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HEALTH AND WELLBEING BOARD

Date: WEDNESDAY, 4 JULY 2018 at 3.00 pm

Committee Room 1
Civic Suite
Lewisham Town Hall
London SE6 4RU

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MEMBERS

Mayor Damien Egan	London Borough of Lewisham	Labour Co-op
Councillor Chris Best	Community Services, London Borough of Lewisham	Labour Co-op
Aileen Buckton	Directorate for Community Services, London Borough of Lewisham	
Val Davison	Lewisham and Greenwich NHS Trust	
Gwen Kennedy	NHS England	
Michael Kerin	Healthwatch Lewisham	
Tony Nickson	Voluntary Action Lewisham	
Roger Paffard	South London and Maudsley NHS Foundation Trust	
Dr Simon Parton	Lewisham Local Medical Committee	
Peter Ramrayka	Voluntary and Community Sector	
Dr Marc Rowland	Lewisham Clinical Commissioning Group	
Dr Danny Ruta	Public Health, London Borough of Lewisham	
Sara Williams	Directorate for Children & Young People, London Borough of Lewisham	

The public are welcome to attend our committee meetings, however occasionally committees may have to consider some business in private. Copies of reports can be made available in additional formats on request.

Members are summoned to attend this meeting

Ian Thomas
Chief Executive
Lewisham Town Hall
Catford
London SE6 4RU
Date: Tuesday, 26 June 2018

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MINUTES OF THE HEALTH AND WELLBEING BOARD

Thursday, 1 March 2018 at 2.00 pm

PRESENT: Mayor Bullock (Chair), Marc Rowland (Vice-Chair), Cllr Chris Best, Alieen Buckton, Val Davison, Peter Ramrayka and Danny Ruta,

ALSO PRESENT: Donna Hayward-Sussex (South London and Maudsley NHS Foundation Trust), Trish Duffy, Councillor John Muldoon, Warwick Tomsett (representing Sara Williams) and Salena Mulhere.

Apologies for absence were received from Tony Nickson, Roger Paffard, Dr Simon Parton, Brendan Sarsfield and Folake Segun.

1. Minutes of last meeting

1.1 The minutes of the last meeting were agreed as an accurate record.

2. Declarations of Interest

2.1 There were no declarations of interest.

3. Referral from the Healthier Communities Select Committee: Social Prescribing Review - Final Report

3.1 Councillor Muldoon introduced the referral from the Healthier Communities Select Committee. The key points to note were:

- The concerns highlighted in the report about evidencing the effectiveness of Social Prescribing.
- A study of the scheme in Rotherham which was assessed by the Kings Fund and found reductions in A&E use, however there was not yet a great volume of evidence.
- Whilst it is reported as beneficial by those using it; in terms of proving wider outcomes outside of that it is challenging
- Perhaps social prescribing is prescribing for individuals in some cases in an attempt to address societal failings: should we not be doing more as a society to address those issues.

3.2 In the resulting discussion it was noted:

- That the review was a very thorough piece of work that raises some very interesting questions, delving below the surface of the evidence available.
- That the work of the scrutiny manager in organizing the review for the Committee and pulling together the final report was excellent.
- Whilst it was difficult to prove efficacy in pounds and pence, this could be addressed as an overall package rather than just one thing for one person.
- Lewisham CCG are very interested in this area.

- Not using the word “patient” as a matter of course could help as this assumes people are ill and need medicine and the health service, whereas some of the challenges could and should be met by wider society through some of the sorts of activities outlined in the report.
- More people should be able to self-refer or peer refer rather than have to go via a GP, to both make the activities more mainstream and less medicinal, and further reducing the burden on the health system.
- Self-referral had increased at the Rushey Green timebank since its inception at the GP Practice and more people stick with the activities if they self-refer – a large number of whom cited social isolation as a reason for referral.
- Ideally people should be able to be sign posted though community connections so they area supported to find the right level of support.
- The Health and Social Care directory online is useful for self-referral includes a wider range of activities (parks, classes) etc. It is constantly updated and is on the Healthcare Partners Website.
- Use of personal budgets for activities to reduce isolation and lift peoples mood could be more useful than medical prevention in some circumstances.
- Aileen is drafting a formal response via Mayor and Cabinet, which will also come back to the HWB in due course.

RESOLVED: To receive the response from officers in due course.

4. Joint Strategic Needs Assessment (JSNA) Update

4.1 Danny Ruta introduced the report. Key points to note were:

- In July last year the Board agreed a process for agreeing topics for JSNA and set up a steering group to manage suggestions and prioritise topics for JSNA.
- The steering group asked for any suggestions for JSNA and received 8 suggestions including mental health, health inequalities and respiratory long-term conditions.
- The steering group considered the suggestions and suggest to the HWB that there are 4 topics considered for JSNA this year: parenting, supported housing, mental health and respiratory long term conditions.
- Because the most common cause for admission after UTI is pneumonia (in Lewisham) there is also a submission from the Safer Stronger Communities Select Committee scrutiny review recommending that a needs assessment is undertaken. The JSNA steering group will receive that in September and will then decide if they want to recommend that is undertaken.

4.2 In the discussion the following key points were noted:

- The process of selection of topics was thorough and the prioritisation matrix helped
- The appended completed JSNA on Cancer was approved to be made public.

4.3 RESOLVED: To note the work of the steering group to date and agree the JSNA on Cancer be uploaded to the website.

5. Pharmaceutical Needs Assessment

5.1 Danny Ruta introduced the report. The key points of note were:

- There is a statutory responsibility for HWB to produce one, although it is the responsibility of NHS England to commission these service, we do this assessment, give it to them and they make decisions about letting pharmacies open.
- NHS England have confirmed they are happy to receive it in the format presented.
- The assessment included a 60 day consultation and a mapping exercise of all pharmaceutical services in the borough.
- There were no negative responses, just suggestions to add in small items of detail which we did in all cases.
- There have been some gaps identified and some suggested improvements to NHS England.

5.2 In the following discussion the following key points were noted:

- Considerable amount of council resources goes into producing this with no real benefit to the Council, however there is some scope to, put some extra effort in to work on how local pharmacies can be of use to the health and wellbeing partnership, which Danny could pull out from the data his service holds.
- This work would be of benefit to the CCG too: - lots of services are delivered through pharmacies on behalf of the CCG in addition to NHS England. Public Health commission pharmacies to do emergency contraception, 17 pharmacies do health checks and they reach what we can't traditionally reach.
- Perhaps a Lewisham pharmacy sector representative should be invited to be on the HWB – they are a key part of a whole system model of care and are an excellent resource, along with opticians and dentists.
- Danny needs to put pressure on NHS England to deliver on the gaps identified within the next 3 years, and this needs to be managed across the STP area.
- This was produced in house by the Public Health Team with the support of the Corporate policy and performance team.

5.3 RESOLVED: To consider how local pharmacies can be involved appropriately in the work of/membership of the Board going forward.

6. Performance Dashboard Update - Exceptions Reporting

6.1 Trish Duffy introduced the report. The key points to note were:

- The CCG are working to increase uptake on health checks.
- Low birth weight now in line with the rest of England, which is a good news story.
- Life expectancy has improved.
- There is additional information in relation to priority 8 and 9 that has not been included within this report which will be circulated to the Board after the meeting.

6.2 In the following discussion the following key points were noted:

- Drilling down into the data is important to make an impact, for example behind the headline figures around smoking cessation, differences in where in wards the services were offered impacted on take up. The service was reduced significantly as 95% of people who stop smoking don't use a smoking cessation service, so the smaller resources are targeted at people who have mental health problem who have a large prevalence of smoking. We no longer target specific geographical areas, we target high risk groups, mental health and pregnant mums online we can reach a wider number of the public.
- This illustrates the points that partners need to drill down in to the data and take targeted actions on these things where we really want to see a difference in Lewisham: overall level of deprivation has changed for better last 10 years, however the detail area by area within the borough tells a slightly different story to the headlines and this needs to be grasped by health and care providers.
- There are differences between groups in our growing population, and while there are more who self-care, there is also an impact of austerity and poverty on many communities in Lewisham.
- There is a need for PH to drill down into the data in the priority area in terms of different groups within Lewisham, particularly where there are fluctuations for different groups so we can do more to target services and improve outcomes.
- Intelligent data from Public Health needs to inform commissioning so we can all commission and deliver smartly and effectively – Lewisham detailed data should be driving what we do as a clinically led organisation.

6.3 RESOLVED: TO note the report

7. Health and Wellbeing Board Mental Health Workshop Update

7.1 Catherine Mbema introduced the report. The key points to note were:

- Initial engagement and feedback has been very positive
- Thrive London advised the workshop is sold out with a waiting list.

7.2 RESOLVED: To note the progress in developing the Thrive approach in Lewisham as requested by the Board.

8. Adult Mental Health - Strategic Procurement Plan for Voluntary Sector Providers

8.1 Kenny Gregory introduced the report. The key points to note were:

- Officers are reviewing the strategic position of commissioning for mental health.
- There are currently 9 contracts with 5 providers cover working age and older adults. Some are working well and some could provide more value.
- All are coming to an end on 31st of March so officers are about to embark on a new procurement process and have realised through reviews that more integrated service delivery would be beneficial with providers collaborating more with each other and primary care and the voluntary sector so that they are also more focused on outcomes for residents.
- The prevalence of mental health needs in Lewisham is high and is anticipated to increase over next 5 years – officers are looking to get more capacity in to increase the level of support and look to provide more prevention and early intervention.
- 3 of the contracts are about recovery and living well, one for dementia support and one for advocacy that picks up the Council's statutory duty around advice and advocacy.
- This work should result in more focused contracts with a greater focus on outcomes and prevention.
- Interim arrangements are in place with current providers, with the hope to conclude the procurement process and have the new contracts in place in September 2018.

8.2 RESOLVED: To note the report.

9. South East London Sustainability and Transformation Partnership including WSMC

9.1 Martin Wilkinson introduced the report. The key points to note were:

- STP wave 2 applications have been submitted, not head anything back yet and know that national planning guidance has been rebranded.
- Whatever the name is, in Lewisham we are pursuing integrated health care and support and we are working together to deliver health care and support.
- The STP framework recognizes the importance of interaction across the area, but also the sovereignty of the borough
- Commissioning have done work on frailty and transitions
- Care in people's homes should play to their strengths and provide care that has the persons whole needs at the heart of what we are doing. Lots of people visit and go in to deal with their particular area some NHS, some Council and some private (domiciliary care) providers and we are looking to see how this could be better joined up and managed.

- We are working through a pilot in Neighborhood 2 to see how it would work, including the financial challenges and pooling budgets. The Trust, Council and Dom Care providers, need some form of agreement and a governance between us to take that forward that we will consideration separately and together as Lewisham partnership
- We have been starting to scope what we could do earlier across the partnership in relation to mental health
- The Population Health Management system should hopefully enable the partnership to use data to drive improvements. We need to make sure the ICT supports the transformation work we are doing, we have been using existing clinical groups to talk about how data could be used in each pathway to the best effect and support self-management where appropriate.

9.2 Resolved: To note the report

10. The Role of Technology in the Delivery of Health and Care

10.1 Aileen Buckton delivered a presentation to the Board. In the following discussion, the following key points were noted:

- We want to work as a MDT in the community but we currently can't get technology to work that allows staff and partners to do that.
- There are lots of opportunities to explore, but we need to be careful of not going for the "shiny new toys" but to make sure we look for opportunities to improve things in practice and that will work. For example Ipads on the stroke ward help when speech is an issue, and could be used more to support people and to enable them to access aftercare.
- Fiona Kirkman could be asked to identify potential technology enabled care options that could make a real difference to the population if we were to receive some further funding. This would need to cover the benefits and anticipated outcomes, things that could make a real difference to outcomes for the population.

10.2 RESOLVED: Fiona Kirkman to be asked to look into further technology enabled care options.

11. Health and Wellbeing Strategy Review

11.1 Salena Mulhere introduced the report. The key points to note were:

- The steering group set up by the board has reviewed progress of delivery against the original HWB priorities, and the wider contextual changes to priorities and the health and care landscape since the adoption of the strategy in 2013 to identify for the Board if the HWB strategy is still appropriate and relevant as is.
- As already agreed by the Board in 2015; the majority of the original priorities are "business as usual" work that Public Health is responsible for

and not necessarily supporting a whole system approach which requires systems leadership for delivery.

- The wider context and drivers surrounding health and wellbeing have changed since 2013 nationally, regionally and locally, with the financial challenges ongoing, the introduction of a regional approach with STPs, and the local approach in Lewisham to integration. However, the Boards statutory responsibility for the development and oversight of the Health and Wellbeing Strategy, and ensuring that it remains fit for purpose, remains.
- The steering group therefore recommends that the Board review and revise the HWB strategy, and that its aims and priorities could be broadened and more holistic in approach.
- The steering group suggest that a revised HWB strategy should consider Quality of Life, Quality of Health, Care and Support and Sustainability.

11.2 In the following discussion, the following key points were noted:

- The Mayor noted his thanks to the members of the steering group for their efforts and a comprehensive report, and confirmed that it was an appropriate time to re-examine the priorities and board focus in the ways set out in the report. This was seconded by other board members.
- It was agreed there was a need for the Board to take system leadership action and to engage people in discussing the key challenges to develop a meaningful strategy, rather than noting reports on work already undertaken.

11.3 RESOLVED: That the HWB Strategy be revised by the Board in 2018/19.
RESOLVED: To thank the Mayor for his leadership of the Board at this his last meeting.

12. Health and Wellbeing Board Work Programme

12.1 The work programme was noted.

13. Information Items

13.1 There were no information items.

Agenda Item 2

Health and Wellbeing Board		
Title	Declarations of interest	
Contributor	Chief Executive – London Borough of Lewisham	Item 2
Class	Part 1 (open)	4 July 2018

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 members' 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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<tr><td>Report Title</td><td colspan="3">Introduction to the Health and Wellbeing Board in the 2018/19 Council Administration</td></tr>
<tr><td>Contributors</td><td>Service Manager SGM Inter-agency, Service Development and Integration</td><td>Item No.</td><td>3</td></tr>
<tr><td>Class</td><td>Part 1</td><td>Date:</td><td>4 July 2018</td></tr>
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1. Purpose

1.1 This report presents the Health and Wellbeing Board with a revised way of working for 2018/19 under the new council administration.

2. Recommendations

2.1 Members of the Health and Wellbeing Board are invited to:

- Discuss and approve the proposed new approach to meetings of the Health and Wellbeing Board.

3. Strategic Context

3.1 The Health and Social Care Act 2012 required the creation of statutory Health and Wellbeing Boards in every upper tier local authority. By assembling key leaders from the local health and care system, the principle purpose of the Health and Wellbeing Boards is to improve health and wellbeing and reduce health inequalities for local residents.

3.2 The activity of the Health and Wellbeing Board (HWB) is focussed on delivering the strategic vision for Lewisham as established in *Shaping our Future* – Lewisham's Sustainable Community Strategy and in Lewisham's Health and Wellbeing Strategy.

3.3 The work of the Board directly contributes to *Shaping our Future's* priority outcome that communities in Lewisham should be Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing.

4. Statutory responsibilities

4.1 There are a number of core duties which underpin the work of Lewisham's Health and Wellbeing Board:

Developing Joint Strategic Needs Assessment (JSNA)

- JSNA is the assessment of current and future health and social care needs of the local population.
- The JSNA process was reviewed and a new approach agreed by the Board last year.
- A JSNA Steering Group, accountable to the Board, has prioritised four thematic JSNA topics that will need to be completed over the coming year: Parenting; Supported Housing; Mental Health; and Respiratory LTCs.
- These proposed topics were approved by the Board in March 2018.

Developing Health and Wellbeing Strategies

- The Health and Wellbeing Strategy is the plan for meeting the needs identified in the JSNA.
- Since 2013, the Board has received regular reports and performance data to help it monitor progress against the Strategy priorities.
- Last year the Board agreed to the establishment of a Strategy Review Group to determine whether the strategy remained fit for purpose.
- The following recommendations from this review were agreed by the Board in March 2018:
    - Agree to the development of a revised Health and Wellbeing Strategy.
    - Agree to a programme of local stakeholder engagement to inform, underpin and communicate the revised Health and Wellbeing Strategy.
    - Agree that the Board should undertake a series of workshops to inform development of a revised Health and Wellbeing Strategy by reviewing the: aims; priorities; delivery plan; monitoring arrangements; Terms of Reference, Board membership and sub-structures.

Approval of the Better Care Fund Plan

- Introduced in 2013, the Better Care Fund (BCF) is a single pooled budget shared between the NHS and local government.
- It is intended to help them work more closely to try to ease pressures in both health and social care while improving service user outcomes.
- The BCF was the first pooled budget over which the Boards have been given oversight and decision making powers over how it is spent locally.
- The Board signed off the BCF Plan in September 2017.
- The 2017-19 Plan continues to fund activity in the following areas: Prevention and Early Action; Community-Based Care and the development of Neighbourhood Care Networks; Enhanced Care and Support to reduce avoidable admissions to hospital; and Estates and IMT.

Scrutiny of Joint Commissioning Plans and Annual CCG Report

- Clinical Commissioning Groups (CCG) must liaise with local Health and Wellbeing Boards when preparing or making significant revisions to their commissioning plans.
- The finalised commissioning plan must be published with the Board's assessment.

