third of GP respondents also highlighted the fact that they already did provide most sexual health services for their patients, only referring complex cases or difficult to treat infections.

8.7.3 Opening hours of clinics were highlighted by both the public and professionals as an issue. This was particularly a problem for working people.

"Too limiting as local sexual health service reduced opening times. patients don't want to take time off work for sexual health issues so need appointments outside of core hours."

8.8 **Public online survey**

8.8.1 195 people responded to the uengage survey in relation to sexual health services. Of these 50.2% had used any sexual services in the borough (including sexual health clinics, online screening, pharmacy or GP). Just over 6.7% identified as gay, lesbian or bisexual.

8.8.2 When asked to what extent they favoured a more comprehensive sexual health offer including STI testing and contraception in a variety of settings the survey showed, nearly 80% supporting this in GP practices, 67% supporting this in pharmacies and 56% supporting online provision (a further 19% were ambivalent). In the comments received from the public there was very strong support for home sampling/online testing.

"Home sampling is a great idea!"

8.8.3 A number of responses highlighted that this was a way to prevent people having to wait in clinics, which often closed early due to the volume of patients, and ensuring those that needed to be seen could get into clinics. A number of respondents also commented that they wanted to have more appointment based services (most sexual health services are currently "walk in and wait"), rather that rushing between clinics trying to get seen, only to find they are closed. On the other hand, the additional anonymity of not having to be registered or make an appointment was felt to be important in encouraging vulnerable young people to access the service.

"It is simply not right that there are so few clinics in Lewisham given how large the borough is. If clinics advertise their closing time as 7pm that's the time the clinic should actually close - it's ridiculous that people at work might make their way to a clinic to find themselves turned away and told to try again during the following day time."

8.8.4 There appeared to be strong support from survey respondents for young people's specialist sexual health services. When asked whether there should be specialist services for young people 79% of respondents favoured an under 19s service. The percentage favouring under 25s and young people's provision within mainstream provision was also high, but slightly less - 75% of respondents favoured an under 25s service and 75% to have young people's provision as part of the mainstream offer, but overall there was strong support for a young people's services for sexual health.
The free text comments suggested that sex education and prevention of pregnancy and STIs should be a key focus for young people.

"There is a need to educate and create easy access to young people separate from general sexual health services and GPs. They are more likely to attend if services are separate."

Some respondents challenged the age cut off at 25 for young people's services (this age is used as this is the peak STI age range), and suggested it should be older or younger.

8.8.5 Feedback from the GP neighbourhoods and LMC was broadly supportive of the sexual health proposals, in particular the promotion of online/ home sampling for STIs and recognising that young people had specific needs which may be best met by specialist services. There was support for a neighbourhood model of delivery of sexual health services, in primary care although some caution regarding the capacity of GPs practices to cope with any increase in demand.

Prevention and sexual health promotion was highlighted frequently as a key component of sexual health service delivery.

8.8.6 The Young Mayor and Advisors highlighted the importance of discreet and confidential services to meet their needs, which were youth friendly. They raised concerns about being 'judged' in mainstream service provision. There was a high degree of enthusiasm for online/self sampling for STI testing, although for younger teenagers there were concerns about having packages sent to their home address. They felt this could be addressed through the "pick up a pack" model already used in sexual health services for self sampling, but extending it to other venues including youth setting, libraries and pharmacies. Prevention and sex and relationships education was also highlighted as a key area by the Young Advisors. There were concerns expressed that many young people in Lewisham were not getting access to sex and relationships education either because schools were not providing it or their parents did not allow them to participate.

8.9 Conclusions

8.9.1 Clinic services

The consultation responses generally support the proposed sexual health service model, particularly the use of online testing. The new service model seems to address many of the concerns regarding existing services. The main issues raised in relation to existing services were:

- Long waits
- Lack of appointments
- Limited opening hours for working people

Response:

The issues raised in relation to clinic capacity and waiting times should be improved by better streaming of patients through the sexual health services, matching need to service. This means clinics can be focused on those who need treatment or at risk groups and STI screening and basic contraception could be managed in a pharmacy or screened online do not need to access a clinic.

In the new service models appointments will be bookable as well as walk in (the local service has just introduced bookable appointments in response to patient feedback).

8.9.2 Young Peoples Services

There appears to be a high level of support from both the public and professionals for young people's sexual health services. It has been acknowledged that there is high level of need in this age group. However, there were some concerns that older women trying to access contraception may have difficulty if services were too focused on young people.

Response:
Further development work and coproduction is required to ascertain what exactly young people's sexual health services should look like and how it fits with the development of a broader health service for 11-19 year olds. Commissioners will look at ways to incorporate the issues raised in relation to sex and relationships education and prevention within the new service models.

In relation to the concerns about access for over 25s, a bookable appointment service for long acting contraception is currently being developed for Lambeth Southwark and Lewisham. This will give women a much wider choice of venues and times to access contraception. High risk groups including BME groups, MSM and those with other vulnerabilities over 25 will continue to be prioritised in clinics whilst other groups will have better access through online service provision for STI testing.

8.9.3 **Impact on Primary Care**

Lewisham CCG and the LMC both raised some concerns that any changes may increase workload in primary care (GPs). However, some GPs responding to the onilen survey also noted that this could reduce workload by signposting patients to online STI testing.

Response
The increase in the pharmacy sexual health offer may in fact reduce some demand for uncomplicated contraception as this can be managed without a GP appointment. Services commissioned from GPs by NHS England including contraception, HIV testing and cervical screening are not in the scope of this work, however there is a commitment from officers to work with the CCG and NHS England to ensure these sexual health services work together to maintain and improve access.

8.9.4 **Achievement of Savings**

The £500,000 savings set against sexual health in 2017/18 will largely be achieved through service redesign moving uncomplicated contraception and STI testing online and into pharmacies, and through a new integrated sexual health tariff (ISHT) for financing sexual health services. It is not anticipated that this should lead to a deterioration in service, but rather an improvement in access but creating more opportunities to test for STIs and access contraception.

The ISHT has been modelled against last year's activity (2015/16) across the London sexual health system and showed an estimated 10% reduction in cost for the same activity. A considerable amount of due diligence and further audit has been carried out to try and ensure that the financial risk to commissioners is minimal.

As part of the recommissioning of sexual health services across London there is broad agreement that this (ISHT) will be the payment mechanism for sexual health services from 1st April 2017. This change should have no impact on service users or service delivery. The new arrangement will be built into contracts from the 1st April 2017. This decision was delegated to officers at 21 October 2015 Mayor and Cabinet (contracts).

9 Procurement Arrangements

9.1 Mayor and Cabinet in September 2015 delegated authority to the Executive Director for Resources and Regeneration to approve the procurement activity to deliver the proposals for Sexual Health.

9.2 Mayor and Cabinet is requested to delegate authority to the Executive Director for Resources and Regeneration to approve the procurement activity to deliver the proposals for Staying Healthy services.

9.3 Mayor and Cabinet is requested to approve competitive tenders for the redesigned Health Visiting and School Nursing services.

10. Financial Implications

10.1 The activity outlined in this report delivers the required level of savings for Staying Healthy and Sexual Health services. The proposals for Health Visiting and School Nursing, in response to consultation, now deliver a reduced level of savings. This leaves the overall proposals delivering only £4.4m of the required £4.7m savings. Further proposals will be developed to deliver the remaining £300,000 saving.

10.2 As the savings proposal in this report detail activity for 01/04/17, they will not address the in-year pressure. A net overspend of 1m is projected in the Council's revenue monitoring of Public Health for 2016/17.

11. Legal Implications

11.1 The Health and Social Care Act 2012 transferred the bulk of Public Health duties to Local Authorities. As such, the budget used to deliver those services is aligned within the Councils financial framework, with the usual duties to produce a balanced budget using public funds. The proposals contained within this report should receive a proper consultation (including statutory scrutiny with the Health Scrutiny Committee) as well as be subject to full Equalities Impact Assessments.

11.2 Where the value of any contract is in excess of £625,000, then under the Public Contract Regulations it is necessary to undertake an EU compliant tendering exercise. Where the nature of the services are not capable of being clearly specified or not capable of accurate pricing due to market conditions, then it is possible to undertake a competitive dialogue with a minimum number of three economic operators. The tendering process, with outcomes, will be the subject of separate reports to the Executive Director to whom authority to decide is delegated. The outcome of the tendering exercise for health visiting and school nurse service will return to mayor and cabinet for award and will be the subject of a full report.

12. Crime and Disorder Act Implications

12.1 There are no crime and disorder implications

13. Equalities Implications and human rights

13.1 The consultations outlined in this report informed equalities analyses for all 3 areas, which are attached as appendices 6-8

14. Environmental Implications

14.1 There are no environmental implications.

15 Conclusion

15.1 This report lays out a range of proposals to realise the savings agreed by Mayor & Cabinet on September 30th 2015, and to balance the reduction to the Public Health grant announced in the 2015 spending review. The activity outlined in this report delivers the required level of savings for Staying Healthy and Sexual Health services. The proposals for Health Visiting and School Nursing, in response to consultation, now deliver a reduced level of savings. This leaves the overall proposals delivering only £4.4m of the required £4.7m savings, with the Council therefore needing to find a £300,000 saving elsewhere in its budget. The report seeks Mayor & Cabinet approval to conduct this activity.

Appendix 1: Lewisham's 9 health and wellbeing priorities

1. achieving a healthy weight
2. increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years
3. improving immunisation uptake

4. reducing alcohol harm
5. preventing the uptake of smoking among children and young people and reducing the numbers of people smoking
6. improving mental health and wellbeing
7. improving sexual health
8. delaying and reducing the need for long term care and support.
9. reducing the number of emergency admissions for people with long-term conditions.

Appendix 2: Allocation of the Public Health grant for 2016/17

PH service area	Includes	value	grant %
CHILDREN 5-19 PUBLIC HEALTH PROGRAMMES	mental health promotion, sexual health education	£40,000	**0.2%**
HEALTH PROTECTION	immunisation, child death review	£85,992	**0.3%**
SEXUAL HEALTH	local clinics, prescribing , GUM, sexual health promotion	£6,257,270	**24.4%**
SUBSTANCE MISUSE	core & YP treatment service, rehab, medication, GPs, aftercare	£4,402,000	**17.2%**
NHS HEALTH CHECK PROGRAMME	Healthchecks, health improvement training	£420,238	**1.6%**
OBESITY	nutrition, vitamin D, breastfeeding	£463,800	**1.8%**
PHYSICAL ACTIVITY	Physical activity programmes	£70,800	**0.3%**
OTHER PUBLIC HEALTH SERVICES	CHIS, Area programmes, administration	£739,408	**2.9%**
PRESCRIBING	smoking medication, LARC, GP substance use medication	£373,256	**1.5%**
MEASUREMENT PROGRAMME	health visiting & school nursing	£8,910,238	**34.8%**
PUBLIC HEALTH ADVICE	support to CCG	£60,000	**0.2%**
PUBLIC HEALTH STAFFING TEAM	staff	£1,097,740	**4.3%**
SMOKING AND TOBACCO	smoking service, tobacco control	£473,738	**1.9%**
	total 16/17 allocated services spend	**£23,394,480**	**91%**

Corporate Reallocations		
LEISURE	£400,000	
CHILDREN'S CENTRE	£550,000	
HOMELESSNESS	£245,000	
VAWG	£400,000	
FOOD & SAFETY	£187,000	
ENVIRONMENTAL PROTECTION	£77,000	
CAMHS	£313,000	
BENEFITS ADVICE	£200,000	
ADULT CARE: PREVENT ISOLATION	£750,000	
NEW 16-17 REALLOCATION	£557,000	
Total 16/17 corporate reallocation	**£3,679,000**	**14%**
total allocated spend against PH grant	**£27,073,480**	**106%**

Appendix 3: Public Health Outcomes Framework 2016-19

VISION

To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest

Outcome measures

Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life

Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)

Alignment across the Health and Care System

* Indicator shared with the NHS Outcomes Framework.

** Complementary to indicators in the NHS Outcomes Framework

† Indicator shared with the Adult Social Care Outcomes Framework

†† Complementary to indicators in the Adult Social Care Outcomes Framework

Public Health Outcomes Framework 2016–2019
At a glance

1 Improving the wider determinants of health

Objective

Improvements against wider factors which affect health and wellbeing and health inequalities

Indicators

1.01 Children in low income families
1.02 School readiness
1.03 Pupil absence
1.04 First time entrants to the youth justice system
1.05 16-18 year olds not in education, employment or training
1.06 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation† *(ASCOF 1G and 1H) **(NHSOF 2.5ii)*
1.07 Proportion of people in prison aged 18 or over who have a mental illness
1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services **(i-NHSOF 2.2) ††(ii-ASCOF 1E) **(iii-NHSOF 2.5i) †† (iii-ASCOF 1F)*
1.09 Sickness absence rate
1.10 Killed and seriously injured casualties on England's roads
1.11 Domestic abuse
1.12 Violent crime (including sexual violence)
1.13 Levels of offending and re-offending
1.14 The percentage of the population affected by noise
1.15 Statutory homelessness
1.16 Utilisation of outdoor space for exercise / health reasons
1.17 Fuel poverty
1.18 Social isolation† *(ASCOF 1I)*

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

2.01 Low birth weight of term babies
2.02 Breastfeeding
2.03 Smoking status at time of delivery
2.04 Under 18 conceptions
2.05 Child development at 2 – 2 ½ years
2.06 Child excess weight in 4-5 and 10-11 year olds
2.07 Hospital admissions caused by unintentional and deliberate injuries for children and young people under 25
2.08 Emotional well-being of looked after children
2.09 Smoking prevalence – 15 year olds
2.10 Self-harm
2.11 Diet
2.12 Excess weight in adults
2.13 Proportion of physically active and inactive adults
2.14 Smoking prevalence – adults (over 18s)
2.15 Drug and alcohol treatment completion and drug misuse deaths
2.16 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison
2.17 Estimated diagnosis rate for people with diabetes mellitus
2.18 Alcohol-related admissions to hospital
2.19 Cancer diagnosed at stage 1 and 2***(NHSOF 1.4v 1.4vi)*
2.20 National Screening Programmes
2.22 Take up of the NHS Health Check programme – by those eligible
2.23 Self-reported well-being
2.24 Injuries due to falls in people aged 65 and over

3 Health protection

Objective

The population's health is protected from major incidents and other threats, whilst reducing health inequalities

Indicators

3.01 Fraction of mortality attributable to particulate air pollution
3.02 Chlamydia diagnoses (15-24 year olds)
3.03 Population vaccination coverage
3.04 People presenting with HIV at a late stage of infection
3.05 Treatment completion for TB
3.06 Public sector organisations with board approved sustainable development management plan
3.08 Antimicrobial Resistance

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

Indicators

4.01 Infant mortality* *(NHSOF 1.6i)*
4.02 Proportion of five year old children free from dental decay** *(NHSOF 3.7i)*
4.03 Mortality rate from causes considered preventable ***(NHSOF 1a)*
4.04 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* *(NHSOF 1.1)*
4.05 Under 75 mortality rate from cancer* *(NHSOF 1.4)*
4.06 Under 75 mortality rate from liver disease* *(NHSOF 1.3)*
4.07 Under 75 mortality rate from respiratory diseases* *(NHSOF 1.2)*
4.08 Mortality rate from a range of specified communicable diseases, including influenza
4.09 Excess under 75 mortality rate in adults with serious mental illness* *(NHSOF 1.5i)*
4.10 Suicide rate***(NHSOF 1.5iii)*
4.11 Emergency readmissions within 30 days of discharge from hospital* *(NHSOF 3b)*
4.12 Preventable sight loss
4.13 Health-related quality of life for older people
4.14 Hip fractures in people aged 65 and over
4.15 Excess winter deaths
4.16 Estimated diagnosis rate for people with dementia * *(NHSOF 2.6i)*

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Public Health England

Protecting and improving the nation's health

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To: Local Authority Chief Executives
Cc: Directors of Public Health

PHE Gateway Number: 2015-502

27 November 2015

Dear everyone

Spending Review

I wanted to write to you following Wednesday's Spending Review announcement about the public health grant to share my thoughts on what this means for the next five years.

First, as anticipated, there will be a reduction. The Chancellor talked about savings in the public health grant, which will be an average real terms saving of 3.9% each year to 2020/21. This translates into a further cash reduction of 9.6% in addition to the £200 million of savings that were announced earlier this year. From the baseline of £3,461m (which includes 0-5 commissioning and takes account of the £200m savings) the savings will be phased in at 2.2% in 16/17, 2.5% in 17/18, 2.6% in each of the two following years, and flat cash in 20/21.

Cuts are never welcome, and this is by no means the only challenge that local authorities face. However, you and your colleagues have already proved that you are capable of managing reductions on this scale. I am confident that you will find ways of continuing the very real progress of the past three years in protecting and improving the public's health and in working to reduce health inequalities.

We do not yet know the implications for individual local authorities. This will depend on decisions about the funding formula, on which the Department of Health has consulted on behalf of ACRA and the political decision on pace of change (how fast we move from historic spend to the formula based target shares). My advice to the Government throughout has been to prioritise stability and certainty for the next two years and concentrate on getting the arrangements right for the transition to full funding through business rates. I believe this reflects what your colleagues have told me on my visits to local authorities across the country.

The Spending Review made a number of further commitments including:

- a commitment to retain the public health grant for 16/17 and 17/18 in order to complete the transition of 0-5s and to work through what we will all need in a world without a ringfence.

- a clear signal that the public health grant will be replaced as we move to a model based on retained business rates. The detail of how this will work needs to be worked through and will be subject to full consultation. We will obviously be keen to ensure that any redistribution mechanism reflects health need and does not exacerbate health inequalities.

- the Government is not proposing to change the statutory prescribed functions for local authorities for 16/17. It is right that local government is trusted to make the best decisions about how to use the resources available.

As you know, improving the public's health is about so much more than services secured through the public health grant – it is about jobs, decent housing, a safe environment and companionship. Following the Spending Review, we can work together to build a far wider programme of action on prevention and improving health and wellbeing, including:

- the settlement for the NHS fully funds the Five Year Forward View, and its commitment to getting serious about prevention.

- understanding how we can best use the additional £1.5 billion invested in the Better Care Fund to maximise system-wide efforts to prevent the preventable.

- the importance of Government action, and in particular action on childhood obesity, is signalled. As you know, PHE have provided clear evidence on how we could reduce sugar consumption. We are now working with the Department of Health to produce an effective Childhood Obesity Strategy.

- the importance of work to health. The provision of new national funds to develop approaches to help people with health problems get back to work speaks to an agenda that I know is important to all of you.

- developing a place-based approach to NHS planning; the planning round for 16/17 and beyond will move to a place-based approach and properly engage local authorities in the decisions about future health services.

- the Government's commitment to real and meaningful devolution provides opportunities for local authorities to join up public services to address the real problems in our communities.

You will be considering the impact of the Spending Review for your authority. I am clear that we have the basis for making a real difference to the public's health in the coming years. I do not underestimate the challenges, but they are nothing to what you have already shown you are capable of.

PHE stands ready to help in whatever way we can.

Best wishes

Yours sincerely

Duncan Selbie
Chief Executive

Equality Analysis Assessment (EAA) Equality impact of proposed changes to preventative health services currently being commissioned by Public Health	
Name of proposal	Public Health Savings (Staying Healthy Services)
Lead officer (s)	Dr Catherine Mbema (Public Health Registrar/Trainee) Catherine.mbema@lewisham.gov.uk /020 8314 3927 Jane Miller (Consultant in Public Health) Jane.miller@lewisham.gov.uk/020 8314 9058
Other stakeholders	Lewisham Clinical Commissioning Group (CCG) Children and Young People's (CYP) Joint Commissioning Lewisham and Greenwich NHS Trust (LGT)
Start date of Equality Analysis	20th July 2016
End date of Equality Analysis	The assessment will need to inform decision-making so the end date should take this into account.

Step1: Identify why you are undertaking an Equality Analysis

This Equality Analysis is being undertaken to examine the impact of changes to preventative services on those with protected characteristics living in Lewisham. The changes to these services are being driven by the need to achieve £4.7 million in savings from the public health budget.

The preventative health services (or 'Staying Healthy' services) facing changes are (1):

- **The Stop Smoking Service (SSS)**

  This is an addiction treatment service, which assists dependent smokers to quit and is delivered by Lewisham and Greenwich Healthcare. The primary role of the Stop Smoking Service is to deliver high quality, evidence-based stop smoking interventions to dependent smokers living in Lewisham. This includes an intensive service for highly dependent smokers provided through group and one to one sessions, and support for moderately dependent smokers through GPs & pharmacies including a hub based model in each neighbourhood.

- **The Community Health Improvement Service (CHIS)**

  This service is delivered by Lewisham and Greenwich Trust and provides a range of health promotion activities targeted at those with poorer health outcomes. It provides behaviour change and healthy lifestyle support through: the Lewisham Lifestyle Hub (LLH) delivering motivational interventions and referrals of those identified as at risk following an NHS Health check; Health Trainers providing one to one and group motivational interviewing and lifestyle coach support and the Healthy Walks programme, which trains walk leaders, develops, promotes and ensures regular health walks to increase participation and uptake of physical activity. It also engages, develops and empowers communities through community development for health improvement and neighbourhood based activities including outreach, participatory budgeting/small grants, networks, negotiating and developing referral pathways into preventative lifestyle activities and interventions, and linking providers of preventative initiatives with community groups.

- **The Children's Weight Management Service**

  The service delivers a range of age-specific evidence-based family interventions for overweight and obese children. The service includes specialist support (dietician, psychologist and physical activity specialist) for obese children with co-morbidities or with complex needs. The service also delivers a range of bespoke workforce training sessions. The children's weight management service supports the mandatory National Child Measurement Programme which identifies that Lewisham has consistently high prevalence of childhood obesity.

- **The Breastfeeding Support Service**

  This service manages the community breastfeeding groups and provision of a breastfeeding peer support service. This includes training new breastfeeding peer supporters and providing on-going supervision to all active volunteer peer supporters. The peer supporters support mothers attending the community breastfeeding groups and on the postnatal ward.

- **The NHS Health Checks programme**

  This service is commissioned to identify 40-74 year olds with a high risk of developing cardiovascular and other conditions. This includes direct commissioning of health checks provided by GPs, pharmacies and To Health (outreach); a call/recall system (every 5 years) and IT. This is a mandatory programme, assessing risk and facilitating early intervention.

Step 2: Identify the changes to your service

The following changes to Staying Healthy services have been proposed (as outlined in the public health savings consultation document presented to Mayor and Cabinet in July 2016 (1)):

1) **Changes to the Stop Smoking Service:**

The Council proposes the re-design and potential re-commissioning of the service to incorporate different delivery models including a greater use of digital and telephone support for less heavily dependent smokers; face to face support from specialists for heavily dependent smokers such as pregnant women, smokers with mental health problems and/or long term conditions and more efficient and effective prescribing of stop smoking medication. The number of smokers able to access the service is likely to reduce.

2) **Changes to the Community Health Improvement Service (CHIS):**

The Council proposes the potential reconfiguration or removal of the services currently delivered by CHIS. This may encompass the following:

- Removal of the health trainer programme, potentially mitigated by the existing community nutrition and physical activity service delivered by GCDA and by expansion of the existing commercial weight management offer (e.g. weightwatchers vouchers).

- Removing the community development element, mitigated by the council investing in health-focussed grants across all 4 Neighbourhoods in Lewisham.

- The removal of the lifestyle hub, mitigated by including advice and onward referral with in the Healthchecks delivery specified in the re-commissioning of the NHS Health Checks programme.

- Priority will be given to supporting emerging neighbourhood delivery models and alignment with wellbeing community development programmes such as Well London, which is an external funding stream.

3) Changes to the children's weight management service:

The Council proposes to integrate the service through investment into a new contract for school nursing. This would require serving notice on the existing service.

The Council also proposes the potential removal of the specialist element of the service: in this scenario children with complex needs would be offered the core programme in the same way as other children. The service will provide a limited range of age-specific targeted programmes with focus on children under the age of 12 with a reach reduced to under 200 families.

4) Changes to the breastfeeding support service

The Council proposes to incorporate this service within a new contract for health visiting. This would require serving notice on the existing service.

5) Changes to the NHS Health Checks programme

The Council proposes the redesign and potential re-commissioning of the programme, including different delivery models for follow-up for those identified as at risk following an NHS Health check. We are aiming for a better integrated pathway, targeting of at risk populations and more effective follow-up for those identified as at risk.

Step 3: Assessment of data and research

A thorough assessment of the data and research required to perform this EAA was undertaken at the outset of the work.
The following data sources were identified:

1) **2011 Census Data** –used to determine the prevalence of having a protected characteristic in the Lewisham population.
2) **Service monitoring data** for all of the services listed above, including age, gender, ethnicity and deprivation data (where available) to determine the current reach of service to different population groups.
3) **Peer-reviewed research** – used to determine the expected health impacts of services on the population and specific population groups (where available).
4) **Stakeholder Consultation** – as described below.

Step 4: Consultation

Overview of consultation:

The public health savings consultation for the proposed changes to Staying Healthy services was approved by the Mayor and Cabinet on 13th July 2016 and took place between 25th July 2016 and 22nd August 2016.

The consultation involved three elements:

1. Online engagement with the public and service users through an online consultation survey delivered via Uengage. This survey aimed to:

   a) Identify service areas which are considered priorities
   b) Obtain views on different ways in which services could be accessed with less or no funding for that area
   c) Obtain views on how the council could facilitate this

2. Online engagement with healthcare and professional stakeholders through an online consultation survey delivered via Uengage.

3. A number of stakeholder meetings with the public and professionals:

   a. Attendance by officers at 4 GP neighbourhood meetings
   b. Attendance by officers at Local Medical Committee meeting

4. Conversations at Lewisham People's Day to discuss proposals and get feedback on existing services

The findings from all of these elements of the consultation exercise have been used to inform this EAA.

Consultation Results:

a) Residents/Service User Online Consultation

There were 195 responses to the resident online consultation survey, with 148 (76%) of these responses coming from Lewisham residents. All subsequent analyses have been based on responses from Lewisham residents only. All electoral wards were represented in the Lewisham resident responses (where postcode was given).

i) Demographic Information

Age and Sex

The majority of resident respondents were female (73%) and aged over 45 years (69%), where this question was answered. According to the 2011 UK Census (2), women made up 51% of the Lewisham population and the comparative age composition of the borough can be seen in Table 1 below.

Table 1: Age composition of survey respondents in comparison to overall Lewisham population

Age Band	Respondent Percentage (%)	Lewisham Population Percentage (2015) (%)
18-24	1	8.7
25-34	12	20.1
35-44	18	17.3
45-54	25	13.5
55-64	24	8.3
65-74	17	4.9
75+	2	4.4

Disability

Of the respondents that answered the question about disability (138 respondents), 14% stated that they had some form of disability. The 2011 Census gave us a proxy figure for disability from the question *'To what extent are your day to day activities limited?'* Taking all respondents who stated their day to day activities were limited to some extent gives Lewisham a borough figure of 14.4%.

Gender reassignment

One hundred and twenty-seven respondents answered the transgender question in the survey, with 6% of respondents stating that their current gender was different from the gender than they were assigned at birth. We do not have a reliable comparator data source for this protected characteristic at local authority level.

Pregnancy and Maternity

Only 1% of respondents answering the question on pregnancy (136 respondents) stated that they were currently pregnant or on maternity leave. We do not have a reliable comparator data source for this protected characteristic at local authority level.

Ethnicity/Race

White British (59%) was the most commonly stated ethnic group of those responding to the question about ethnicity (140 respondents). Only 10% of respondents were Black Caribbean, 7% White other, 5% Black African and 4% Irish. According to the 2011 UK Census (2), in Lewisham 41.5% of residents were estimated to be of White British ethnicity, 11.2% Black Caribbean, 11.6% Black African, 10.1% White Other and 1.9% White Irish ethnicity.

Religion/Belief

No religion (42%) and Christianity (42%) were the most commonly stated religious beliefs among respondents to the question about religion (137 respondents). A minority of respondents stated that they were Muslim (1%), Jewish (1%) or Buddhist (1%), and 13% followed another religion or preferred not to say. In the 2011 Census (2), 52.8% of Lewisham residents were estimated to be Christian, 27.2% of no religion, 6.4% Muslim, 1.3% Buddhist, and 0.2% Jewish.

Sexual Orientation

The majority of respondents to this question, 80% of the 136 respondents, stated that they were heterosexual, with 6% stating that they were gay or lesbian and 2% stating that they were bisexual. Just over 11% of respondents preferred not to state their sexual orientation in response to this question. We do not have a reliable comparator data source for this protected characteristic at local authority level.

Marriage and Civil Partnership

There was not a question about this protected characteristic in the survey.