- The Draft Partnership Commissioning Intentions for Adults 2017/18 and 2018/19 were agreed by the Board in November 2016.
- In addition, when the annual performance review of the CCG is undertaken, the Board must be consulted before the review is finalised.
- Lewisham CCG Annual Report 2017/18 was provided to the Board as an information item in March 2018.

5. Development of the Health and Wellbeing Board

5.1 Following the local elections in May 2018, Damien Egan became the new Mayor of Lewisham and thereby the Chair of the Health and Wellbeing Board.

5.2 An induction development workshop was held for the new Chair to meet the existing Board members, and to discuss the role and direction of the Board in the context of the new council administration.

5.3 A summary of key discussion points regarding the Board and its way of working were as follows:

- Refresh and re-energise the Board
- Act as a systems leader
- Add value to what is being done elsewhere
- Expedite the pace of change re integration
- Focus on fewer things but deliver tangible results
- Be outward looking and collaborative
- Address issues holistically
- Prioritise work around health inequalities
- Make better use of the data available

5.4 Members discussed the main areas of focus for the next 12 months and it was collectively agreed that the focus of the Board should be on health inequalities – i.e. reducing the health inequalities that exist between different groups, and exploring ways to improve the physical and mental health of all Lewisham residents. There was also a discussion as to whether the Board should set itself a ‘big question’ around health inequalities that they should attempt to address over the course of the year.

6. Revised approach to meetings of the Health and Wellbeing Board

6.1 Aside from the statutory responsibilities detailed above (Section 4), the recent work of the Board has been largely focussed on the receipt and agreement of report recommendations from across the partnership.

6.2 At the informal workshop it was agreed that the Board needed to refresh and re-energise itself, with more time dedicated to discussion and a greater emphasis on delivering tangible results. It was noted that the Board has the authority, systems control and collective connections to be more ambitious.

6.3 To help facilitate this, it was felt that the Board's time should be used to focus on a smaller number of game-changing activities and creating the environment for others to deliver. The Board should provide overarching systems leadership rather than delving into work that has already been done.

6.4 Going forward, Health and Wellbeing Board meetings will therefore be used primarily to progress the 'big question' around health inequalities e.g. Black, Asian and Minority Ethnic (BAME) health and wellbeing, mental health, social isolation, obesity etc.

6.5 Statutory items that require a decision by the Board will be added to the agenda as and when required. Generally all other items (e.g. annual reports) will feature as 'information only' items and will not be discussed by the Board unless there is a compelling reason for them to be discussed. This will free-up the Board to focus on fewer issues but deliver a greater impact. The Board will continue to convene three times per year.

6.6 Between meetings, as part of Board members commitment to ongoing leadership development, a forum will be established to facilitate development, briefing and peer –challenge in a Health and Social Care Leaders Forum.

6.7 Board membership will continue to be reviewed throughout the year to ensure that the right people are around the table to deliver on its priorities. Changes to membership identified as necessary by the Board will be recommended to Full Council, in line with the Council's constitution.

7. Financial implications

7.1 There are no specific financial implications arising from this report or its recommendations.

8. Legal implications

8.1 Members of the Board are reminded of their responsibilities to carry out statutory functions of the Health and Wellbeing Board under the Health and Social Care Act 2012. Activities of the Board include, but may not be limited to the following:

- To encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area.
- To provide such advice, assistance or other support as its thinks appropriate for the purpose of encouraging the making of arrangements under Section 75 NHS Act 2006 in connection with the provision of such services.
- To encourage persons who arrange for the provision of health related services in its area to work closely with the Health and Wellbeing Board.
- To prepare Joint Strategic Needs Assessments (as set out in Section 116 Local Government Public Involvement in Health Act 2007).

- To give opinion to the Council on whether the Council is discharging its duty to have regard to any JSNA and any joint Health and Wellbeing Strategy prepared in the exercise of its functions.
- To exercise any Council function which the Council delegates to the Health and Wellbeing Board, save that it may not exercise the Council's functions under Section 244 NHS Act 2006.

8.2 The Equality Act 2010 (the Act) introduced a new public sector equality duty (the equality duty or the duty). 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.

8.3 In summary, 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.

8.4 The duty continues to be a "have regard duty", and the weight to be attached to it is a matter for the Mayor, bearing in mind the issues of relevance and proportionality. It is not an absolute requirement to eliminate unlawful discrimination, advance equality of opportunity or foster good relations.

8.5 The Equality and Human Rights Commission has recently issued Technical Guidance on the Public Sector Equality Duty and statutory guidance entitled "Equality Act 2010 Services, Public Functions & Associations Statutory Code of Practice". The Council must have regard to the statutory code in so far as it relates to the duty and attention is drawn to Chapter 11 which deals particularly with the equality duty. The Technical Guidance also covers what public authorities should do to meet the duty. This includes steps that are legally required, as well as recommended actions. The guidance does not have statutory force but nonetheless regard should be had to it, as failure to do so without compelling reason would be of evidential value. The statutory code and the technical guidance can be found at: http://www.equalityhumanrights.com/legal-and-policy/equalityact/equality-act-codes-of-practice-and-technical-guidance/

8.6 The Equality and Human Rights Commission (EHRC) has previously issued five guides for public authorities in England giving advice on the equality duty:

1. The essential guide to the public sector equality duty
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3. Engagement and the equality duty
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9. Equalities implications

9.1 The principle purpose of the Health and Wellbeing Boards is to improve health and wellbeing for local residents.

9.2 This report is proposing that the focus of the Board's activity for 2018-19 is on reducing health inequalities.

10. Crime and disorder implications

10.1 There are no specific crime and disorder implications arising from this report or its recommendations.

11. Environmental implications

11.1 There are no specific environmental implications arising from this report or its recommendations.

If there are any queries on this report please contact Stewart Weaver-Snellgrove, Principal Officer, Policy, Service Design and Analysis, London Borough of Lewisham on: 020 8314 9308 or by e-mail at stewart.weaver-snellgrove@lewisham.gov.uk

HEALTH AND WELLBEING BOARD			
Report Title	The 'Big Question' and BAME Health Inequalities		
Contributors	Service Manager SGM Inter-agency, Service Development and Integration	**Item No.**	4
Class	Part 1	**Date:**	4 July 2018

1. Purpose

1.1 To consider whether the Board should set itself a 'big question' that they should attempt to address over the course of the year.

1.2 To facilitate a discussion amongst members of the Health and Wellbeing Board around Black, Asian and Minority Ethnic (BAME) health inequalities.

2. Recommendations

2.1 Members of the Health and Wellbeing Board are invited to:

- Agree whether to set itself a 'big question' and if so identify what this question should be.
- Discuss health inequalities within the BAME community based upon the data sets provided by the partner organisations
- Agree any specific actions the Board wishes to be taken to further understand/address BAME health inequalities.

3. Strategic Context

3.1 The Health and Social Care Act 2012 required the creation of statutory Health and Wellbeing Boards in every upper tier local authority. By assembling key leaders from the local health and care system, the principle purpose of the Health and Wellbeing Boards is to improve health and wellbeing and reduce health inequalities for local residents.

3.2 The activity of the Health and Wellbeing Board (HWB) is focussed on delivering the strategic vision for Lewisham as established in *Shaping our Future* – Lewisham's Sustainable Community Strategy and in Lewisham's Health and Wellbeing Strategy.

3.3 The work of the Board directly contributes to *Shaping our Future's* priority outcome that communities in Lewisham should be Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing.

4. Background

4.1 At the recent informal workshop between existing members and the new Chair it was discussed whether the Board should set itself a 'big question' that they should attempt to address over the course of the coming year. It was also agreed that the main areas of focus for the Board over the next 12 months should be on health inequalities.

5. The 'Big Question'

5.1 The Board has a unique position in that it is the only forum where political and clinical leaders come together to share the local care and health system on a democratically accountable and statutory basis. This provides the Board with the authority and connection to get things done and remove roadblocks that may be experienced elsewhere.

5.2 The Board has already indicated that it could contribute added value by focusing on fewer things but delivering tangible results. The identification of a 'Big Question' is intended to help them refine this activity.

5.3 The 'Big Question' could provide a narrative thread through all Board meetings over the coming year to ensure that people, priorities and resources are more targeted and co-ordinated to deliver around an agreed theme or issue.

5.4 An example would be the prevention agenda, which sits at the heart of the integration between health and social care. The Board might wish to identify "*what can each organisation represented on the Board do to prevent escalation of need" or "what can each organisation represented on the Board do to encourage and support people to take greater responsibility for improving their own health and wellbeing*?"

5.5 Any question identified by the Board needs to be sufficiently broad to enable an evolving dialogue over the course of its meetings. The question should also be complementary to the focus on health inequalities within Lewisham.

6. Health inequalities

6.1 Members have agreed that the Board's work programme over the next 12 months should focus on the causes of health inequalities, reducing the health inequalities that exist between different groups, and exploring ways to improve the physical and mental health of all Lewisham residents. This should include issues such as BAME health and wellbeing, social isolation and obesity.

6.2 It might be helpful to apply a consistent format to this ongoing agenda item, to provide some structure and ensure that appropriate supporting data is available to inform the Board's discussions.

6.3 When looking at each area of health inequalities, the Board may wish to consider the following questions:

a) What is the **nature** of the inequality?
b) What are the **causes** of this inequality?
c) What **further information do we need** to understand and address this inequality?
d) What is each organisation **currently doing** to address this?
e) What else **could we do** to reduce this inequality (e.g. to improve outcomes for a specific cohort or condition)?
f) Do we **need to change** any of our services **to improve** the experience/ accessibility or outcomes?
g) Do we need to work more closely together or **support each other differently** to address this?
h) What **next steps** do we want to be taken to address this inequality?

7. BAME Health Inequalities

7.1 At the informal workshop, members agreed that the area of health inequalities that the Board should focus on initially is within Black, Asian and Minority Ethnic (BAME) communities.

7.2 Commissioning, Public Health, Lewisham and Greenwich NHS Trust and South London and Maudsley NHS Foundation Trust agreed to work together to start to pull together data sets and intelligence on the key BAME health and wellbeing issues and inequalities in Lewisham to inform the discussions of the Board.

7.3 The initial data identified by the organisations are appended to this report. These data sets should be used to inform the Board's discussion and assist in beginning to respond to the questions posed above, and in identifying where the Board would like to focus in more detail.

7.4 Below is some high level data around BAME Health Inequalities nationally and in Lewisham.

7.5 General

- Lewisham's black and minority ethnic communities are at greater risk from health conditions such as diabetes, hypertension and stroke.
- 54% of people diagnosed with type 2 diabetes in Lewisham are from a BAME background. The prevalence of diabetes is significantly higher in Black Caribbean, Indian, Pakistani, and Bangladeshi men than in the general population.
- The lifetime risk of being diagnosed with prostate cancer varies by ethnicity. The lifetime risk of being diagnosed with prostate cancer is 13.2-15.0% for White males, while in Black males it is significantly higher (23.5-37.2%), and in Asian males it is significantly lower (6.3-10.5%).

7.6 Mental Health (National)

- There is an over-representation of young men from BME groups in mental health services.
- African Caribbean men are much more frequently diagnosed with psychosis than White men- and are more likely to be detained under the Mental Health Act.
- People in the Black broad ethnic group were the most likely to have been detained under the Mental Health Act in 2016/17 – with 272.1 detentions per 100,000 Black people. The second highest rates of detention when looking at the broad ethnic groups were for people recorded as being in the Other ethnic group – however, these are considered to be overestimates because ‘other’ categories were often used by default where the specific ethnicity of a person was unknown. People in the White ethnic group had the lowest rate of detention, at 67.0 per 100,000 White people.

7.7 Childhood Obesity (National)

- In both the 4 to 5 and the 10 to 11 age groups, Black African children were the most likely to be overweight in 2015/16, with almost a third (31.2%) of the younger group and nearly half (45.9%) of the older group overweight.
- In 2015/16, Black African children aged 4 to 5 were more than twice as likely to be overweight compared with Indian children, of whom 14.5% were overweight.
- Among children aged 10 to 11, children from the Mixed White and Asian group were least likely to be overweight (30.1%) in 2015/16, followed by Chinese children (30.2%).

7.8 Drug & Alcohol Misuse

- The prevalence of drug dependence varies with ethnicity. Black men are more likely (12.4%) and South Asian men are least likely (1.5%) than men from other ethnic groups surveyed, to report symptoms of dependence. In women this ranged from 4.8% of Black women to 0.2% of South Asian women.
- Individuals recorded as white British made up the largest ethnic group in treatment (60%, 690) in Lewisham with a further 11% (130) from other white groups. This compares with general population of 42% and 12% respectively.
- In Lewisham Black African (11.6%) residents are now more numerous than Black Caribbean (11.2%) and Black Other have also seen a sizable increase from 2.1% to 4.1%. Yet Black African and Black Caribbean residents appear to be less well represented in treatment at 2.9%, 6.1% respectively.

7.9 Patient Experience

- CCG Systems Intelligence Team provided detailed patient experience data from primary care that showed that BME patients with long term conditions feel less supported by health services than White British Groups.

7.10 Commissioning, Public Health, Lewisham and Greenwich NHS Trust and South London and Maudsley NHS Foundation Trust agreed to work together to produce the following data sets and intelligence on the key BAME health and wellbeing issues in Lewisham:

a. Appendix 1 –CAMHS Equalities Data
b. Appendix 2 – Public Health BME Health Inequalities Report
c. Appendix 3 – Public Health BME Health Inequalities Slide Pack

7.11 These data sets should be used to inform the Board's discussion and assist in responding to the questions posed above.

8. Financial implications

8.1 There are no specific financial implications arising from this report or its recommendations.

9. Legal implications

9.1 Members of the Board are reminded of their responsibilities to carry out statutory functions of the Health and Wellbeing Board under the Health and Social Care Act 2012. Activities of the Board include, but may not be limited to the following:

- To encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area.
- To provide such advice, assistance or other support as its thinks appropriate for the purpose of encouraging the making of arrangements under Section 75 NHS Act 2006 in connection with the provision of such services.
- To encourage persons who arrange for the provision of health related services in its area to work closely with the Health and Wellbeing Board.
- To prepare Joint Strategic Needs Assessments (as set out in Section 116 Local Government Public Involvement in Health Act 2007).
- To give opinion to the Council on whether the Council is discharging its duty to have regard to any JSNA and any joint Health and Wellbeing Strategy prepared in the exercise of its functions.
- To exercise any Council function which the Council delegates to the Health and Wellbeing Board, save that it may not exercise the Council's functions under Section 244 NHS Act 2006.

9.2 The Equality Act 2010 (the Act) introduced a new public sector equality duty (the equality duty or the duty). 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.

9.3 In summary, 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.

9.4 The duty continues to be a "have regard duty", and the weight to be attached to it is a matter for the Mayor, bearing in mind the issues of relevance and proportionality. It is not an absolute requirement to eliminate unlawful discrimination, advance equality of opportunity or foster good relations.

9.5 The Equality and Human Rights Commission has recently issued Technical Guidance on the Public Sector Equality Duty and statutory guidance entitled "Equality Act 2010 Services, Public Functions & Associations Statutory Code of Practice". The Council must have regard to the statutory code in so far as it relates to the duty and attention is drawn to Chapter 11 which deals particularly with the equality duty. The Technical Guidance also covers what public authorities should do to meet the duty. This includes steps that are legally required, as well as recommended actions. The guidance does not have statutory force but nonetheless regard should be had to it, as failure to do so without compelling reason would be of evidential value. The statutory code and the technical guidance can be found at: http://www.equalityhumanrights.com/legal-and-policy/equalityact/equality-act-codes-of-practice-and-technical-guidance/

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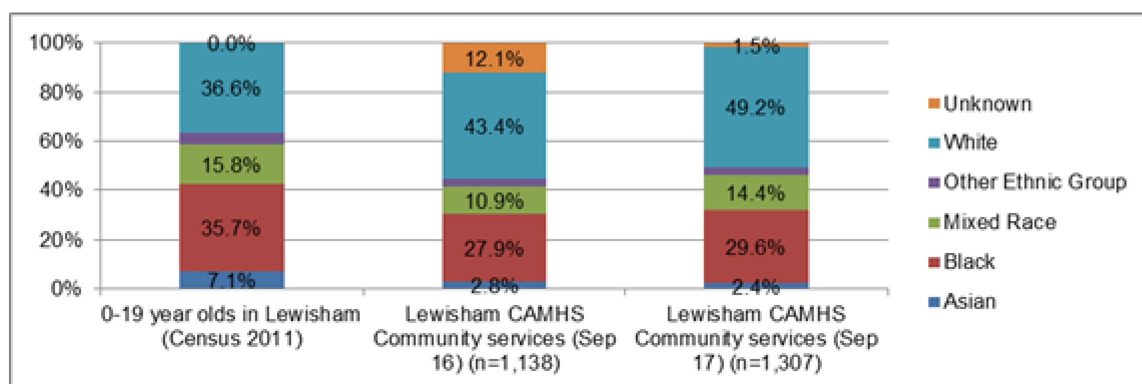
CAMHS Equalities Data

	Asian	Black	Mixed race	Other ethnic group	White	Unknown
0-19 year olds in Lewisham (Census 2011)	7.1%	35.7%	15.8%	4.8%	36.6%	0.0%
Lewisham CAMHS Community services (Sep 16) (n=1,138)	2.8%	27.9%	10.9%	2.8%	43.4%	12.1%
Lewisham CAMHS Community services (Sep 17) (n=1,307)	2.4%	29.6%	14.4%	2.9%	49.2%	1.5%



The table and chart above show the ethnicity of service users in September 2016 and September 2017 in Lewisham CAMHS services as recorded in ePJS, in comparison with the ethnicity of 0-19 year olds in the borough of Lewisham as per the 2011 census. Initial observations from this data is an under representation of people of Asian and Black ethnicity, as well as an improvement in the internal recording of the data between September 2016 and September 2017 (note the reduction in the recording of status 'unknown').

In order to have a clearer picture of what may be happening and to ensure equitable access, experience and outcomes for service users, the CAMHS Directorate have committed to the CAMHS Equality Objective, with a particular focus on Asian and Black girls. This started in 2017 but will be expanded to Lewisham this financial year.

Suggestions

- Delivering a community engagement project, working with teachers, pupils and parents of a local secondary school to better understand and access MH services.
- Significantly improve the recording of service users' ethnicity to enable analysis.
- Review and learn from work that has already taken place in other boroughs.
- Work with other stakeholders if improvements in processes or collaboration are identified.

Plans

Work to date has been focussed on improving data quality to enable meaningful analysis and identify core areas of focus. The CAMHS Operational Governance meeting in July will focus on the Equality Objective, reviewing the learning from work carried out to date and discussing areas of difference and learning across the boroughs. Planning from that meeting will come from a review of the overall objective as well as specific service areas. The Trust Equality Manager, Performance & Contracts Manager and CAMHS PPI Facilitator are due to attend to provide information, advice and recommendations and to ensure Trust wide support for the process.

Black, Asian and Minority Ethnic (BAME) Health Inequalities in Lewisham

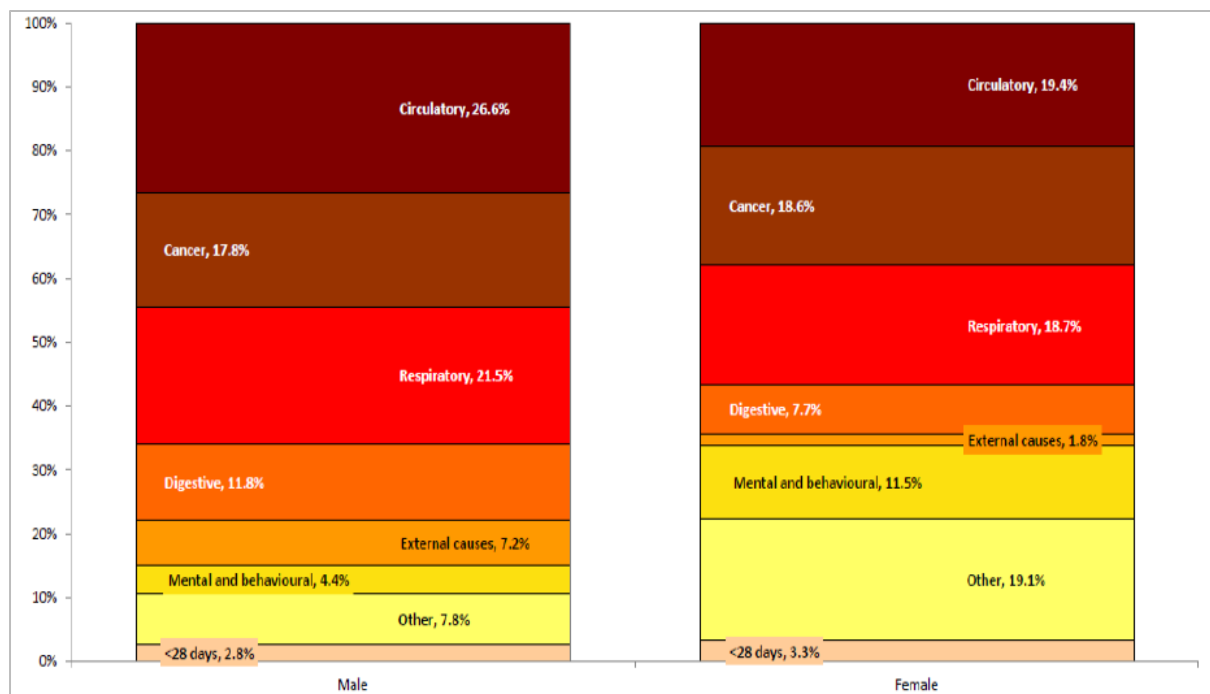
Health and Wellbeing Board Discussion Paper

Wednesday 4th July 2018

1. Health Inequalities in Lewisham

Lewisham Public Health has recently developed the 'Picture of Lewisham' slideset, which provides an annual overview of population health in Lewisham. This overview outlines some of the disease categories that contribute the most to health inequalities in Lewisham in terms of premature mortality i.e. a measure of unfulfilled life expectancy (see Figure 1).

Figure 1: Breakdown of the life expectancy gap between Lewisham's most deprived quintile and Lewisham's least deprived quintile by broad cause of death, 2012-2014



Source: Public Health England

The disease categories highlighted here may present a useful place to start in an attempt to identify the most significant health inequalities in BAME groups in Lewisham. Analysis of primary care, secondary care and mental health data to identify local differences in prevalence of the following disease categories will provide a high-level needs assessment of BAME health locally for the most important contributors to health inequalities in the borough:

- Prevalence of cardiovascular disease by ethnic group (likely most accurate from primary care EMIS data)
- Prevalence of respiratory disease by ethnic group (likely most accurate from primary care EMIS data)

- Prevalence of common and serious mental ill health by ethnic group (a preliminary analysis for serious mental illness has previously been performed in addition to prevalence work around mental health – see Appendices 1 and 2 – N.B. Appendix 2 is a separate document)
- Prevalence of most common types of cancer by ethnic group (The recent cancer JSNA for Lewisham will guide this analysis and is available at: http://www.lewishamjsna.org.uk/sites/default/files/Cancer%20JSNA%20-%20final.pdf)

Nationally available literature and data on BAME inequalities may also help to guide analysis of the data to specific disease subgroups within which BAME health inequalities are likely to occur. National work addressing the drivers of these inequalities i.e. the wider or social determinants of health will also provide a useful basis when planning and/or reviewing work to address inequalities that are identified.

2. Best practice for BAME health

An alternative approach to assessing how well Lewisham is performing in terms of BAME health would be to measure our performance in line with nationally recognised best practice. In May 2018, the National Institute for Health and Clinical Excellence (NICE) released a quality standard entitled, 'Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups' (NICE, QS167, 2017). The quality standard highlights some of the specific areas of inequality for people from black, Asian and other minority ethnic groups, such as increased health risks, poor access to and experience of services, and worse health outcomes. The guidance aims to support public authorities in considering their equality duty when designing, planning and delivering services, and will be a useful framework for any action that the Health and Wellbeing Board chooses to support to improve BAME health locally. The quality statements included in the guidance can be seen in Box 1 below.

Box 1: Six quality statements

Statement 1: People from black, Asian and other minority ethnic groups have their views represented in setting priorities and designing local health and wellbeing programmes.

Statement 2: People from black, Asian and other minority ethnic groups are represented in peer and lay roles within local health and wellbeing programmes.

Statement 3: People from black, Asian and other minority ethnic groups at high risk of type 2 diabetes are referred to an intensive lifestyle change programme.

Statement 4: People from black, Asian and other minority ethnic groups referred to a cardiac rehabilitation programme are given a choice of times and settings for the sessions and are followed up if they do not attend.

Statement 5: People from black, Asian and other minority ethnic groups can access mental health services in a variety of community-based settings.

Statement 6: People from black, Asian and other minority ethnic groups with a serious mental illness have a physical health assessment at least annually.

The quality standard is expected to **contribute** to improvements in the following outcomes among black, Asian and other minority groups:

- prevalence of excess weight and obesity
- physical activity levels
- tobacco use
- inequality in hospital admissions and detentions under the Mental Health Act compared with the general population using mental health services (BAME inequality demonstrated in Lewisham data).

Many of the existing health equalities in Lewisham will be driven by the distribution of social determinants such as housing and education in the borough. Changes to services to improve experience, access and quality of services for BAME groups in line with the NICE quality standard will therefore only play a part in addressing the inequalities.

3. Where Lewisham is now in relation to best practice for BAME health

Existing data from the Public Health performance dashboards, Mental Health joint commissioning team reports, and publicly available LGT and SLAM data could be used to assess where Lewisham in relation to best practice for promoting health and preventing premature mortality in BAME groups as per the NICE guidance outlined above where data is available.

For the purposes of this report, the outcome measures for the first NICE quality statement have been used to demonstrate how this assessment could be performed. The structure, process and output measures could also be examined in more detail when the inequalities in the main outcome measures have been explored. Where data is not available to make the assessment for outcomes, the most likely data sources have been outlined.

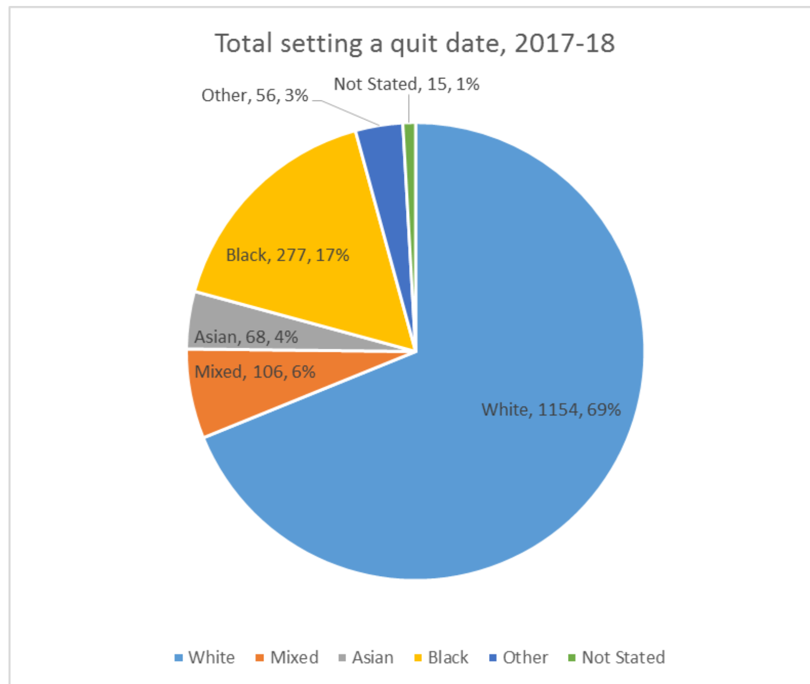
a) Designing health and wellbeing programmes

i) Uptake of local health and wellbeing services among people from black, Asian and other minority ethnic groups.

Lewisham Stop Smoking Service (SSS)

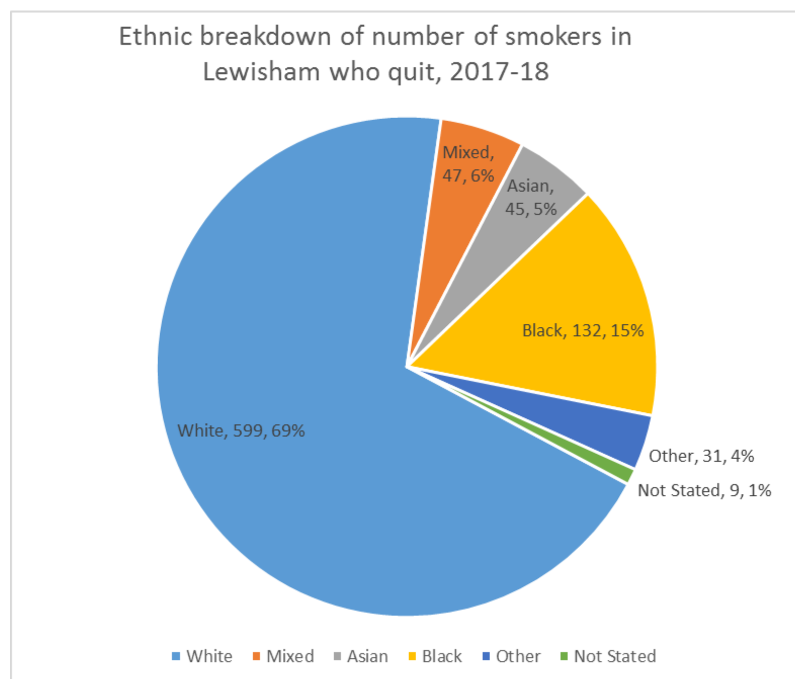
Of those engaging with the Lewisham stop smoking service, the proportion of people setting a 4 week quit date by ethnic group can be seen in chart xx below. The proportion of people then going on to successfully quit smoking at 4 weeks after setting a quit date by ethnic group can be seen in chart xxx below. It is difficult to ascertain whether those from BAME groups are underrepresented in the service (for both quit date and quit rate) as we have not analysed smoking prevalence by BAME group locally. Since smoking is a key risk factor for several long-term conditions and overall premature mortality it will be an important next step to ascertain this from data collected in both primary and secondary care services in Lewisham.

Chart 1: Total number and percentage of Lewisham SSS users setting a quit date by ethnic group in 2017-18 financial year



Data Source: Lewisham Stop Smoking Service

Chart 2: Total number and percentage of Lewisham SSS users who quit smoking by ethnic group in 2017-18 financial year



Data Source: Lewisham Stop Smoking Service

NHS Health Checks

The delivery of NHS health checks in Lewisham to those aged between 40-74 years is almost representative of the proportion of BAME groups in Lewisham (see Charts 3 and 4 below).

Chart 3: Percentage of NHS health checks delivered by ethnic group in 2017-18 financial year

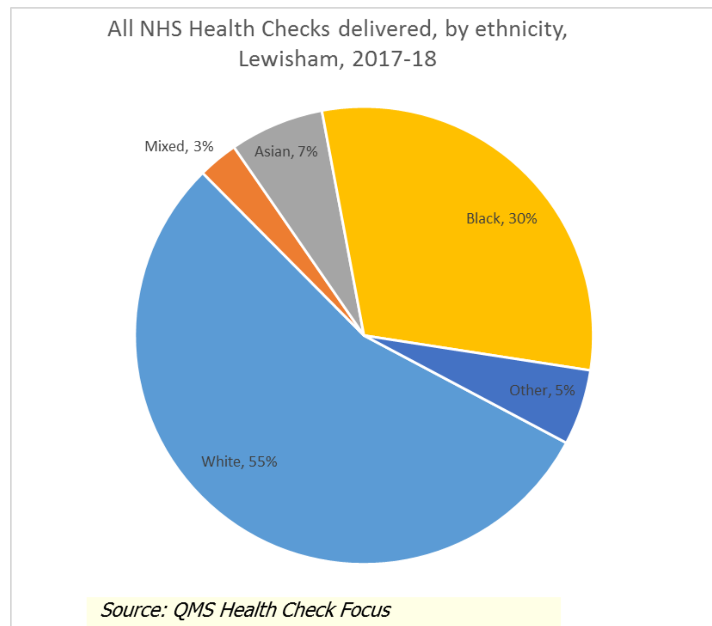
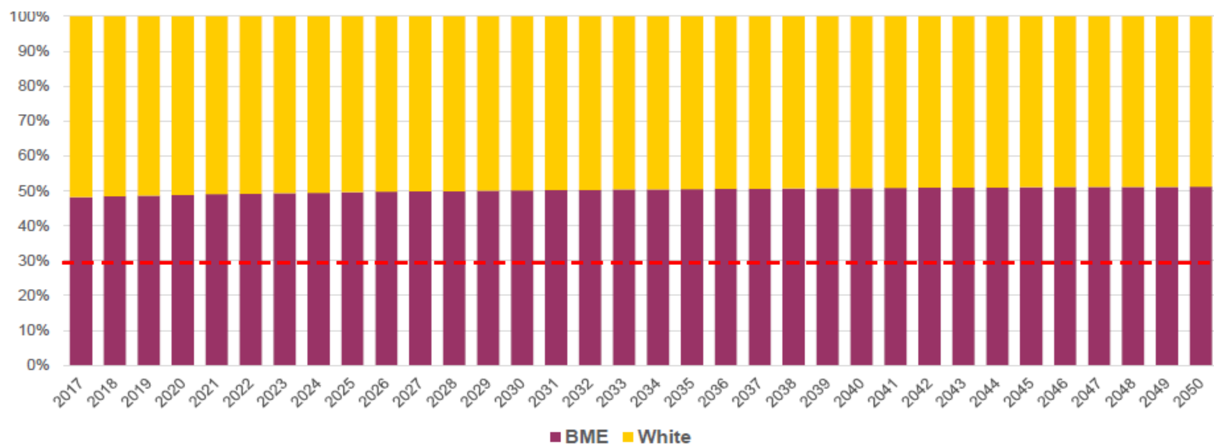


Chart 4: Proportion of BAME population in Lewisham 2018-2050



Source: 2015 Round Ethnic Group Population Projections, GLA

Data required

Data required	**Likely Data Source**
Proportion of people from black, Asian and other minority ethnic groups referred to local health and wellbeing services who feel that the services meet their needs.	Service questionnaires
Prevalence of obesity among local people from black, Asian and other minority ethnic groups	Primary Care (EMIS)/National Child Measurement Programme
Physical activity levels among local people from black, Asian and other minority ethnic groups	Modelling using national survey data
Prevalence of tobacco use among local people from black, Asian and other minority ethnic groups	Modelling using national survey data/Primary Care (EMIS)
Mental wellbeing among local people from black, Asian and other minority ethnic groups	Primary Care (EMIS)/SLAM

4. Key Discussion Points

- Which of the approaches outlined above would be most appropriate to use to explore BAME health and health inequalities in Lewisham (premature mortality, NICE quality standard assessment, additional areas of known inequality e.g. sexual health)?
- What resources are available to undertake further data analysis and assessment (e.g. JSNA process, analytical capacity across the partnership)?
- What else is missing from considerations concerning BAME health and health inequalities (e.g. wider determinants of health, overlap with other areas of disproportionality i.e. criminal justice, qualitative information)?