N.B. Due to the small sample size of the resident respondents to the online consultation and the representation of those with protected characteristics in the sample as described above, the consultation results outlined below should be interpreted with caution since they may not be entirely representative of all resident viewpoints within the borough.

ii) General comments

In the free text sections of the survey the main themes that emerged from general comments were:

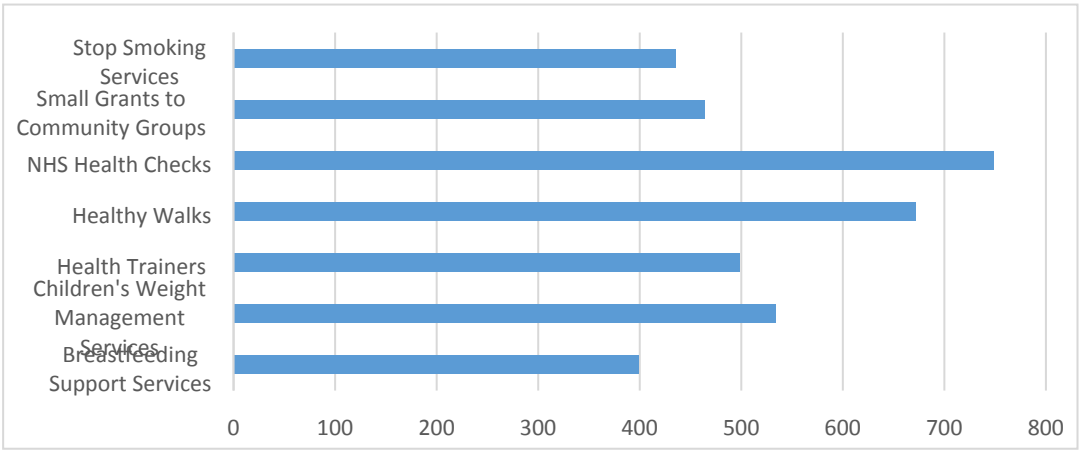
- Objection to ranking or prioritising services ('all services are important')
- Some understanding of the changes and what has been proposed ('proposals very well thought through')
- Opposition to changes for several reasons (likely negative effect on most vulnerable residents/lack of investment in prevention)
- Some concern about the accessibility of the consultation (language and lack of computer literacy mentioned as possible barriers)
- Taking personal responsibility for health (people 'should be able to rise to the challenge' and 'take personal responsibility for their own wellbeing')

iii) Service specific feedback

In the online consultation questionnaires for both residents and professionals, respondents were asked to rank their most preferred service out of the following 7 services: Breastfeeding support services, children's weight management services, health trainers, healthy walks, NHS Health Checks, small grants to community groups and Stop smoking services. In order to fully capture the priorities of respondents, the rankings were weighted (i.e. 7 points were accrued for each respondent ranking a service 1st, 6 for 2nd, 5 for 3rd and so on) and then summed to produce a final summary score for each service. This process was performed for the resident and professional questionnaires respectively.

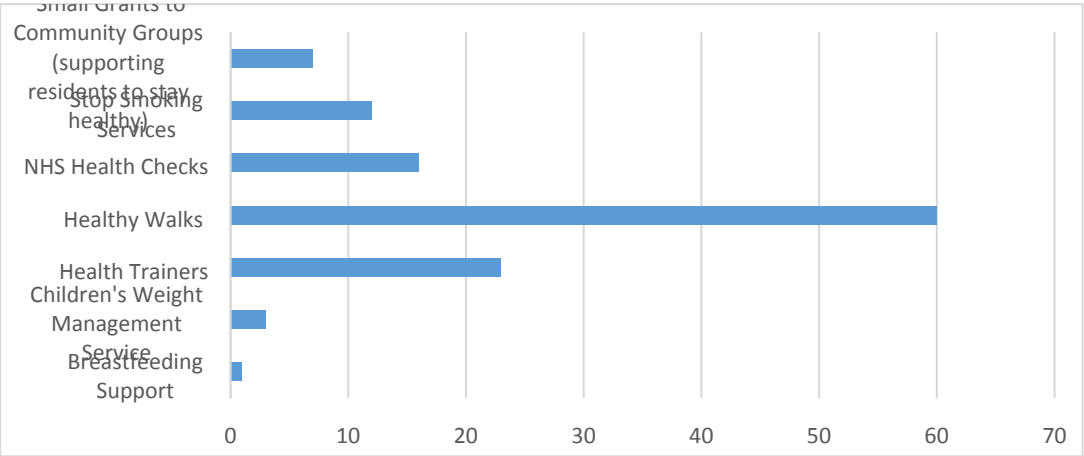
Of the 146 resident respondents who performed the service ranking exercise in the survey, NHS Health Checks was ranked as their most preferred 'Staying Healthy' service. A breakdown of the summary score ranking by service can be seen in Figure 1 below.

Figure 1:Summary score ranking of 'Staying Healthy' services by resident respondents



There was some correlation between the summary score rankings and the reported use of 'Staying Healthy' services, which can be seen in Figure 2 below, particularly for the Healthy Walks programme.

Figure 2: Number of resident respondents' using 'Staying Healthy' services



The Stop Smoking Service (SSS)

Though not the most highly ranked service by residents (ranked 6th most preferred), the importance and value of the service in the community was demonstrated in free text comments in the online consultation. The a number of respondents also perceived that the proposed changes to SSS would have a mostly negative (43%) rather than positive (12%) impact.

The acceptability of a redesigned SSS delivery format including a combination of face-to-face, telephone and text for low-risk smokers may be high amongst residents since 30% of respondents most favoured this delivery model in comparison to individual face-to-face (27%), group (25%), website (11%), online (4%) or telephone support (3%) models. Since the evidence base demonstrating increased benefit of using the combination delivery format in comparison to the current model is yet to be established, a local evaluation of this revised format for smokers in low-risk groups should be undertaken if employed.

The Community Health Improvement Service (CHIS)

Resident respondents ranked the 'Healthy Walks' component of CHIS as their 2nd most preferred 'Staying Healthy' service, with the 'Health Trainer' component being ranked 4th and 'Small grants'/community development elements 5th most preferred. However, respondents felt that the proposed changes to all 3 components of CHIS would have a mostly negative impact rather than a positive one. Some very passionate responses for the 'Healthy Walks' programme were received with some respondents commenting that the service was good for both physical and mental health and for increasing social connections.

The Children's Weight Management Service

This service was ranked as the 3rd most preferred service by resident respondents with a large majority of respondents feeling that the proposed changes to the service would have a negative impact (44%). Several comments made about the child weight management service represented the view that efforts to address

childhood obesity should be focused on schools.

The Breastfeeding Support Service

Resident respondents ranked the service as their least preferred service, however, the value of the service in terms of its potential health impacts was recognised by residents in some free text comments. When asked about the likely impact of the proposed changes, resident respondents largely felt that the changes would have a negative impact (38%) in comparison to having a positive impact (10%) or none at all (21%).

The NHS Health Checks programme

Resident respondents ranked NHS Health Checks as their most preferred service and felt that the changes would have a negative impact on the service (47%) in comparison to those who felt that there would be no impact (11%) or a positive impact (19%).

b) Healthcare and Professional Online Consultation

There were 87 responses to the professional online consultation survey, with 70% of respondents being healthcare professionals and 26% responding on behalf of an organisation where respondent type was stated. A further 4% of respondents placed themselves in the 'other' category.

i) Respondent Type

Of the healthcare professional respondents, 27% were GPs, 20% pharmacists, and 6% health visitors where roles were stated. The remaining proportion of this group was made of a range of allied health professionals, specialist practitioners, and community workers. Of those responding on behalf of organisations, 30% were responding on behalf of a GP practice, 41% on behalf of another NHS organisation, 20% on behalf of a voluntary sector organisation and 10% a range of other professional organisations where the organisation was given.

ii) General comments

In the free text sections of the survey, the main themes that emerged from the general comments include the following:

- Concern from GPs that any reduced service capacity resulting from the proposed changes will place increased burden on primary care, increasing work load while being unfunded.
- General concerns that the cuts will impact those of low socio-economic background the most, leading to an increase in health inequality.
- Concern that this will not save money in the long term, ('Prevention is always better than cure') and that these measures will result in an increased burden.
- General agreement that if cuts are made, they should be approached in an evidence-based fashion, protecting the most cost-effective services.

iii) Service Specific Feedback

The Stop Smoking Service (SSS)

SSS were ranked as the most preferred service by professional respondents in comparison to other services, with many respondents commenting on the effectiveness and strong evidence base for the service. The cost-effectiveness, particularly in the long run was also mentioned multiple times alongside concern that cuts to this service would disproportionally affect those in lower socio-economic groups, since they are more likely to smoke and the SSS supports the 'hardest to reach' and most vulnerable Lewisham residents.

The Community Health Improvement Service (CHIS)

Professional respondents ranked 'Healthy Walks' as their least preferred service. This was similar for the 'Health Trainer' component, which was ranked as their 6th most preferred service. The 'Small grants'/community development element of the service, was ranked as the 5th most preferred service.

The Children's Weight Management Service

Respondents to the professional online consultation also ranked the children's weight management service as their 3rd most preferred service, however concerns were expressed about the potential negative impacts of the changes most notably that childhood obesity affects those of lower socio-economic status the most, and that any reduction in capacity of the service would increase health inequalities.

The Breastfeeding Support Service

Respondents to the professional consultation survey also recognised the importance of breastfeeding support being a vital early intervention and that not providing support for mothers would lead to poor outcomes for children in the long-term. However, professional respondents only ranked the service as their 4th most preferred 'Staying Healthy' service.

The NHS Health Checks programme

Professional respondents ranked NHS Health Checks as their 2nd most preferred service with respondents commenting that more pharmacies should be used to provide health checks. The benefit of identifying those with risk factors early was also recognised in further comments.

c) Feedback from stakeholder meetings

The feedback from stakeholder meetings was largely consistent with the findings from the online surveys.

From the stakeholder meetings with professionals the following additional themes were identified:

- Recognition about how difficult it is for local authorities regarding austerity and current cutbacks.
- Concern about impact the savings will have on primary care, both in terms of demand and cost shifting.
- Disappointment that cuts are being made to prevention services when they

are vital underpinning services to support the transformation of health and social care.

At the People's Day community event, the largest proportion of participants engaging with the consultation display (24%) ranked the NHS Health Checks programme as the most important public health service out of 7 options listed. This was closely followed by the Healthy Walks programme (19%). When asked about their preference for delivery of support to stay healthy, face to face support was overwhelmingly ranked as preferable to online or telephone support. Online support was ranked as being marginally favourable to telephone support.

N.B. Further consultation results specifically for the Breastfeeding support services and Children's Weight Management Services are available as part of the consultation into changes currently being made to Children's and Young People's services in Lewisham.

Step 5: Impact Assessment

The findings of the consultation, census data from 2011, service monitoring to date and peer-reviewed research evidence, have been brought together in this section to inform the impact assessment. For each service, the impact of the proposed changes has been classified as **positive, negative or equivocal** for each of the nine protected characteristics.

Overall consultation response on equalities

In the online consultation, the overall perceived impact of the proposed changes on the protected characteristic groups in Lewisham was given by both resident and professional respondents. The responses are summarised in Figures 3 and 4 below.

Figure 3: Summary of resident online consultation responses for equalities impacts

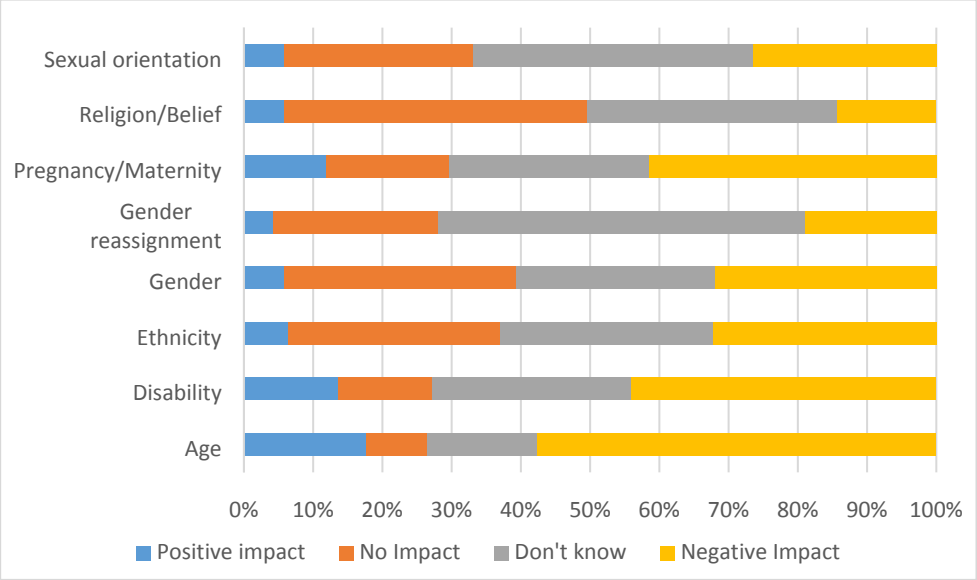
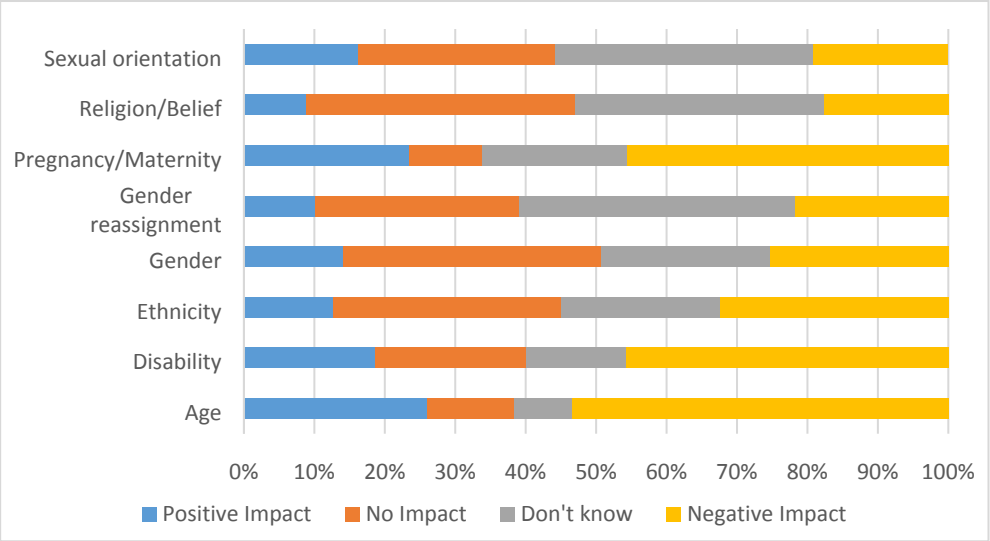


Figure 4: Summary of professional online consultation responses for equalities impacts



For both residents and professionals, it was felt that there would be a positive impact, no impact or unclear impact of the proposed changes for most of the protected characteristic groups. However, it was felt that the protected groups that would be most negatively impacted by the proposed changes were Age, Disability and Pregnancy/Maternity. The potential reasons for these perceptions have been outlined in the impact assessment for by service area below in the relevant service sections.

Respondents were most uncertain about the potential impacts for the Gender Reassignment, Sexual Orientation and Religion/Belief protected characteristic groups, with some respondents commenting that they did not feel that they had enough information to make this judgement on potential impacts.

NB The impact on the marriage/civil partnership characteristic was not measured in this part of the survey.

Impact assessment by service

1. **The Stop Smoking Service (SSS)**

The current stop smoking service in Lewisham reaches 3,500 smokers each year (7.2% of the estimated 48,500 smokers locally), with approximately 50% of these smokers quitting smoking successfully at 4 weeks after starting a smoking cessation programme. This demonstrates good reach of the service against the NICE benchmark of smoking cessation services reaching 5% of smokers in the population (3). A health equity audit of the SSS performed in 2013 revealed that:

- Younger smokers and female smokers over 60 appeared to be underrepresented in those accessing the service.
- Indian men, Chinese men, white Irish men and black Africans of both genders were least represented in users of the SSS in the context of the estimated number of smokers.

Positive impacts of changes to this service:

Disability

In the proposed changes to the service, specialist support will focus specifically on the most heavily dependent smokers in the borough including those with mental health conditions and/or long term conditions. The evidence based specialist support provided by the service will therefore aim to target the groups that most require it. Since this is the only element of specialist support to be retained by the service, there may be a relative positive benefit for smokers in the disability protected characteristic group.

Negative impacts of changes to this service:

Ethnicity/Race

Since all smokers may no longer be able to access the more targeted specialist support as proposed, there may be a disproportionately negative impact of the changes for those that particularly benefitted from universal specialist support, namely Black African smokers (4). Black Africans smokers in Lewisham have been shown to be more likely to use and be successful using the one to one specialist sessions provided by community advisors than other ethnicities.

The new delivery model for all smokers will consist of a combination of face-to-face, telephone and text support which will mitigate against this negative impact since all smokers entering the service will have a face-to-face meeting to determine the level of support required. If deemed to be in need of additional support this will be identified and addressed following the initial meeting.

Equivocal impacts of changes to this service:

Age, Sex, Religion/Belief, Pregnancy/Maternity, Gender Reassignment, Sexual Orientation and Marriage/Civil Partnership

Although male and older users (those aged 50-59 years) of the SSS have been shown to be more successful than women and younger users (those aged between 15-19 years) respectively in quitting smoking (4), the elements of the service that these users tend to be most successful with (e.g. GPs for male service users) are not due to face any changes in the savings proposals. There will therefore be no disproportionate impact on these protected characteristic groups.

Since data is not routinely available for pregnancy/maternity, religion/belief, gender reassignment, sexual orientation and marital status from users of the SSS, it is unclear if the proposed changes will have any disproportionate impact on residents in these protected characteristic groups.

2. Breastfeeding support services

The community breastfeeding groups that are run through the breastfeeding support services support see approximately 900 new women a year. In the most recent quarter (Jan-March 2016), 131 new women attended one of 6 community groups (5). The six groups are located throughout the borough and all wards of the borough are represented by attendees of the groups.

Positive impacts of changes to this service:

Age

The majority of mothers attending the Lewisham breastfeeding groups in the latest quarterly monitoring report for 2016 were aged between 30 and 39 years (74%), which is consistent with previous reporting periods (5). Since younger mothers are not as well represented in attendees to the groups the proposed changes will present an opportunity to seek to support younger mothers and has already been incorporated into new contracts for the service.

Ethnicity/Race

The breastfeeding support services in Lewisham are predominantly attended by 'White British' or 'White Other' women (49% and 19% of attendees respectively for the first quarter of 2016) (5). This is not representative of the current ethnic mix within the borough. The proposed redelivery of the service through health visiting therefore presents an opportunity for the service to improve its reach and engage with BME groups in the population and may therefore have a positive impact on this protected characteristic group in Lewisham.

Negative impacts of changes to this service:

Pregnancy/Maternity

The capacity of the breastfeeding service in Lewisham is to be retained and so there are no anticipated negative impacts of the proposed changes to any of the protected characteristic groups. However, it should be noted that both residents and professionals expressed concern that the Pregnancy/Maternity protected characteristic group will be negatively affected by changes to this service, with some respondents commenting that 'changes to breastfeeding support may have a negative effect on breastfeeding education/ awareness in pregnant women' and that 'women will have poorer support with breastfeeding'.

Equivocal impacts of changes to this service:

Sex, Religion/Belief, Gender Reassignment, Sexual Orientation and Marriage/Civil Partnership

This service is exclusively for females (i.e. new mothers), however, the impact for those in this protected characteristic group overall will be equivocal since the capacity of the service is to be unchanged.

Similarly to other services, data is not routinely available for religion/belief, gender reassignment, sexual orientation and marital status for users of breastfeeding support services, therefore the impact of the proposed changes on residents in these protected characteristic groups cannot be fully determined. Although as mentioned earlier there are no anticipated negative impacts on these groups due to the retention of overall capacity of the service in the proposals.

3. NHS Health Checks

In 2015/16, approximately 5,400 NHS Health Checks were carried out across the borough, with the majority of checks being carried out (71%) in GP surgeries. For the same period, 54% of those having a health check were female. Reach into some BME groups is particularly good (further information is provided below). However, uptake rates in Lewisham overall are slightly below the national average (34% in Lewisham compared with 45% in England as a whole) (6).

Positive impacts of changes to this service:

Ethnicity/Race

As mentioned above, the programme in Lewisham currently has a good reach in terms of ethnic representation among attendees of health checks (e.g. in 2015/16 the rate of health checks in Black Africans was 20.7/1000 in comparison to 19.7/1000 for White residents in Lewisham) (6). A contributory factor to this reach is the provision of health checks by pharmacy and community outreach providers in Lewisham. The continued use of pharmacy providers in the programme in the proposed changes will therefore enable this positive element of the programme to be preserved for this protected characteristic. However, some of this may be offset by the reduction in community health checks in the proposed changes that may also have been successful in reaching residents in this group. Were this the case the impact will be reduced but still positive overall.

Negative impacts of changes to this service:

It is hoped that the capacity of the NHS Health Check programme is to be retained and so there are no anticipated negative benefits of the proposed changes to any of the protected characteristic groups.

Equivocal impacts of changes to this service:

Age, Sex, Disability, Religion/Belief, Pregnancy/Maternity, Gender Reassignment, Sexual Orientation and Marriage/Civil Partnership

This service is targeted at those aged between the ages of 40 and 74, and there is a slightly higher proportion of women having health checks than men in the borough, however since capacity of the service is to remain the same the impact on those in the age and sex protected characteristic groups is thought to be equivocal.

Data is not routinely available for pregnancy/maternity, religion/belief, gender reassignment, sexual orientation and marital status from those undergoing an NHS Health Check, therefore the specific impact of the proposed changes on residents in these protected groups cannot be determined. However as mentioned above there are no anticipated negative impacts on these groups due to the retention of overall capacity of the service in the proposals.

4. Community Health Improvement Service (CHIS)

CHIS provides a number of services which include:

- The Healthy Walks programme:

  For the 2015/16 period, an average of 300 people per month participated in regulars walks (at least once per week), with a total of 314 new walkers joining across the year (7). The programme in Lewisham has been able to engage with a significantly higher percentage of participants with long term health conditions or disabilities compared to other 'Walking for Health' schemes nationally and those based in London (19% for Lewisham, compared to 10-11% for the national and London averages) (8). A third of the scheme's participants are from BME groups, which is much better when compared to other London based schemes (8).

- The Health Trainer service:

  For the 2015/16 period there were 13 registered health trainers providing one-to-one support, over a total of 698 lifestyle support sessions. There were 491 referrals into the scheme in the same period with the majority of referrals coming from health professionals (71.3%). Of the total number of referrals, 166 (33.4%) people referred received one-to-one lifestyle support from health trainers, with 109 (65.6%) people achieving a lifestyle change and 59 (35.5%) people achieving 30 minutes of physical activity per week (7). In the same period, the service reached predominantly women (75% of those referred were female) and had good reach to ethnic groups (45% of those referred were of Black African and Caribbean ethnicity) (9).

- Lewisham Lifestyle Hub (LLH):

  For the 2015/16 period, there were 957 referrals received by the hub, with most referrals coming from pharmacies (55%). The majority of those being referred to the hub were female (67%) and aged between 40 and 59 years (82%), although these age groups are reflective of those having NHS health Checks in the borough (who largely make up those referred to the hub). The hub has good reach into BME groups with 14% of those referred in this period being African, 11% Caribbean, and 8% White British (9).

- Community Development component: In 2016, 17 organisations were awarded participatory budgeting funding to run projects in Lewisham. A total of 628 people participated in these project activities and 66% of these participants reported an increase in mental wellbeing after being involved in project activities (9). Improved physical health, including maintained or increased fitness and energy, weight loss, a sense of physical well-being and more effective management of chronic health problems like back pain and diabetes, were identified as outcomes. Participants with severe pain and mobility difficulties reported how becoming more physically active had helped them to manage their conditions, with what they described as life changing effects (10).

Positive impacts of changes to this service:

There are not expected to be any overall positive impacts for any of the protected

characteristic groups.

Negative impacts of changes to this service:

Age, Sex and Ethnicity/Race

The LLH, Health Trainer and Healthy Walks components of CHIS have managed to achieve good reach to BME groups, particularly Black African and Caribbean groups as mentioned above and the LLH and Health Trainer components have a majority of females being referred to their services. These services are also mostly for those in the NHS Health Check eligibility age group (40-74 years). These groups could therefore be disproportionately affected by changes to this component of CHIS, however the single referral route into CHIS is the NHS Healthchecks programme, and the reach of this will be retained so any impact is unlikely.

With reference to the latest CHIS Annual report and monitoring data it was not possible to readily assess the potential equalities impact of the community development work of CHIS, although historical and verbal reports confirm that the CD work of CHIS was very effective at reaching BME and more deprived communities.

Equivocal impacts of changes to this service:

For the Healthy Walks programme, some demographic data is available for service users but it is insufficient to determine use by protected characteristic groups, however there are no planned changes to delivery of this service.

Data is not routinely collected for pregnancy/maternity, religion/belief, gender reassignment, sexual orientation and marital status from those using the different elements of CHIS. It is therefore unclear how any of these protected characteristics will be impacted by changes to this service.

5. The Children's weight management service

The service delivers a range of age-specific evidence-based family interventions for 375 overweight and obese children in Lewisham, which suggests that the service reaches approximately 4% of the estimated 9,000 obese children (under 16's) in the borough (1). In the first year of contract there were 151 initial assessment for the specialist service, 187 children accessing the service and 72 completers to date. The service is predominantly attended by female children in borough and has representative attendance from children from BME backgrounds as further described below (11).

Positive impacts of changes to this service:

There are no anticipated overall positive impacts for any of the protected characteristic groups.

Negative impacts of changes to this service:

Disability

The additional support currently offered in addition to the MEND element of the service for those with additional comorbidities and needs is to be removed in the

proposed changes. Those in this protected characteristic group with need of the service may therefore be disproportionately affected by no longer having access to additional support. The incorporation of the service into school nursing may help to mitigate this negative health impact by maintaining close links with children with complex needs to provide some additional support where required.

Ethnicity/Race

This service currently has good reach to BME groups with 71.4% attending the service in the last quarter of 2015 being from a BME background (11). Although the capacity of the service will be reduced, the new service will ensure that the reach to BME groups will reflect the Lewisham population to minimise any disproportionate impact to this group

Sex

The weight management service has predominantly female attendees, with 72% of those attending the service in the last quarter of 2015 being female (11). The high proportion of females reflected the provision of a targeted programme for postnatal women in the service, to mitigate for the removal of this service provision women will have access to an extended commercial weight management programme.

Age

The integration of school nursing into the service may mean better follow up of those in overweight/obese groups requiring MEND since the National Child Measurement Programme (NCMP) taking place in schools initially helps to identify overweight and obese children in need of the service. However, since there will be reduced capacity of the service to provide additional support to children, this may be offset any new benefit for young people overall. Additionally respondents to both the residents and professional online surveys felt that young people would be disproportionately negatively affected by changes to this service as highlighted in the overall consultation equalities impact summary above.

Equivocal impacts of changes to this service:

Data is not routinely collected for pregnancy/maternity, religion/belief, gender reassignment, sexual orientation and marital status from those using this service and so it is unclear how any of these protected characteristics will be impacted by changes to this service.

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7. Public Health Community Health Improvement Service (CHIS) Performance Checkpoint Report 2015-16.
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9. Lewisham Community Health Improvement Service (CHIS) Annual Report. April 2016.
10. North Lewisham Health Improvement Programme: evaluation report, Lewisham Public Health 2013
11. Children's Weight Management Service Quarterly Monitoring data. Lewisham Public Health 2015-16.

Step 6: Decision/ Result

The final results of the EAA by service can be summarised in the following table:

Service	Equality Impact
The Stop Smoking Service (SSS)	Positive: Disability Negative: Ethnicity/Race Equivocal: All other
Breastfeeding Support Services	Positive: Age, Ethnicity/Race Negative: Pregnancy/Maternity Equivocal: All other
NHS Health Checks	Positive: Ethnicity/Race Negative: Nil Equivocal: All other
Community Health Improvement Service (CHIS)	Positive: Nil Negative: Age, Sex, Ethnicity/Race Equivocal: All other
The Children's weight management service	Positive: Nil Negative: Age, Sex, Ethnicity/Race, Disability Equivocal: All other

Step 7: Equality Analysis Action Plan

The following mitigations in the way of an action plan will be undertaken for the anticipated negative impacts identified:

Service	Mitigation Action
The Stop Smoking Service (SSS)	**Ethnicity/Race** Careful monitoring of users of the service following the introduction of the proposed changes will have to be performed in addition to an evaluation of the new service model to mitigate against any negative impacts for this protected characteristic group.
Breastfeeding Support Services	**Pregnancy/Maternity**

	It will be important to ensure that awareness of the continued reach and capacity of the service is communicated effectively within the borough, particularly through channels that will reach potential users of the service.
NHS Health Checks	Nil required
Community Health Improvement Service (CHIS)	**Age, Ethnicity/Race** The introduction of the National Diabetes Prevention Programme in Lewisham will help to provide an avenue for all of those that are found to be 'pre-diabetic' following an NHS Health Check to receive evidence-based behavioural support to prevent the onset of diabetes. Since those from BME backgrounds are considered to be at greater risk of developing Type 2 Diabetes, this programme will help to mitigate any negative impact realised from the removal of the LLB for those identified as being at high risk in this population group. As mentioned above, the existing community nutrition and physical activity service delivered by GCDA and the expansion of the existing commercial weight management offer (e.g. weightwatchers vouchers) may also mitigate against the proposed changes to CHIS. The community development nature of the community nutrition and physical activity service will target black African and black Caribbean communities.
The Children's weight management service	**Age, Disability, Ethnicity/Race, Sex** Close monitoring of service use and health outcome data following the introduction of the proposed changes, particularly to capture data on these protected characteristics among service users will be vital to identify if any negative impacts on these groups are realised and to work to mitigate them when/if they arise.
Sign Off	
Detail the date that your Equality Analysis was signed off by your DMT.	