Appendix One

Severe Mental Illness Health Inequality Analysis

Introduction and Background

Severe mental illness (SMI) is a group of mental health conditions characterised by psychosis. They tend to have poorer prognosis, are more likely to require hospitalisation, and are often are comorbid with other health problems. They can cause large reduction in life expectancy, in the range of 10-20 years. Given the severity of the problem and the issues of inequality we know can exist in diagnosis and accessing mental health services, analysis of local level data should be regularly undertaken to ensure any inequalities gaps are found and remedied. This analysis focuses on the diagnosis and prevalence of severe mental illness, and examines if there are any readily apparent inequalities that may require further investigation.

Key messages are:

- Lewisham has a higher prevalence of severe mental illness across the entire population, when compared to London and England.
- When this is broken down by demographic and compared to the Annual Psychiatric Morbidity Survey, Lewisham has a lower prevalence in younger people, and in particular young women, possibly reflecting underdiagnoses of this population with SMI.
- There is also a higher prevalence of SMI diagnosed in white ethnic groups. Due to the Lewisham data being taken from the GP register, this might reflect an inequality by ethnic group in terms of being registered at GPs
- There are several important limitations with these data – the most apparent is that this looks primarily at prevalence rather than outcomes, such as mortality, morbidity or access to treatment.
- A more detailed investigation should be conducted into health inequalities in severe mental illness and should investigate alternative data sources that may give outcome or service access data

Data Sources

Some routinely collected data that provides a high level overview of SMI prevalence is available on Public Health England Fingertips but this does not include data broken down by age, gender or ethnicity. [1]

Local level data for the borough of Lewisham was extracted from EMIS Web, the GP IT system. Patient data with the read codes associated with severe mental illness, including schizophrenia, bipolar affective disorder and other causes of psychosis (see appendix 1 for full details) was extracted and aggregated, so no patient identifiable information was available. By using the GP data we get important demographic information including age, gender and ethnicity. The main weakness of this data is that we will be missing any of the population with SMI that are not registered with a GP, or whose GP have not been informed about an SMI diagnosis.

[1] https://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness

Finding comparison data was more difficult, as prevalence estimates of severe mental illness are not routinely collected by age, gender or ethnicity. The Annual Psychiatric Morbidity Survey (APMS) [2] has been used instead to give an idea of the prevalence of SMI in England. The survey is commissioned and analysed by NHS Digital. It uses a multi-level stratification process to ensure that the sample (total sample size of 14,000) is representative of the England population. The weaknesses of using this data for comparison is that this is a survey of households rather than of GP lists, so the populations are not exactly the same, and the survey is not conducted by a mental health professional. However the survey itself has been well validated [3] and should still provide useful information for comparison.

Additional information is provided by South London and Maudsley Foundation Trust (SLAM). They have a clustering report that can give an idea of how many SMI patients end up making use of their services. The clusters aren't exactly a match for SMI, but by combing the clusters that include psychotic conditions, most SMI patients should be included.

Analysis

Overview

Table 1. Estimated prevalence of SMI in ages 16+

Lewisham	**0.72%**
London	0.51%
England	0.40%

Table 2. Prevalence of SMI in GP registered residents

Lewisham	**1.31%**
London	0.90%
England	1.09%

Source: PHE Fingertips

Lewisham has a significantly higher prevalence of severe mental illness, both using the estimate from the total population and the more precise numbers of only those registered at GP surgeries than both London and England. This could be due to a number of reasons. Lewisham's demographics may make SMI a more common condition – the most common age for diagnosis is 20-40, and Lewisham has a younger population than the average England population. Also it is possible that the higher prevalence reflects a greater diagnosis rate in Lewisham. The ratio between the estimated prevalence in the general population and those that are registered with GPs is similar between London and Lewisham, indicating that the proportion of SMI patients that are registered with GPs in Lewisham is similar to that of London.

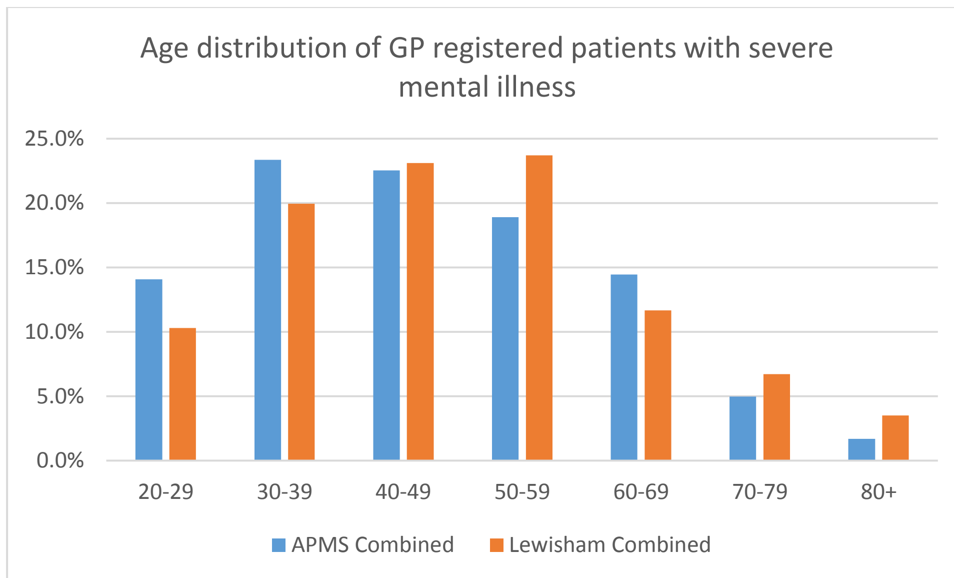
Local Level data

Age

Table 3. Prevalence of SMI by age, comparing Lewisham with the Annual Psychiatric Morbidity Survey – under 20s excluded (APMS)

	20-29	**30-39**	**40-49**	**50-59**	**60-69**	**70-79**	**80+**
Lewisham	10.3%	19.9%	23.1%	23.7%	11.7%	6.7%	3.5%
APMS	14.1%	23.3%	22.5%	18.9%	14.5%	5.0%	1.7%

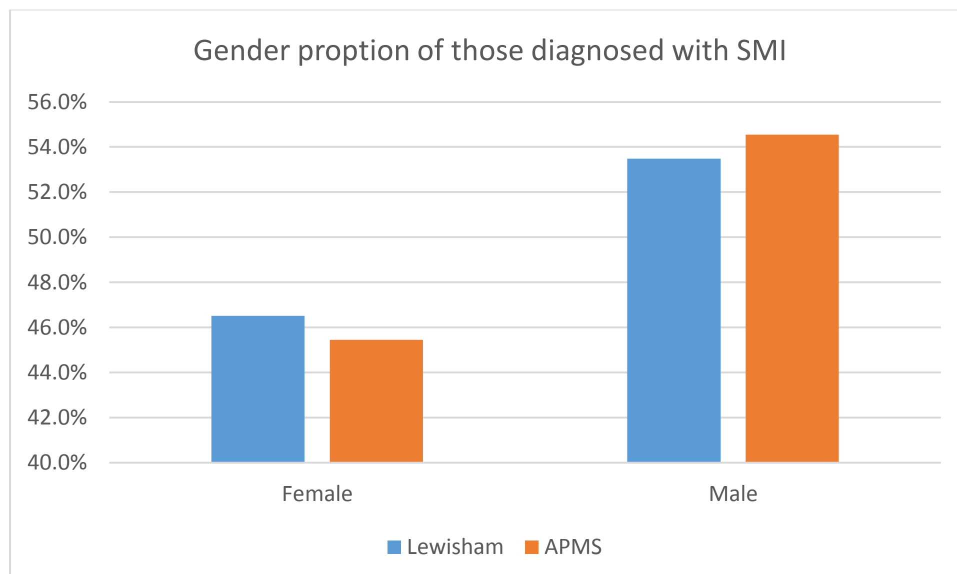
[2] Annual Psychiatric Mortality Survey 2014, NHS Digital - http://content.digital.nhs.uk/catalogue/PUB21748
[3] Bebbington, Paul, and Tony Nayani. "The psychosis screening questionnaire." *Int J Methods Psychiatr Res* 5.1 (1995): 11-19.



When compared to the Annual Psychiatric Morbidity survey data, broken down by age group. Lewisham has a broadly similar distribution of prevalence of severe mental illness to that of the APMS. There may be a slight increase in prevalence in the 50-59 group. Given that Lewisham has a relatively young population compared to the general population of England, we might actually expect the younger age groups to have a higher prevalence, so these results may actually reflect that there is under diagnosis of severe mental illness in our younger populations.

Gender

	Lewisham	APMS
Female	46.5%	45.5%
Male	53.5%	54.5%



There is a similar distribution of severe mental illness between the genders, with males more likely to be diagnosed with severe mental illness. An important note, is that neither the CCG data, nor the APMS, makes allowances for transgender individuals. While it is unlikely the absolute numbers would be large, it is a potential inequality that should be considered.

Age and Gender

Table 3. Age distribution of males with SMI

	20-29	30-39	40-49	50-59	60-69	70-79	80+
APMS Males	9.1%	23.5%	27.8%	22.3%	14.9%	2.3%	0.0%
Lewisham Males	11.6%	21.6%	23.9%	23.5%	10.6%	5.8%	2.0%

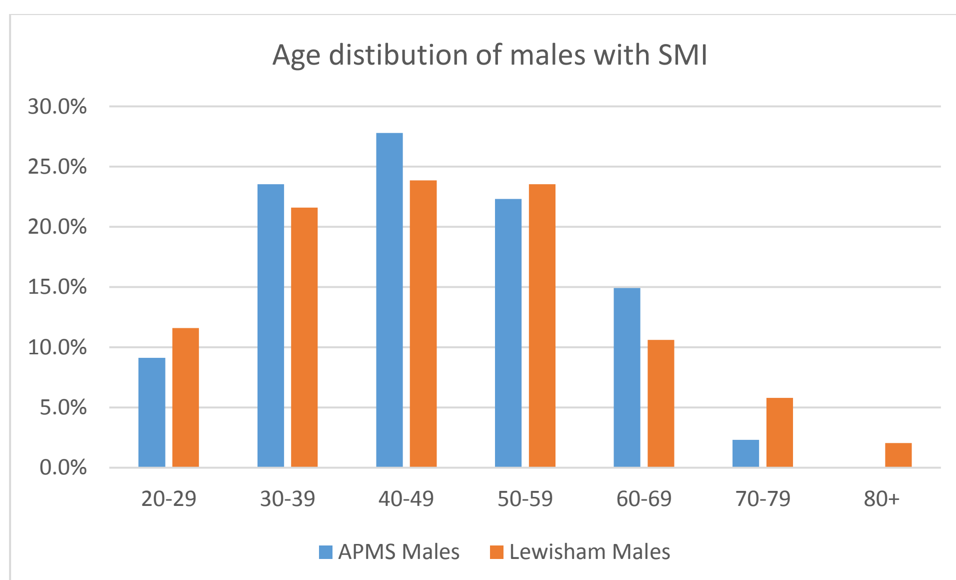
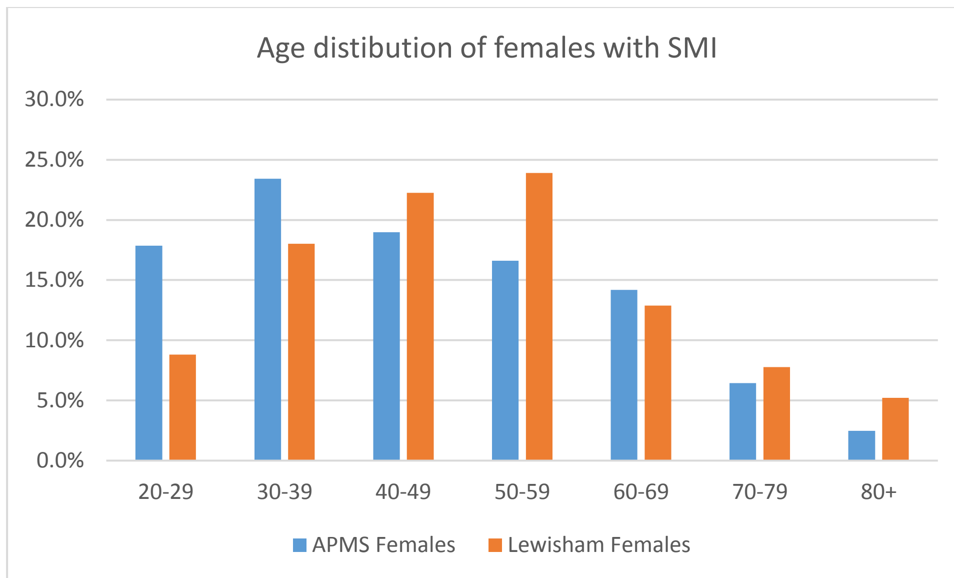


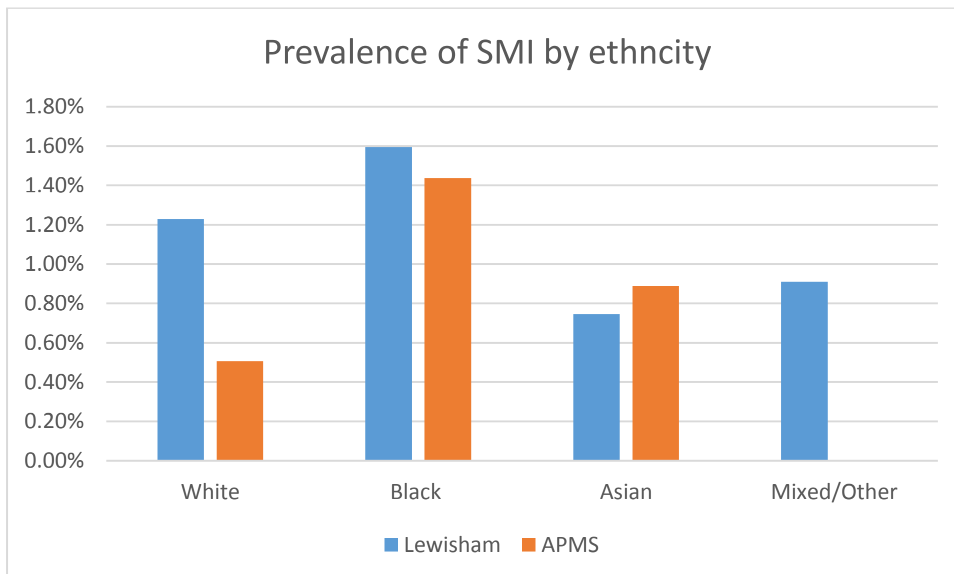
Table 4. Age distribution of males with SMI

	20-29	30-39	40-49	50-59	60-69	70-79	80+
APMS Females	17.9%	23.4%	19.0%	16.6%	14.2%	6.4%	2.5%
Lewisham Females	8.8%	18.0%	22.2%	23.9%	12.9%	7.8%	5.2%



When age and gender are further stratified, it appears that males follow a very similar trend to the APMS, while for females there appears to be a significant difference, with lower prevalence in the younger age groups and a higher age groups. This again might reflect an underdiagnoses of Lewisham residents with SMI, particularly in young women.

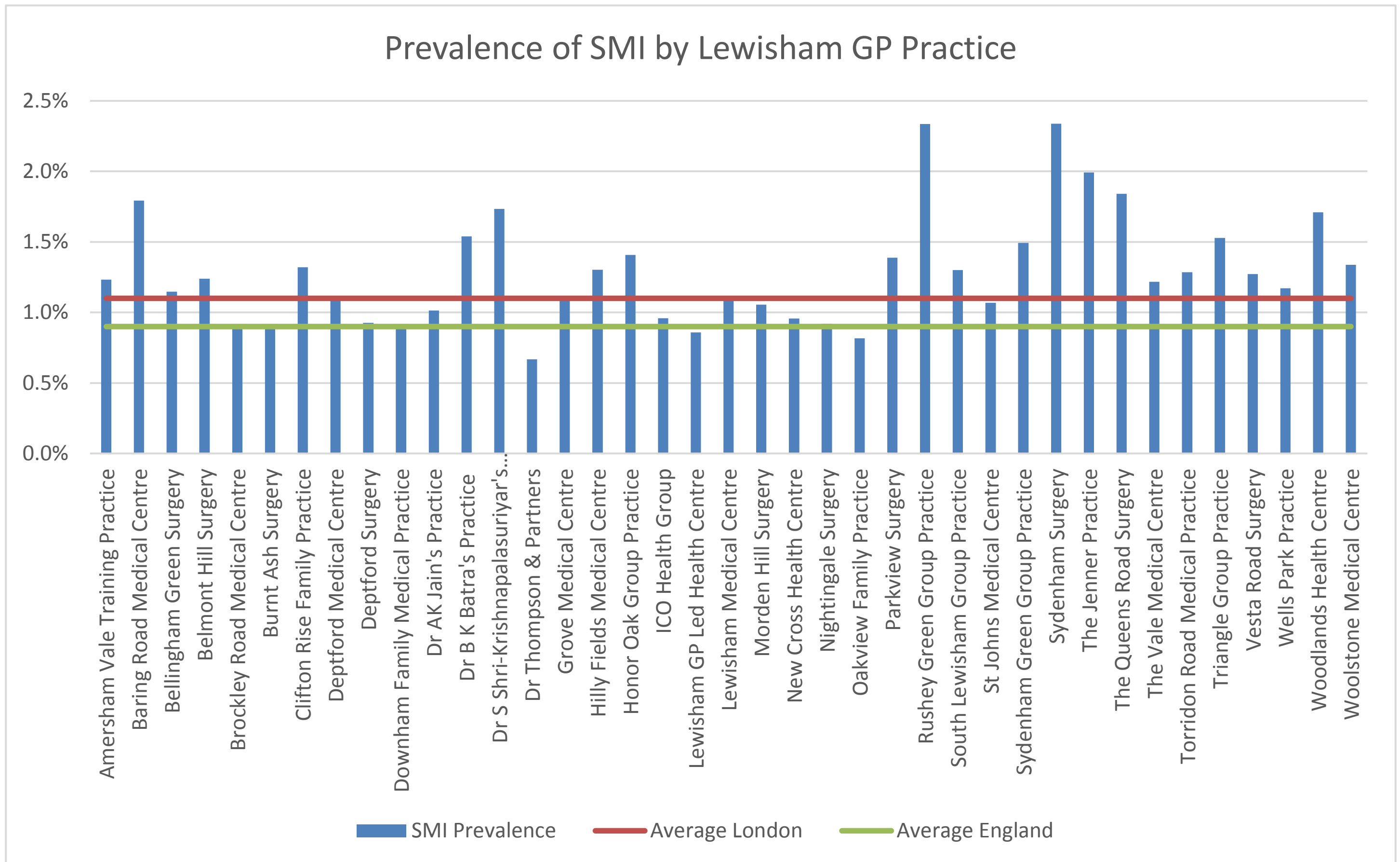
Ethnicity



Compared with the APMS, Lewisham follow the trend of those of black ethnicity having a significantly higher prevalence than those of white ethnicity. However Lewisham has a significantly higher prevalence of SMI in the white population. This could be due to the Lewisham data being from GP registers and the possibility that the white population are more likely to be registered at a GP, while the APMS is form household surveys, and therefore would not make this distinction. The APMS survey

also did not pick up any of mixed/other residents with SMI, although this might represent the small sample size in the survey, while it makes up approximately 30% of the Lewisham population.

By Practice



There is significant variation in the prevalence of SMI patients registered by GP practices in Lewisham, ranging from 0.7% to 2.3%. This could reflect the significant differences in the population these practices serve, both in terms of demographics and socioeconomic status. It could also be due to practices having different rates of registering patients on the SMI register. With a 3-fold difference between the practices with the highest and lowest prevalence, it would be worth investigating the factors that have influenced these results to ensure that all practices are providing equally effective care and reviews of these patients.

By location/deprivation

- Information on service use

Psychosis Community service access	Number of patients in service	Estimated population of neighbourhood	Percent of neighbourhood
Neighbourhood 1	151	71000	0.21%
Neighbourhood 2	221	66000	0.33%
Neighbourhood 3	79	77600	0.10%
Neighbourhood 4	159	78300	0.20%

	BME population %	Age 25-64 %	Age 65+ %	Average IMD score (Higher is more deprived)
Neighbourhood 1	53.3	60.2	6.3	32.0
Neighbourhood 2	40.2	61.7	9.9	23.3
Neighbourhood 3	49.0	55.0	10.5	31.3
Neighbourhood 4	27.0	42.7	59.1	27.0

Source: http://www.localhealth.org.uk

Looking at the SLAM data for community service access, there is some variation across the neighbourhoods of Lewisham (groupings of 4-5 wards), even when accounting for the difference in size of total population. This year, Neighbourhood 2 (the north east of the borough) has over 3 times the number of residents using the psychosis community service compared to Neighbourhood 3 (south east of the borough). This could be due to differences in the Neighbourhood populations (i.e. SMI prevalence etc.), although it would seem such a large difference in access could not be explained by this alone. Breaking down each Neighbourhood to look at some basic demographics shows that Neighbourhood 3 has a higher BME population and is more deprived than Neighbourhood 2, both of which could lead to a decreased rate of access to community services. However, Neighbourhood 1 has a higher deprivation and BME population than Neighbourhood 3, yet has twice as many people accessing the community service, so other factors must be at play.

Another reason for the disparity could also be due to differences in capacity of each service - if this is the case it is important to know whether there are residents of Neighbourhood 3 not able to access the community services e.g. because there nearest available service is in a different neighbourhood, and too far away.

Conclusions

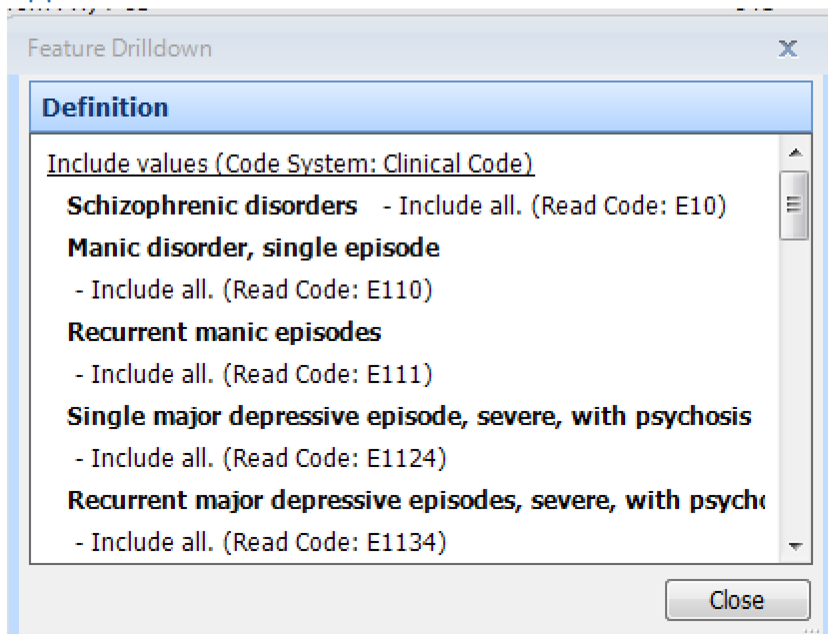
Lewisham has a higher prevalence of severe mental illness across the entire population, when compared to London and England. When this is broken down by demographic and compared to the APMS, Lewisham has a lower prevalence in younger people, and in particular young women, possibly reflecting underdiagnoses of this population with SMI. There is also a higher prevalence of SMI diagnosed in white ethnic groups. Due to the Lewisham data being taken from the GP register, this might reflect an inequality by ethnic group in terms of being registered at GPs (and therefore reduce the likelihood of regular reviews for these patients).

There are several important limitations with these data – the most apparent is that this looks primarily at prevalence rather than outcomes, such as mortality, morbidity or access to treatment. While a low prevalence could indicate that these populations are not being diagnosed, not registered with GPs, or not being picked up on the SMI register (and therefore less likely to have their care reviewed) we cannot use prevalence alone to work out if any or all of these factors are playing a role, and what are the root causes that mean these populations are not being diagnosed.

There are also some notable gaps in the data; key factors that may increase risk of mental illness and could be sources of inequality, such as sexual orientation or transgender status. Socio-economic status could also be explored in greater depth. While deprivation as a whole has been analysed, more detailed factors could also be investigated to ensure equality in for example, the unemployed or those who have been in contact with the criminal justice system.

A more detailed investigation into health inequalities in severe mental illness should investigate alternative data sources that may give outcome or service access data, which would provide a more in-depth view of where the inequalities lie, and would provide more actionable intelligence.

Appendix 1- Read codes included in EMIS data extract



Feature Drilldown

Definition

Include values (Code System: Clinical Code)

Schizophrenic disorders - Include all. (Read Code: E10)

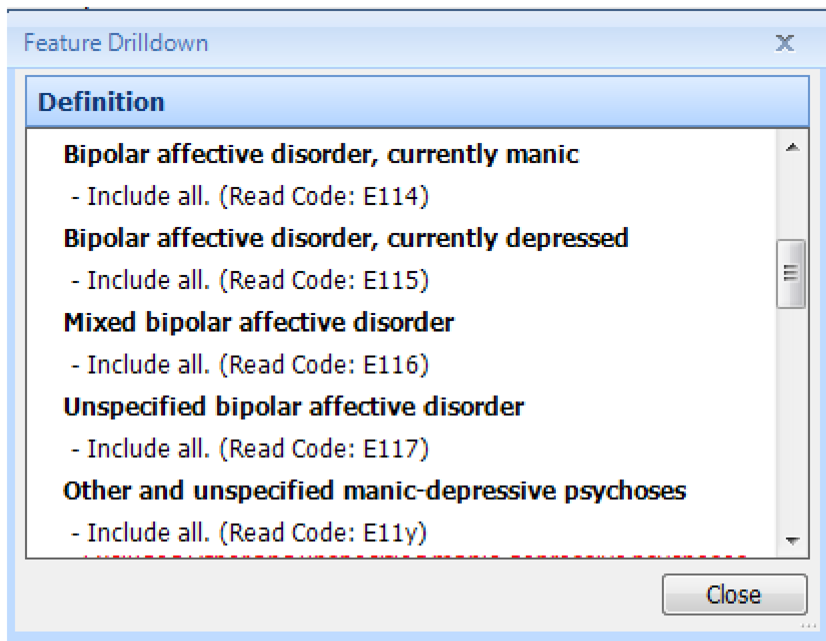
Manic disorder, single episode - Include all. (Read Code: E110)

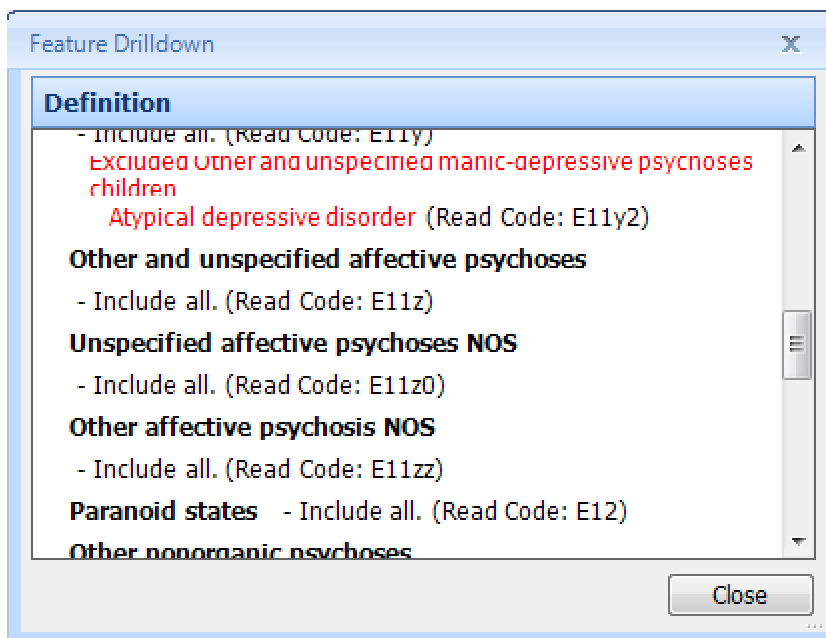
Recurrent manic episodes - Include all. (Read Code: E111)

Single major depressive episode, severe, with psychosis - Include all. (Read Code: E1124)

Recurrent major depressive episodes, severe, with psych - Include all. (Read Code: E1134)

Close


Feature Drilldown
Definition
Bipolar affective disorder, currently manic
- Include all. (Read Code: E114)
Bipolar affective disorder, currently depressed
- Include all. (Read Code: E115)
Mixed bipolar affective disorder
- Include all. (Read Code: E116)
Unspecified bipolar affective disorder
- Include all. (Read Code: E117)
Other and unspecified manic-depressive psychoses
- Include all. (Read Code: E11y)
Close


Feature Drilldown
Definition
Excluded Other and unspecified manic-depressive psychoses
children
Atypical depressive disorder (Read Code: E11y2)
Other and unspecified affective psychoses
- Include all. (Read Code: E11z)
Unspecified affective psychoses NOS
- Include all. (Read Code: E11z0)
Other affective psychosis NOS
- Include all. (Read Code: E11zz)
Paranoid states - Include all. (Read Code: E12)
Close

Feature Drilldown

Definition

Other nonorganic psychoses

- Include all. (Read Code: E13)

Excluded Other nonorganic psychoses children

Agitated depression (Read Code: E135)

Schizotypal personality - Include all. (Read Code: E2122)

[X]Schizophrenia, schizotypal and delusional disorders

- Include all. (Read Code: Eu2)

[X]Manic episode - Include all. (Read Code: Eu30)

[X]Bipolar affective disorder

- Include all. (Read Code: Eu31)

Close

Feature Drilldown

Definition

[X]Severe depressive episode with psychotic symptoms

- Include all. (Read Code: Eu323)

[X]Major depression, severe with psychotic symptoms

- Include all. (Read Code: Eu328)

[X]Recurrent depress disorder cur epi severe with psyc sy

- Include all. (Read Code: Eu333)

Recurrent major depressive episodes, severe, with psych

- Include all. (Read Code: Eu32A)

Single major depressive episode, severe, with psychosis,

- Include all. (Read Code: Eu329)

Close

Appendix Three

NHS
Lewisham
Clinical Commissioning Group

BME prevalence in MH services

Key Issues related to SMI prevalence in 'Black Communities'

- Lewisham has a higher prevalence of severe mental illness (SMI) across the entire population, when compared to London and England.
- April 2018 AMPH stats - illustrate that 35% of all MHAA referrals were for people that 'categorise themselves as Black'
- Black and minority ethnic (BME) residents are underrepresented in referrals to the local Improving Access to Psychological Services (IAPT)
- Compared with the Annual Psychiatric Mortality Survey (APMS) 2014 Lewisham's GP register has a higher rate of SMI amongst the Black population, however there is also a higher rate of SMI within the white population when comparing the APMS and GP register
- People that 'categorise themselves as Black' are overrepresented in Crisis and Psychosis care pathways within the community and inpatient services

Ethnicity profile of service users in acute wards (Sept 2016 – 2017)

	Asian	Black	Mixed race	Other Ethnic Groups	White	Unknown
Profile of adults on CPA (Sep 16) (n=6,148)	6.20%	44.80%	3.40%	3.70%	41.20%	0.60%
Lewisham Acute Wards (Sep 16) (n=74)	1.40%	48.60%	5.40%	5.40%	39.20%	0.00%
Trust-wide profile of adults on CPA (Sep 17) (n=7,690)	5.70%	42.20%	3.30%	4.60%	42.80%	1.50%
Lewisham Acute Wards (Sep 17) (n=98)	4.10%	49.00%	2.00%	6.10%	38.80%	0.00%

Ethnicity profile of service users in Forensic Pathways (Sept 2016 – 2017)

	Asian	Black	Mixed Race	Other Ethnic Group	White	Unknown
18-65 year olds in Lewisham (Census 2011)	7.50%	25.40%	5.20%	5.40%	56.60%	0.00%
Forensic Pathway service users Lewisham (Sep 16) (n=203)	1.50%	64.50%	3.90%	2.00%	27.60%	0.50%
Forensic Pathway service users Lewisham (Sep 17) (n=197)	0.50%	66.50%	3.00%	3.60%	25.40%	1.00%

Ethnicity profile of service users in Early Intervention (Sept 2016 – 2017)

	Asian	Black	Mixed	Other Ethnic groups	White	Unknown
Ethnic profile of expected cases of psychosis in Lewisham	1.00%	51.00%	7.00%	0.00%	19.00%	22.00%
Lewisham Early Intervention services (Sep 16) (n=208)	3.40%	56.70%	5.80%	6.30%	26.90%	1.00%
Lewisham Early Intervention services (Sep 17) (n=237)	4.20%	52.30%	5.10%	4.20%	34.20%	0.00%

Ethnicity profile of service users in Promoting recovery services (Sept 2016 – 2017)