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EQUALITY ANALYSIS ASSESSMENT (EAA)	
Name of Proposal	▪ Redesign of Health Visiting, School Nursing & Children's Centres
Lead Officers	▪ Rosalind Jeffrey (CYP Commissioning Change Lead) ▪ rosalind.Jeffrey@lewisham.gov.uk / 0208 314 7093 ▪ Andrew McVitty (National Management Trainee) ▪ andrew.mcvitty@lewisham.gov.uk / 0208 314 2210
Other Stakeholders	▪ Public Health ▪ CYP Joint Commissioning ▪ Lewisham & Greenwich NHS Trust
Start Date Of EAA	▪ January 2016
End Date Of EAA	▪ Initial EAA - August 2016 ▪ *NB this EAA will be updated as proposals are developed and finalised by January 2017*

Step 1: Identify Why You Are Undertaking An Equality Analysis

The responsibility for commissioning 0-5 and 5-19 year old public health services transferred to the Local Authority in October 2015 and April 2013 respectively. In the Government's Spending Review and Autumn Statement 2015 the government announced funding reductions for these public health services.

For Lewisham this has resulted in a significant decrease in funding for 2017/18. The Council is therefore consulting on proposals to re-design its 0-19 service, encompassing: Health Visiting, School Nursing and Children Centres.

The CYP Joint Commissioning team has to find savings of approximately £2 million from its existing Health Visiting and School Nursing budgets for the next financial year. Lewisham's Children Centre budget, which was reduced by £1.8 million last financial year, will not undergo any further funding reductions.

Given that the proposed changes will involve the re-design and development of new policies, procedures and operational practices, it is necessary to undertake an Equality Analysis Assessment (EAA). This assessment will consider the effect of the proposed service changes, analyse whether the extent to which they are likely to impact on different protected characteristics within the local community, and identify mitigating actions to address any disproportionately negative impacts.

Step 2: Identify The Changes To Your Service

The CYP Joint Commissioning Team commissions a range of health and social care services for 0-19 year olds in Lewisham. Proposed changes to this service encompass the re-design of Health Visiting, School Nursing and Children Centres, discussed below:

Health Visiting

Current Provision: Health Visiting is a home visiting service for all families with a child under 5 years. Health Visitors assess the health and support needs of new parents and their babies through a series of health and development checks. These happen during pregnancy, just after birth, and then when the child is 6-8 weeks, 7-11months and 2-2.5 years. Additional reviews may also be carried out at 3-4 months and 3.5 years depending on a family's vulnerability status. Health Visitors support parents with advice on all aspects of caring for their child, as well as making sure children are protected from harm and their safeguarding needs are met. Where families are seen to be particularly vulnerable, Health Visitors will provide more support with additional visits.

Proposed Changes: Approximately £1million needs to be found from the Health Visiting service budget for the 2017/2018 financial year.

Current Provision	Proposed Changes
1. Health visitors carry out five children's developmental health checks (in pregnancy, new birth, 6-8 weeks, 7-11 months and 2-2.5 years) in the family home.	**1.** In future, two of these checks – the 7-11 month check and the 2-2.5 year check for families not identified as vulnerable – might be delivered in Children's Centres and in groups. All other checks will continue to be done in the home.
2. Health visitors currently run baby clinics in Children's Centres and GP practices. Parents can take their babies to these clinics for weighing and advice.	**2.** In future, we might: • Reduce the overall number of clinics delivered with the aim of them all being done in Children's Centres. • Introduce parental weighing of babies at clinics while continuing to provide access to a Health Visitor for advice.
3. Health visitors currently provide five mandatory health checks for families. They also provide additional checks for some families at 3-4 months and 3.5 years. The government is consulting on changes to these mandatory health checks, which is likely to give Lewisham and other local authorities more flexibility to target additional checks at the most vulnerable families.	**3.** In future Health Visitors might: • Only provide checks during pregnancy for women identified as vulnerable by maternity services. Other women will continue to have access to GPs and midwives for health checks during their pregnancy. • Health visitors might only offer additional checks at 3-4 months and 3.5 years to families that are identified as vulnerable.
4. Health visitors currently support 3 out of	**4.** In future, we might transfer management

the 6 'breast feeding groups' in Lewisham, by giving advice on feeding, weaning, mother and baby's health and nutrition. These groups, and the provision of the volunteer breastfeeding peer supporters, are coordinated by the Breast Feeding Network.	of these groups to the health visiting service, supported by maternity services.
5. A significant amount of the current health visiting budget is spent on a range of administrative activities.	**5.** In future, we will develop new ways of delivering this support (such as better use of technology) which would mean we could reduce the budget for administration.
6. The health visiting service currently provides community clinics to deliver BCG vaccinations to babies that have not received this after birth.	**6.** In future, we might develop a local dedicated immunisation team that will be able to deliver these clinics.

School Nursing

Current Provision: Lewisham has a school nursing service which works with schools to improve the health and wellbeing of children and young people by providing advice, information and guidance on:

- Keeping healthy
- Immunisations
- Emotional health
- Risk taking behaviours such as drugs and alcohol
- Sexual health education (appropriate to the child's age)
- Healthy eating and weight management
- Providing extra support to young people with complex needs

The school nursing service also helps make sure young people with more complex needs can receive extra support when they need it; and works with others to ensure children are protected from harm.

Proposed Changes: Approximately £1 million needs to be found from the Health Visiting service budget for the 2017/2018 financial year. To lessen the impact we plan on transferring funding from other services and integrating these services into a new service for school-aged children, see below:

Current School Age Nursing Service	Proposed Changes
1. School nurses currently offer a health assessment to children when they enter primary school.	**1.** In future, school nurses might provide a combined assessment for reception children consisting of a: • School entry health assessment. • National Child Measurement Programme (weight checks for reception and also for year 6 children).

	• Hearing and vision screening.
2. MyTime Active currently deliver a weight management programme for children in Lewisham.	**2.** In future, we will develop closer links between our weight management programme and our school nursing service so that children who are overweight have access to better support.
3. The school nursing service currently plays a key role in safeguarding and child protection.	**3.** In future, we will continue to require school nurses to undertake health assessments for all children and young people aged 5-19 years when they become looked after or under the protection of the local authority. Protecting vulnerable children will continue to be a priority and school nurses will still attend statutory meetings to support children and families when this is needed.
4. The school nursing service currently supports the health and emotional wellbeing of children and young people through school drop-ins, appointments and health promotion work. However, school nurses have limited capacity to do this work.	**4.** In future, we might redesign this element of the service to create a dedicated 'teenage health service' which will: • Be accessible from a number of venues in the borough as well as from schools. • Offer online advice and face to face support about health and emotional wellbeing, alcohol and drugs misuse, and sexual health. • Signpost and refer young people to other local services.
5. School nurses also provide support to children with long term conditions and disabilities.	**5.** In future, a dedicated nursing team, supported by the community paediatric team, might provide support for these children, for example by providing health assessments, helping develop individual care plans, and training school staff on how to look after children with long term conditions and disabilities in schools.
6. The school nursing service currently delivers immunisations to school age children.	**6.** In future, immunisations will continue to be provided in schools but might be delivered by a different immunisation

	team.

Children Centres

Current Provision: Children's Centres are places where families can access a range of services and information such as health, education and social care. They also provide spaces where parents and carers can bring their children to play and learn and to meet other children and families. Some services that are supported by health visitors, such as breastfeeding groups, are delivered directly from Children's Centres. Lewisham has 16 children's centres located in different buildings around the borough.

Proposed Changes: We are not proposing to reduce funding for Lewisham's children's centres. Budgets for children's centres in Lewisham have already been reduced in 2015-16. However, existing contracts come to an end in March 2017 and new contracts need to be commissioned. This opens opportunities to improve Children Centres, including which services they provide and where services are provided from.

In the future we might:

- Offer the same services, but targeted towards families with higher needs.
- Offer the same services at fewer and/or different locations.
- Operate services through a 'hub and spoke' model in each of the boroughs four defined localities (N, middle, S.E, S.W). 'Hubs' will act as a central focus point delivering a core set of services and activities throughout the day in each area. Smaller 'spokes' will deliver targeted outreach programmes based on local need and on a more intermittent basis. This will include the use of schools and community settings.
- Co-locate Children's Centres with other health and educational services.
- Integrate the one-to-one family support service provided by Children's Centres with our health visitor support for vulnerable families.

We also want to make sure that Children's Centres are a central part of our new Early Help strategy which aims to ensure that families with children and young people at risk of harm are provided with more coherent joined-up support.

Step 3: Assessment Of Data And Research

As part of the EAA process, a scoping exercise was undertaken to assess the initial impact that the proposed changes to the 0-19 service may potentially have on relevant protected characteristics (age, disability, gender, ethnicity, sexual orientation, religion or belief, gender reassignment and pregnancy & maternity). Proposals were categorised by the potential 'positive, negative or neutral' impact they may have on users. The outcome is summarised in the grid below:

Health Visiting

Proposal	Age	Disability	Ethnicity	Gender	Sexual Orientation	Religion or Belief	Gender Reassignment	Pregnancy & Maternity
Deliver 7-11 months and 2-2.5 year checks for families not identified as vulnerable in groups at Children's Centres	**Neutral**	**Negative, Low**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Negative, Low**
Reduce the overall number of baby clinics delivered with the aim of them all being done in Children's Centres	**Neutral**	**Negative, Low**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Negative, Low**
Introduce parental weighing of babies at clinics (whilst continuing to provide access to a Health Visitor for advice)	**Neutral**	**Negative, Low**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Negative, Low**
Only provide checks during pregnancy for women identified as vulnerable by maternity services (other women will continue to have access to GPs and midwives for health checks during their pregnancy)	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Negative, Low**
Only offer additional checks at 3-4 months and 3.5 years to families that are identified as vulnerable	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**
Transfer management of Lewisham's breastfeeding groups to the health visiting service (supported by maternity services)	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**
Reduce the budget for administration by developing new ways of delivering this support (such as better use of technology)	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**

Develop a local dedicated immunisation team that will be able to provide community clinics to deliver BCG vaccinations to babies who have not received this after birth	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**

School Nursing

Proposal	**Age**	**Disability**	**Ethnicity**	**Gender**	**Sexual Orientation**	**Religion or Belief**	**Gender Reassignment**	**Pregnancy & Maternity**
Provide a combined assessment for reception children consisting of a school entry health assessment, National Child Measurement Programme (weight checks for reception and also for year 6 children) & hearing and vision screening	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**
Develop closer links between our weight management programme and our school nursing service so that children who are overweight have access to better support	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**
Require school nurses to attend ICPC and first core group meetings (subsequent attendances will be assessed according to the health needs of the individual child)	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**
Require school nurses to physically locate safeguarding leads in the new redesigned Multi-Agency Safeguarding Hub (MASH)	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**
Create a dedicated 'teenage health service' which will be accessible from a number of venues in the borough as well as from schools, be provided by a mixture of health and non-health staff, offer online advice and one to one support about health and emotional wellbeing and risk behaviours e.g. alcohol or drugs misuse & sexual health and signpost and refer young people to other local services	**Positive, Low**	**Negative, Low**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**

Create a dedicated nursing team, supported by community children's doctors, to provide support to children with long term conditions and disabilities (and train school staff on how to look after these children in schools)	**Neutral**	**Positive, Medium**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**
Continue to provide immunisations in schools, but deliver these via a different immunisation team	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**

Children Centres

Proposal	**Age**	**Disability**	**Ethnicity**	**Gender**	**Sexual Orientation**	**Religion or Belief**	**Gender Reassignment**	**Pregnancy & Maternity**
Offer the same services at fewer or different locations (such as an area based 'hub' supported by smaller sites, including the use of schools and community settings)	**Neutral**	**Negative, Low**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**
Offer the same services, but targeted towards families with higher needs	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**
Co-locate Children's Centres with other health and education services	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**
Integrate the one-to-one family support service provided by Children's Centres with our health visitor support for vulnerable families	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**	**Neutral**

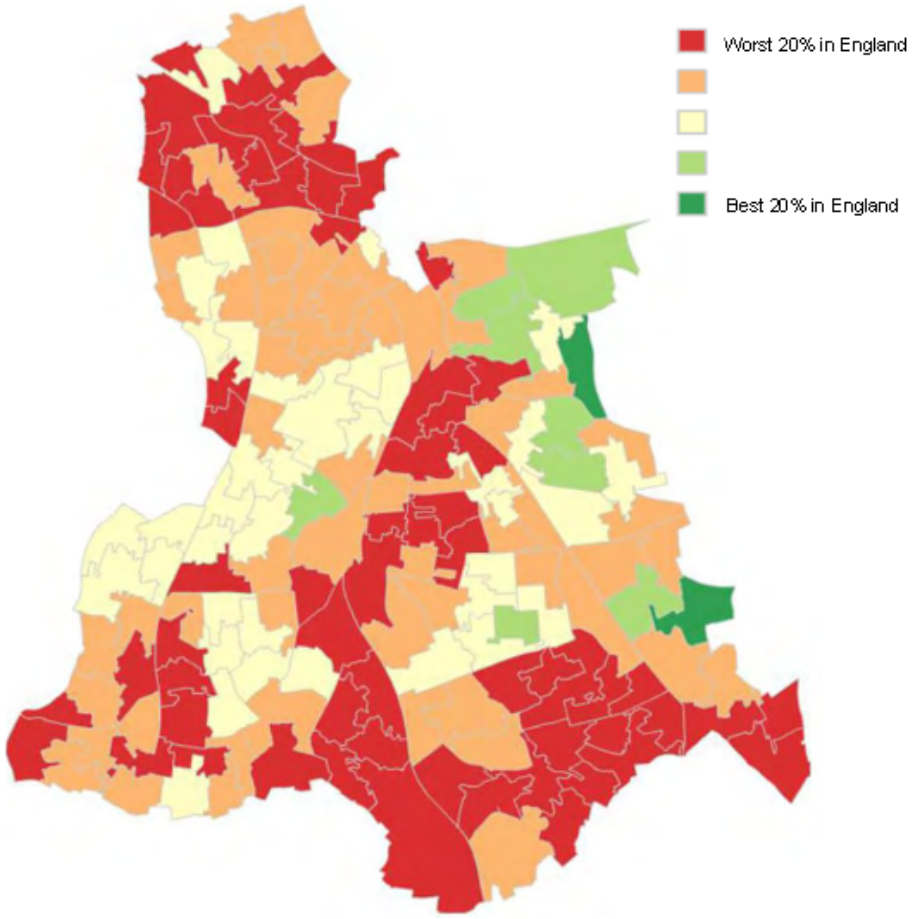
From this scoping exercise, it is possible to observe that the protected characteristics most likely to be adversely affected by the redesign of the 0-19 service are disability pregnancy and maternity. The proposals were seen to have a neutral impact on those within the categories of age, ethnicity, sexual orientation, gender reassignment and religion or belief.

These potential impacts are analysed further below, supported by local data.

Contextual Data
Key data findings:

- Lewisham is ranked as the 48th most deprived local authority area in the country with an average score of 28.59[1]. This is out of a possible 32,844 local authority areas.
- There are areas of significant deprivation in the north, central and southern parts of the borough (Fig 3). The populations of these areas experience many of the problems associated with poverty: poor health and educational outcomes, unemployment, homelessness, low pay and inequality.
- A significantly greater proportion of Lewisham's children live in poverty than is the case in England and London as a whole (Fig 4). Almost 26% of children in Lewisham's primary and secondary schools are in receipt of free School Meals, a proxy indicator for child poverty.

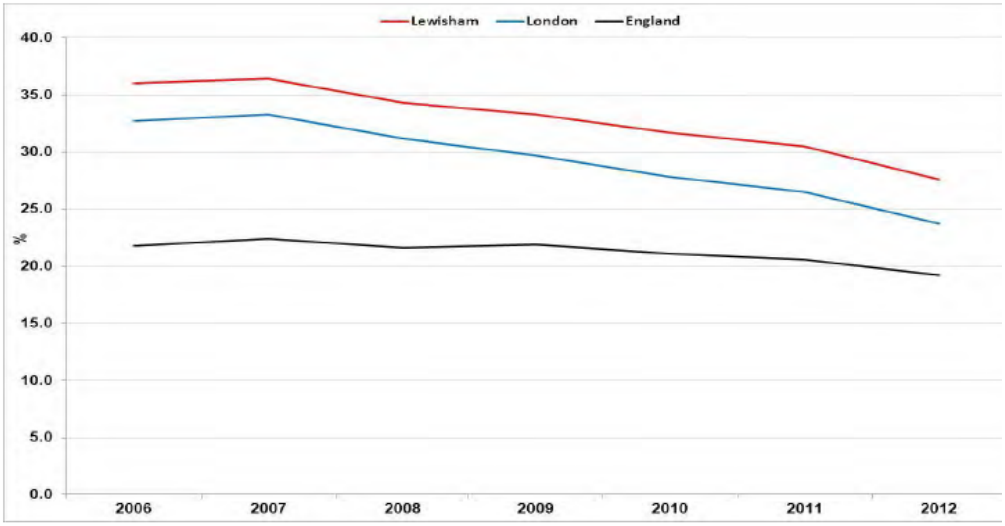
Figure 3: Indices of Multiple Deprivation 2015 – Lewisham Super Output Areas



(Source: Department for Communities and Local Government)

Figure 4: % of Children Aged under 16 in Poverty

[1] IMD 2015



(Source: HM Revenue and Customs 2012)

- In 2013/2014 a total of 640 Lewisham households including dependent children or a pregnant woman were homeless. Homeless children are at increased risk of depression, behavioural problems and poor educational attainment.
- Lewisham's typical household income is 6% lower than the London average, with four wards (Downham, Whitefoot, Bellingham & Evelyn) having an income level that was more than 15% lower. We also know that in 2011 there were 7,599 households with dependent children (6.5% of the total) where no adults were in employment.
- There is a direct correlation between high levels of deprivation and childhood obesity. In Lewisham childhood obesity rates remain significantly higher than the average for England. In 2013/14 Lewisham was again in the top quintile (highest fifth) of Local Authorities in obesity prevalence rates for children in Year 6.
- In 2013/2014, 6% of Lewisham women were reported to be smoking at time of delivery. This is slightly above the London average but considerably lower than the national average of 12%.

Ensuring the availability of high quality services for a population experiencing rapid growth, which is so diverse and where greater numbers of people experience deprivation than in England as a whole, is a major challenge.

Local and national data (including: the 2011 Census, information from the Office of National Statistics and Lewisham's 2015 Annual Public health Report) for these protected characteristics has been analysed below:

Age:

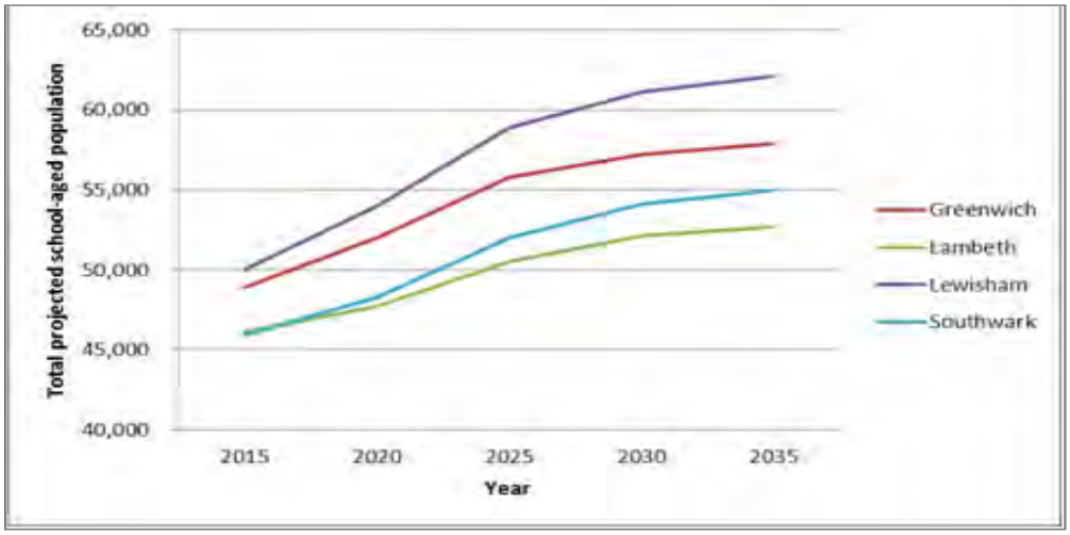
Key data findings:

- Lewisham is the second most populous inner London Borough, home to approximately 291,900 residents. This is estimated to rise rapidly to over 318,000 by 2021 due to high birth and borough immigration rates. The highest growth is expected in Lewisham Central, Rushey Green, New Cross and Evelyn wards.
- Using GLA estimates, there are 22, 726 children aged 0-4 years in Lewisham in 2016[2] of whom

51.5% are boys.

- Recent data suggests Lewisham's birth rate has fallen. Broadly speaking, since 2011 there has been relatively limited growth overall in the population of children aged 0-4 years in Lewisham (22,659 in 2011 and 22,726 in 2016 with slight decreases in the overall population of children aged 0-4 years in 2015 and 2016).
- However, for the population of children aged 0-4 years, there are significant variances between wards and Children Centre Service Areas (CCSAs). Key population growth wards for children aged 0-4 years in Lewisham are largely concentrate in CCSA 1 (Evelyn and New Cross wards particularly) and the wards of Lewisham Central and Blackheath in CCSA 2. By contrast, all wards in CCSAs 3 and 4 will see reducing numbers of children aged 0-4 years across 2015- 2019 (except Rushey Green in Service Area 3 which will remain broadly the same).[3]
- Lewisham has a slightly younger age profile than the rest of inner London. Currently 24% of Lewisham's population are below the age of 19[4] representing just over 70,000 young people, compared to 22.5% for inner London. Of this figure 10% of Lewisham's population are aged 0-5 representing just over 29,000 young children.
- Figure 1 below shows how the school aged population is expected to rise significantly over the next 20 years.

Figure 1: School Aged Population Projections (5-19 year olds)



(Source: GLA Projections 2012)

- Lewisham has a young population (usually defined as under 25) experiencing high levels of sexual health need in relation to contraception, pregnancy, sexually transmitted infections (STIs) and sexual behaviours.
- Although dropping, Lewisham has the highest under 18 years birth rate in London, produced through a combination of a high teenage conception rates and lower than average abortion rates in this age group[5].

[2] See 2014 Round of Demographic Projections, GLA Intelligence Unit (used also by Lewisham Strategic Partnership)
[3] Lewisham Council, Children Efficiency Assessment, August 2016
[4] ONS 2014 Mid-Year Population Estimates

- Targets for the reduction of teenage conceptions for 15–17 year olds in Lewisham remain extremely challenging. The annual rate of 48.6 teenage conceptions per 1,000 remains in the bottom quartile nationally, and the 7th bottom in the capital.
- Almost all adults aged 16 to 24 years were recent internet users (99.2%), in contrast with 38.7% of adults aged 75 years and over. (ONS, 2016: https://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/bulletins/internetusers/2016)

From the data it is evident that the recent rise in Lewisham's birth rate and number of children locally presents challenges to local services in meeting needs. Although birth rates have begun to drop off there is still a large number of young children moving through Lewisham's social health, care, and educational services.

Children and young people (aged 0-19) and their parents (most likely aged 25-50) will be impacted by any changes to services for 0-19 as the service is directed at them. This, however, is not to discount other age groups who may also be affected, such as those with child care responsibilities (older siblings, grandparents etc.) and those becoming parents/carers at older ages (50+).

Proposed changes to the service to increase the use of technology, specifically internet use, may impact negatively on older people, who are less likely to use the internet. However, we are primarily considering parents/carers of child bearing age who will be familiar / comfortable with using this kind of technology. Whilst parents may be encouraged to use online facilities (where available) the input that a family will get from the service will still be dependent on the HVs assessment of the family's needs - so technology will not replace the clinical decision making employed to ensure that children are safeguarded.

The proposals do not discriminate on the basis of age, and the proposed service will remain directed at supporting babies, young children and their families.

The proposal to create a teenage health service to provide multi agency support to teenagers is designed to improve access and support for these children and young people and so the anticipated impact will be a positive one for this age group.

Disability:

Key data findings:

- In Lewisham Council's 2007 Residents Survey, of the 1,042 people surveyed, 14% of respondents described themselves as disabled. In the ONS Annual Population survey data for 2007 14.2% of people of working age were categorised as disabled. In the 2011 Census, 15.6% of Lewisham residents were classed as not in good health.
- Children and young people with an identified Special Educational Need (SEN) who have been issued with an Education, Health and Care plan, or Statement of Special Educational Needs, currently account for 2.7% of the school age population in Lewisham. This is comparable to Lewisham's neighbours, and to London and England as a whole.
- Of these children, 75% are male and around 50% have a diagnosis of Autism Spectrum Disorder

[5] Lewisham Annual Public Health Report 2015

(ASD), which is significantly higher than the national average.

- Of children with special education needs in Lewisham, 83% have their needs met within Local Authority maintained provision (39% Maintained Special School; 35% Maintained Mainstream School; 9% Maintained Resource Base/SEN unit).
- Overall SEN projection calculations suggest Lewisham will see a minimum increase of 7.7% in Education, Health and Care plans over the next ten years.
- Estimated rates of mental health disorders (including conduct, emotional, hyperkinetic (ADHD) and eating disorders) in Lewisham are broadly comparable to neighbouring boroughs (Table 1).
- 25.0% of disabled adults had never used the internet in 2016, down from 27.4% in 2015. (ONS, 2016 as above)

Table 1: Prevalence of Key Child & Adolescent Mental Health Problems

	Any mental health disorder		Conduct disorders		Emotional disorders		Hyperkinetic disorders		Eating disorders
	5-16yrs		5-16yrs		5-16yrs		5-16yrs		16-24yrs
	Prevalence (%)	No. of children	Prevalence (%)	No. of children	Prevalence (%)	No. of children	Prevalence (%)	No. of children	No. of young people
Lewisham	9.46	3,765	5.78	2,299	3.66	1,457	1.57	623	4,381
Greenwich	9.65	3,749	5.93	2,304	3.74	1,451	1.60	623	4,192
Lambeth	9.89	3,758	6.08	2,310	3.86	1,466	1.66	629	4,655
Southwark	9.81	3,582	6.02	2,199	3.83	1,396	1.63	594	5,381
London	9.35	109,616	5.70	66,838	3.65	42,748	1.54	18,050	126,462
England	9.60	-	5.80	-	3.70	-	1.50	-	-

(Source: ONS survey Mental Health of Children and Yong People in Great Britain (2004) & Adult Psychiatric Morbidity Survey (2007))

Proposals to change some Health Visiting checks from taking place in the home to Children's Centres may have a negative impact on parents/carers with disabilities, if they do not have suitable transport options to access Children's Centres.
Likewise, the proposals to reduce the overall number of baby clinics with the aim of all of them being delivered in Children's Centres.
Officers will explore options throughout the development of the service proposals to mitigate against this.

It is possible that for some parents with disabilities, the proposal to introduce parental weighing of babies at clinics may have a negative impact. However, access to health visitors will continue to mitigate against this.

It is possible that geographical changes in the Teenage Health Service and Children Centre location may adversely affect the ability of some users to reach new sites and access services.
As in proposals to Health Visiting, officers will explore options throughout the development of the service proposals to mitigate against this.

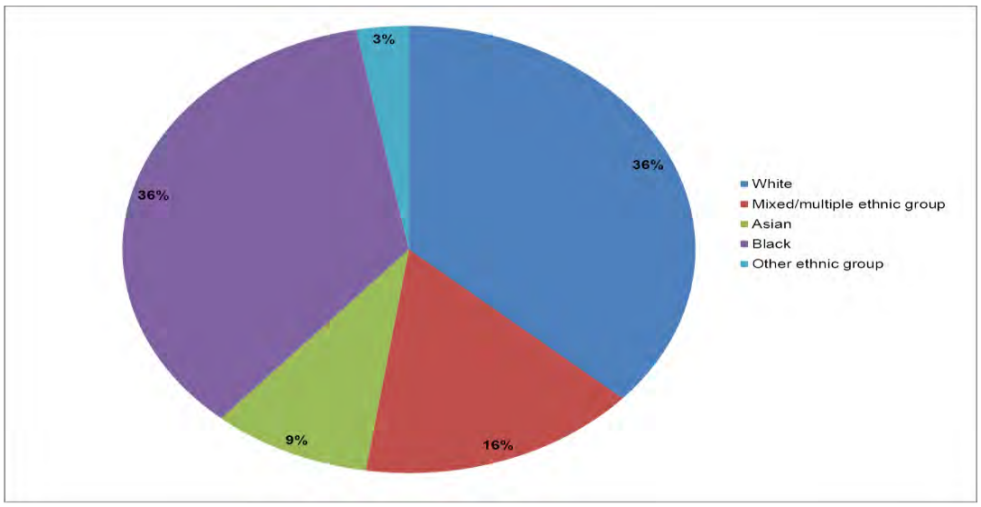
The proposal to create a dedicated nursing team to provide support to children with long term conditions and disabilities is to improve support for these children and young people and so the anticipated impact will be appositive one for children and young people with disabilities.