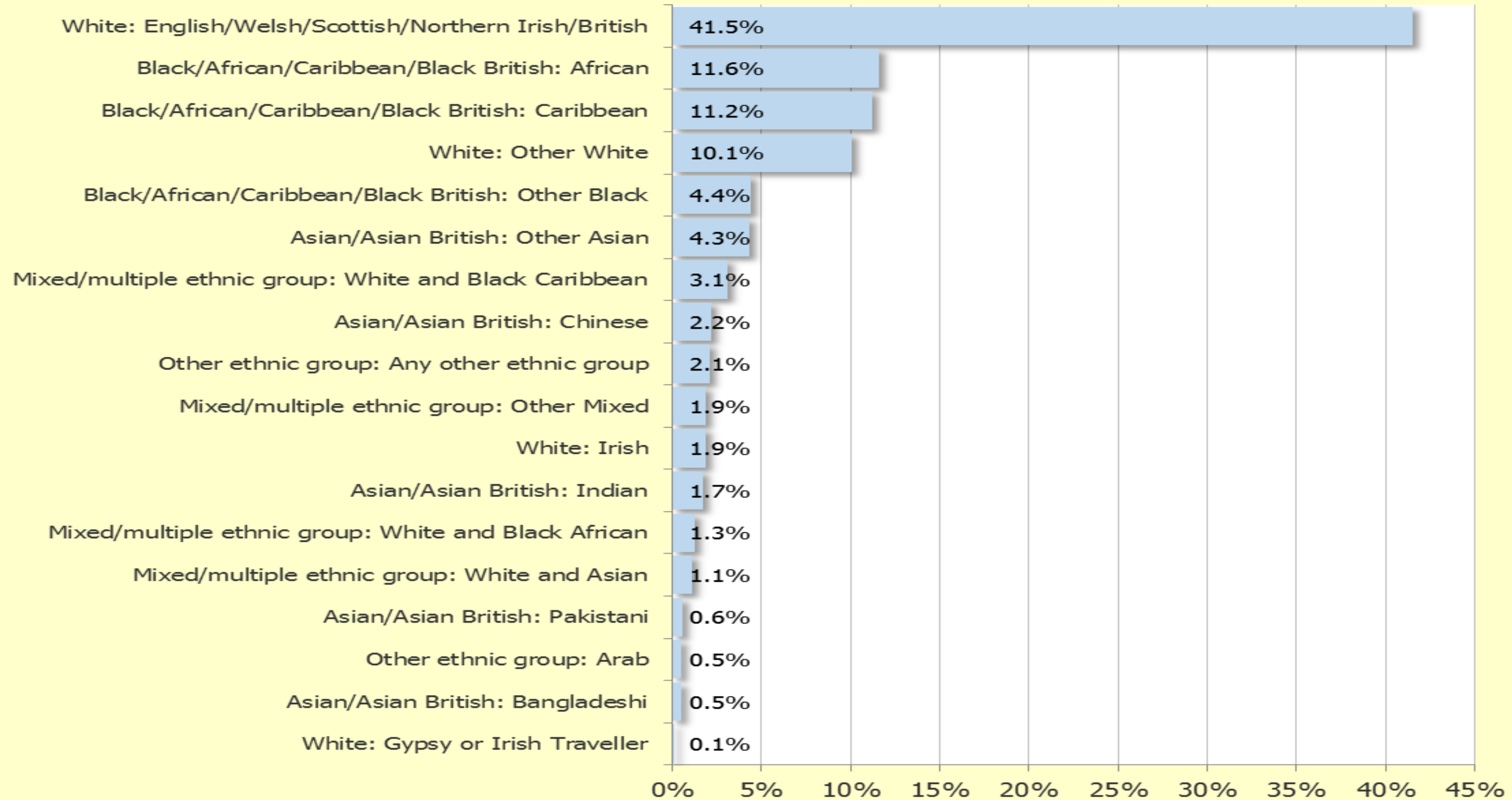
	Asian	Black	Mixed	Other Ethnic Groups	White	Unknown
18-65 year olds in Lewisham (Census 2011)	7.50%	25.40%	5.20%	5.40%	56.60%	0%
Lewisham Promoting Recovery Teams (Sep 16) (n=1,109)	7.40%	49.50%	2.90%	2.20%	38.10%	0%
Lewisham Promoting Recovery Teams (Sep 17) (n=1,104)	5.30%	50.40%	3.10%	4.80%	36.20%	0.2%

Ethnicity profile of service users in Assessment and Liaison Teams (Sept 2016 – 2017)

	Asian	Black	Mixed	Other ethnic groups	White	Unknown
18-65 year olds in Lewisham (Census 2011)	7.50%	25.40%	5.20%	5.40%	56.60%	0%
Lewisham Assessment & Liaison teams (Sep 16) (n=676)	5.00%	19.20%	2.80%	4.40%	58.00%	10.50%
Lewisham Treatment (teams Sep 16) (n=239)	4.20%	18.80%	2.90%	3.80%	66.50%	3.80%
Lewisham Assessment & Liaison teams (Sep 17) (n=780)	6.20%	20.50%	4.20%	5.30%	56.90%	6.90%
Lewisham Treatment teams (Sep 17) (n=248)	4.00%	18.10%	5.20%	5.20%	66.10%	1.20%

Improving Access to Psychological Therapies Demographic data 2017/18

	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Overall Performance 2017/18	% of people in Ethnic & Age Group Lewisham (ONS data 2011)
Male	787 (35%)	723 (32%)	796 (33%)	771 (32%)	3077 (33%)	-
Female	1493 (65%)	1509 (68%)	1614 (67%)	1627 (68%)	6243 (67%)	-
Over 65	147 (6%)	101 (4%)	124 (6%)	148 (6%)	543 (5%)	9.3%
White	1384 (61%)	1302 (58%)	1436 (59%)	1393 (58%)	5515 (59%)	53.6%
Mixed	156 (7%)	178 (8%)	178 (7%)	195 (8%)	707 (8%)	7.4%
Asian or Asian British	114 (5%)	140 (6%)	111 (5%)	131 (5%)	496 (5%)	9.3%
Black or Black British	460 (20%)	481 (22%)	518 (21%)	486 (20%)	1946 (21%)	27.2%
Chinese or other Ethnic Group	31 (1%)	67 (3%)	72 (3%)	73 (3%)	243 (3%)	2.7%
To Be Confirmed	134 (6%)	66 (3%)	99 (4%)	120 (5%)	425	


Ethnicity profile for Lewisham. Annual percentages, 2011 Census
White: English/Welsh/Scottish/Northern Irish/British
41.5%
Black/African/Caribbean/Black British: African
11.6%
Black/African/Caribbean/Black British: Caribbean
11.2%
White: Other White
10.1%
Black/African/Caribbean/Black British: Other Black
4.4%
Asian/Asian British: Other Asian
4.3%
Mixed/multiple ethnic group: White and Black Caribbean
3.1%
Asian/Asian British: Chinese
2.2%
Other ethnic group: Any other ethnic group
2.1%
Mixed/multiple ethnic group: Other Mixed
1.9%
White: Irish
1.9%
Asian/Asian British: Indian
1.7%
Mixed/multiple ethnic group: White and Black African
1.3%
Mixed/multiple ethnic group: White and Asian
1.1%
Asian/Asian British: Pakistani
0.6%
Other ethnic group: Arab
0.5%
Asian/Asian British: Bangladeshi
0.5%
White: Gypsy or Irish Traveller
0.1%
0%
5%
10%
15%
20%
25%
30%
35%
40%
45%

Ethnic Breakdown of people accessing mental health voluntary sector services - 2016/17

	Prevention and Recovery			Talking Therapies		Advocacy	
Ethnicity	**B&L Mind**	**Family Health Isis**	**Sydenham Gardens**	**Metro**	**Cassel**	**Rethink**	**Voice Ability**
Black British				6			
Black Caribbean	42	132	5	2	31		61
Black African	32	81	6	26	9	8	76
Other Black background	44	5	1		9	8	5
White and Black Caribbean	19	20	2		7	2	
White and Black African	8						11

SAIL connections ethnicity data (LCCG Public Sector Equality Duty Report 2017–2018)

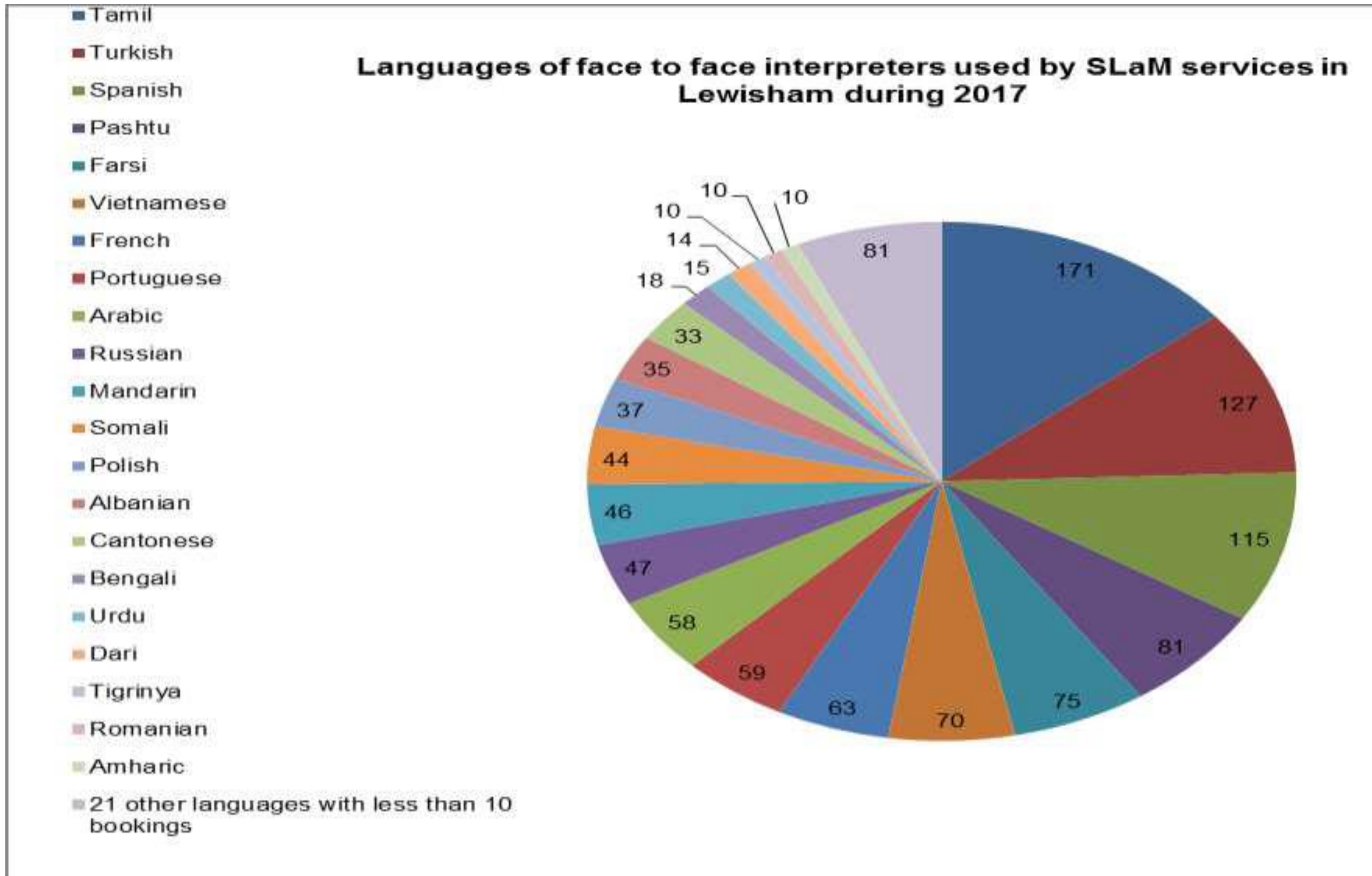
Of those supported to the end of December 2017 the breakdown of these characteristics is below:

Gender: 61% were female 39% male

Ethnicity	Per centage	Ethnicity	Per centage
White British	56.5	White Mixed (White & Other)	0.9
Black or Black British (Caribbean)	22.0	Asian or Asian British (Banglasdeshi)	0.5
Black or Black British (African)	5.6	Asian or Asian British (Pakistani)	0.5
White Irish	3.7	Black or Black British (Other)	0.5
Other Ethnic Group	3.3	Chinese	0.5
Asian or Asian British (Other)	2.3	Turkish Cypriot	0.5
Undisclosed	1.4	White Mixed (White & Black Caribbean)	0.5
Asian or Asian British (Indian)	0.9	White Other	0.5

Housing Type	Percentage
Housing Association	26.6
Owned	34.9
Rented (private)	8.9
Rented (council)	29.6

Languages of face to face interpreters (SLaM) (Sept 2016 – 2017)



SLaM Face to Face Interpreter bookings - 2016-2017

Lewisham SLaM service	Total bookings	Top language
IAPT	465	Tamil (84)
Promoting Recovery	151	Somali (38)
Assessment & Liaison	143	Tamil (30)
CAMHs Community	114	Pashtu (36)
Acute wards	91	Spanish (13)
Early Intervention	25	Farsi (17)
MHOAD CMHT	32	Russian (9)
Memory Service	25	Arabic (4) & Cantonese (4)
Home Treatment	14	Farsi (8)
Forensic	3	N/A
Complex Care	2	n/a

HEALTH AND WELLBEING BOARD				
Report Title	Joint Strategic Needs Assessment Update			
Contributors	Director of Public Health, London Borough of Lewisham		Item No.	5
Class	Part 1	Date:	4 July 2018	
Strategic Context				

1. Purpose

1.1 To request approval for four completed Joint Strategic Needs Assessment (JSNA) Topic Assessments as part of the agreed process at the July 2017 Health and Wellbeing Board and to highlight the publication of the 'Picture of Lewisham', a macro-level summary JSNA.

1.2 The four completed JSNA Topic Assessments are:

- Repeated Removals of Children into Social Care
- Young People in Contact with the Criminal Justice System
- Air Quality (Refresh)
- Maternal Mental Health

2. Recommendation/s

Members of the Health and Wellbeing Board are recommended to:

2.1 Approve the completed JSNAs and comment on the Picture of Lewisham.

3. Policy Context

3.1 The production of a JSNA became a statutory duty on PCTs and upper tier local authorities in 2007. The Health and Social Care Act 2012 placed a new statutory obligation on Clinical Commissioning Groups, the Local Authority and NHS England to jointly produce and to commission with regard to the JSNA. The Act placed an additional duty on the Local Authority and CCGs to develop a joint Health and Wellbeing Strategy for meeting the needs identified in the local JSNA.

3.2 The objective of a JSNA is to provide access to a profile of Lewisham's population, including demographic, social and environmental information. It also provides access to in-depth needs assessments which address specific gaps in knowledge or identify issues associated with particular populations/services. These in-depth assessments vary in scope from a focus on a condition, geographical area, or a segment of the population, to a combination of these. The overall aim of each

needs assessment is to translate robust qualitative and quantitative data analysis into key messages for commissioners, service providers and partners.

3.3 The most recent version of the JSNA can be found here: www.lewishamjsna.org.uk.

3.4 The priorities of The Health and Wellbeing Strategy 2013-2023 were informed by the JSNA.

4. Background

4.1 To undertake its responsibilities the Board needs to be periodically updated on the local population and its health needs. Individual JSNA topics provide in-depth analysis and recommendations for that specific service/population group.

5. JSNA Steering Group

5.1.1 The JSNA Steering Group is responsible for topic prioritisation, review and approval of completed assessments to recommend to the Health and Wellbeing Board. The group is now fully established and has been meeting bi-monthly since November 2017. It has representation from Public Health, Lewisham CCG, Voluntary Action Lewisham, a representative of the local community organisations, Children and Young People's Commissioning, Health Watch and the Local Medical Committee.

5.2 Recently approved JSNAs

5.2.1 A number of JSNA topic assessments have recently been approved by the JSNA Steering Group to come to the Health and Wellbeing Board for sign off:

- Repeated Removals of Children into Social Care
- Young People in Contact with the Criminal Justice System
- Air Quality (Refresh)
- Maternal Mental Health

5.3 Picture of Lewisham

5.3.1 The macro-level JSNA aims to describe the population of Lewisham in terms of the key health and socio-demographic characteristics, including mortality, morbidity, ethnicity and inequalities. The current format is a PowerPoint Presentation with links to core datasets. It will be refreshed annually.

5.4 Further JSNA work for 2018/19

5.4.1 An Adults with Autism JSNA Topic Assessment is nearing completion. Topic assessments on Parenting and Supported Housing are currently underway, with Respiratory and Mental Health to be completed later in

the year. JSNA Topic Assessment Refreshes will be undertaken on Sexual Health, Falls, Healthy Weight, Immunisations and Tobacco Control.

6. Financial implications

6.1 There are no specific financial implications. However the financial implications of any recommendations arising from the assessments will be considered either during or once the assessments are completed as appropriate.

7. Legal implications

7.1 The requirement to produce a JSNA is set out above.

7.2 Members of the Board are reminded that under Section 195 Health and Social Care Act 2012, Health and Wellbeing Boards are under a duty to encourage integrated working between the persons who arrange for health and social care services in their area.

8. Crime and Disorder Implications

8.1 There are no Crime and Disorder Implications from this report.

9. Equalities Implications

9.1 JSNAs are a continuous process of strategic assessment and planning, with a core aim to develop local evidence, based priorities for commissioning which will improve health and reduce inequalities. Equalities Implications have been highlighted throughout the body of the report.

10. Environmental Implications

10.1 There are no Environmental Implications from this report.

11. Conclusion

11.1 The new JSNA process is progressing and aims to become embedded in strategic planning in future years.

If you have any difficulty in opening the links above or those within the body of the report, please contact Stewart Snellgrove (Stewart.Snellgrove@lewisham.gov.uk; 020 8314 9308), who will assist.

If there are any queries on this report please contact Patricia Duffy, Public Health, Lewisham Council, on *0208 314 7990, or by email at:* ***patricia.duffy@lewisham.gov.uk***

Lewisham Public Health Team

Mothers and families who have children repeatedly taken into care in Lewisham

A Health Needs Assessment

DRAFT

Sharif Ismail, Specialist Registrar in Public Health
4-1-2017

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Executive Summary

- There is growing concern among practitioners and policymakers concerning high intensity needs among cohorts of women and/or families who repeatedly have children taken into care. The number of families affected in Lewisham is small (24 women who had previously had at least one child removed entered care proceedings in 2014/15), but the health and wellbeing implications for those affected, and cost implications for services are significant.
- This small cohort accounts for a significant proportion of the total administrative burden on the care system in Lewisham. In 2014/15, 28% of all care proceedings in the borough involved women who had previously had children removed. Most women (50%) had had one or two children removed previously, but 20% had had five or more children taken into care previously.
- Health and social needs in this cohort are complex and it is common for multiple needs to overlap. For 47 women in Lewisham who entered repeat care proceedings between quarter 1 2014/15 and quarter 3 2015/16, 53% had documented mental health problems, 53% either currently or historically engaged in substance misuse, and 51% had a history of domestic violence. Housing problems were also common (19% of the sample). Over 50% of the sample had three or more overlapping areas of need.
- Service user perspectives emphasise immense barriers to service access for this cohort, and in particular the lack of social and emotional support at critical transition points as parents are entering or coming out of the care proceedings process.
- Assuming an annual caseload of 24 mothers in Lewisham who have experienced prior removals per year, the estimated annual cost in family court legal fees is around £230,000. The additional cost of child care for children born to these women who are subsequently removed from their care is estimated at £486,000 per annum, giving a total within year cost of around £714,000.
- There is currently no national-level strategy to address needs for mothers who experience repeated removals of children into care. Some innovative programmes to address needs among women who experience repeated removals have been developed at local level, however. All offer variations on a keyworker service model, offering social and emotional support to affected women, and working to improve access to specialist services.
- These programmes include Pause in Hackney, which mandates long-acting reversal contraception (LARC) but offers a range of interventions in return. The estimated one-year cost of establishing a Pause practice in Lewisham would be around £434,000, with an anticipated return on investment (ROI) of around 180% for the first 18 months. Positive Choices/MPower in Suffolk does not mandate LARC but offers a lower intensity service model than Pause. It would cost around £135,000 to deliver for a year in Lewisham, with an anticipated ROI of 166-379% over 18 months.
- Recommendations from this needs assessment include the establishment of a new service offering targeted support for women who experience repeat removals, and emphasising social and emotional support needs during care proceedings, and integrated, tailored support afterwards (or between rounds of care proceedings). In light of funding constraints, commissioners may wish to consider a slim-line service model (either as jointly-delivered service in partnership with a Pause practice in a neighbouring borough, or modelled on the 3-member of staff model developed by Positive Choices/MPower in Suffolk). There is a key role for the Public Health Team in helping to develop a business case for the service and developing indicators to support monitoring and evaluation.

Introduction

- There is growing concern among practitioners and policymakers concerning cohorts of women and/or families who repeatedly have children taken into care. While the overall number of individuals and/or families concerned in any given locality is usually small, the health and wellbeing implications for those affected are considerable. Costs for authorities involved – Lewisham included – are often also significant, combining legal fees associated with protracted court proceedings, and heavy burdens of care for both affected parents and children taken into care in the short-, medium- and long-term.
- However, the needs of birth parents who experience repeated removals have historically been neglected. There has conventionally been an overwhelming (and understandable) focus on the safety of the child, with little attention given to supporting parents in the hope of arresting cycles of repeated care proceedings over the long term. To a large extent, this focus has been driven by the primary statutory duty of care to children where they may be vulnerable to harm. In recent years this imbalance has begun to shift, with the emergence of a number of innovative programmes focused either exclusively on affected women, or on whole families. There is also increasing research interest in this neglected area.[1]
- The purpose of this report is to provide a Health Needs Assessment (HNA) describing key characteristics of the population of women in Lewisham who have experienced repeated removals, an outline of the scale and scope of needs (health, social and other) among this group, and identify suitable interventions to address them. This is primarily an epidemiological HNA, focusing on normatively defined needs (with some information provided on expressed need by the populations in question). The focus of this report is on interventions targeting women and/or families; it does not address interventions aimed at children.

Problem definition

- An important problem in repeated removal is defining the population affected. This problem results partly from the way that legal system in England operates – i.e. the extent to which the needs of the child are prioritised over those of birth parents. It is widely acknowledged that Family Courts approach care proceedings primarily with the interests of the child at the forefront, and often only considering "index" cases (i.e. the case before them at any one time). The needs of parents are often only peripherally addressed, and there is often a failure to take a long-term view on challenges for particular parents or families (substance misuse or chronic mental ill-health, for example) who have experienced removals in the past. This may increase the probability of repeated cycles of court proceedings occurring.
- The academic literature has also been largely silent on this topic, however. Although a number of public law profiling studies have highlighted that it is not uncommon for a child in care proceedings to have an older sibling already in care or adopted, wider family circumstances have rarely been the focus of research concern.[2] Recent studies have focused attention on birth mothers, on the basis that they are usually consistent presences in the early development of their children, and

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[1] Broadhurst, K., Alrouh, B., Yeend, E. et al (2015). Connecting events in time to identify a hidden population: birth mothers and their children in recurrent care proceedings in England. British Journal of Social Work, bcv130; Broadhurst, K.E., Alrouh, B., Mason, C.S. et al (2016). Women and infants in care proceedings in England: new insights from research on recurrent care proceedings. Family Law. 46, 2, p. 208-211. 4 p.

[2] Broadhurst, K.E., Alrouh, B., Mason, C.S. et al (2016). Women and infants in care proceedings in England: new insights from research on recurrent care proceedings. Family Law. 46, 2, p. 208-211. 4 p.

because some of the most difficult ethical questions arising from the problem of recurrent care proceedings concern female reproductive autonomy (this is discussed in depth later in this report).[3] Other researchers, however, have focused on "birth relatives" or even family units on the basis that consideration of service offers for family units beyond the birth mother may be needed in the event that children are taken into care (grandparents, for instance, may be affected by this decision if they have provided bridging care for the child).[4] There are similar differences among practitioners over the extent to which, for example, husbands or partners are targeted for intervention in cases of repeat removal.

- In this HNA, we have focused on characteristics and needs of birth mothers who experience repeat removals. Partners and wider families have not been considered.

What do we know?

Facts and figures

Characteristics of the affected population nationally

- There is little systematic evidence on the frequency with which women and/or families undergo recurrent care proceedings on a population level in the UK. The best evidence currently available from England comes from a longitudinal analysis of national records from the Children and Family Court Advisory and Support Service (CAFCASS). This study does not provide numbers on the size of the population who experience repeat removals, but gives figures on recurrent rates (in other words, the recurrence rate for women who have at least one child taken into care).

- Reviewing some 43,500 cases relating to birth mothers between 2007 and 2014, this study found an average recurrence rate for care proceedings is 29%, but this value ranges from 24% to 38% (Portsmouth having the highest recurrence rate nationwide).[5] Recurrence rates in London are on a par with or lower than the national average overall, with one exception: Southwark, where the recurrence rate is 32%. Recurrence rates are defined with respect to the birth mother; in 32% of cases recorded in this study there is no information on the father. However, just under 50% of cases are defined as "recurrent couple" i.e. the mother and father appear together in more than one set of care proceedings.

- Some local authority analyses have estimated cohort sizes for women who have experienced repeated removals in their area. A feasibility study conducted in Hackney (which has a comparable population size to Lewisham) in 2013 estimated that there were 49 women in the borough who had experienced repeat removals, between them accounting for 205 children in care.[6] Estimates of cohort sizes are few, however, partly in recognition of the highly mobile nature of this population.

[3] Cox P. Marginalized mothers, reproductive autonomy, and 'repeat losses to care'. Journal of law and society. 2012 Dec 1;39(4):541-61.

[4] Neil E, Cossar J, Lorgelly P, Young J. Helping birth families: Services, costs and outcomes. British Association for Adoption & Fostering; 2010.

[5] Broadhurst, K., Alrouh, B., Yeend, E. et al (2015). Connecting events in time to identify a hidden population: birth mothers and their children in recurrent care proceedings in England. British Journal of Social Work, bcv130

[6] Hackney Pause (n.d.). Pause: creating space for change. Project brochure. Online at: http://www.pause.org.uk/wp-content/uploads/2015/03/Pause-Brochure-Email-friendly.pdf [accessed on 9/2/17]

Size and characteristics of the population locally

- It is not possible on available data to determine the exact size of the population of women who have experienced repeat removals in Lewisham at any one time. As the literature makes clear, women in this group often have chaotic lives and may be very mobile across London and indeed outside the city. However, the number of in-year care proceedings cases gives a sense of the numbers involved. In 2014/15 we know that 24 women in Lewisham were subject to care proceedings. The number of cases (and number of affected children) by quarter for Lewisham are given in Table 1 below. In 2015-16, 17% of all care proceedings in Lewisham issued at birth concerned mothers who had previously had children taken into care. In the preceding two years, the equivalent figures were 26% and 18% respectively. Nationally, evidence suggests that up to 24% of cases passing through the family justice system relate to birth mothers who have previously been through the system.[7] Table 1 below puts figures for Lewisham context and demonstrates a consistent pattern of cases being lodged by quarter over the past few years in the borough:[8]

	Q1	Q2	Q3	Q4	% of all cases issued
2013/14					40 %
2014/15	9 cases 9 children	5 cases 6 children	8 cases 8 children	4 cases 4 children	28%
2015/6	2 cases 2 children	4 cases 4 children	7 cases 9 children	2 cases 3 children	18.5%

Table 1. Care proceedings in Lewisham (and the number of children involved in these cases) involving women who had previously experienced removals between 2013/14 and 2015/16 [source: Children's Social Care data]

- From analyses of national data, the recurrence rate in Lewisham is 29% i.e. in line with the national average. These data come from a single (albeit well-conducted) population-level study based on CAFCASS records.[9]

- Figures from Children's Social Care in Lewisham for the period quarter 1 2014/15 to the end of quarter 3 2015/16 show that 47 women were involved in care proceedings, having previously had children removed. Of these, a majority were aged 30 and under, although a substantial proportion of the group (17%) were aged 41 and over, and the children involved in care proceedings in these cases were usually older. Although local data from other areas in Britain are in short supply, these figures are comparable with findings from the Pause feasibility study in Hackney, although there is a greater proportion of women in the youngest and oldest age groups in Lewisham. Comparisons should be treated with caution, however, as the population sizes involved are small, and samples were taken at different time points.

[7] Broadhurst, K., Alrouh, B., Yeend, E. et al (2015). Connecting events in time to identify a hidden population: birth mothers and their children in recurrent care proceedings in England. British Journal of Social Work.
[8] Data supplied by Laura Vaz, Family Social Work Service, Lewisham Children's Social Care
[9] Broadhurst K (n.d.). Understanding recurrent care proceedings: Birth mothers, fathers and children, caught in a cycle of repeat public law proceedings. Cardiff University CASCADE Event presentation. Online at: http://wp.lancs.ac.uk/recurrent-care/files/2015/09/CardiffCASCADEEvent.pdf [accessed on 11th

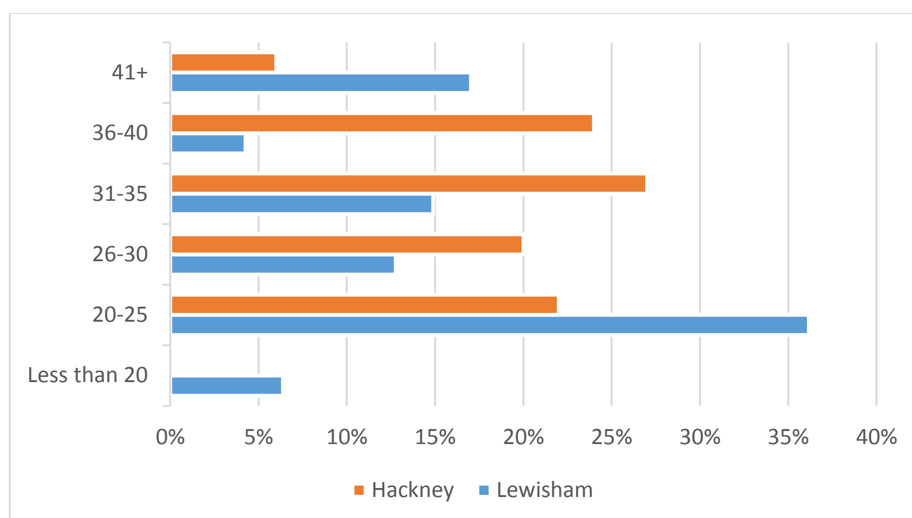

Figure 1. Age distributions of cohorts of women experiencing repeat removals in Lewisham (blue bars) and Hackney (red bars) [sources: Children's Social Care data (Lewisham); Pause program feasibility study (Hackney)]

- A majority of the women (57%) were of White British ethnicity, with most of the remainder being of various Black or Black British ethnic origins, and a small number of mixed ethnicity.
- Numbers of children previously taken into care for the affected women vary. Most (50%) had had one or two children removed before their current care proceedings, but a minority of women had had large numbers of children removed: 20% of the cohort had had five or more children taken into care previously. None of the women had had more than six children removed in the past. In this respect, the cohort in Lewisham differs slightly from comparable populations elsewhere. Data from the Pause program in Hackney, for example, show a number of women who had had 7 or more children removed. Because the population sizes are so small, it is not possible to say whether there is a statistically significant difference in the proportion of women in Lewisham experiencing repeat removals.

The scale, scope and nature of needs among the local population

- Assessing the spectrum of need in this population is challenging. A key reason for this is that no single service gathers data in a comprehensive way on women who experience repeat removals. Information is instead held across a number of services, and often only peripherally addresses the needs of parents (most data are gathered by children's services – for whom the focus is collecting information on the child rather than the birth parents). However, it is possible to draw some general observations for the population in Lewisham by triangulating data from a number of snapshots across different services. In this section, information from the following sources is presented: (1) data from Children's Social Care in Lewisham; (2) data from Lewisham Lifeline, a dedicated service for young people up to the age of 25 with substance misuse, domestic violence, mental health or related issues; (3) interviews with service providers who may have contact with women experiencing repeat removals; and (4) case vignettes from interviews with women in Lewisham who have experienced repeated removals.
- The most comprehensive data on characteristics of this population of women in Lewisham are gathered by Children's Social Care at Lewisham Council. These data are extracted from case notes for children entering case proceedings, and from notes gathered by social workers involved in the cases. Figures for the period quarter 1 2014/15 to the end of quarter 3 2015/16 were reviewed for this needs assessment, and show that, for the 47 women involved in care proceedings having previously had children removed, mental health problems (53%), substance misuse (53%) and/or

domestic violence (51%) were by far the most common presenting issues at initial contact with services. Housing problems were common (19% of the sample). Mothers in this sample commonly had a history of being in looked after care themselves or childhood exposure to abuse. Key statistics are presented in Figure 2 below, along with relevant statistics from the Pause feasibility study in Hackney. These comparisons are indicative only, and should be treated with caution for the reasons outlined above.

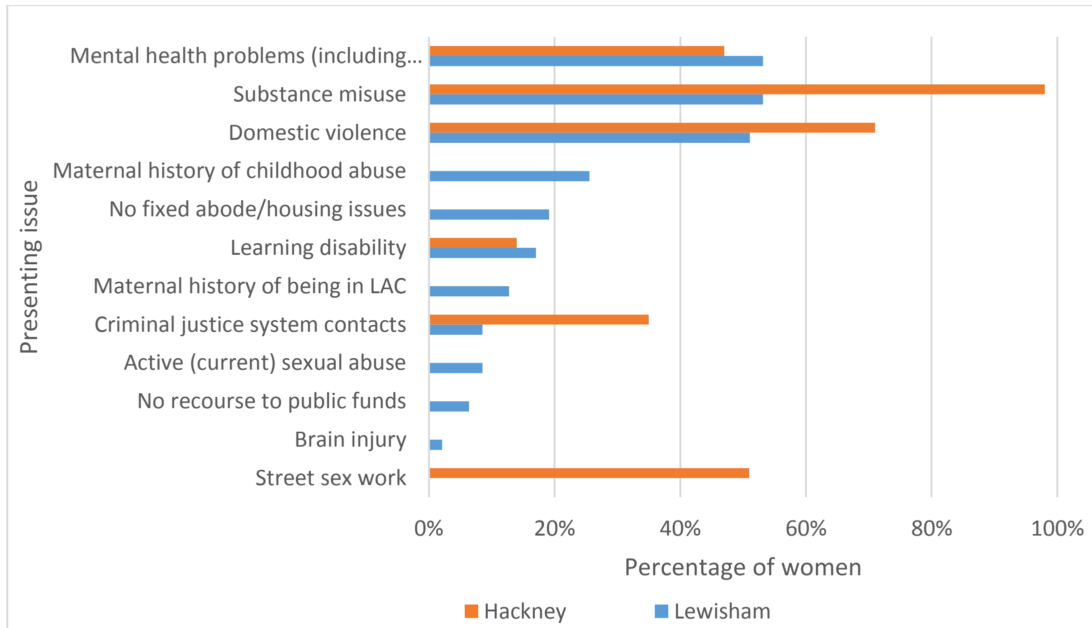

Figure 2. Presenting issues among 47 women in care proceedings in Lewisham (blue bars) between Q1 2014/15 and Q3 2015/16, who had previously had children taken into care. Data for Hackney from the Pause program feasibility study in 2013 are provided for rough comparison [sources: Children's Social Care data (Lewisham); Hackney Pause feasibility study]

- Academic evidence on repeated removals suggests that affected women often have multiple and complex needs. This is supported by data from the Lewisham sample, as shown in Figure 3 below; over 50% of the sample have three or more inter-current areas of need.