Ethnicity:

Key data findings:

- The 2011 Census identified Lewisham as the 14th most ethnically diverse local authority nationally, with around 45% of residents coming from a black and minority ethnic background and 1 in 3 residents born outside the UK.
- Overall members of 94 ethnic groups make up Lewisham's population with over 170 languages spoken. The most common are French, Tamil, Somali, Vietnamese, Turkish, Polish, Lingala and Portuguese (Translation Requests, 2007-2012), whilst nearly 10% of all households do not contain any residents who speak English as their main language.
- Nearly half the residents of the borough (46.5%) are from a black or minority ethnic (BME) background, although this rises to over 70% within the school population. Black African residents (11.6%) are now more numerous than Black Caribbean residents (11.2%).
- Around two thirds of Lewisham's 0–19 year olds are part of a black or minority ethnic (BME) group (Fig 2).

Figure 2: 0-19 Population by Broad Ethnic Group



(Source: 2011 Census)

- The number of residents identifying themselves as 'White British' has decreased from 56.9% in 2001 to 41.5% in 2011. Those identifying themselves as 'White Other' has risen dramatically, most likely as a result of migration from other EU countries.

Whilst no direct impact is anticipated from the proposals, BME households are disproportionately affected by local service reductions as they are more likely to live in deprived areas, tend to experience higher levels of child poverty and inequality, and access state support mechanisms such as the proposed 0-19 service. Officers will continue to analyse service level data and access to services to ensure that any negative impact is recognised and mitigated where possible.

Gender:

Key data findings:

- Males comprise 49% of Lewisham's population, females 51%. These proportions are not expected to significantly change in the next few years.

- 2011 Census data reveals that 91.5% of lone parents are female.

Exact data needs to be collected, but the majority of users of the 0-19 services are women. Therefore any proposed changes will have a greater impact on women overall. Monitoring and further data collation and analysis is required to ensure that any potential impact on gender from the wider proposed changes, and specific proposals within this are anticipated and mitigated where possible.

Sexual Orientation:

- About 0.4% of Lewisham households comprise same sex couples in civil partnerships. This is more than double the average for England[6]

No impact is anticipated on sexual orientation

Religion or Belief:

- Christianity was the most common religion in Lewisham at the time of the 2011 Census (53%), followed by Islam (6%). About 27% of people stated they had no religion and 9% did not state their religion or belief.

Religion	Lewisham %	London %	England %
Christian	52.8	48.4	59.4
Buddhist	1.3	1	0.5
Hindu	2.4	5	1.5
Jewish	0.2	1.8	0.5
Muslim	6.4	12.4	5
Sikh	0.2	1.5	0.8
Other religion	0.5	0.6	0.4
No religion	27.2	20.7	24.7
Religion not stated	8.9	8.5	7.2

No impact is anticipated on religion or belief

Gender Reassignment:

Further data relating to gender reassignment is required. However no impact is anticipated on gender reassignment.

Pregnancy and Maternity:

Key data findings:

[6] 2011 Census

- Early access to maternity services in Lewisham remains low – 79% compared to 86% access to maternity services nationally.
- It is estimated that up to 20% of women in the UK develop a mental health problem in pregnancy or within a year of giving birth. In Lewisham this would equate to approximately 1,019 affected women every year. It is recognised that perinatal mental health problems in women have a huge personal impact on them and their families.
- In Lewisham, breastfeeding prevalence at 6-8 weeks after delivery is 74.3%[7]. This is significantly better than the average prevalence for England overall
- Children in lone parent families are at a greater risk of poverty and therefore of poor health outcomes. The 2011 Census revealed that there were 13,239 lone parents households in Lewisham, an increase of 1,997 from 2001.
- Women from deprived backgrounds in Lewisham are especially at greater risk of poor pregnancy and maternity outcomes than women from more affluent areas. Deprivation is associated with increased rates of stillbirth, premature delivery, low birth weight babies, neonatal deaths, infant mortality and mental health issues, although these conditions are not limited to deprivation alone.

The proposed changes to 0-19 services will have an impact on pregnancy and maternity overall, as this group is a high proportion of users. Any proposed changes that result in a reduced service offer, will therefore mean that fewer pregnant women will access the service. However the individual elements of the proposals do not discriminate against this protected characteristic as this group will remain a key user group of the proposed service.

Step 4: Consultation

The consultation on the proposed changes to the 0-19 service took place between July and August 2016. It consisted of two online surveys, one for public respondents and one for professional's respondents. Face to face public surveys were also conducted in Children Centres to increase the reach of the consultation. In total 6 Children's centres were visited and a total of 25 individuals consulted.

In total, there were 306 responses for the public consultation. There were 72 responses for the Professional consultation.,

A detailed analysis of demographic information provided by public respondents can be found below by protected characteristic:

Age:

There were 298 responses to this question. The table below outlines the number of respondents within each age group.

Age Group	Number (%)
Under 18	1 (0.34%)
18-24	4 (1.34%)
25-29	13 (4.36%)

[7] Lewisham Public Health Information Portal

30-34	44 (14.77%)
35-39	55 (18.46%)
40-44	53 (17.79%)
45-49	24 (8.05%)
50-54	28 (9.40%)
55-59	28 (9.40%)
60-64	20 (6.71%)
65 +	15 (5.03%)

Disability:

There were 297 responses to this question. 270 respondents (90.91%) declared they had no disability, 15 respondents (5.05%) declared they had some form of disability, whilst 12 respondents (4.04%) did not wish to declare their status. The chart below represents the category of disability for the 15 positive respondents:

Category	Number (%)
Physical Impairment	1 (5.00%)
Sensory Impairment	1 (5.00%)
Mental Health Condition	6 (30.00%)
Learning Disability/Difficulty	6 (30.00%)
Long-Standing Illness Or Health Condition	5 (25.00%)
Other	1 (5.00%)

(**NB:** the total number of answers is greater than the 15 positive respondents due to individuals being able to select multiple options)

Ethnicity:

There were 292 responses to this question.

Ethnicity	Number (%)
<u>White:</u>	
English/Welsh/Scottish/Northern Irish/British	179 (61.30%)
Irish	19 (6.51%)
Gypsy or Irish Traveller	1 (0.34%)
Any other white background	23 (7.88%)
<u>Mixed/Multiple Ethnic Groups:</u>	
White and Asian	2 (0.68%)
White and Black Caribbean	2 (0.68%)

Any other mixed/multiple ethnic background	2 (0.68%)
Asian/Asian British:	
Chinese	3 (1.03%)
Indian	8 (2.74%)
Any other Asian background	4 (1.37%)
Black/African/Caribbean/Black British:	
African	13 (4.45%)
Caribbean	15 (5.14%)
Any other Black/ African/ Caribbean background	3 (1.03%)
Any other ethnic group	
Other ethnic group	1 (0.34%)
I'd rather not say	17 (5.82%)

It is clear from this EAA, that it does not reflect the wider ethnic profile of Lewisham which is far more diverse and less dominated by white ethnicities.

Gender:

There were a total of 293 responses to this question. Of the total responses, 40 respondents (13.65%) were male and 240 (81.91%) were female. 13 respondents (4.44%) did not declare their gender.

Sexual Orientation:

There were 291 responses to this questions.

Sexual Orientation	Number (%)
Straight/heterosexual	255 (87.63%)
Gay/Lesbian	6 (2.06%)
Bisexual	3 (1.03%)
Rather not say	27 (9.28%)

Religion or Belief:

There were 295 responses to this question.

Religion or Belief	Number (%)
None	127 (43.05%)
Christian (all denominations)	131 (44.41%)
Buddhist	2 (0.68%)

Hindu	3 (1.02%)
Jewish	2 (0.68%)
Muslim	5 (1.69%)
Sikh	3 (1.02%)
Rather not say	22 (7.46%)

Gender Reassignment:

There were 257 responses to this question. 219 respondents (85.21%) stated their gender was the same as that assigned to them at birth, whilst 26 respondents (10.12%) stated that their gender was different. 12 respondents (4.67%) declined the opportunity to respond.

Pregnancy and Maternity:

There were 295 responses to this question. 241 respondents (81.69%) stated they were not pregnant or on maternity leave, whilst 39 respondents (13.22%) stated that they were. 15 respondents (5.08%) declined to comment.

Key Findings:

The appendices … below provide a holistic overview of the views expressed by respondents about the specific proposals of the 0-19 service redesign. These have been categorised into positive and negative comments under proposed changes to the Health Visiting, School Nursing and Children Centre services.

The most dominant findings for each service area include:

Health Visiting:

In many cases respondents felt HV offered a good and supportive service that had helped them through challenging times.

However, many respondents also believed that HV was unnecessary in many circumstances, especially during pregnancy, and that the advice given lacked clarity and tailoring to individual's needs. The service could also be intrusive and performed at inconvenient times in one's home.

Respondents would be happy to travel to CCs for HV activities performed in group settings as long as the destination was easily accessible, times were convenient and there was a space for confidential and professional advice. This could also free up time for HV to devote more of their time on patient care rather than travel and administration, as well as expose families to other professional activities they may not be aware of through engagement with CCs.

Concerns were however raised over how changes could reduce the ability for HV to assess and monitor child and parent vulnerability, as well as putting too much responsibility on parents to assess their own child's health and wellbeing from a medical point of view.

School Nursing:

Proposals for changes to the school nursing service were met with a largely positive response. Key themes emerging from respondent's comments surrounded improved service organisation and collection of data, a wider more accessible and dedicated service for teenagers, as well as

improvement in the early identification of vulnerability and obesity through better integration of school nursing within existing support networks.

However, there were a number of concerns raised. These were primarily themed around a potential lack of resources to implement changes, the training level of school nurses to deal with long term disability, as well as overloading already stretched school nurses with increased amounts of work and responsibility. This could also impact on the ability of school nurses to identify vulnerability. Further concerns surrounded the ability or willingness of teenagers to engage in or be able to travel to a new teenage hub, as well as losing already strong relationships with School nurses

Children Centres:

Positive comments included the ability of the service to offer a wider selection of activities at fewer, but larger, locations to more people in a geographical area. The hub and spoke model may also create service efficiencies by reducing the geographical doubling up of support, helping to save time and money, whilst also providing a stronger base from which Health Visitors can interact and communicate with service users and other professionals. High calibre staff may also be attracted and retained.

Negative comments surrounded concerns over transport, accessibility and the location of hubs and spokes, especially for disabled and less mobile users. Furthermore, there were concerns over the capacity of hubs to deal with large numbers, reduced 1-to-1 support, and the loss of a sense of community at current well established centres. Furthermore, although many respondents felt those most in need should get preferential treatment, there were large concerns that non-vulnerable families would be left behind and, as a result, could fall into vulnerability themselves. Maintaining universal provision was therefore seen as a resounding necessity, reducing stigmatization and improving social mixing.

NB: It is worth noting that some respondents found it difficult to understand what certain consultation questions were asking, as well as finding the level of detail too small to make an informed decision. This could have had an impact on the results of the consultation.

Step 5: Impact Assessment

The Equality Act 2010 sets out the different ways in which it's unlawful to treat someone. This Equality Analysis Assessment has been undertaken to ensure that the Council has met its responsibilities under the Equality Act 2010, specifically to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between people from different groups
- Foster good relations between people from different groups

The assessment of the likely impact of the proposed changes to the 0-19 service on the protected characteristics identified in the Equality Act 2010 has been based on an analysis of the relevant data, research and consultation results outlined above.

Overall Assessment

Overall, the proposed changes to 0-19 services will have a larger impact on age, gender, and pregnancy and maternity, as the majority of users of the service are children and young people, women and pregnant women or those with babies and young children. Any proposed changes that

result in a reduced service offer, will therefore mean that fewer pregnant women will access the service. And any proposed changes that alter the way the service is accessed will also mean that these groups will have to change the way they access the service

However the individual elements of the proposals do not discriminate against these protected characteristics as these groups will remain key users of the proposed service, and children and young people, women and pregnant women will still form the majority of users of the services.

It is important to continue to monitor the proportion of men who access the service to ensure that there is no impact on them from the proposed changes.

Specific proposals have been found to have a possible negative impact on disability; for example, changing the location of HV checks from in the home to Children's Centres may have an impact on people with disabilities being able to travel to the new location. Officers will continue to explore options to mitigate any potential negative impact.

Other proposals have been found to have a positive impact; the teenage health service and dedicated nursing team for children with long term conditions and disabilities.

This EAA would benefit from further data, specifically service level data, and this will be collected where available to inform proposals as they are developed and finalised.

Step 6: Decision/Result

The analysis of relevant data, research and consultation results has determined that the proposed changes to the 0-19 service do not discriminate or have dramatically adverse impact on any protected characteristics within the local community. As a result, no major amendments are required.

This decision will be reviewed regularly to ensure that equalities issues continue to be positively reflected in the delivery of the 0-19 scheme.

Step 7: Equality Analysis Action Plan

This plan (see below) has been developed to support the implementation of additional actions identified during the EAA process. It will be reviewed every three months to track progress and measure whether the actions have had their intended effect/outcomes.

1. Insufficient data collected regarding the equalities profile of service users
   There are some areas where further data is required to ensure a full EAA can be completed. This will be collected as the proposals are developed, and this EAA will be updated. Completed by December 2016.
2. Further options will be explored to mitigate against a reduction in home visits for the universal Health Visitor caseload, should people want to attend but have difficulties in doing so, and for any changes in location of any services across the 0-19 proposals. For example provision of taxis. This will be completed and this EAA updated by December 2016.
3. This EAA, and the action plan will be updated as the proposals for the 0-19 service are developed and finalised, and when the contract is recommended for award by January 2017

Step 8: Sign Off
As part of the report process for Mayor and Cabinet, this EAA, when finalised, will be reviewed and signed off by a representative from the Corporate Equalities Board, the relevant Heads of Service within the directorate and the Executive Director for Children and Young People

Equality Impact Assessment Report	Please enter responses below in the right hand columns
Date to DMT	18.08.2016
Title of Project, business area, policy/strategy	Sexual Health
Author	**Ruth Hutt, Consultant in Public Health**
Job title, division and department	**Public Health**
Contact email and telephone	**Ruth.hutt@lewisham.gov.uk 020 8314 7610**

London Borough of Lewisham Full Equality Impact Assessment Report	Please enter responses below in the right hand columns.
1.0 Introduction	
1.1 Business activity aims and intentions *In brief explain the aims of your proposal/project/service, why is it needed? Who is it aimed at? What is the intended outcome? What are the links to the cooperative council vision, corporate outcomes and priorities?*	To transform integrated sexual health services (Genito-urinary medicine services and reproductive and sexual health services) as provided to residents of Lewisham and to all London residents (given the services are, by statute, open access) by: • Extending the reach and use of online sexual health services already provided in Lewisham and integrating the digital sexual health service (checkurself), which is offered online, on smart phones and other digital platforms, into the clinic service to deliver basic sexual health • Developing the targeted clinical service offer to improve access to those who are most at risk and the most vulnerable – these being primarily, but not exclusively: BME communities; young people; and men who have sex with men. • Providing (and increasing use of) self-sampling services at clinics and self-sampling 'click and collect' services • Reviewing service sites where the outcome will be an improved service offer ie. improved access to a range of clinicians skilled to deliver on range of needs, including the most complex, at times that best meet the needs of residents. • Improving access to long-acting reversible contraception (LARC) • Improved access to basic sexual health services in pharmacies and GPs The proposed changes are aligned with those taking place in sexual health services throughout London. Alignment is overseen by the London Sexual Health Transformation Programme. Alignment is key given the open access nature of the services.

2.0 Analysing your equalities evidence	
2.1 Evidence	
Protected characteristics and local equality characteristics	**Impact analysis**
Race	Nationally ethnicity has a key effect on the level of risk of poor sexual health between particular groups of people. For example, there is a higher prevalence of STIs among African and Caribbean communities and a lower prevalence among Asian communities, when compared with the white British population (Shahmanesh et al., 2000; Low et al, 2001). The HPA report *Sexually transmitted infections in black African and black Caribbean communities in the UK: 2008 report* highlights the following: • Black African and Black Caribbean communities in the UK are disproportionately affected by STIs. The higher prevalence of STIs in both the black African and the black Caribbean populations means that, even though their levels of high-risk sexual behaviour may be similar to those of other communities, they run an increased risk of acquiring an infection. • The Black Caribbean community is disproportionately affected by bacterial STIs, especially gonorrhoea. Data from the Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) in 2007 shows that, among heterosexuals diagnosed with gonorrhoea at 26 GUM clinics, 26 per cent were black Caribbean and 6 per cent were black African. In Lewisham 54% of the population belong to the White group, 46% to Black, Asian and Minority Ethnic group. The evidence below demonstrates the inequalities in sexual health faced by Black and Minority Ethnic groups, in particular, black African and black Carribean Lewisham residents.

Sexually Transmitted Infections

Where recorded, in 2014, 41.1% of new STIs diagnosed in Lewisham were in people born overseas. The chart below shows new STIs by ethnic groups. Whilst the white group has the largest proportion of STIs this is due to over representation of white gay men being diagnosed with STIs (see sexual orientation).

Source: HPA Web Portal

HIV

An estimated 107,800 people were living with HIV in the UK in 2013. Along with men who have sex with men (MSM), black Africans are the groups most affected by HIV infection. (LASER 2014)

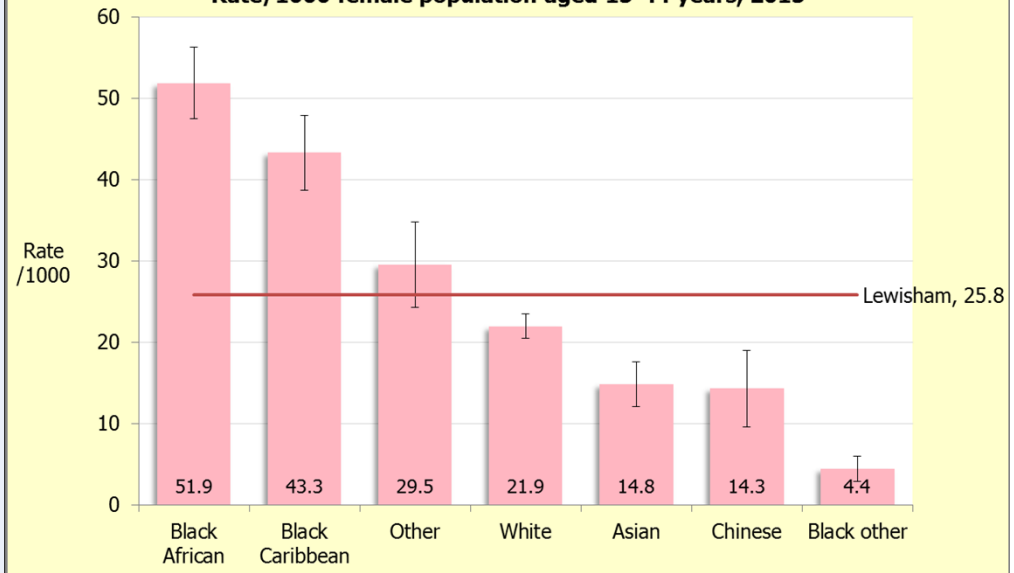
In 2014, 1,729 adult residents (aged 15 years and older) in Lewisham received HIV-related care: 1,075 (number rounded up to nearest 5) men and 660 (number rounded up to nearest 5) women. Among these, 38.5% were white, 39.4% black African and 9.8% black Caribbean. With regards to exposure, 39.2% probably acquired their infection through sex between men and 55.0% through sex between men and women. (PHE Laser Report)

Nationally the proportion of undiagnosed HIV remains particularly high amongst black African men (38%).

Termination of Pregnancy

There appears to be considerable variation in abortion rates by ethnic group. Black African and Black Carribean Lewisham resident women aged 15-44 years have over twice the rate of abortion of white women. The reasons for this are not currently well understood and may relate to barriers to accessing contraceptive services. These may include: a lack of awareness of contraceptive methods available; cultural acceptiblity of the available methods; logistical issues such as location and opening times; and language barriers.

Chart 21: Termination of pregnancies in Lewisham by ethnicity. Rate/1000 female population aged 15-44 years, 2015



Source: BPAS/MSI/Kings

Health Inequalities and BME Comnmunities

Evidence gathered locally during the consultation on the Lambeth, Southwark and Lewisham Sexual Health Strategy Section 3.1 and from research, (eg African Health and Sex Survey, 2013-14, Sigma Research, LSHTP, A Review of research Among Black African Communities Affected by HIV in the UK and Europe, Medical Research Council) also indicates that these health inequalities are driving factors including:

	• Late Diagnosis of HIV • Difficulties in accessing services, including HIV testing services • Difficulties in accessing information about HIV and HIV prevention • Deprivation and immigration status • HIV stigma Reproductive and sexual health services in Lewisham, Lambeth and Southwark have been shown to be good at meeting the sexual health needs of key priority groups, particularly younger people and BME populations. In 2012-13 black residents in those boroughs were twice more likely to use the service than others. (LSL Sexual Health Strategy and Epidemiology Report). The transformed services will continue to target BME communities given the burden of sexual ill health that these communities carry. Online services and clinic receptions will stream those BME residents who are vulnerable and at risk into clinics to access both medical help and, where appropriate sexual health promotion interventions. Self-sampling 'click and collect' services will provide quick and easy access to testing for those who seek anonymity.There is no anticipated reduction in the capacity of the service. Access will be improved for BME residents as the online service will free up appointments within the clinic service. The new service model will complement the RISE sexual health promotion programme which has been running since April to work with BME communities in relation to sexual health. The impact on race is thus **positive**
Gender	The evidence below demonstrates the inequalities in sexual health related to gender in Lewisham residents **Sexual Transmitted infections and sexual behaviour** 6,631 new STIs were diagnosed in residents of Lewisham in 2014 (3,592 in men and 3,084 in women), a rate of 2317.1 per 100,000 residents (men 2554.0 and women 2084.7) (gender was not specified or unknown for 5 episodes).

	(PHE LASER Report) Reinfection with an STI is a marker of persistent risky behaviour. In Lewisham, an estimated 7.3% of women and 12.2% of men presenting with a new STI at a GUM clinic during the five year period from 2010 to 2014 became reinfected with a new STI within twelve months. Nationally, during the same period of time, an estimated 7.0% of women and 9.0% of men presenting with a new STI at a GUM clinic became reinfected with a new STI within twelve months. In Lewisham, an estimated 6.6% of women and 12.4% of men diagnosed with gonorrhoea at a GUM clinic between 2010 and 2014 became reinfected with gonorrhoea within twelve months. Nationally, an estimated 3.7% of women and 8.0% of men became reinfected with gonorrhoea within twelve months. Please also see **Sexual orientation** for rates on MSM **Conceptions and terminations** For evidence and assessment in relation to young women please see please see **Pregnancy and maternity.** Data from the Checkurself online chlamydia and gonorrhoea screening service indicates that the service is more popular with women than with men, with 79% of users being female. Online services and clinic receptions will stream those women who are vulnerable and at risk into clinics to access both medical help and, where appropriate sexual health promotion interventions. There is no anticipated reduction in the capacity of the service. Access will be improved for women both via the digital service and via increased capacity in clinics to see the most in need. Women need physical access to clinics for contraception interventions such as implants, coils and injections where as it is possible to manage some of the STI testing and treatment through online, text messaging and sending out prescriptions. The developing service model is designed to improve access to contraception for women by creating capacity in clinics through shifting screening for STIs online.

	The impact on gender is thus **positive**
Gender re-assignment	Although there is a lack of evidence the little that is available indicates that trans people experience health inequalities (eg Transgender Sexual and Reproductive Health: Unmet Needs and Barriers to Care April 2012 National Center for Transgender Equality), including sexual health inequalities which may include higher rates of STIs, and difficulties accessing services and relevant information. It has been estimated that there are 20 transgender people per 100,000 population, meaning that there are approximately 50-60 transgender people in Lewisham. 6% of respondents to the online consultation on sexual health services identified as a gender other than that assigned at birth. The impact is thus **unknown**
Disability	There is limited data and research available on the needs of people with learning disabilities or physical disabilities. There are approximately 12,600 moderately or severely disabled people of working age in Lewisham and around 40,000 with a common mental disorder. However, the number of people living with HIV who are also disabled and/or have a mental health problem in Lewisham is unknown. Despite the success of anti-HIV treatments which result in PWHIV being able to live long and healthy lives small numbers, especially those diagnosed late, will become ill and may become disabled. In addition evidence indicates that PWHIV experience higher rates of mental health illness (eg Psychological support services for people living with HIV, National AIDS Trust, 2010) than their peers. Disabled people who may find it hard to travel to clinics will be able to access digital services and, if they require it, have test kits delivered to the door. Those disabled people who cannot access digital services will be able to access services via the clinic reception and will be streamed into clinic services as appropriate. There is currently no data about access to sexual health services by those with a learning disability. Anecdotally, services report seeming small numbers of individuals with

	learning disability and are able to support this client group. Support for all individuals with disability to access sexual health services will be form part of the new service specifications for clinic services. The impact on disability is thus **positive**
Age	Nationally there are clear inequalities in the sexual health of young people. It has been shown that they have relatively high rates of unintended pregnancies and sexually transmitted infections (STIs), with the exception of HIV. Young people aged between 15 and 24 years experience the highest rates of new STIs. In Lewisham, 41% of diagnoses of new STIs made in GUM clinics were in young people aged 15-24 years. Young people are also more likely to become reinfected with STIs, contributing to infection persistence and health service workload. In Lewisham, an estimated 13.4% of 15-19 year old women and 14.9% of 15-19 year old men presenting with a new STI at a GUM clinic during the five year period from 2010 to 2014 became reinfected with an STI within twelve months. Teenagers may be at risk of reinfection because they lack the skills and confidence to negotiate safer sex. The chlamydia detection rate in 15-24 year olds in Lewisham in 2015 was 5,434 per 100,000 population, the highest in the country. 50.2% of 15-24 year olds were tested for chlamydia. Nationally, 22.5% of 15-24 year olds were tested for chlamydia with a 1,887 per 100,000 detection rate. Since chlamydia is most often asymptomatic, a high detection rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. The detection rate is not a measure of prevalence. PHE recommends that local areas achieve a rate of at least 2,300 per 100,000 resident 15-24 year olds, a level which is expected to produce a decrease in chlamydia prevalence. Areas already achieving this rate should aim to maintain or increase it, other areas should work towards

	it. Such a level can only be achieved through the ongoing commissioning of high-volume, good quality screening services across primary care and sexual health services. **Sex and relationships education (SRE)** Evidence also indicates that access to high quality sex and relationships education (SRE) is instrumental in delaying the onset of first sex and promoting relationship skills (UNESCO 2009, NICE 2010, Kirby, 2007) Evidence gathered locally during the consultation on the Lambeth, Southwark and Lewisham Sexual Health Strategy and from research, (eg Health Promotion, Inequalities and Young People's Health: A systematic review of research, Oliver S et al, Institute of Education, 2008, NatSal, 2015) indicates that these sexual health inequalities are driven factors including: • Skills and confidence in negotiating safer sex • Gender roles and assumptions • Difficulties in accessing sexual health services • Difficulties in accessing information about HIV and HIV prevention • Deprivation • Stigma around STIs • Availablity of Sex and relationships education at school Reproductive and Sexual Health Services in Lewisham (and Lambeth & Southwark) have been shown to be good at meeting the sexual health needs of key priority groups, particularly younger people and BME populations. Data from online sexual health services run in other inner London boroughs indicate that the service is highly popular with young people (35% of users are under 24 in Lambeth). Feedback on the service indicates that young people value the anonymity, the confidentiality and the speed at which the service delivers results. Test kits will not have to be delivered to young people's homes but via a 'click and collect' service thus

	guaranteeing confidentiality. Research indicates that digital technology is the most preferred route for young people to access many services, including health services (Use of Digital Technology, RCN, 2016). This was supported by a survey conducted by the Come Correct Scheme at the 2016 Lewisham People's Day, which found that 50% of young people responding would prefere to register for condoms online. Over three quarters of respondents also stated they would like to receive their condoms by pick up from a local place. Digital services and clinic receptions will stream those young who are vulnerable (including all under 16) and at risk into clinics to access both medical help and, where appropriate sexual health promotion interventions. There is no anticipated reduction in the capacity of the service. Access will be improved for young people both via the digital service and via increased capacity in clinics to see the most in need. Feedback from the Lewisham Young Advisors is that young people also value the ability to walk into an environment which delivers other services rather than just sexual health so that people don't know why they are attending. Pharmacies (for contraception and STI screening) and libraries (for condoms or picking up STI screening packs) were cited as examples. **The impact on young people is thus positive**
Sexual orientation	The evidence below demonstrates the inequalities in sexual health related to sexual orientation. The number of STI diagnoses in MSM has risen sharply in England in recent years. Gonorrhoea is the most commonly diagnosed STI among MSM and, given recent increases in diagnoses, is a concern due to the emergence of antimicrobial resistance in gonorhoea. Several factors may have contributed to the sharp rise in diagnoses among MSM including condomless sex associated with HIV seroadaptive behaviours and the use of recreational drugs during sex (chemsex). More screening of extra-genital (rectal and pharyngeal) sites in MSM using nucleic acid amplification tests (NAATs) will also have improved detection of gonococcal and chlamydial infections in recent years.

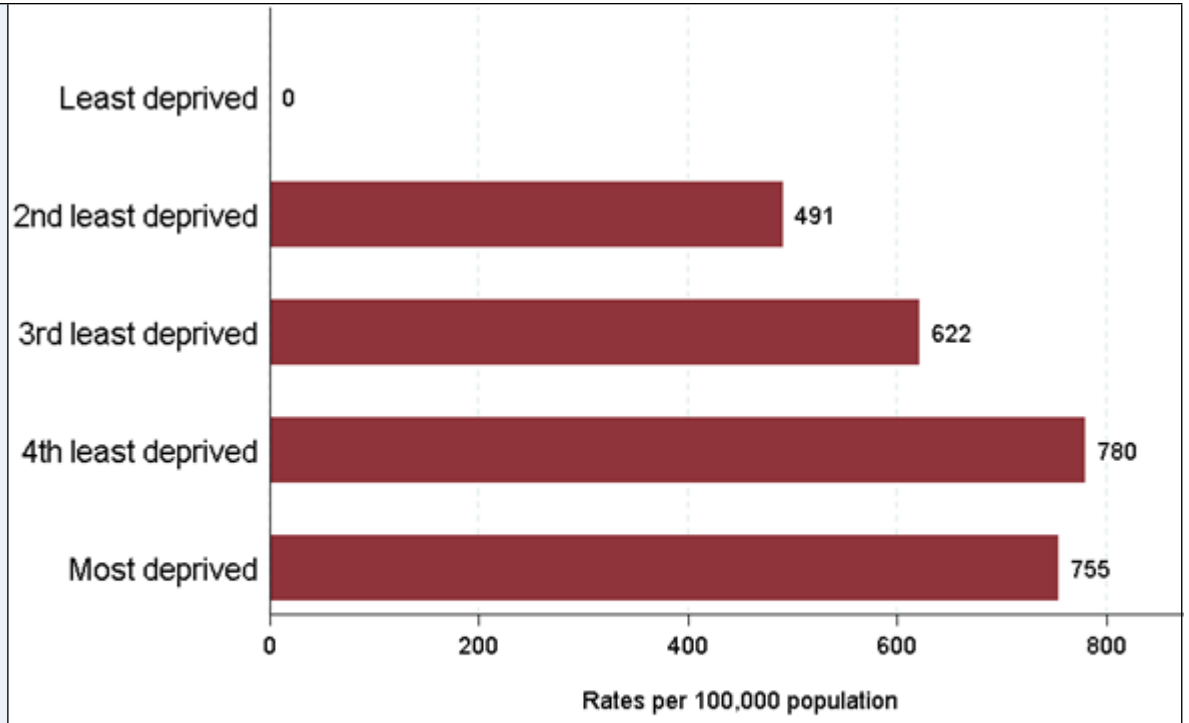
	Sexually transmitted infections In Lewisham in 2015, for cases in men where sexual orientation was known, 917 of new STIs were among MSM compared to 1202 in heterosexual men. There are estimated to be 4,000 MSM in Lewisham between 15-44 (ages in which most infections are diagnosed) compared to 72,124 men in total. This suggests a very significant over representation of MSM with STIs. Please note that the numbers for MSM presented in this report include homosexual and bisexual men. The majority of syphilis cases in London are diagnosed in men who have sex with men (MSM) in central London, with a slightly older age profile than the profile for STIs overall in London. Almost all cases of syphilis (96.5%) diagnosed in 2015 were male, with 89.9% diagnosed in MSM. Lewisham had over 100 new cases of syphilis in 2015 **Substance misuse** There is specific concern around increasing sexual risk taking behaviours in MSM associated with recreational drug use and correlated with a rise in HIV and STI diagnoses. **Health Inequalities and MSM** Evidence gathered locally during the consultation on the past Lambeth, Southwark and Lewisham Sexual Health Strategy Section 3.1 and from research including also indicates that these health inequalities are driven by factors including: • Difficulties in accessing services, including HIV testing services • Difficulties in accessing information about HIV and HIV prevention • HIV stigma • Increased risk taking behaviour There is evidence to show that for many MSM the internet is a prefered route for access to services and health interventions and a key platform for delivering STI and HIV interventions (eg The Health and Wellbeing of BME, gay and other MSM, 2014, PHE). The current London HIV Prevention Programme delivers a raft of digital sexual

	health and HIV prevention interventions targeted at MSM that have been well evaluated. Also Lambeth and Southwark's current digital sexual health service is well used by MSM (14% of users are MSM) but still not as popular as clinics. The service will be adopting marketing that is more suitable and targeted at MSM with the aim of increasing uptake. Digital services and clinic receptions will stream those MSM who are vulnerable (and at risk into clinics to access both medical help and, where appropriate sexual health promotion interventions. There is no anticipated reduction in the capacity of the service. Access will be improved for MSM both via the digital service and via increased capacity in clinics to see the most in need. Lesbian women have much lower rates of STI infection, although there is still a residual risk which is often overlooked. Anecdotally, lesbian women have reported barriers to accessing sexual health services, in particular cervical screening on the basis that they are not perceived to be at risk. Whilst their risk maybe lower than for heterosexual women they should still be encouraged to attend for cervical screening. **The impact on sexual orientation is thus positive**
Religion and belief	There is limited evidence on the relationship between religion and belief and sexual health. However, evidence gathered locally during the consultation on the Lambeth, Southwark and Lewisham Sexual Health Strategy indicates that: • The role faith leaders play is important in relation to delivering work in the sexual health promotion and HIV prevention work in the community • Involving local faith organisations eg. churches and mosques is important in relation to delivering work in the sexual health promotion and HIV prevention work in the community Lewisham commission RISE sexual health promotion services to work with faith leaders and faith communities on sexual health issues. The impact is thus **unknown**
Pregnancy and maternity	**Abortion** In Lewisham, the total abortion rate per 1,000 females population aged 15-44 years

	was 25.6, while in England the rate was 16.2 (2015). Of those women under 25 years who had an abortion in that year, the proportion of those who had had a previous abortion was 34%, while in England the proportion was 27.0%. **Contraception** The rate per 1,000 women of long acting reversible contraception (LARC) prescribed in primary care was 11.4 for Lewisham, 16.1 for London and 32.3 per 1,000 women in England. The rate of LARCs prescribed in sexual and reproductive health (SRH) services per 1,000 women aged 15 to 44 years was 67.1 for Lewisham, 33.0 for London and 31.5 for England. (PHE LASER Report) **Teenage conception** Most teenage pregnancies are unplanned and around half end in an abortion. While for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty. In addition to it being an avoidable experience for the young woman, abortions, live births and miscarriages following unplanned pregnancies represent an avoidable cost to health and social care services. Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems.

	In 2014, in Lewisham: • The under 18 conception rate per 1,000 female aged 15 to 17 years was 31.3, while in England the rate was 22.8. Previous analysis of teenage pregnancies in Lewisham showed higher rates in Black ethnic groups compared to Asian and white groups. **Services** Further developments in the future sexual health model include the development of post-natal contraception. This will have a direct impact on women who have recently had a baby enabling them to plan any subsequent pregnancy without needing to arrange a clinic or GP visit straight after their baby is born. Evidence indicates that the risk of unplanned pregnancy is associated with: • age (being under 18 or over 40) • alcohol consumption • deprivation Digital services and clinic receptions will stream those women who are vulnerable and at risk into clinics to access contraception advice and interventions. Those who have complex contraception needs (ie either as a result of physiological, medical, social or psychological need) will find it easier to access an appropriately qualified clinician. Digital services will provide detailed and easy to read information on the range of contraception available, where to access it and the best methods to meet need. This will have the benefit of increasing access to simple contraception and freeing up clinical consultation time in both sexual health clinics and general practice. Improved access to LARC will form the part of the contracts with GP Federations for 2016/17. A central booking system for LARC to by managed by BPAS and to be introduced in 2016 in LSL will also increase access to LARC. The impact on pregnancy and maternity is thus **positive**
Marriage and civil partnership	There is a lack of evidence on the relationship between marriage and civil partnership and sexual health. Data is collected in all sexual health services on marriage and civil

	partnership and future research eg service reviews, can capture information on service use and the characteristic. The impact is thus **unknown**
Socio-economic factors	Socio-economic deprivation (SED) is a known determinant of poor health outcomes and data from GUM clinics show a strong positive correlation between rates of acute STIs and the index of multiple deprivation across England. There is also evidence of greater domestic violence in areas of deprivation, particularly during recessions, which also has a relationship with poor sexual health. The relationship between STIs and SED is probably influenced by a range of factors such as the provision of and access to health services, education, health awareness, health-care seeking behaviour and sexual behaviour. This is mirrored in the rates of STIs in Lewisham which show a positive correlation with wards of greater deprivation. There is evidence from African countries of at link between domestic/sexual violence and abortion. This may in part explain the higher rates of abortion in this ethnic group seen in local data. ***Rates* of new STIs by deprivation category in Lewisham (GUM diagnoses only): 2014(***



Source: Data from Genitourinary Medicine Clinics
Rates based on the 2011 ONS population estimates
Excludes chlamydia diagnoses made outside GUM
*Please note that to prevent deductive disclosure the underlying number of STI diagnc
used to calculate the rates in this figure has been rounded up to the nearest 5

Clinic receptions will stream those who are most vulnerable and at risk into clinics to access help. As well as screening for sexual risk the clinic will screen (as is current practice) for domestic violence and drug use. Those with the greatest sexual health need will find it easier to access the help they need and clinicians will have more time to spend with those with more complex needs

	The impact on Socio-economic factors is thus **positive**
Language	Lewisham is a very ethnically diverse borough, and for many residents English may not be a fist language. However, there is a lack of robust evidence on the links between language and sexual health promotion. Clinics have access to translators and produce sexual health information in languages other than English. However, given the lack of research the impact is thus **unknown**
Health	For the impact with regards to sexual health and groups of people, see **sections above.**
2.2 Gaps in evidence base *What gaps in information have you identified from your analysis? In your response please identify areas where more information is required and how you intend to fill in the gaps. If you are unable to fill in the gaps please state this clearly with justification.*	There are gaps in: • Sexual health and transgender • Language • Religion and belief • Marriage and Civil Partnership There is a lack of evidence and research in these areas in relation to sexual health. Transformed services will have the ability to monitor in relation to transgender and language needs. Services are provided to all irrespective of religion and belief and marriage and civil partnership.
3.0 Consultation, Involvement and Coproduction	

3.1 Coproduction, involvement and consultation *Who are your key stakeholders and how have you consulted, coproduced or involved them? What difference did this make?*	Key stakeholders are: • Lewisham CCG • Lewisham and Greenwich NHS Trust • The London Sexual Health Transformation Programme • General Practice and Community Pharmacy in Lewisham • Local Medical Committee • Sexual health clinicians & service managers • Sexual health service users • Young People • LB Southwark • LB Lambeth • LB Bromley The LSL Sexual Health Transformation Programme has been in place since April 2015 and has been co-producing and designing the transformed services. The Programme consists of a Steering Group chaired by the Integrated Director of Commissioning and comprising of representatives from all stakeholder groups. The proposed new service has been designed and contract and finance agreed via workstream groups made up of stakeholders. These groups are: • Clinical and service model • Finance and contracts • Primary care Extensive consuslation was undertaken in 2013/14 to inform the direction for the model as part of the LSL Sexual Health Stategy development. This included two stakeholder events and focus groups with key target groups (MSM, BME communities and young people). The work endorsed the model. Additional consulation with the public and service users was undertaken in summer 2015 when with public events held in Lambeth, Southwark and Lewisham and focus groups in

	all boroughs to identify views on residents in accessing sexual health services online and via primary care. The subsequent report identified that residents were happy to access services via both channels, the main barriers being practical (ie being unaware of the digital service. Being unable to book convenient appointments in primary care) – the LSL Transformation Project has taken these in to account in its planning (eg freeing up appointments in general practice by providing digital access to simple contraception) Additional consultation on all the public health proposals in Leiwsham was undertaken in July - August 2016 with service users and residents, including sexual health. The sexual health service consultation included: • online survey for professionals • online survey for public • Attendance by officers at 4 GP neighbourhood meetings • Attendance by officers at Local Medical Committee meeting • Attendance by officers at CCG membership forum • Attendance by officers at Young Advisors meeting • Attendance by officers CCG senior management team meeting • Attendance by officers at Lewisham People's Day to discuss proposals and get feedback on existing services. **Professional online survey** In total 87 professionals completed the online survey in relation to sexual health. Most of the feedback in relation to existing sexual health clinic provision was positive, however, long waits to be seen and clinics closing early was highlighted as feedback that professionals had received from patients. The importance of the additional level of anonymity the clincis provided was also mentioned. Around a third of GP respondents also highlighted the fact that they already did provide most sexual health services for their patients, only referring complex cases or difficult to treat infections.

	Public online survey 195 people responded to the uengage survey in relation to sexual health services. Of these slightly over half (50.2%) had used any sexual services in the borough (including sexual health clinics, online screening, pharmacy or GP). 6.7% identified as gay, lesbian or bisexual. Just over seven percent identified themselves with a gender other than that they had been assigned at birth. When asked to what extent they favoured a more comprehensive sexual health offer including STI testing and contraception in a variety of settings the survey showed, nearly 80% supporting this in GP practices, 67% supporting this in pharmacies and 56% supporting online provision (a further 19% were ambivalent). In the comments received from the public there was very strong support for home sampling/online testing. *"Home sampling is a great idea!"* A number of responses highlighted that this was a way to prevent people having to wait in clinics, which often closed early due to the volume of patients, and ensuring those that needed to be seen could get into clinics. A number of respondents also commented that they wanted to have more appointment based services (most sexual health services are currently "walk in and wait"), rather that rushing between clinics trying to get seen, only to find they are closed. On the other hand, the additional anonymity of not having to be registered or make an appointment was felt to be important in encouraging vulnerable young people to access to the service. *"It is simply not right that there are so few clinics in Lewisham given how large the borough is. If clinics advertise their closing time as 7pm that's the time the clinic should actually close - it's ridiculous that people at work might make their way to a clinic to find themselves turned away and told to try again during the following day time."* There appeared to be strong support from survey respondents for young people's specialist

	sexual health services. When asked whether there should be specialist services for young people 79% of respondents favoured an under 19s service. The percentage favouring under 25s and young people's provision within mainstream provision was also high, but slightly less - 75% of respondents favoured an under 25s service and 75% to have young people's provision as part of the mainstream offer, but overall there was strong support for a young people's services for sexual health. The free text comments suggested that sex education and prevention of pregnancy and STIs should be a key focus for young people. *"There is a need to educate and create easy access to young people separate from general sexual health services and GPs. They are more likely to attend if services are separate."* Some respondents challenged the age cut off at 25 for young people's services (this age is used as this is the peak STI age range), and suggested it should be older or younger. Feedback from the GP neighbourhoods and LMC was broadly supportive of the sexual health proposals, in particular the promotion of online/ home sampling for STIs and recognising that young people had specific needs which may be best met by specialist services. There was support for a neighbourhood model of delivery of sexual health services, in primary care although some caution regarding the capacity of GPs practices to cope with any increase in demand. The Lewisham Clinical Commissioning Group also highlighted a concern that the new service model may lead to unfunded work in GP practices. Prevention and sexual health promotion was highlighted frequently as a key component of sexual health service delivery. Young people highlighted the importance of discreet and confidential services to meet their needs, which were youth friendly. They raised concerns about being 'judged' in mainstream service provision. There was a high degree of enthusiasm for online/self

	sampling for STI testing, although for younger teenagers there were concerns about having packages sent to their home address. They felt this could be addressed through the "pick up a pack" model already used in sexual health services for self sampling, but extending it to other venues including youth setting, libraries and pharmacies. Prevention and sex and relationships education was also highlighted as a key area by the Young Advisors. There were concerns expressed that many young people in Lewisham were not getting access to sex and relationships education either because schools were not providing it or their parents did not allow them to participate.
3.2 Gaps in coproduction, consultation and involvement *What gaps in consultation and involvement and coproduction have you identified (set out any gaps as they relate to specific equality groups)? Please describe where more consultation, involvement and/or coproduction is required and set out how you intend to undertake it. If you do not intend to undertake it, please set out your justification.*	The final model for young people's sexual health service provision will require further engagement and co-production with their involvement. It is anticipated that this will form part of the procurement process and service specification development. Using existing service providers who are working directly with communities which experience poorer sexual health outcomes, commissioners will ensure that new service models continue to meet the needs of these communities and improve sexual health outcomes.
4.0 Conclusions, justification and action	
4.1 Conclusions and justification *What are the main conclusions of this EIA? What, if any, disproportionate negative or positive equality impacts did you identify at 2.1? On what grounds do you justify them and how will they be mitigated?*	The consultation responses generally support the proposed sexual health service model, particularly the use of online testing. The issues raised in relation to clinic capacity and waiting times should be improved by better streaming of patients through the sexual health services, matching need to service - so those who do can be seen in a pharmacy or screened online do not need to access a clinic. There appears to be a high level of support from both the public and professionals for young people's sexual health services. Further work to may be require to ascertain what

	this should look like and how it fits with the development of a broader health service for 11-19 year olds, and incorporates the issues raised in relation to sex and relationships education and prevention. The £500,000 savings set against sexual health in 2017/18 will largely be achieved through service redesign moving uncomplicated contraception and STI testing online and into pharmacies, and through a new integrated sexual health tariff for financing sexual health services. It is not anticipated that this should lead to a deterioration in service, but rather an improvement in access but creating more opportunities to test for STIs and access contraception.
4.2 Equality Action plan *Please list the equality issue/s identified through the evidence and the mitigating action to be taken. Please also detail the date when the action will be taken and the name and job title of the responsible officer.*	
Equality Issue	**Mitigating actions**
Transgender	Monitor service uptake and use Include specific questions concerning transgender issues in service quality/feedback surveys
Language	Monitor service user language requirements and develop materials/services to meet requirements

APPENDIX 9 – RESPONSES TO THE PUBLIC CONSULTATION ON CHANGES TO HEALTH VISITING AND SCHOOL NURSING

Health Visiting

Proposal	% Strongly Agree + Agree	% Strongly Disagree + Disagree	% Neither Agree nor Disagree	Key Findings
Deliver 7-11 months and 2-2.5 year checks for families not identified as vulnerable in groups at Children's Centres	35.57%	48.66%	15.44%	**Positive** • CC is a nice environment and allows for social mixing. • The service is already offered like this in many people's experience. • When mother and child are mobile then it is reasonable for them to go to CCs for checks. • Allowing HVs more time to perform their duties is very important. Not travelling to people's houses would allow this, as well as saving money. • As long as the service is the same people are happy to travel for more one off based checks. **Negative** • Individual and confidential advice and support would be necessary and very important. Group settings may reduce the ability for parents to discuss personal issues in this manner. • Groups may lead to unhealthy comparisons of children with one another by parents. • Routine checks in a family home hugely necessary to assess vulnerability and care status. • Health visitors were a waste of time. They lacked knowledge, checks were too basic and it was all about ticking a box rather than meeting individual needs.

Reduce the overall number of baby clinics delivered with the aim of them all being done in Children's Centres	29.83%	56.27%	13.22%	**Positive** • Attending sessions in CCs helps introduce parents to other services and support on offer (breastfeeding, weaning, sleep management etc.) whilst socialising with others in similar situations and a nice environment. • GPs are already overcrowded and do not have the same dedicated service as CCs. Delivering them in CCs seems reasonable and sensible. • CCs are a nicer environment. • Recommend making different days/times of the week available for those who work **Negative** • All clinics (both GPs and CCs) are overcrowded and waiting times are long, this will be exacerbated if clinic numbers are reduced. Children will suffer knock on effects. • Many people have strong relationships with their GPs. Moving clinics to CCs would reduce the sense of community and trust, as well as make it more difficult for people to access weighing facilities due to travel difficulties. • Reducing investment can create greater costs later in the health care lifecycle

Introduce parental weighing of babies at clinics (whilst continuing to provide access to a Health Visitor for advice)	29.83%	56.27%	13.22%	**Positive** • Increases the control parents have over child health checks, empowering them. • Provides the opportunity for parental weighing without the sometimes unnecessary need for excessive HV advice, i.e. it will reduce the medicalization of healthcare at a young age. • Parental weighing will save time, increase parental confidence and responsibility. • As long as more vulnerable children are watched over most families can manage weighing by themselves. **Negative** • Worry that at risk children may be missed if parental weighing is implemented too widely and professionals are unable to see everyone on an individual basis. • Parents may lack experience with equipment and the health indicators they are looking for, for a healthy child. • Parental weighing can cause parents to become anxious and weigh their child too often. This could lead to depression and other anxieties. • Travelling longer distances with new born babies is difficult. Having a wide spread of geographic accessibility would be a necessity for new families, with clinics offered weekly.

Only provide checks during pregnancy for women identified as vulnerable by maternity services (other women will continue to have access to GPs and midwives for health checks during their pregnancy)	37.96%	46.10%	13.56%	**Positive** • Many people were unaware that HV checks during pregnancy were an option and did not feel they needed the support (However, lack of communication a negative factor). • Many people don't see the point of seeing a HV when they access the same advice and support from midwives and GPs anyway. Keeping care under maternity services for a while after birth would mean a continuity of care that HVs can't deliver • Constant visits from multiple health professionals can 'trap' people at home. • However, there must continue to be sufficient GP and midwife support. • Some people thought that more HV checks could be combined with routine visits to other health professionals. E.g. 3.5 years children could access checks in nurseries. • At risk families should definitely continue to receive this support. **Negative** • Many children will slip through the net if we only target known vulnerable families. Vulnerability is not always easy to spot and linked to key indicators like deprivation. It can develop quickly and in all families. Reducing this step reduces the ability to spot vulnerability. • Vulnerability needs to be clearly defined and assessment channels clearly identified. • Missing vulnerable children may in turn put pressure on children's social care further down the line, increasing costs. • Building antenatal relationships with HVs very important for future interaction

Only offer additional checks at 3-4 months and 3.5 years to families that are identified as vulnerable	37.96%	46.10%	13.56%	**Positive** • 3.5year visit is less important as children are most likely to be in some form of childcare by this point. • As long as vulnerability criteria is clearly defined than GP and midwife checks are sufficient for most families following birth not identified as in need of extra support. • Many respondents support families identified as vulnerable that need extra support **Negative** • The 3-4month check is essential for HVs as they are able to discuss post pregnancy support such as weaning and breastfeeding, it provides a real opportunity to see mum and baby together after the initial 6week visit and look for signs of postnatal depression. • Many people who wouldn't identify as Vulnerable said they felt they could have used more support in the early months after pregnancy, especially after a first birth. • Many parents seemed unaware that these checks were additional and not part of the mandatory 5 developmental checks already delivered. Nevertheless many believed they should be delivered as standard to help prevent vulnerability and improve a child's development. • Targeting vulnerability can increase stigmatization of certain people

Transfer management of Lewisham's breastfeeding groups to the health visiting service (supported by maternity services)	33.33%	31.29%	26.87%	**Positive** • The service has just received Baby Friendly Initiative level 3 and so is well placed to manage these groups. • Voluntary services should be overseen by professional expertise and support to ensure it is carrying out services properly. • As long as the service continues and the providers are qualified to deliver then it doesn't matter who provides this support. • However, the council should continue to support the input of volunteers as they are helpful and can reduce the clinical atmosphere of what is supposed to be a therapeutic intervention for the mother and child. **Negative** • Many parents worry if the HV service has enough expertise, experience and capacity to deliver these sessions properly. They believe HV would require more training if they run this service. Many believe the breastfeeding network is best placed to deliver advice and support through its voluntary and multiagency working model. • Taking away volunteer networks reduces a dedicated community service that value and care for mothers without the need for local authority input, control and resources. Why not transfer all breastfeeding support to the voluntary network? • Useful to have independent advice. In many experience HV experience and views are mixed. • How would this save money or make the service better? Seems like increasing the workload of HV who lack the ability to deliver.

Reduce the budget for administration by developing new ways of delivering this support (such as better use of technology)	58.53%	20.40%	17.39%	**Positive** • Increased and improved online resources may be beneficial for those who lack the time to call HV services or lack the language skills to interact with them. Making calls can be a long and laborious process to access information or make appointments. Online booking services would make organisation easier for both HV and parents, saving time and money. • Online access to information is 24/7 and not limited to HV working hours. • A lot of information is duplicated by midwifery and health visiting, the booklets and leafletting cost could be reduced by merging resources. • Mobile working should be introduced so that health visitors can complete the necessary notes at the visit, whilst offline if necessary, and not have to continuously travel between the office and appointments to input data. Agile and mobile working a must. • If the technology introduced would lead to more efficiency, a reduction in costs and improved contact times then this would benefit the service. However, proposals lack detail at this point. **Negative** • Must consider there are those without internet access or the knowledge to use more technical solutions. Those identified as vulnerable are more likely to have poor online and technology access. Some service users also liked the reassurance of being able to talk to someone on the phone instead of a computer screen. • Administration is a vital component of HV service delivery. However better technology could mean the loss of admin jobs. Many people would not support this. Furthermore, if admin staff are lost it may also lead to decreased clinical time for HV's and therefore poorer outcomes for families as they have to absorb more administrative duties. • The success of technological

				improvements depends on IT systems and training. These must be in place before technological improvements made. Currently they are not. • Many fear technological improvements will be too costly to be implemented fully.

Develop a local dedicated immunisation team that will be able to provide community clinics to deliver BCG vaccinations to babies who have not received this after birth	55.22%	18.51%	21.89%	**Positive** • Many people would be happy to travel to one off appointments from a dedicated service as long as they knew there was enough supply and they had a guaranteed timetabled slot. Reliability of obtaining vaccinations, especially BCGs, has been poor. • If this improves access, supply is distributed better, and vulnerable families are targeted it is a good idea. Local teams would be able to more effectively monitor areas and provide simple and consistent information. • HVs are already constrained with their functions, taking the load of the BCG clinics off them will be ideal to help them focus more on their primary responsibilities. • It can be frustrating for many parents to have to go to numerous locations for vaccinations. Local dedicated support should have a single location for ease of access. **Negative** • All new-borns should be offered BCGs by midwives as occurs in other boroughs. • The nurse immunizing must continue to assess and report back to the HV team any concerns they have. Assessing a baby and observing parent-child interaction is best done by community nurses who are part of the health visitor team. It is really important that this work is joined up and not separate from the HV service. • All immunisations should be delivered in the same place by the same team. It gets confusing with numerous locations and health professionals. • Having a dedicated BCG immunisation team is not a good idea as it is likely to mean lower paid/skilled nurses doing a task-orientated role instead of community monitoring.

School Nursing

Proposal	% Strongly Agree + Agree	% Strongly Disagree + Disagree	% Neither Agree nor Disagree	Key Findings
Provide a combined assessment for reception children consisting of a school entry health assessment, National Child Measurement Programme (weight checks for reception and also for year 6 children) & hearing and vision screening	78.26%	5.14%	12.65%	**Positive** • The combined assessment is a good way for early intervention and to collect data. It is also a good idea if it is organised properly, since one assessment to cover all bases will save time for parents and children, and also money. **Negative:** • Time: a realistic amount of time needs to be allowed for the combined check, and how this would work for all children, in all schools. • Some comments talked about the workload of nurses, which was already stretched and how they would not have capacity for such an assessment. • There were also concerns about not having checks at primary school age, and how would changes in a child's vulnerability be detected. • Some respondents commented that they didn't understand what the proposals meant and how the health checks worked now, whilst others thought this might cost more money in the long run.

Develop closer links between our weight management programme and our school nursing service so that children who are overweight have access to better support	83.33%	3.17%	10.32%	**Positive:** • It makes sense and enables early identification, which lowers the cost of tackling obesity later in life. • GP's and schools themselves do not current adequately address the issue, so having school nurses pick this up could be beneficial. • There was lots of surprise that this wasn't the case already. **Negative:** • The programme needs to be resourced properly, and not just provide identification but also support afterwards. • The programme would also need to be careful it doesn't lead to stigma and has to be a holistic service. • Concerns about capacity and understanding of this issue by school nurses were also raised, and the evidence base behind this was questioned.

Require school nurses to attend ICPC and first core group meetings (subsequent attendances will be assessed according to the health needs of the individual child) Require school nurses to physically locate safeguarding leads in the new redesigned Multi-Agency Safeguarding Hub (MASH)	83.06%	7.26%	6.45%	**Positive** • Many agreed overall but wanted to make sure all children could still access the service. • School nurses should have a greater role in CP cases than they do at the moment. This would increase safeguarding of vulnerable children. • Some respondents felt that school nurses are able to create better relationships with children and parents than teachers. **Negative** • Some respondents were unsure if this proposal meant a reduction of universal service and a focus only on the vulnerable. • This service should be for all children, it is pointless of school nurses to do this as they do not get to know the children adequately enough, and for that reason they should be present at all CP meetings. • They should also have reduced workload in terms of meetings in order to meet the needs of the most vulnerable children.

Create a dedicated 'teenage health service' which will be accessible from a number of venues in the borough as well as from schools, be provided by a mixture of health and non-health staff, offer online advice and one to one support about health and emotional wellbeing and risk behaviours e.g. alcohol or drugs misuse & sexual health and signpost and refer young people to other local services	63.71%	20.16%	12.50%	**Positive** • It is sensible to have a dedicated service for teenagers as long as it is accessible and adequately resourced. • The service needs to be widely available and encourage teenagers to attend. Lewisham has high needs which schools cannot meet, so this will be a welcome addition if it works. **Negative** • Some children may not be able to access the hubs due to parental control, so there still needs to be access within schools for help. • Some young people may not go out of their way to access the service outside school and so drop-ins at schools are still essential. • There were a few comments about how these hubs are best placed in schools as any other location would reduce the amount of young people going to them (good promotion is essential). • Who would run the service? was another concern (some mentioned school nurses are being suited) and a risk highlighted was it becoming a 'non-contact' service. • Another comment stated that the service should be open to pre-teens as well, as well as being available online (although we cannot assume everyone has access to the internet). • Seeing as needs of teenagers, especially mental health issues are increasing, the proposed cut of 22% is seen as 'dangerous' by some respondents.

Create a dedicated nursing team, supported by community children's doctors, to provide support to children with long term conditions and disabilities (and train school staff on how to look after these children in schools)	55.33%	24.59%	16.39%	**Positive** • It is good in principle as long as school nurses are adequately resourced and trained to be able to deal with such conditions and disabilities. **Negative** • GP's would be able to deal with this more effectively, and school nurses are not trained for this. They are also over stretched already. This should be left to specialist doctors and nurses, and the school nurse should have a more universal role. • A number of respondents commented that they were unsure about what this actually meant, and how this was different from what was already present.
Continue to provide immunisations in schools, but deliver these via a different immunisation team	35.08%	27.42%	33.87%	**Positive** • This is welcomed as it frees up school nurses to concentrate on other more important health and safeguarding issues. • The immunisation team should be made up of professionals, such as GP's and nurses and be able to deliver this efficiently, and should also be trained to work with young people. **Negative** • Delivery of immunisations is part of holistic care, and this would be broken up by different providers. • School nurses are perceived as doing this well already, so why change something that is working. • There were also concerns that the relationship children had with their school nurse, would be lost, and if the child had, for example, a phobia of needles, an immunisation service wouldn't be able to provide personal care as a school nurse would.

Appendix 9

Children Centres (Public)

Proposal	% Strongly Agree + Agree	% Strongly Disagree + Disagree	% Neither Agree nor Disagree	Key Findings
Offer the same services at fewer or different locations (such as an area based 'hub' supported by smaller sites, including the use of schools and community settings)	32.63%	44.56%	19.65%	**Positive** • Offering a wider service at fewer hubs is a good cost effective measure • Increased provision to more residents • Local schools should be used as hubs where services would be accessible to larger proportions of people • Could offer consistency of service across multiple sights – Deptford Park Play Club a good example of how this could look. • Hopefully well trained and more experienced staff attracted and retained **Negative** • Transport, accessibility and increased administration concerns • Concern over the capacity of hubs and the likelihood of overcrowding, reducing 1-to-1 support • Loss of local CC communities • Fewer locations offer less choice • Service should be reduced, but not the number of locations

Offer the same services, but targeted towards families with higher needs	30.88%	46.32%	20.70%	**Positive** • Targeting support may reduce the doubling up of service provision. • Many respondents thought this was a worthwhile policy, helping those most in need **Negative** • Many respondents felt they may be neglected and left behind if they were not classifieds as high need - especially more affluent families. • The same facilities should be on offer to all. Do not stigmatize less vulnerable families and reduce social mixing. • Vulnerabilities can develop quickly and in many different socio-economic situations, not just for traditional vulnerable characteristics.
Co-locate Children's Centres with other health and education services	61.06%	13.68%	22.11%	**Positive** • May improve sharing information and overall awareness of what the local health service has to offer • This already occurs in some people's experience and has been useful **Negative** • It can be confusing travelling to multiple destinations and speaking to many different people
Integrate the one-to-one family support service provided by Children's Centres with our health visitor support for vulnerable families	52.48%	14.54%	22.70%	**Positive** • HV are experienced practitioners and can easily support the practice, supervise children centre staff whilst supporting families and children • This will help improve communication between these services. **Negative** • Transport considerations. Meting vulnerable families in their home continues to be vital. • The added team management would be a very large additional demand on the HV team. The change is financially driven and would impact greatly on the health visitor workload • One-to-one should remain open to all without the need to be selected

APPENDIX 10 – RESPONSES TO THE STAKEHOLDER/PROFESSIONAL PUBLIC CONSULTATION ON CHANGES TO HEALTH VISITING AND SCHOOL NURSING

Health Visiting

Proposal	% Agree	% Disagree	% Neither Agree nor Disagree	Key Findings
Deliver 7-11 months and 2-2.5 year checks for families not identified as vulnerable in groups at Children's Centres	Service Users 16.18% Professionals 24.64%	Service Users 57.35% Professionals 44.93%	Service Users 26.47% Professionals 30.43%	**Positive** • Many experience developmental health checks in CCs rather than individuals homes at the moment anyway. • Professionals will have a more stable working environment working in the same location for longer periods of time. Home visits are time consuming. Will help professionals to manage workload better. • To be successful the correct equipment and facilities must be in place for group checks. • Bringing families into children's centre may expose them to other professionals and activities that they may otherwise not be aware of. **Negative** • Concern over the confidentiality of information in groups and the ability and comfort of parents to open up about concerns with many others around. • Group situations are not appropriate to identify developmental concerns or safeguarding issues. Privacy is essential for the accuracy of assessments. • Disclosure of important issues is more likely if a relationship has been established between HV and parent. Groups reduce the ability for a more personal service. • Reducing checks in people's homes removes safeguarding consistency of checking parent and child's living environment.

Proposal	% Agree	% Disagree	% Neither Agree nor Disagree	Key Findings
				Vulnerability can develop quickly and at any given time. • Relying on people to attend CCs may increase non-attendance of parents.
Reduce the overall number of baby clinics delivered with the aim of them all being done in Children's Centres	Service Users 17.91% Professionals 23.19%	Service Users 59.70% Professionals 56.52%	Service Users 22.39% Professionals 20.29%	**Positive** • CCs are positive and dedicated environments that can also signpost families to numerous other services available. Offer social and community based environment. • Would be a more efficient use of the limited number of HVs available. • Could shift sessions from a purely medical approach to a wider, more inclusive session providing support with breast feeding, healthy eating etc. **Negative** • CCs may not be as accessible as GP surgeries for many. • Reduces joined up working between GP and HV services. • Clinics are already busy and overcrowded, so reducing the number would exacerbate this. • Concern this is taking nursing back to task orientated work and target setting. Reduces consideration of individual need.

Appendix 10

Proposal	% Agree	% Disagree	% Neither Agree nor Disagree	Key Findings
Introduce parental weighing of babies at clinics (whilst continuing to provide access to a Health Visitor for advice)	Service Users 17.91% Professionals 23.19%	Service Users 59.70% Professionals 56.52%	Service Users 22.39% Professionals 20.29%	**Positive** • This could reduce HV workload and them to target time to those most in need. • Empowers parents to know more about their child's health and development. • Group settings could help reduce stigmatization of more vulnerable families. **Negative** • Parents may not understand how to use the equipment or know which health indicators to look for. Equals diminished accuracy and reliability. • This would limit a health professional's ability to monitor child and parent, potentially increasing safeguarding concerns. • Personal interaction and continuity or seeing the same GP/HV will be decreased. This may deter parents as it is unfamiliar and less focussed.
Only provide checks during pregnancy for women identified as vulnerable by maternity services (other women will continue to have access to GPs and midwives for health checks during their pregnancy)	Service Users 18.18% Professionals 25%	Service Users 60.61% Professionals 50%	Service Users 21.21% Professionals 25%	**Positive** • Midwife and GP are more than adequate for this function. Die to staff numbers this may be happening in some cases anyway. • Maintaining midwife support a few months after birth would be useful in maintaining personal relationships and continuity of care. • Empowers mother and is less intrusive. **Negative** • How do you identify vulnerability of child/parent? Checks in the home before birth are significant in this process. • This may increase workload of GPs.

Appendix 10

Proposal	% Agree	% Disagree	% Neither Agree nor Disagree	Key Findings
Only offer additional checks at 3-4 months and 3.5 years to families that are identified as vulnerable	Service Users 18.18% Professionals 25%	Service Users 60.61% Professionals 50%	Service Users 21.21% Professionals 25%	**Positive** • Focus is better placed on vulnerable families and will free up HV time for those most in need. **Negative** • 3-4 month checks are at a critical time for many development i.e. introducing solid food, maternal mental health, accident prevention discussion, infant social and emotional well-being. Should be open to all, especially all 1st time mothers. • How do you identify children who become vulnerable and need a 3-4 month check? Increases the chance of many falling through the net if not offered to all.
Transfer management of Lewisham's breastfeeding groups to the health visiting service (supported by maternity services)	Service Users 39.39% Professionals 35.82%	Service Users 28.79% Professionals 28.36%	Service Users 31.82% Professionals 35.82%	**Positive** • Health visitor services have contact with the children and families until the age of 5 years. It is important that this message is reinforced following birth through breastfeeding support. This helps to build relationships with service users and therefore to identify vulnerabilities earlier. • Helps in continuity of care, especially if lined to maternity services. **Negative** • Breast feeding network are specialists in breastfeeding, health visitors do not have the same depth of knowledge/experience or training as these specialists. • HV services are already under resourced and under capacity. Why stop a service that works so well and is largely manned by volunteers. • Concerns the number of groups available may reduce.

Appendix 10

Proposal	% Agree	% Disagree	% Neither Agree nor Disagree	Key Findings
Reduce the budget for administration by developing new ways of delivering this support (such as better use of technology)	Service Users 44.62% Professionals 53.03%	Service Users 23.08% Professionals 28.79%	Service Users 32.31% Professionals 18.18%	**Positive** • If the technology introduced leads to more efficiency and reduction in costs this would be of benefit to both service users and professionals, provided there is adequate training and implementation. **Negative** • Concerns admin duties would actually increase for clinical staff, preventing patient care. This could be due to the loss of admin staff which is offset through technological innovation. • Concerns appropriate electronic equipment would not be provided. • Some users may lack access to technological solutions and prefer using phones to book appointments and seek advice.

Appendix 10

Proposal	% Agree	% Disagree	% Neither Agree nor Disagree	Key Findings
Develop a local dedicated immunisation team that will be able to provide community clinics to deliver BCG vaccinations to babies who have not received this after birth	Service Users 64.62% Professionals 64.18%	Service Users 10.77% Professionals 7.46%	Service Users 24.62% Professionals 28.36%	**Positive** • A centralised hub would make more efficient working • Clinics are overcrowded and very busy so creating new services to absorb capacity would be good (as long as funding and trained staff available) • Appointment based system would work well if it could be implemented • Will free up HV time for home visits/assessments **Negative** • This will reduce the holistic approach to care and safeguarding, reducing the ability of HVs to engage more widely in a child's health and development. • If a team only does this work they become deskilled and task focused and this is a safeguarding risk. • The supply of BCGs is very low at the moment and therefore a dedicated team would lack the resources to be effective.

School Nursing

Proposal	% Agree	% Disagree	% Neither Agree nor Disagree	Key Findings
Provide a combined assessment for reception children consisting of a school entry health assessment, National Child Measurement Programme (weight checks for reception and also for year 6	Service Users 67.21% Professionals 62.30%	Service Users 8.20% Professionals 6.56%	Service Users 24.59% Professionals 31.15%	**Positive** • The combined assessment is a better use of time, as long as there is a realistic amount allocated for the combined check, which needs to be thorough and holistic. • It is good for early intervention, and allows services to be developed around the child to give them the support they

children) & hearing and vision screening				need, and not have their attainment impacted later on in life. **Negative** • Reception age it is difficult for children to fully participate in hearing and sight tests. The earliest time this is possible is year 1. • Therefore, these tests should be revisited when the child is slightly older, or else things will be missed due to the child being unable to understand/communicate.
Develop closer links between our weight management programme and our school nursing service so that children who are overweight have access to better support	Service Users 82.54% Professionals 76.19%	Service Users 6.35% Professionals 4.76%	Service Users 11.11% Professionals 19.05%	**Positive** • That it makes sense and enables early identification, which lowers the cost of tackling obesity later in life, especially when resources are strained. • School Nurses have good relationships with children, so this makes sense, as long as there is joined up working and collaboration between professionals, especially GPs. **Negative** • The programme needs to be properly resourced, as historically there has been a poor uptake of weight management courses from parents. • Concerns over the capacity of school nurses to take this on were raised, as well as the impact on children having visible support for their weight in a school environment. • Others commented that MyTime should deliver this programme instead of school nurses.

Require school nurses to attend ICPC and first core group meetings (subsequent attendances will be assessed according to the health needs of the individual child) Require school nurses to physically locate safeguarding leads in the new redesigned Multi-Agency Safeguarding Hub (MASH)	Service Users 52.46% Professionals 50.79%	Service Users 14.75% Professionals 17.46%	Service Users 32.79% Professionals 31.75%	**Positive** • It is good that there was a coordinated care approach and different professionals working together, such as MASH, in order to safeguard those most vulnerable. • Other comments suggested it was positive that schools take more of an active role in safeguarding, as it is the primary concern for everyone. **Negative** • Comments focused on the vital role of the school nurse, and the fact that they should be attending all meetings, as the voice of the child. This allows the school nurses to keep informed of any developments, and pick up things that other professionals may have missed. • Communication between different agencies was also claimed to be bad, which is having a negative impact on safeguarding, as well as lack of respect for the role of the school nurse.

Create a dedicated 'teenage health service' which will be accessible from a number of venues in the borough as well as from schools, be provided by a mixture of health and non-health staff, offer online advice and one to one support about health and emotional wellbeing and risk behaviours e.g. alcohol or drugs misuse & sexual health and signpost and refer young people to other local services	Service Users 62.71% Professionals 62.30%	Service Users 23.73% Professionals 21.31%	Service Users 13.56% Professionals 16.39%	**Positive** • It is sensible to have a dedicated service for teenagers as Lewisham has high needs which schools cannot meet, and there is a lack of services in the borough for them. • Other respondents felt that the service should be run by school nurses, and a mix of professionals outside the school environment, to increase trust and confidentiality. **Negative** • Capacity- and how stretching a service that was already limited would work. • Others feared that face to face support would be replaced by online support, which they felt was not suitable. • Many comments suggested existing structures should be invested in and improved, as well as increasing the marketing of existing services, as opposed to creating other ones. • Another respondent felt that we are treating teens as adults, whereas they need more support in schools.

Create a dedicated nursing team, supported by community children's doctors, to provide support to children with long term conditions and disabilities (and train school staff on how to look after these children in schools)	Service Users 65% Professionals 63.93%	Service Users 16.67% Professionals 22.95%	Service Users 18.33% Professionals 13.11%	**Positive** • It is a good way to **normalise disabilities and other lifelong conditions** to have this support in a school environment, which would lead to better understanding. • Some School Nurses commented that they **already have good relations with specialists** who they work with, and get advice and support from. **Negative** • **They would rather the community nurses and specialist teams** with more knowledge pick up this work. • They were also concerned that school nurses were **over stretched** already.

Continue to provide immunisations in schools, but deliver these via a different immunisation team	Service Users 35% Professionals 33.87%	Service Users 15% Professionals 19.35%	Service Users 50% Professionals 46.77%	**Positive** • This is welcomed as it **frees up school nurses time to concentrate on other more important health and safeguarding issues**. • The immunisation team would be able to work across a variety of **locations** and be more **efficient** than the current system. **Negative** • Delivery of immunisations is part of **holistic care**, and provides an opportunity for the school nurse to **make contact with the children and identify** any other problems. • School nurses would already be **familiar** with the children, and understand which of them may need more support for getting their immunisations done.

Children Centres

Proposal	% Strongly Agree + Agree	% Strongly Disagree + Disagree	% Neither Agree nor Disagree	Key Findings
Offer the same services at fewer or different locations (such as an area based 'hub' supported by smaller sites, including the use of schools and community settings)	35.38%	49.23%	13.85%	**Positive** • Efficient use of limited resources • Reduce duplication • Better co-ordination and centralisation of service **Negative** • Concerns over capacity and accessibility • Could increase admin costs • Need to make sure CCs are located in areas of the most need

Offer the same services, but targeted towards families with higher needs	34.92%	50.79%	14.29%	**Positive** • Targeted work for families with higher needs is appropriate, as these families are often referred to Children's Centres via the early intervention service and are more in need **Negative** • Family support needs to be able to respond to a wide range of need, not just families identified on the HV targeted caseload • Vulnerability not always obvious • Lacking vulnerability does not mean you will not need support • Stigmatization increased and social mixing reduced if targeted families grouped together
Co-locate Children's Centres with other health and education services	68.25%	9.52%	22.22%	**Positive** • Co-location and integration will improve communication and contact between services and increase referral rates • Useful for families to have only one place to travel to **Negative** • As the HV service deals with the under 5s, it does not make sense co-locating with education services.
Integrate the one-to-one family support service provided by Children's Centres with our health visitor support for vulnerable families	57.58%	25.76%	15.15%	**Positive** • If Children's centre workers are in the same team as HVs they will work better together and reduce duplication • Helps CCs to provide a consistent offer across the borough that is evidenced based and has clear outcomes **Negative** • HVs do not have the capacity or funding to deliver this support • HVs should mainly be a medical resource

Health Impact Assessment

Impact of changes to public health commissioned preventative health ('Staying Healthy') services on population health

Dr Catherine Mbema

August 2016

Contents

Executive Summary

- The preventative services currently being commissioned by the public health department at Lewisham Council are currently being revised in a programme of changes to be introduced in the 2017/18 financial year.
- Health Impact Assessment was chosen as the method to assess the potential population health implications of the proposed changes.
- The potential population health impacts for each of the services facing changes were identified following a brief examination of the following aspects of each service: service description; peer-reviewed evidence base for the service; current uptake/reach of the service; and consultation results.

Breastfeeding Support Services

- Breastfeeding support services in the form of peer support have a moderate evidence base in the UK setting with postnatal and targeted peer support being shown to be most beneficial. The current Lewisham breastfeeding support services have both of these evidence based elements.
- Breastfeeding prevalence at 6-8 weeks is currently above the England average in Lewisham.
- The reach of the current breastfeeding support services is good. However, mothers in the 'White British' ethnic group predominantly attend services. These mothers are also largely aged over 25, which is not reflective of the age distribution and diversity of the borough. The service design and new contract does therefore present an opportunity to improve the reach of the service to underserved population groups. Effective promotion of the redesigned service through appropriate channels for these population groups will be important to achieve this.
- Although the service is not ranked as highly in terms of importance as other 'Staying Healthy' services by residents or professionals, the value of the service in terms of its potential health impacts is recognised by both groups.
- Redesign of the service may have minimal health impact on attendees of the service if capacity is retained. However, in the proposed redesign of the service, efforts should be encouraged in the new contract to improve the reach of the service to underserved population groups to avoid any health inequalities in relation to breastfeeding in the borough.

Stop Smoking Services

- There is a good evidence base for the effectiveness of stop smoking services in improving success in quitting smoking for those that attend. The current format of SSS being delivered in Lewisham contains many of the main evidence based elements.
- The reach of the service is good in Lewisham, however particular population groups appear to have greater success in quitting as a result of attending various parts of the service i.e. men and black African smokers and those in deprived areas that attend the specialist adviser service. These population groups are most likely to be affected by any reduction in the capacity of the service than other population groups.
- Though not the most highly ranked service by residents, the importance and value of the service in the community has been demonstrated in the consultation responses. The acceptability of a redesigned SSS delivery format including a combination of face-to-face, telephone and text may be high amongst residents as indicated by the online consultation results although the evidence base for this is unclear. A local evaluation of this revised format should be undertaken if employed.

- The reduction in the capacity of the specialist support for all members of the community is likely to have an impact on population health, particularly for those from deprived and Black African population groups. However, the use of new channels of delivery may encourage service use from currently underrepresented population groups.

NHS Health Checks

- There is a growing body of evidence examining the effectiveness of NHS health checks but the effectiveness of NHS Health Checks in improving long-term outcomes has yet to be clearly demonstrated
- The evidence-based short-term health impacts of NHS Health Checks include: the increased chance of identifying new comorbidities and prescribing statins and/or hypertensive medication or the first time in those having a check.
- The uptake of the service in Lewisham could be improved but has good reach across genders and those of different ethnicities within the borough.
- The service is ranked highly in terms of preference for both residents and professionals.
- Since the capacity of the NHS Health Checks service is to be retained, the known short-term health benefits of having an NHS health check are expected to be preserved.

Community Health Improvement Service (CHIS)

- There are varying levels and quality of evidence for the different components of CHIS.
- All services within CHIS have been shown to have good reach in Lewisham, however the LLH has been shown to have particularly good reach for residents in 'Black African' and 'Black Caribbean' groups.
- It is expected that the population health impacts resulting from the elements of CHIS that have the strongest evidence base for population health impact i.e. Healthy Walks and the community development work will remain albeit in different delivery formats.
- Residents and professionals had differing perspectives of the CHIS services, with residents ranking 'Healthy Walks' quite highly but professionals ranking all CHIS services as the least preferred.
- It is unclear from the available evidence whether the changes to the LLH and health trainer services will have a positive or negative health impact, although BME users of LLH may be disproportionately impacted by being unable to access a service that they had particularly good representation at.
- The introduction of the National Diabetes Prevention Programme, the existing community nutrition and physical activity service delivered by GCDA and the expansion of the existing commercial weight management offer (e.g. weightwatchers vouchers) may all work to mitigate against negative health impact resulting from the proposed changes to CHIS.

Children's Weight Management Service

- There is a good evidence base for the MEND element of the children's weight management service, demonstrating both short and intermediate term impact for improvement in BMI and waist circumference measurements in overweight and obese children.
- Both residents and professionals ranked these services as their 3rd most preferred service.
- The service reaches approximately 4% of the estimated 9,000 obese children (under 16's) in the borough.

- There is expected to be a negative population health impact for those unable to access the additional support alongside MEND following the introduction of the proposed changes. This may be particularly the case for girls, BME children, and children with complex needs.
- Close monitoring of service use and health outcome data following the introduction of the proposed changes, particularly to capture demographic data for service users will be vital to identify if any negative impacts are realised and to work to mitigate them when/if they arise.

1. Introduction

1.1 Background

The preventative services currently being commissioned by the public health department at Lewisham Council are currently being revised in a programme of changes to be introduced in the 2017/18 financial year. These preventative health services facing changes are:

- Breastfeeding support services
- Stop smoking services
- NHS Health Checks
- The Community Health Improvement service (CHIS)
- Children's weight management services

The changes to these services are being driven by the need to achieve £800k of savings from the staying healthy budget, as a contribution to £4.7 million in savings from the public health budget by 1 April 2017. In order to ensure that any subsequent population impact has been duly recognised and mitigated against, two pieces of work have been undertaken as part of the change programme. The first has been undertaken to assess the population equalities impact of the proposed changes i.e. an Equalities Analysis Assessment (EAA). The second has been undertaken to assess the potential population health impact of the proposals and Health Impact Assessment (HIA) has been chosen as the method to assess this. The HIA will be the main focus of this report and includes the EAA as an integral part of its assessment.

1.2 Health Impact Assessment Overview

Health impact assessment (HIA) can be defined as 'a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population' (1). This method provides a systematic and objective framework within which potential health impacts can be identified.

HIA typically involves the following stages:

- Screening
- Scoping
- Appraisal of evidence/assessment
- Reporting and recommendations
- Monitoring and evaluation

1.3 Scope of Health Impact Assessment

HIA typically considers a broad range of health impacts based on wider determinants of health models and identifies how a proposal or policy will alter these determinants (1). Some of the determinants that are usually considered are demonstrated by the Dahlgren and Whitehead 'Determinants of Health' model in Figure 1 below:

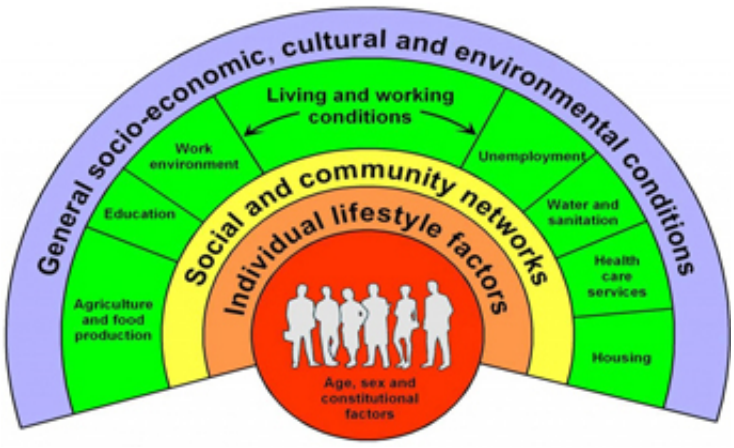


Figure 1. The Determinants of Health, Dahlgren and Whitehead (1992)

Following the initial scoping exercise, it was felt that this HIA should focus on a narrower range of population health impacts (i.e. those pertaining to individual lifestyle factors and social community networks using the model above) due to the rapid nature of the work and the interventions under consideration in this HIA. However it should be noted that broader implications of the proposed changes may also be possible.

1.4 Data Sources Used

A wide range of data sources have been used to inform the appraisal stage of the HIA.

1.4.1 Consultation

A consultation exercise was carried out to explore the views of Lewisham residents concerning the proposed changes to preventative health services. Three types of consultation were undertaken as part of this exercise:

- An online consultation questionnaire for Lewisham residents (148 responses were received from Lewisham residents). The majority of resident respondents were female (73%), aged over 45 years (69%), and White British (59%).
- An online consultation questionnaire for Lewisham professional stakeholders (87 responses were received for the professional survey). The majority of respondents were healthcare professionals (70%).
- A range of stakeholder meetings across the borough where feedback on the savings plan was collated.
- Conversations at Lewisham People's Day to discuss proposals and get feedback on existing services (70 members of the public were engaged in these discussions).

A detailed summary of the consultation responses in addition to demographic data of the consultation respondents can be found in the 'consultation' section of the EAA.

In the online consultation questionnaires for both residents and professionals, respondents were asked to rank their most preferred service out of the following 7 services: Breastfeeding support services, children's weight management services, health trainers, healthy walks, NHS Health Checks, small grants to community groups and Stop smoking services. In order to fully capture the priorities of

respondents, the rankings were weighted (i.e. 7 points were accrued for each respondent ranking a service 1st, 6 for 2nd, 5 for 3rd and so on) and then summed to produce a final summary score for each service. This process was performed for the resident and professional questionnaires respectively. These summary scores can be seen in Appendix 1.

1.4.2 Routine Data

A large number of routine data sources were used to inform this HIA, in addition to reports collating routine data e.g. quarterly service monitoring reports. These data sources have been referenced throughout the report where used.

1.4.3 Peer-reviewed research

In order to summarise the evidence-base for the services and any alternative ways of delivering these services, rapid reviews of the literature were performed. Due to the rapid nature of the HIA, the searches were restricted to the PubMed and Cochrane databases. Only review articles published in English were included in the subsequent evidence summaries. Where existing evidence reviews had already been performed for the service, this was used to summarise the evidence.

Where necessary, the strength of the evidence obtained has been grading according to the following grading system (2):

Grade	Description
A	Strong body of evidence in support (two or more systematic reviews, meta-analyses or equivalent high-grade evidence)
B	Some evidence – broadly supportive (a range of individual qualitative or quantitative studies – with or without controls generally supporting the intervention)
C	Conflicting evidence of effectiveness (some studies in favour, some against)
D	Insufficient evidence to judge in favour or against (evidence largely in the form of expert opinion)

1.5 Structure of report

The potential population health impacts for each of the services listed above has been outlined in this report after a brief examination of the following aspects of each service: service description; peer-reviewed evidence base for the service; current uptake/reach of the service; and consultation results.

The health impacts identified have been described in terms of their nature, likelihood, scale and timing. The distribution of health impacts across different population groups in the borough has primarily been explored through the aforementioned EAA but has been summarised in the description of the nature of health impacts.

References

1. Health Impact Assessment: Main Concepts and Suggested approach. Gothenburg Consensus Paper. European Centre for Health Policy. (December 1999)
2. Ismail, S. Self-care and Self-management Support for Health Improvement in Lewisham. Lewisham Council. (November 2015)

2. Breastfeeding support services

2.1 Description of the service

The Breastfeeding Network project in Lewisham manages six community breastfeeding groups and the provision of a breastfeeding peer support service. This includes training 24 new breastfeeding peer supporters and providing on-going supervision to all active volunteer peer supporters (around 30). The peer supporters support mothers attending the community breastfeeding groups and on the postnatal ward (total 1200 hours of volunteer time per annum) (1).

2.2 Evidence for the service

There are clear evidence-based health benefits associated with breastfeeding for both mothers and infants, which include the reduction in the incidence of infant infections for the baby, improvement in emotional attachment between mother and baby, reduction in the risk of breast cancer for mothers (2) (evidence grade A). Exclusive breastfeeding has even greater potential benefits if continued for at least 6 months (3). In order to realise these benefits at a population level there is an incentive to encourage and support breastfeeding where possible among mothers. Peer support and community-based interventions are one means of doing this, however they have a mixed evidence base in the UK setting (evidence grade B). There is good evidence that lay support significantly reduces the risk of not breastfeeding (4) and the National Institute for Health and Clinical Excellence (NICE) has produced guidance that lay support should be used to increase breastfeeding, particularly among women with low incomes (5). However, peer support has mostly been shown to be beneficial in UK settings if provided in the postnatal period and if targeted i.e. aimed at those who are already considering breastfeeding (6,7).

In addition to health benefit for the mothers and babies attending the service, there are evidence-based benefits for peer supporters who volunteer their time to support the service. Volunteering has been shown to improve both the physical and mental wellbeing of volunteers (8). Additionally, a greater sense of belonging to a community and improved sense of well-being may result from community engagement when approaches are used that help communities to work as equal partners with professionals (9).

2.3 Reach (uptake)

In Lewisham, breastfeeding prevalence at 6-8 weeks after delivery is 74.3% (10). This is significantly better than the average prevalence for England overall. The community breastfeeding groups support approximately 900 new women a year. In the most recent quarter (Jan-March 2016), 131 new women attended one of 6 community groups (11). The six groups are located throughout the borough and all wards of the borough are represented by attendees of the groups. The majority of mothers attending the Lewisham breastfeeding groups in the latest quarterly monitoring report for 2016 were aged between 30 and 39 years (74%) and of ‘White British’ ethnicity (49%), which is consistent with previous reporting periods (10).

2.4 Proposed changes to the existing service

The Council proposes to incorporate this service within a new contract for health visiting. This would require serving notice on the existing service. It is intended that a similar level of support will be provided to peer supporters and breastfeeding groups.

2.5 What did people say?

At 'People's Day, a community event in Lewisham, participants ranked breastfeeding support services as the least preferred public health service out of 7 options listed. This is similar to responses received from Lewisham residents to the online consultation survey, where breastfeeding support services were ranked the least preferred 'Staying Healthy' service according to the summary score calculated (see Appendix 1). However, when asked about the likely impact of the proposed changes, resident respondents largely felt that the changes would have a negative impact (38%) in comparison to having a positive impact (10%) or none at all (21%). Free text comments in the consultation survey included views that mothers needed support to breastfeed particularly younger mothers and those form deprived areas. Some also showed understanding that breastfeeding reduces the risk of obesity in childhood for breastfed babies.

In response to the professional online consultation, breastfeeding support services were ranked as the 4th most preferred 'Staying Healthy' service. Free text comments expressed that this service received positive feedback from mothers. It was also felt that early interventions were the most important and that not providing support for mothers would lead to poor outcomes for children in the long run.

2.6 Health Impact of changes

Element of health impact	Description
Nature	The capacity of the breastfeeding groups and peer support is due to be preserved in the redesign of the service and has already been reflected in the new service contract. The negative impact of the changes anticipated by residents may therefore not materialise. However, if the changes in service delivery impact in anyway upon accessibility and acceptability of the service, the numbers of those attending the service may be impacted and subsequently impact upon the continuation of breastfeeding in mothers that use the service. This may subsequently impact upon breastfeeding rates at 6-8 weeks in Lewisham and associated positive health impacts with continuation of breastfeeding.
Likelihood	Uncertain
Scale	Any health impacts will predominantly affect new mothers and infants across the borough. The protected characteristics identified in the EAA as being most likely to be impacted by the proposed changes are: age (i.e. since mainly older mothers currently attend the service), ethnicity/race (i.e. since the service is predominantly attended by 'White British' and 'White Other' women at present), and the pregnancy/maternity group as mentioned above.
Timing	There may be both short and long term health impacts: **Short-term:** Potential impact on service access and acceptability for different population groups. **Long-term:** Potential impact on breastfeeding rates at 6-8 weeks and subsequent significant health impacts for mother and baby as described above.

2.7 Mitigations

Effective delivery and promotion of the redesigned service will be essential to ensure that access to the service is maintained and improved for population groups not currently accessing the service in a representative way.

2.8 Summary

- Breastfeeding support services in the form of peer support have a moderate evidence base in the UK (evidence grade B) setting with postnatal and targeted peer support being shown to be most beneficial. The current Lewisham breastfeeding support services have both of these evidence based elements.
- Breastfeeding prevalence at 6-8 weeks is currently above the England average in Lewisham.
- The reach of the current breastfeeding support services is good. However, mothers in the 'White British' ethnic group predominantly attend services. These mothers are also largely aged over 25, which is not reflective of the age distribution and diversity of the borough. The service design and new contract does therefore present an opportunity to improve the reach of the service to underserved population groups. Effective promotion of the redesigned service through appropriate channels for these population groups will be important to achieve this.
- Although the service is not ranked as highly in terms of importance as other 'Staying Healthy' services by residents or professionals, the value of the service in terms of its potential health impacts is recognised by both groups.
- Redesign of the service may have minimal health impact on attendees of the service if capacity is retained. However, in the proposed redesign of the service, efforts should be encouraged in the new contract to improve the reach of the service to underserved population groups to avoid any health inequalities in relation to breastfeeding in the borough.

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1. Public Health Savings Consultation Document. Executive Directors of Community Services at Lewisham Council. Lewisham Council, Mayor and Cabinet report, June 2016.

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10. Lewisham Public Health Performance Dashboards. Public Health Information Portal. Available at: http://portal.lewishamjsna.org.uk/Lifestyle_&_Behaviour_Results.html?option=Breast_Feeding <Accessed 9th August 2016>

11. Lewisham Quarterly Report on NCT Services. Lewisham Council, May 2016.

3. Stop Smoking Services

3.1 Description of the service

The current Stop Smoking Service (SSS) is provided by Lewisham and Greenwich NHS Trust (LGT). The primary role of the SSS is to deliver high quality, evidence-based stop smoking interventions to dependent smokers living in Lewisham, including medication. This includes a more intensive service for highly dependent smokers, provided through group and one to one sessions at a range of venues throughout the borough, and support for moderately dependent smokers through GPs & pharmacies including a hub based model in each neighbourhood (1).

3.2 Evidence for the service

There is good evidence for the effectiveness and cost-effectiveness of English stop smoking services in getting smokers to successfully quit smoking. These services are expected to offer behavioural support and medication to all smokers in their community and also ensure that they are treating smokers proportionally to their demographics in their area (2). Behavioural support is typically provided via face-to-face or groups sessions. Several randomised controlled trials have demonstrated both the short-term and long-term effectiveness such SSS in helping smokers to stop smoking (2) (Evidence Grade A). When services are provided optimally, the proportion of service users who stop for 4 weeks should be approximately 50%, with 15% lasting 12 months, compared with 15% at 4 weeks and less than 5% at 12 months if these smokers tried to stop unaided (2). Additionally several high quality studies have shown that face-to-face behavioural support for smoking cessation provided individually or in groups can improve success in quitting smoking in comparison to no support (3). There is also evidence that smoking cessation programs for those in high risk groups (e.g. those who already have LTCs but have continued smoking) featuring more intensive intervention (e.g. motivational interviewing) is clinically effective in reducing smoking rates at 1 year, particularly for people with coronary heart disease (4).

A rapid review of evidence was recently performed on behalf of the Association for Directors in Public Health earlier this year exploring the alternative channels of delivering SSS i.e. via telephone, online and digital apps (3). It found that there was good evidence of effectiveness (systematic reviews of RCTs) for telephone (pro-active and reactive) and mobile phone stop smoking support, with studies reporting a 2-3% increase in quit rate for telephone support. However, none of the studies identified in the review compared telephone or mobile phone support with the current service models of face-to-face or group support for SSS. The most common comparators used in the studies identified were the provision of self-help materials/leaflets or one-off telephone advice calls. It is therefore only possible to say that mobile phone, telephone and internet support to help quit smoking can be effective channels of delivery but may not necessarily be as or more effective than face-to-face or group support (evidence grade D).

3.3 Reach (Uptake)

The current stop smoking service in Lewisham reaches 3,500 smokers each year (7.2% of the estimated 48,500 smokers locally), with approximately 50% of these smokers quitting smoking successfully at 4 weeks after starting a smoking cessation programme. This demonstrates good reach of the service against the NICE benchmark of smoking cessation services reaching 5% of smokers in the population (1). A health equity audit of the SSS performed in 2013 revealed that (5):

- Younger smokers and female smokers over 60 appeared to be underrepresented in those accessing the service.

- Indian men, Chinese men, white Irish men and black Africans of both genders were least represented in users of the SSS in the context of the estimated number of smokers.
- Black African smokers in Lewisham have been shown to be more likely to use and be successful using the one to one specialist sessions provided by community advisors than other ethnicities. Those from lower socio-economic groups have also been shown to be more successful with one-to-one support.

3.4 Proposed changes to the existing service

The Council proposes the re-design and potential re-commissioning of the service to incorporate different delivery models including a greater use of digital and telephone support for less heavily dependent smokers; face to face support from specialists for heavily dependent smokers such as pregnant women, smokers with mental health problems and/or long term conditions and more efficient and effective prescribing of stop smoking medication. The number of smokers able to access the service is likely to reduce.

3.5 What did people say?

At the community event, participants ranked stop smoking services as the 5th most important public health service out of 7 options listed. When asked about their preference for delivery of support to stay healthy, face-to-face support was overwhelmingly ranked as preferable to online or telephone support. Online support was ranked as being marginally favourable to telephone support.

Though not the most highly ranked service by residents in the online consultation (ranked 6th most preferred), the importance and value of the service in the community was demonstrated in free text comments sections of the survey. The majority of respondents also perceived that the proposed changes to SSS would have a mostly negative (43%) rather than positive (12%) impact.

The acceptability of a redesigned SSS delivery format including a combination of face-to-face, telephone and text for low-risk smokers may be high amongst residents since 30% of respondents most favoured this delivery model in comparison to individual face-to-face (27%), group (25%), website (11%), online (4%) or telephone support (3%) models. Since the evidence base demonstrating increased benefit of using the combination delivery format in comparison to the current model is yet to be established, a local evaluation of this revised format for smokers in low-risk groups should be undertaken if employed.

SSS were ranked as the most preferred service by professional respondents in comparison to other services, with many respondents commenting on the effectiveness and strong evidence base for the service. The cost-effectiveness, particularly in the long run was also mentioned multiple times alongside concern that cuts to this service would disproportionally affect those in lower socio-economic groups, since they are more likely to smoke and the SSS supports the 'hardest to reach' and most vulnerable Lewisham residents.

3.6 Health impact of changes

Element of health impact	Description
Nature	The reduction in the capacity of the specialist support for all members of the community may have a negative impact on population health, particularly for some population groups. The use of different channels of support may conversely encourage engagement with the service from underrepresented population groups.

Likelihood	Uncertain
Scale	Any negative population health impacts are most likely to affect population groups in Lewisham that may no longer be able to access specialist support where they were more likely to achieve better quitting success i.e. those from deprived and Black African population groups as also identified in the EAA.
Timing	Any negative population health impacts could be realised in both the short and long-term: **Short-term:** In the short-term, if any negative impacts are realised due to reduced access for the population groups mentioned above, there may be a reduction in the number of successful quit attempts in these groups, which may affect quit rates for Lewisham overall. Fewer smokers in these population groups may therefore experience the following short-term benefits (6): • Normalising of heart rate and blood pressure within 20 minutes of quitting smoking. • Breathing becomes easier and the lung's functional abilities start to increase within 72 hours of stopping smoking. • Blood circulation in the gums and teeth becomes similar to that of a non-user between 10 days and 2 weeks of stopping smoking. **Long-term:** In the long-term any negative impacts may result in fewer smokers in these population groups experiencing the following health long-term health benefits: • Reduction in the excess risk of coronary heart disease, heart attack and stroke by half within one year of stopping smoking. • Reduced risk of lung cancer to between 30-50% of that for a continuing smoker after 10 years of stopping smoking. There may also be long-term health impacts for those exposed to the secondhand smoke of continuing smokers which include (7): • Increased risk of respiratory infections, ear infections and more severe and frequent asthma attacks in infants and children. • Increased risk of coronary heart disease and lung cancer in adults.

3.7 Mitigations

Careful monitoring of users of the service following the introduction of the proposed changes will have to be performed in addition to an evaluation of the new service model to mitigate against any negative population health impacts.

3.8 Summary

- There is a good evidence base for the effectiveness of stop smoking services in improving success in quitting smoking for those that attend. The current format of SSS being delivered in Lewisham contains many of the main evidence based elements.
- The reach of the service is good in Lewisham, however particular population groups appear to have greater success in quitting as a result of attending various parts of the service i.e. men and black African smokers and those in deprived areas that attend the specialist adviser service. These population groups are most likely to be affected by any reduction in the capacity of the service than other population groups.
- Though not the most highly ranked service by residents, the importance and value of the service in the community has been demonstrated in the consultation responses. The acceptability of a redesigned SSS delivery format including a combination of face-to-face, telephone and text may be high amongst residents as indicated by the online consultation results although the evidence base for this is unclear. A local evaluation of this revised format should be undertaken if employed.
- The reduction in the capacity of the specialist support for all members of the community is likely to have an impact on population health, particularly for those from deprived and Black African population groups. However, the use of new channels of delivery may encourage service use from currently underrepresented population groups.

3.9 References

1. Miller J, Iyasere E, Scott G, Thomas L, Waites D. Briefing paper for Lewisham CCG: Investing in Stop Smoking, Alcohol and Healthy Weight Services saves the health service money. June 2016.
2. West R, May S, West M, Croghan E et al. Performance of English stop smoking services in first 10 years: analysis of service monitoring data. August 2013.
3. Lamb P, Ramzanali Z. Rapid review of channel shifting in stop smoking services. March 2016.
4. Ismail, S. Self-care and Self-management Support for Health Improvement in Lewisham. Lewisham Council. (November 2015)
5. Pringle, E. Health Equity Audit of Lewisham's Stop Smoking Service. Lewisham Public Health. January 2013.
6. Stop Smoking Recovery Timetable. Available at: http://whyquit.com/whyquit/A_Benefits_Time_Table.html <Accessed on 31st August 2016>
7. Smoke free website. Secondhand smoke webpage. Available at: https://smokefree.gov/secondhand-smoke <Accessed on 31st August 2016>

4. NHS Health Checks

4.1 Description of the service

The NHS Health Check programme is commissioned to identify 40-74 year olds with a high risk of developing cardiovascular and other conditions. This includes direct commissioning of health checks provided by GPs, pharmacies and To Health (outreach); a call/recall system (every 5 years) and IT. This is a mandatory programme, assessing risk and facilitating early intervention (1).

4.2 Evidence for the service

Public Health England and NICE have adopted a position of support for NHS Health Checks despite uncertainties around the literature evidence because: the programme in England is more carefully targeted than models evaluated elsewhere, and modelling on hidden burden of disease (especially for diabetes) suggests that population level threats to health nationwide are substantial and a major up-lift in prevention and early diagnosis is needed (1).

There is a growing body of evidence examining the effectiveness of NHS health checks, however, the effectiveness of NHS Health Checks in improving long-term outcomes has yet to be clearly demonstrated (evidence grade D). The most recent and thorough evaluation of the NHS Health Check programme (2) found that in the first four years of the programme, NHS Health Checks were effective at identifying new co-morbidities in those attending a health check in comparison to those that had not. Heath checks were also shown to be effective in increasing first-time prescriptions of statins and anti-hypertensive medication in those that have had a check in comparison to those that have not (evidence grade B).

4.3 Reach (uptake)

In 2015/16, approximately 5,400 NHS Health Checks were carried out across the borough, with the majority of checks being carried out (71%) in GP surgeries. For the same period, 54% of those having a health check were female. Reach into some BME groups is particularly good (further information is provided below). However, uptake rates in Lewisham overall are slightly below the national average (34% in Lewisham compared with 45% in England as a whole) (3).

4.4 Proposed changes to the existing service

The Council proposes the redesign and potential re-commissioning of the programme, including different delivery models for follow-up for those identified as at risk following an NHS Health check. We are aiming for a better integrated pathway, targeting of at risk populations and more effective follow-up for those identified as at risk.

4.5 What did people say?

Resident respondents ranked NHS Health Checks as their most preferred service and felt that the changes would have a negative impact on the service (47%) in comparison to those who felt that there would be no impact (11%) or a positive impact (19%).

Professional respondents ranked NHS Health Checks as their 2nd most preferred service with respondents commenting that more pharmacies should be used to provide health checks. The benefit of identifying those with risk factors early was also recognised in further comments.

4.6 Health Impact of changes

Element of health impact	Description
Nature	Since the capacity of the NHS Health Checks service is to be retained, the known health benefits of having a health check are expected to be preserved.
Likelihood	Fairly certain
Scale	Any impacts are most likely to impact upon adults within the health check age range (40-74 years) and service providers of health checks and associated services (e.g. providers of the new National Diabetes Prevention programme).
Timing	Any population health impacts will be mostly realised in the short-term in line with the best available evidence. These will include a possible change in the uptake of health checks and subsequent referral or treatment based on the health check risk assessment.

4.7 Mitigations

Ongoing monitoring of NHS Health Check uptake rates and the demographic make-up of attendees should ensure that any unexpected impacts are identified.

4.8 Summary

- There is a growing body of evidence examining the effectiveness of NHS health checks but the effectiveness of NHS Health Checks in improving long-term outcomes has yet to be clearly demonstrated
- The evidence-based short-term health impacts of NHS Health Checks include: the increased chance of identifying new comorbidities and prescribing statins and/or hypertensive medication or the first time in those having a check.
- The uptake of the service in Lewisham could be improved but has good reach across genders and those of different ethnicities within the borough.
- The service is ranked highly in terms of preference for both residents and professionals.
- Since the capacity of the NHS Health Checks service is to be retained, the known short-term health benefits of having an NHS health check are expected to be preserved.

4.9 References

1. Ismail, S. Self-care and Self-management Support for Health Improvement in Lewisham. Lewisham Council. (November 2015)

2. Robson J, Dostal I, Sheikh A, et al. The NHS Health Check in England: an evaluation of the first 4 years. BMJ Open 2016;6: e008840. doi:10.1136/ bmjopen-2015-008840

3. Under-75 CVD Public Health Performance Dashboard. Lewisham Public Health. July 2016.

5. Community Health Improvement Service (CHIS)

5.1 Description of the service

The Community Health Improvement Service (CHIS) is delivered by Lewisham and Greenwich Trust and provides a range of health promotion activities targeted at those with poorer health outcomes. It provides behaviour change and healthy lifestyle support through: a lifestyle hub delivering motivational interventions and referrals to people identified as at risk following an NHS Health check; Health Trainers providing one to one and group motivational interviewing and lifestyle coach support (over 80% of those supported by the service sustain behavioural change after 24 weeks) and the Healthy Walks programme, which trains walk leaders, develops, promotes and ensures regular health walks to increase participation and uptake of physical activity. It also engages, develops and empowers communities through community development for health improvement and neighbourhood based activities including outreach, participatory budgeting/small grants, networks, negotiating and developing referral pathways into preventative lifestyle activities and interventions, and linking providers of preventative initiatives with community groups (1).

5.2 Evidence for the service

There are varying levels and quality of evidence for the different components of CHIS:

a. *Lewisham Lifestyle Hub (LLH)*: There is no peer-reviewed evidence identified in this HIA that examined the effectiveness of a hub model like LLH improving health outcomes. An external evaluation of the LLH noted that the motivational interviewing for those having an NHS Health Check was extremely valuable (2). However in its current form it is unclear how effective the LLH has been bringing about lifestyle behaviour change for residents in the borough in comparison to other potential referral models (evidence grade D).

b. *Health Trainers:* An evidence review for this component of CHIS was performed in November 2015. The review found that for health trainers, high grade evidence on their impact is in short supply, but available studies indicate that they may lead to short-term improvements in some health related behaviours. However, there is no evidence that they bring about sustained behaviour change, and wider community impacts remain unclear (evidence grades C and D). Economic evaluations of lay health trainer programmes have shown that they are cost-effective at NICE thresholds (3).

c. *Healthy Walks:* For the healthy walks programme, there is good evidence that walking groups increase rates of physical activity and have positive health effects – both on objective measures of physical fitness and mental wellbeing. Cost effectiveness analyses indicate that most measures to promote physical activity in primary care and community settings are cost-effective, but that walking groups are particularly so (3).

d. *Community development and participatory budgeting*: The effectiveness of community development-based approaches lies in the confidence and strength engendered by building the number and strength of face to face social networks (with friends, family, colleagues and so on). There is also NICE guidance (4) in support of programmes on this model. In terms of participatory budgeting, the evidence review mentioned above found very little research that addressed the role of participatory budgeting in improving health outcomes of participants. It did however cite a systematic review undertaken for the Department of Communities and Local Government, which found that participatory budgeting can improve relations between citizens

and government bodies, enhance community cohesion and drive local service improvements, but health and wellbeing were not addressed as outcomes. Some international evidence of positive effects on health and wellbeing from countries such as Brazil – where there is a long history of participatory budgeting at local level – was also found but these effects had not yet been replicated in the UK (evidence grade B) (3).

5.3 Reach (uptake)

a. Lewisham Lifestyle Hub (LLH): For the 2015/16 period, there were 957 referrals received by the hub, with most referrals coming from pharmacies (55%). The majority of those being referred to the hub were female (67%) and aged between 40 and 59 years (82%), although these age groups are reflective of those having NHS health Checks in the borough (who largely make up those referred to the hub). The hub has good reach into BME groups with 14% of those referred in this period being African, 11% Caribbean, and 8% White British (5).

b. The Health Trainer service: For the 2015/16 period there were 13 registered health trainers providing one- to-one support, over a total of 698 lifestyle support sessions. There were 491 referrals into the scheme in the same period with the majority of referrals coming from health professionals (71.3%). Of the total number of referrals, 166 (33.4%) people referred received one-to-one lifestyle support from health trainers, with 109 (65.6%) people achieving a lifestyle change and 59 (35.5%) people achieving 30 minutes of physical activity per week (5). In the same period, the service reached predominantly women (75% of those referred were female) and had good reach to ethnic groups (45% of those referred were of Black African and Caribbean ethnicity) (7).

c. The Healthy Walks programme: For the 2015/16 period, an average of 300 people per month partook in regulars walks (at least once per week), with a total of 314 new walkers joining across the year (6). The programme in Lewisham has been able to engage with a significantly higher percentage of participants with long term health conditions or disabilities compared to other 'Walking for Health' schemes nationally and those based in London (19% for Lewisham, compared to 10-11% for the national and London averages) (6). A third of the scheme's participants are from BME groups, which is much better when compared to other London based schemes (6).

d. Community Development and Participatory Budgeting: In 2016, 17 organisations were awarded participatory budgeting funding to run projects in Lewisham. A total of 628 people participated in these project activities and 66% of these participants reported an increase in their mental wellbeing after being involved in project activities (7). Improved physical health, including maintained or increased fitness and energy, weight loss, a sense of physical well-being and more effective management of chronic health problems like back pain and diabetes, were identified as outcomes. Participants with severe pain and mobility difficulties reported how becoming more physically active had helped them to manage their conditions, with what they described as life changing effects. (8)

5.4 Proposed changes to the existing service

The Council proposes the potential reconfiguration or removal of the services currently delivered by CHIS. This may encompass the following:

- Removal of the health trainer programme, potentially mitigated by the existing community nutrition and physical activity service delivered by GCDA and by expansion of the existing commercial weight management offer (e.g. weightwatchers vouchers).

- Removing the community development element, mitigated by the council investing in health-focussed grants across all 4 Neighbourhoods in Lewisham.

- The removal of the lifestyle hub, mitigated by including advice and onward referral with in the Healthchecks delivery specified in the re-commissioning of the NHS Health Checks programme.

- Priority will be given to supporting emerging neighbourhood delivery models and alignment with wellbeing community development programmes such as Well London, which is an external funding stream.

5.5 What did people say?

Resident respondents ranked the 'Healthy Walks' component of CHIS as their 2nd most preferred 'Staying Healthy' service, with the 'Health Trainer' component being ranked 4th and 'Small grants'/community development elements 5th most preferred. However, respondents felt that the proposed changes to all 3 components of CHIS would have a mostly negative impact rather than a positive one. Some very passionate responses for the 'Healthy Walks' programme were received with some respondents commenting that the service was good for both physical and mental health and for increasing social connections.

Professional respondents, however, ranked 'Healthy Walks' as their least preferred service. This was similar for the 'Health Trainer' component, which was ranked 6th most preferred. The 'Small grants'/community development element of the service, was ranked as the 5th most preferred service.

5.6 Health Impact of changes

Element of health impact	Description
Nature	The elements of CHIS that have the strongest evidence base for population health impact i.e. Healthy Walks and the community development work are due to largely remain albeit in different delivery formats. It is therefore expected that the population health impacts resulting from these elements will be minimal. It is unclear from the available evidence whether the changes to the LLH and health trainer services will have a positive or negative health impact although BME users of LLH and Health Trainers may be disproportionately impacted by being unable to access a service that they had particularly good representation at.
Likelihood	Uncertain
Scale	Any health impacts realised will predominantly occur in the adult population of Lewisham and potentially more so for the BME users of the LLH for reasons described above. With reference to the latest CHIS Annual report and monitoring data the EAA was unable to readily assess the potential equalities impact of the community development work of CHIS, although historical and verbal reports confirm that this work of CHIS was very effective at reaching BME and more deprived communities. It is likely that these groups could be disproportionately affected by any reduction.
Timing	It is unclear whether any health impacts realised due to the changes

	to CHIS overall will occur in the short- or long-term due to lack of definitive evidence.

5.7 Mitigations

The introduction of the National Diabetes Prevention Programme in Lewisham will help to provide an avenue for all of those that are found to be 'pre-diabetic' following an NHS Health Check to receive evidence-based behavioural support to prevent the onset of diabetes. Since those from BME backgrounds are considered to be at greater risk of developing Type 2 Diabetes, this programme will help to mitigate any negative impact realised from the removal of the LLH for those identified as being at high risk in this population group.

As mentioned above, the existing community nutrition and physical activity service delivered by GCDA and the expansion of the existing commercial weight management offer (e.g. weightwatchers vouchers) may also mitigate against the proposed changes to CHIS. The community development nature of the community nutrition and physical activity service will target black African and black Caribbean communities.

5.8 Summary

- There are varying levels and quality of evidence for the different components of CHIS.
- All services within CHIS have been shown to have good reach in Lewisham, however the LLH has been shown to have particularly good reach for residents in 'Black African' and 'Black Caribbean' groups.
- It is expected that the population health impacts resulting from the elements of CHIS that have the strongest evidence base for population health impact i.e. Healthy Walks and the community development work will remain albeit in different delivery formats.
- Residents and professionals had differing perspectives of the CHIS services, with residents ranking 'Healthy Walks' quite highly but professionals ranking all CHIS services as the least preferred.
- It is unclear from the available evidence whether the changes to the LLH and health trainer services will have a positive or negative health impact, although BME users of LLH may be disproportionately impacted by being unable to access a service that they had particularly good representation at.
- The introduction of the National Diabetes Prevention Programme, the existing community nutrition and physical activity service delivered by GCDA and the expansion of the existing commercial weight management offer (e.g. weightwatchers vouchers) may all work to mitigate against negative health impact resulting from the proposed changes to CHIS.

5.9 References

1. Public Health Savings Consultation Document. Executive Directors of Community Services at Lewisham Council. (June 2016)

2. Harkin, J. Lewisham Lifestyle Hub: An Early Review. (2014)

3. Ismail, S. Self-care and Self-management Support for Health Improvement in Lewisham. Lewisham Council. (November 2015)

4. National Institute for Health and Clinical Excellence (NICE). Community engagement: improving health and wellbeing and reducing health inequalities. NICE guidelines [NG44]. March 2016.

5. Public Health Community Health Improvement Service (CHIS) Performance Checkpoint Report 2015-16.
6. Walking for health team response to Lewisham Public Health Consultation. August 2016.
7. Lewisham Community Health Improvement Service (CHIS) Annual Report. April 2016.
8. North Lewisham Health Improvement Programme: evaluation report, Lewisham Public Health 2013

6. Children's weight management services

6.1 Description of the service

MyTime Active deliver a children's weight management programme (MEND) in Lewisham. The service delivers a range of age-specific evidence-based family interventions for overweight and obese children in the borough. The service includes specialist support (dietician, psychologist and physical activity specialist) for obese children with co-morbidities or with complex needs. The service also delivers a range of bespoke workforce training sessions. The children's weight management service supports the mandatory National Child Measurement Programme which identifies that Lewisham has consistently high prevalence of childhood obesity (1).

6.2 Evidence for the service

There is good randomised controlled trial evidence for the MEND (Mind, Exercise, Nutrition, and Do It) programme (evidence grade B). In its ideal form the programme should involve a 9-week programme consisting of 18 sessions (2 hours group sessions held twice weekly) run by two MEND with groups of between 8-15 children and their accompanying adult or guardian. A multi-centre RCT conducted in 2010, found that children attending the MEND programme had significantly reduced waist circumference and BMI measurements in comparison to children that had not yet started the programme at 6 months from baseline (2). However, the significance of reducing waist circumference in children is not yet established and in this study children were also given free-family access to a community swimming pool for a further 12 weeks following the end of the 9-week MEND programme (2). Long-term impacts of participation in the programme have also been examined with one retrospective longitudinal study demonstrating significant reduction in BMI z-score for boys at 2.4 years from baseline and significant improvements in waist circumference and psychological indices overall at 2.4 years from baseline, however this evidence did not involve comparison with a suitable control group (3).

6.3 Reach (uptake)

For the 2014/15 period, the prevalence of overweight (including obesity) for children in the reception class and year 6 in Lewisham was 23.7% and 39.3% respectively. This was higher in both groups than the average prevalence for England overall in the same period (21.9% for reception class and 33.2% for year 6) (4).

The service delivers a range of age-specific evidence-based family interventions for 375 overweight and obese children in Lewisham, which suggests that the service reaches approximately 4% of the estimated 9,000 obese children (under 16's) in the borough (1). In the first year of contract there were 151 initial assessment for the specialist service, 187 children accessing the service and 72 completers to date. The service is predominantly attended by female children in borough and has representative attendance from children from BME backgrounds as further described below (5).

6.4 Proposed changes to the existing service

The Council proposes to integrate the service through investment into a new contract for school nursing. This would require serving notice on the existing service.

The Council also proposes the potential removal of the specialist element of the service: in this scenario children with complex needs would be offered the core programme in the same way as other children. The service will provide a limited range of age-specific targeted programmes with focus on children under the age of 12 with a reach reduced to under 200 families.

6.5 What did people say?

This service was ranked as the 3rd most preferred service by resident respondents with a large majority of respondents feeling that the proposed changes to the service would have a negative impact (44%). Several comments made about the child weight management service represented the view that efforts to address childhood obesity should be focused on schools.

Respondents to the professional online consultation also ranked the children's weight management service as their 3rd most preferred service, however concerns were expressed about the potential negative impacts of the changes most notably that childhood obesity affects those of lower socio-economic status the most, and that any reduction in capacity of the service would increase health inequalities.

6.6 Health Impact of changes

Element of health impact	Description
Nature	There is expected to be a negative population health impact for those unable to access the additional support provided alongside the MEND programme. This may particularly be the case for female children and those from BME backgrounds.
Likelihood	Certain
Scale	Any health impacts realised will predominantly affect overweight and obese children in the borough, particularly girls and those from BME backgrounds as mentioned above. In the EAA, the protected characteristic groups that were mostly likely to be negatively affected were: disability, ethnicity/race, age and sex for the reasons outlined above in terms of service reach and the nature of the proposed changes.
Timing	Both short- and long-term impacts may be realised: **Short-term:** Persistence of overweight and obesity in affected children. **Long-term:** There are several evidence-based long-term sequelae of overweight and obesity in childhood and adolescence, which include (6): -Increased likelihood of adult obesity -Increased likelihood of adult cardiovascular disease and diabetes -Increased likelihood of cardiovascular mortality and colon cancer for men.

6.7 Mitigations

Close monitoring of service use and health outcome data following the introduction of the proposed changes, particularly to capture demographic data for service users will be vital to identify if any negative impacts are realised and to work to mitigate them when/if they arise.

6.8 Summary

- There is a good evidence base for the MEND element of the children's weight management service, demonstrating both short and intermediate term impact for improvement in BMI and waist circumference measurements in overweight and obese children.
- Both residents and professionals ranked these services as their 3rd most preferred service.
- The service reaches approximately 4% of the estimated 9,000 obese children (under 16's) in the borough.
- There is expected to be a negative population health impact for those unable to access the additional support alongside MEND following the introduction of the proposed changes. This may be particularly the case for girls, BME children, and children with complex needs.
- Close monitoring of service use and health outcome data following the introduction of the proposed changes, particularly to capture demographic data for service users will be vital to identify if any negative impacts are realised and to work to mitigate them when/if they arise.

6.9 References

1. Public Health Savings Consultation Document. Executive Directors of Community Services at Lewisham Council. (June 2016)

2. Sacher P, Kolotourou M, Chadwick P, Cole T, Lawson M, Lucas A, and Singhal A. Randomized Controlled Trial of the MEND Program: A Family-based Community Intervention for Childhood Obesity. February 2010.

3. Kolotourou M, Radley D, Gammon C, Smith L, Chadwick P, and Sacher P. Long-Term Outcomes

following the MEND 7–13 Child Weight Management Program. Childhood Obesity. Volume 11, Number 3. June 2015.

4. National Child Measurement Programme (NCMP) Local Authority Profile. Public Health England. Available at: http://fingertips.phe.org.uk/profile/national-child-measurement-programme/data#page/0 <Accessed 25th August 2016>

5. Children's Weight Management Service Quarterly Monitoring data. Lewisham Public Health 2015-16.

6. Dietz WH. Childhood weight affects adult morbidity and mortality. J. Nutr. February 1, 1998

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7. Conclusions and Recommendations

This HIA has identified some key areas of potential health impact resulting from the proposed changes, most notably in relation to changes to Stop Smoking Services, CHIS and Children's Weight Management Services. Where these impacts have been identified measures to mitigate against them have been proposed and can be summarised in the following recommendations:

Breastfeeding Support Services

- Effective delivery and promotion of the redesigned service through health visiting will be essential to ensure that access to the service is maintained and improved for population groups not currently accessing the service in a representative way.

Stop Smoking Services

- Careful monitoring of users of the stop smoking service following the introduction of the proposed changes will have to be performed in addition to an evaluation of the new service model to mitigate against any negative population health impacts.

NHS Health Checks

- Ongoing monitoring of NHS Health Check uptake rates and the demographic make-up of attendees should ensure that any unexpected impacts are identified.

Community Health Improvement Service (CHIS)

- The introduction of the National Diabetes Prevention Programme, the existing community nutrition and physical activity service delivered by GCDA and the expansion of the existing commercial weight management offer (e.g. weightwatchers vouchers) should all work to mitigate against negative health impact resulting from the proposed changes to CHIS.

Children's Weight Management Service

- Close monitoring of service use and health outcome data following the introduction of the proposed changes, particularly to capture demographic data for service users will be vital to identify if any negative impacts are realised and to work to mitigate them when/if they arise.

Appendix 1: Preference Ranking Summary Scores for online resident and professional surveys

Table 1: Preference Ranking Summary Scores for online resident's survey

Service	Summary Score	Overall Preference Ranking
NHS Health Checks	749	1
Healthy Walks	672	2
Children's Weight Management Services	534	3
Health Trainers	499	4
Small Grants to Community Groups	464	5
Stop Smoking Services	436	6
Breastfeeding support services	399	7

Table 2: Preference Ranking Summary Scores for online professional's survey

Service	Summary Score	Overall Preference Ranking
Stop Smoking Services	425	1
NHS Health Checks	332	2
Children's Weight Management Services	315	3
Breastfeeding Support Services	256	4
Small Grants to Community Groups	235	5
Health Trainers	232	6
Healthy Walks	193	7

Children and Young People Select Committee			
Title	Select Committee work programme		
Contributor	Scrutiny Manager	Item	5
Class	Part 1 (Open)	14 September 2016	

1. Purpose

To advise Committee members of the work programme for the 2016/17 municipal year, and to decide on the agenda items for the next meeting.

2. Summary

2.1 At the beginning of the new administration, each select committee drew up a draft work programme for submission to the Business Panel for consideration.

2.2 The Business Panel considered the proposed work programmes of each of the select committees on 24 May 2016 and agreed a co-ordinated overview and scrutiny work programme. However, the work programme can be reviewed at each Select Committee meeting so that Members are able to include urgent, high priority items and remove items that are no longer a priority.

3. Recommendations

3.1 The Committee is asked to:

- note the work plan attached at **Appendix B** and discuss any issues arising from the programme;
- specify the information and analysis required in the report for each item on the agenda for the next meeting, based on desired outcomes, so that officers are clear on what they need to provide;
- discuss the information and analysis required for the scope on the Committee's review into transition from primary to secondary school as listed in **section 6** of this report;
- review all forthcoming key decisions, attached at **Appendix C**, and consider any items for further scrutiny.

4. The work programme

4.1 The work programme for 2016/17 was agreed at the Committee's meeting on 13 April 2016.

4.2 The Committee is asked to consider if any urgent issues have arisen that require scrutiny and if any existing items are no longer a priority and can be removed from the work programme. Before adding additional items, each item should be considered against agreed criteria. The flow chart attached at **Appendix A** may help Members decide if proposed additional items should be added to the work

programme. The Committee's work programme needs to be achievable in terms of the amount of meeting time available. If the committee agrees to add additional item(s) because they are urgent and high priority, Members will need to consider which medium/low priority item(s) should be removed in order to create sufficient capacity for the new item(s).

5. The next meeting

5.1 The following reports are scheduled for the meeting on 14 September 2016:

Agenda item	Review type	Link to Corporate Priority	Priority
Response to recommendations CIAG in schools	In-depth review	Young people's achievement and involvement and Protection of Children	High
Education Commission Action Plan and referral response	Performance monitoring	Young people's achievement and involvement and Protection of Children	High
Scoping Paper – Indepth review on Transition from Primary to Secondary	In-depth review	Young people's achievement and involvement and Protection of Children	High
Lewisham Safeguarding Childrens Board Annual Report	Performance monitoring	Protection of Children	High
Update on Secondary School Improvement Strategy inc. provisional results	Performance monitoring	Young people's achievement and involvement	High
Music Services Proposals	Policy Development	Young people's achievement and involvement	Medium

5.2 The Committee is asked to specify the information and analysis it would like to see in the reports for these item, based on the outcomes the committee would like to achieve, so that officers are clear on what they need to provide for the next meeting.

6 Scoping Paper – in-depth review on Transition from Primary to Secondary

6.1 The Children and Young People Select Committee has agreed to undertake a review into the transition between primary and secondary schools (key stage 2 to key stage 3) as its in-depth review for the 2016/17 municipal year.

6.2 At this meeting, members of the Committee and Young Advisors are asked to consider whether there are particular points they wish to ensure are covered in the detailed scope that the Committee will consider at its October meeting.

It is proposed that the review considers a number of indicators such as attainment, attendance, participation, behaviour, bullying and mental health and looks to find good practice examples of where transition is working well and how this can be replicated.

6.3 The review could look at the national and local context, at the issues faced by schools, local authorities, pupils and parents. It will draw on national experts and look at examples from local schools and experiences from young people in Lewisham. A recent academic study at UCL on identifying factors that predict successful and difficult transitions to secondary schools could be particular useful when considering the national context and good practice.

6.4 The review is likely to include a number of visits to local schools. These could include: Barings Primary School; Bonus Pastor and St William of York; and/or Conisborough and Rangefield. The visits would look at partnerships between schools and how the schools prepare, pupils, parents and teachers for the transition.

6.5 The Committee have already noted that they are keen to draw on the views and experiences from Young Advisors and to ensure that Young Advisors are involved in the review process. They therefore particularly welcome contributions at this meeting to help shape the scope of the review.

6.6 The review would be timely as the Committee's findings could feed into the on-going work being undertaken by the CYP Directorate on transition and good practice in particular the Transition Review and the work of the LBL Transition Working Party.

7. Financial Implications

There are no financial implications arising from this report.

8. Legal Implications

In accordance with the Council's Constitution, all scrutiny select committees must devise and submit a work programme to the Business Panel at the start of each municipal year.

9. Equalities Implications

9.1 The Equality Act 2010 brought together all previous equality legislation in England, Scotland and Wales. The Act included a new public sector equality duty, replacing the separate duties relating to race, disability and gender equality. The duty came into force on 6 April 2011. It covers the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

9.2 The Council must, in the exercise of its functions, have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not.
- foster good relations between people who share a protected characteristic and those who do not.

9.3 There may be equalities implications arising from items on the work programme and all activities undertaken by the Select Committee will need to give due consideration to this.

10. Date of next meeting

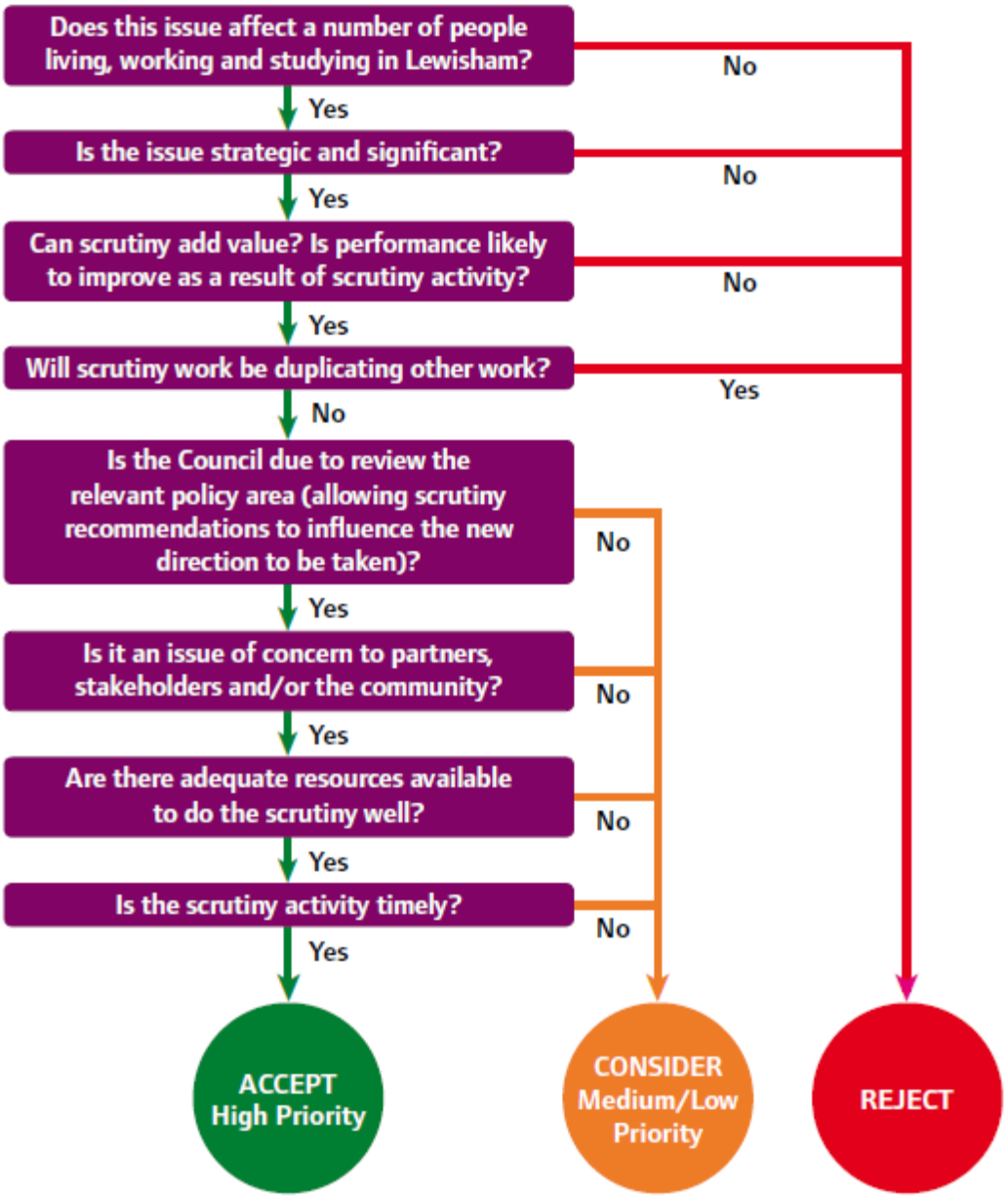
10.1 The date of the next meeting is Wednesday 12 October 2016.

Background Documents

Lewisham Council's Constitution

Centre for Public Scrutiny: the Good Scrutiny Guide

Scrutiny work programme – prioritisation process



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Children and Young People Select Committee 2016/17

Programme of Work

Work Item	Type of review	Priority	Strategic Priority	Delivery deadline	13-Apr	08-Jun	13-Jul	14-Sep	12-Oct	10-Nov	11-Jan	28-Feb
Lewisham Future Programme	Standard item	High	CP2 & CP7	Ongoing				Savings				
Election of the Chair and Vice-Chair	Constitutional requirement	High	CP10	Apr								
Select Committee work programme 2015/16	Constitutional requirement	High	CP10	Apr								
Independent Advice & Guidance in School	in depth review	High	CP2&CP7	Apr		report			Response to recs			
Report of Education Commission	Performance monitoring	High	CP2	Apr	UPDATE				Action Plan & referral response			
Employee Led mutual for the Youth Service	Information Item	Medium	CP2 & CP7	Apr	UPDATE	UPDATE						
Introduction to Young Mayor and Advisors	Information Item	Medium	CP2	Apr								
Annual Report on attendance and exclusions	Performance monitoring	Medium	CP2&CP7	Jun								
Response to referral on Ofsted Action Plan	Performance monitoring	Medium	CP2&CP7	Jun		RESPONSE						
Alternative Education Provision	policy development	Medium	CP2	Jun								
Childrens Social Care Ofsted Action Plan	Performance monitoring	High	CP2&CP7	Jul								
Upate on implementation of SEND Strategy	Performance monitoring	High	CP2&CP7	Jul								
Early Help Strategy	Performance monitoring	High	CP2&CP7	Jul								
In-depth review Transition from Primary to Secondary School	Indepth review	High	CP2&7	Ongoing				informal discussic	Scope	Evidence 1	Evidence 2	Report
Health Savings -school nursing and health visiting	Performance monitoring	high	CP2&CP7	Sep								
Lewisham Safeguarding Children's Board Annual Report	Standard item	High	CP7	Oct								
Childrens Social Care Workforce Strategy	Performance monitoring	High	CP2&CP7	Nov								
Further Education - update on area reviews	Information Item	Medium	CP2	Nov								
Human Trafficking Organisation -External speaker	Information Item	High	CP7	Nov								
Safeguarding Services 6-monthly Report	Standard item	High	CP2&CP7	Jan								
Update on secondary school improvement strategy inc provisional results	Performance monitoring	High	CP2	Oct								
Child sexual exploitation Update	Standard item	High	CP2&CP7	Ongoing								
Music Services Proposals	Policy development	Medium	CP2	Oct								
School's Places Strategy Update	Performance monitoring	Medium	CP2	Jan								
Annual Schools Standards Report (primary and secondary)	Standard item/performance monitoring	High	CP2	Feb								
Childcare Strategy Update -including increase provision for 3 yr olds	Policy development	Medium	CP2	Feb								
Corporate Parenting and LAC Annual Report	Standard item/performance monitoring	High	CP2&CP7	Feb								

	Item completed
	Item on-going
	Item outstanding
	Proposed timeframe
	Item added

Meetings					
1)		13 April	5)		12 october
2)		8 June	6)		10 November
3)		13 July	7)		11 January
4)		14 September	8)		28 February

Shaping Our Future: Lewisham's Sustainable Community Strategy 2008-2020		
	Priority	
1	Ambitious and achieving	SCS 1
2	Safer	SCS 2
3	Empowered and responsible	SCS 3
4	Clean, green and liveable	SCS 4
5	Healthy, active and enjoyable	SCS 5
6	Dynamic and prosperous	SCS 6

Corporate Priorities		
	Priority	
1	Community Leadership	CP 1
2	Young people's achievement and involvement	CP 2
3	Clean, green and liveable	CP 3
4	Safety, security and a visible presence	CP 4
5	Strengthening the local economy	CP 5
6	Decent homes for all	CP 6
7	Protection of children	CP 7
8	Caring for adults and older people	CP 8
9	Active, healthy citizens	CP 9
10	Inspiring efficiency, effectiveness and equity	CP 10

FORWARD PLAN OF KEY DECISIONS

Forward Plan September 2016 - December 2016

This Forward Plan sets out the key decisions the Council expects to take during the next four months.

Anyone wishing to make representations on a decision should submit them in writing as soon as possible to the relevant contact officer (shown as number (7) in the key overleaf). Any representations made less than 3 days before the meeting should be sent to Kevin Flaherty, the Local Democracy Officer, at the Council Offices or kevin.flaherty@lewisham.gov.uk. However the deadline will be 4pm on the working day prior to the meeting.

A "key decision"* means an executive decision which is likely to:

(a) result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates;

(b) be significant in terms of its effects on communities living or working in an area comprising two or more wards.

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
June 2014	**Surrey Canal Triangle (New Bermondsey) - Compulsory Purchase Order Resolution**	07/09/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
May 2016	**The Future of Lewisham Music Service**	07/09/16 Mayor and Cabinet	Councillor Paul Maslin, Cabinet Member for Children and Young People and Councillor Damien Egan, Cabinet Member Housing		
June 2016	**Federations - Revisions to Instruments of Government**	07/09/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
August 2016	**Gypsy and Traveller Local Plan Consultation**	07/09/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**LGO Report against Lewisham**	07/09/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Primary School Expansion**	07/09/16	Sara Williams, Executive		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
	Proposal - Permission for Consultation	Mayor and Cabinet	Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
May 2016	**Street Lighting Variable Lighting Policy**	07/09/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**Syrian Refugees Resettlement Programme**	07/09/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**1 Year Extension Passenger Transport Framework for CYP and Community Services Transport Provision**	07/09/16 Mayor and Cabinet (Contracts)	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
August 2016	**Out of Hours Service Contract Extension**	07/09/16 Mayor and Cabinet (Contracts)	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
August 2016	**2016 Schools Minor Works Contract**	07/09/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
		(Contracts)	Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
February 2016	**Insurance Renewal**	09/16 Overview and Scrutiny Business Panel	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Carer Specialist Information Advice and Support Service Contract**	20/09/16 Overview and Scrutiny Business Panel	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
August 2016	**Procurement Sexual Health Services**	20/09/16 Overview and Scrutiny Business Panel	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
August 2016	**Review of Highway Maintenance Contract Variation**	20/09/16 Overview and Scrutiny Business Panel	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**Accounts 2015-16**	21/09/16	Janet Senior, Executive		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
		Council	Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Deptford Parish Council Petition and Community Governance Terms of Reference**	21/09/16 Council	Kath Nicholson, Head of Law and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Gypsy and Traveller Local Plan Consultation**	21/09/16 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**Gypsy and Traveller Local Plan Site Selection**	21/09/16 Council	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**LGO Report against Lewisham**	21/09/16 Council	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		
April 2016	**Autistic Spectrum Housing**	28/09/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
August 2016	**Recommendations of the Broadway Theatre Working Group**	28/09/16 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
August 2016	**Catford Housing Zone Funding Award and Terms**	28/09/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Damien Egan, Cabinet Member Housing		
June 2016	**Children and Young People Public Health Nursing Redesign**	28/09/16 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
February 2016	**Disposal of Copperas Street Depot Creekside**	28/09/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
February 2016	**Health and Social Care Devolution Pilot**	28/09/16 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
August 2016	**LIP Annual Spending Submission 2017/18 and 2016/17 Update**	28/09/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**Lewisham Future Programme**	28/09/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
May 2016	**Lewisham Homes Loan Acquition Programme parts 1 and 2**	28/09/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
January 2016	**New Bermondsey Housing Zone Bid Update**	28/09/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
June 2016	**Options for 118 Canonbie Road**	28/09/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
August 2016	**Outcome of Public Health Savings Consultation and Approval to Procure**	28/09/16 Mayor and Cabinet	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
			Health, Wellbeing and Older People		
August 2016	**Private Rented Sector Discharge Policy**	28/09/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
August 2016	**Secondary School Re-organisation/Expansion Proposal Permission for Consultation**	28/09/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
August 2016	**The Wharves Deptford - Compulsory Purchase Order Resolution**	28/09/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
February 2016	**Contract Award/s Planned Preventative Maintenance, Repairs, Building Cleaning and Related Services**	28/09/16 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**Deptford Reach Development**	19/10/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
August 2016	**Discretionary Rate Relief**	19/10/16	Aileen Buckton,		

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Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
	Review	Mayor and Cabinet	Executive Director for Community Services and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Financial Forecasts 2016/17**	19/10/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Heathside & Lethbridge Phase 5 Compulsory Puchase Order**	19/10/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
August 2016	**Heathside & Lethbridge Phase 6 Parts 1 & 2**	19/10/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Damien Egan, Cabinet Member Housing		
May 2016	**Schools with License deficits**	19/10/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
August 2016	**Treasury Management Mid-Year Update**	19/10/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
			Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Update on action plan following Education Commission Report**	19/10/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
August 2016	**Community Premises Management Contract Permission to Tender**	19/10/16 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Joan Millbank, Cabinet Member Third Sector & Community		
August 2016	**Family Support Service Contract Award**	19/10/16 Mayor and Cabinet (Contracts)	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
August 2016	**Footways Contract Award**	19/10/16 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**Re-Procurement Managed Service Interpretation, Translation and Transcription**	01/11/16 Overview and Scrutiny Business	Janet Senior, Executive Director for Resources & Regeneration and		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
	Services Contract award	Panel	Councillor Kevin Bonavia, Cabinet Member Resources		
May 2016	**Annual Complaints Report**	09/11/16 Mayor and Cabinet	Janet Senior, Executive Director for Resources & Regeneration and Councillor Joe Dromey, Cabinet Member Policy & Performance		
August 2016	**Regionalising Adoption**	09/11/16 Mayor and Cabinet	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
August 2016	**Review of National Non Domestic Rates - Discretionary Discount Scheme for Businesses Accredited to Living Wage Foundation**	09/11/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Carriageway Resurfacing Contract Award**	09/11/16 Mayor and Cabinet (Contracts)	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**School Minor Works Programme 2017**	09/11/16 Mayor and Cabinet (Contracts)	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin,		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
			Cabinet Member for Children and Young People		
August 2016	**Deptford High Street (North) Contract Award**	22/11/16 Overview and Scrutiny Business Panel	Janet Senior, Executive Director for Resources & Regeneration and Councillor Alan Smith, Deputy Mayor		
August 2016	**Consultant Appointment 2016 Schools Minor Works Contract**	22/11/16 Overview and Scrutiny Education Business Panel	Sara Williams, Executive Director, Children and Young People and Councillor Paul Maslin, Cabinet Member for Children and Young People		
May 2016	**Main Grants Programme 2017-18 Appeals Against Proposals**	30/11/16 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Joan Millbank, Cabinet Member Third Sector & Community		
May 2016	**2017-18 Council Tax Reduction Scheme**	07/12/16 Mayor and Cabinet	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Contract Extensions for Accommodation Based Services and Floating Support Service**	07/12/16 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best,		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
			Cabinet Member for Health, Wellbeing and Older People		
August 2016	**Fusion Leisure Contract Variation**	07/12/16 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
May 2016	**Main Grants Programme 2017-18 Allocation of Funding**	07/12/16 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Joan Millbank, Cabinet Member Third Sector & Community		
May 2016	**Prevention and Inclusion Team Award of Contracts**	07/12/16 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Janet Daby, Cabinet Member Community Safety		
August 2016	**Prevention Inclusion and Public Health Commissioning Contract Award**	07/12/16 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Chris Best, Cabinet Member for Health, Wellbeing and Older People		
May 2016	**Council Tax Reduction Scheme 2017-18**	18/01/17 Council	Kevin Sheehan, Executive Director for		

FORWARD PLAN – KEY DECISIONS					
Date included in forward plan	**Description of matter under consideration**	**Date of Decision Decision maker**	**Responsible Officers / Portfolios**	**Consultation Details**	**Background papers / materials**
			Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		
August 2016	**Community Premises Management Contract Award**	08/02/07 Mayor and Cabinet (Contracts)	Aileen Buckton, Executive Director for Community Services and Councillor Joan Millbank, Cabinet Member Third Sector & Community		
May 2016	**Council Budget 2017-18**	22/02/17 Council	Kevin Sheehan, Executive Director for Customer Services and Councillor Kevin Bonavia, Cabinet Member Resources		