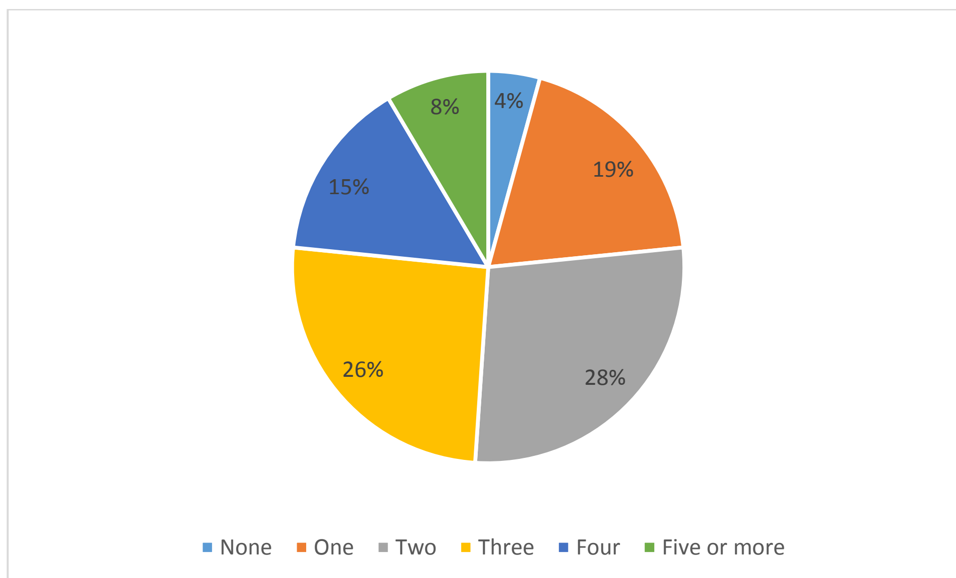

Figure 3. Number of presenting issues among 47 women in care proceedings in Lewisham (blue bars) between Q1 2014/15 and Q3 2015/16, who had previously had children taken into care [source: Lewisham Children's Social Care data]

- A second source of data on women who experience repeated removals is the formal Children's Social Care data system in Lewisham. Coverage of information relating to birth parents is variable as the primary focus of this system is on the needs of children. However, analysis of cases relating to 52 women (and 82 affected children and young people) known to Children's and Young People's Services in Lewisham as a result of repeated removals over a two-year period (November 2014 to October 2016) revealed a spectrum of issues among parents with mental health problems (55%) and domestic violence (50%) predominating – in line with findings reported above. However, in this analysis, substance misuse proved a relatively unusual presenting factor for referral to children's services. Important caveats to these data include the fact that they do not clearly disaggregate between presenting factors among birth mothers as opposed to their partners.

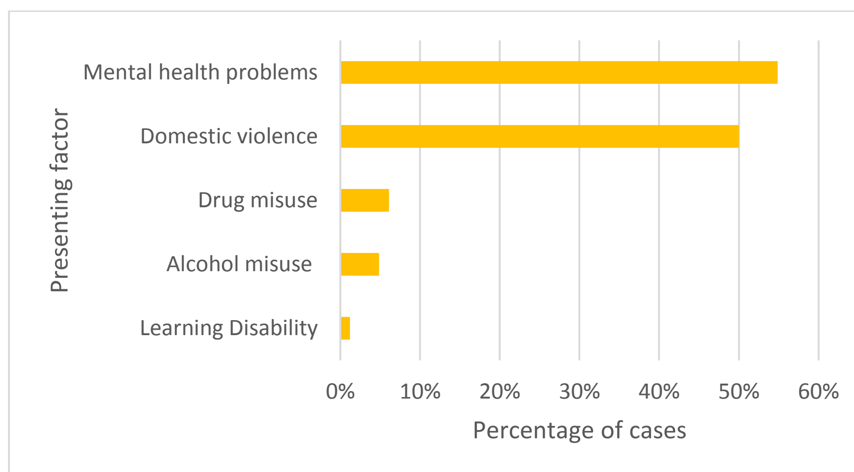

Figure 4. Presenting issues among 52 women in care proceedings in Lewisham between November 2014 and October 2016, as documented through Children's Social Care data systems in the Council.

- A third source of data – principally for younger women – is the Lewisham Lifeline service which supports young people up to the age of 25 with a variety of problems. A snapshot of data from this service between April 2015 and November 2016 showed that 9 women aged between 16 and 25 who had previously had at least one child removed had been in contact with the service. Of these 9 women, all had experienced domestic violence, two had diagnosed mental health conditions, 5 were in varying forms of supported accommodation (including one in LAC), and 8 had a history of substance misuse (principally cannabis).

- Statistical findings are supported by qualitative evidence from service providers and potential clients interviewed for this HNA. Service providers acknowledge the diversity and complexity of needs among women in this population, many of whom were themselves previously looked after children. They described particular challenges with a small number of women with very chaotic lives including a combination of poorly controlled psychiatric conditions (notably medication-resistant schizophrenia), personality disorder or learning disability, poly-substance misuse and unstable housing arrangements.

Case vignette: the scale, scope and nature of needs

Sarah

Sarah is now in her mid-30s and has had two children taken into care in the past. Although she reported a supportive family environment as a child in a single-parent household, she left home at 15 after a breakdown in relations with her mother, and since that time had had a complex history of

escalating substance misuse (cannabis, crack, speed, LSD but clean for some time now), binge drinking, unstable housing and sofa surfing and a spell in prison.

- Data on costs associated with this group are not collected comprehensively. However, using cost estimates from national sources, and assuming an annual caseload of 24 mothers in Lewisham who have experienced prior removals per year, the **estimated annual cost in family court legal fees is around £230,000**. The additional cost of child care for children born to these women who are subsequently removed from their care is estimated at **£486,000 per annum**, giving a **total within year cost of around £714,000**. These costs do not include the additional burden imposed by specialist NHS care for babies born to mothers with, for example, active substance misuse problems (many will require lengthy stays in Special Care Baby Units or even Neonatal Intensive Care depending on the scale of maternal substance misuse), or the ongoing costs of specialist input for mothers with active mental health problems, substance misuse problems, subject to domestic violence or other complaints. The case for improved preventive work on grounds of cost savings to the Council is strong.
- Bringing together findings from these sources, it is clear that **domestic violence, substance misuse and mental health problems are common presenting issues in this population**. In addition, there is a **large burden of multimorbidity** (both clinical and social), with many women reporting complex needs not readily addressed by single services operating in silos. Additionally, academic evidence on the self-perpetuating nature of entry and exit from care – sometimes over generations – is supported by data from Lewisham showing that a large proportion of these women were themselves in LAC or exposed to forms of abuse or neglect during their childhoods. Finally, there is **small sub-group of women within this population without recourse to public funds for whom challenges to engagement and service provision are particularly acute**.
- There are some notable differences from figures for other boroughs in London (although difficulties in data access and comparability should be noted). Data from Hackney show that a much higher proportion of mothers have substance misuse problems (98% of cases), **and around half are or have been involved in street sex work**. There are no data from Lewisham to suggest that street sex work is a comparable problem in the cohort locally, but this may reflect shortfalls in data collection rather than a true difference between the boroughs.

What are the key inequalities?

- Although data are in short supply for the population of women affected by repeat removals in Lewisham, evidence given above suggests that it is representative of the population of the borough as a whole in terms of ethnicity. There is no robust evidence of women from any one ethnic group being disproportionately affected by recurrent removals in Lewisham. Similarly the age distribution of affected women in Lewisham is fairly uniform.
- Insofar as inequalities exist in respect of women in this population, they lie mainly in terms of access to services (in the view of providers who may have contact with affected women). Local services such as Lewisham Lifeline (the Hub) provide integrated support on a keyworker model to women under the age of 25, including those who have experienced repeated removals, which are not available to older women in this cohort. Service providers also reported particular difficulties engaging with some clients in this population, particularly those with poorly controlled mental health problems (schizophrenia) or learning disability.

Targets and performance

- Some targets and measures applied to existing services (in relation mainly to other target populations) capture some aspects of performance that are relevant to women who experience repeat removals. For example, the Public Health Dashboard on Violence Against Women and Girls (VAWG) captures domestic abuse and sexual offence rates per 1,000 population, and the proportion of Multi-Agency Risk Assessment Conference (MARAC) referrals in Lewisham by agency or department on an annual basis (including referrals from Children's Social Care). The most recent figures show that the crude rate of domestic abuse in Lewisham was equal to London average in 2014/15, but that the sexual offence rate in the borough was higher than both the London and national averages. The proportion of MARAC referrals originating from Children's Social Care in the borough declined from 3% in 2015 to 1% in 2016. The overall number of MARAC referrals from all services also declined over the same period.
- Similarly, for substance misuse, we know that overall penetration rates for treatment for opiate and/or crack use in Lewisham are lower than the national average, with 34.4% of the estimated number of opiate and/or crack users in treatment compared with 52.1% nationally. Nevertheless, treatment completion rates among both opiate and non-opiate-using clients are equivalent to national average, if slightly lower than London average.

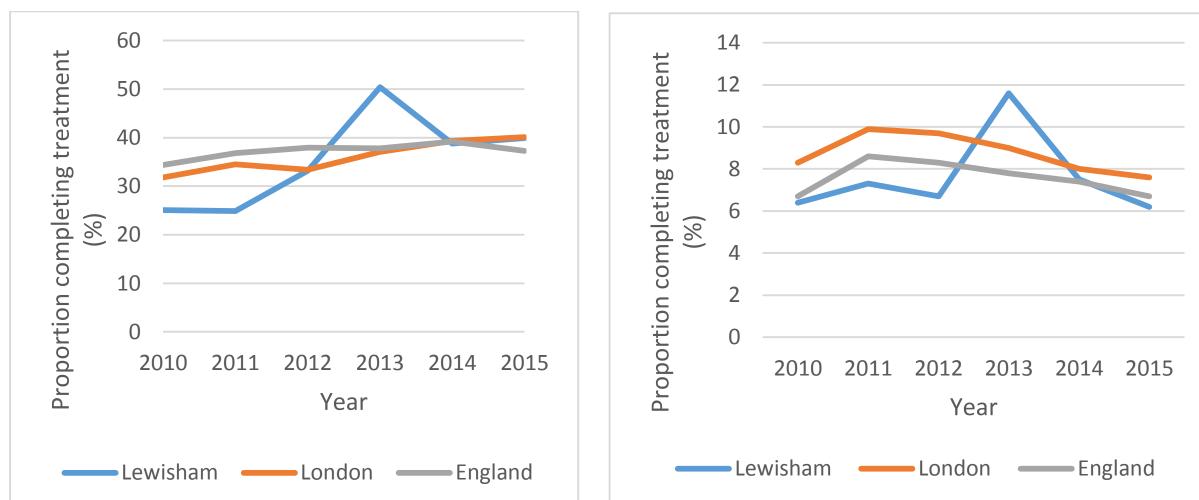

Figure 5. Proportion of non-opiate (left) and opiate (right) using clients completing treatment in Lewisham between 2010 and 2015 (source: Public Health Outcomes Framework, indicators 2.15i and 2.15ii)

- However, none of these performance figures distinguish between different kinds of service client, and there are currently no targets or performance measures specific to women who experience repeat removals. This Health Needs Assessment is intended to contribute to the development of a new service to address needs in this group in Lewisham. Implementation of the new service will require the identification of a series of additional measures to track performance against key outcomes for women who experience repeat removals.

National and local strategies

- This population group has historically been neglected by policy at both local and national level – a fact repeatedly highlighted in the academic literature.[10] Nationally, policymakers have focused on

[10] Broadhurst, K., Alrouh, B., Yeend, E. et al (2015). Connecting events in time to identify a hidden population: birth mothers and their children in recurrent care proceedings in England. British Journal of Social Work, bcv130; Broadhurst, K.E., Alrouh, B., Mason, C.S. et al (2016). Women and infants in care proceedings in England: new insights from research on recurrent care proceedings. Family Law. 46, 2, p. 208-211. 4 p.

improving outcomes for children in and out of care through population-level measures designed to support early development (e.g. Sure Start) or target interventions for families and communities who experience multiple forms of deprivation. The Social Exclusion Unit and its successor, the Social Exclusion Task Force operated between 1997 and 2010[11] and focused specifically on supporting cross-governmental work on social exclusion some of which touched on women experiencing repeated removals (among other groups). However, there was no dedicated focus within any of the Unit's reports or initiatives on women falling into this cohort.

- The current government's **Troubled Families programme** is the most high profile current initiative to address multiple deprivation, targeting 120,000 families nationwide to whom key workers are assigned to help "turn around" harmful behaviours including domestic violence, relationship breakdown, mental and physical health problems. Delivery of this programme is through local authorities on a payment-by-results basis.
- A variety of local initiatives have been developed by local authorities in recent to tackle repeated removals, in recognition of the high health, social and financial costs associated with this group. Evidence on the most prominent programs is presented in the next section. In Lewisham, building child and family resilience, and keeping children safe, are key priorities under the Children and Young People's Plan 2015-18. Implementation is supported by emphasising an early intervention approach in Children's Services, and activities through – among others – the Violence Against Women and Girls Action Plan and Safeguarding Children Board's action plan.[12] From the perspective of birth parents, the Lewisham Health and Wellbeing Strategy includes reducing alcohol harm (priority 4), improving mental health and wellbeing (priority 6) and improving sexual health (priority 7) – all of which are significant challenges in this population of women – among its top 10 priority outcomes.[13] However, the strategic approach to support for mothers and/or parents who experience repeated removal has to date been indirect, with a focus on signposting affected individuals into existing services rather than dedicated support.

What works for women and/or families that experience repeat removals?

- Evidence on the effectiveness of interventions for women who experience repeated removal is, for the most part, early stage and documented impact on health and other outcomes is tentative. A summary of the most promising interventions currently operating in England on a local level, their associated impact at 18 months, along with anticipated return on investment (in the context of Lewisham) is presented in Table 2 below.

Service	Features	Impact (all at 18 months)	Return on investment
Pause Hackney, Islington, Newham,	• *Staffing:* 4-5 key workers, 1 service manager • *Eligibility:* exclusive focus on women; no children currently in	For 20 women: • No further pregnancies	• Anticipated one-year cost in Lewisham would be around **£433,960** (for the full service)

[11] These bodies operated using an assumed definition of social exclusion as "a shorthand label for what can happen when individuals or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown".
[12] Lewisham Children and Young People's Plan 2015-18. Priority Area: Identify and protect children and young people at risk of harm. Online at: http://www.lewisham.gov.uk/myservices/socialcare/children/cypp/Pages/-Identify-and-protecting-children-and-young-people-at-risk-of-harm-and-ensure-they-feel-safe.aspx [accessed 9/2/17]
[13] Lewisham Health and Wellbeing Board (2015). Lewisham Health and Wellbeing Strategy Draft Refresh, 2015-18. Online at: https://www.lewisham.gov.uk/myservices/socialcare/health/improving-public-health/Documents/LewishamHWBStrategyRefresh2015.pdf [accessed 9/2/17]

others	care of the mother; LARC take-up obligatory • *Offer:* integrated set of interventions, potentially incorporating therapy (e.g. counselling), health support (GP assessment, specialist nurse input), education and employment advice, practical support (e.g. housing, budgeting), and reflective work.	• 50% supported to find stable housing; 35% and 40% supported into mental health services and domestic violence services respectively • 10% started work (PT)	• **Return on Investment is estimated at 183%** over the first 18 months
Positive Choices/ MPower Suffolk	• *Staffing:* 2 keyworkers, 1 service manager • *Eligibility:* work with women, occasionally partners; no children currently in care of mother; LARC uptake strongly encouraged (not obligatory) • *Offer:* one-to-one support emphasising trust-building between the support workers and clients. Once a relationship has been established, personal goals are identified along with practical ways of achieving these. Particular interventions chosen are flexible according to individual client's needs.	For 65 women: • No further pregnancies • 24% of enrolled women and/or partners found employment and 23% accessed training in the evaluation period • 44% established average, good or excellent relationships with family/friends	• Anticipated one-year cost in Lewisham around **£135,000** • **Return on Investment estimated at between 166% and 379%** over first 18 months
Family Drug and Alcohol Court (FDAC) Camden, Islington, Lambeth, others	• *Staffing:* variable • *Eligibility:* work with families; proximate cause of children being deemed at risk identified as substance misuse; the point of intervention is at the time of referral for court proceedings. • *Offer:* built into the legal care proceedings process; specially-trained judges work with a team of social workers, psychiatrists, substance misuse workers and others to offer personalised package of support and treatment. Aims to give parents the chance to show that they can care for their children.	• Family re-unite rate of 39%, compared with 21% for families going through regular process. • 48% of FDAC mothers and 36% of fathers no longer misusing substances (versus 39% of mothers in control group; all control group fathers still using)	• Anticipated one-year cost in Lewisham around **£380,000** • In 2014-15 in London, FDAC had a case load of 40 families, on which £560,000 was spent with an expectation of a gross saving of £1.29m over 5 years to public sector bodies (a 5-year return on investment of 230%)

Table 2. Three local services for women and/or families who experience repeat removal, and the evidence associated with their impact.

- Some local services have been established in England that are modelled on one or more of the interventions listed above. For example, the SPACE program in Cambridgeshire, which has been operating for around a year, draws directly on the service specification for Positive Choices/MPower in Suffolk and has been designed with advisory support from them. Impact evaluations for this service are pending.

- An important example of pan-European service model development is provided by **Action for Change**, an initiative with a UK base in the Tri-borough in London, but working also in Hungary, Italy and Romania. Action for Change is a two-year project funded by the European Commission's Daphne III initiative (supporting violence-prevention work continent-wide) aiming to support individuals who have experienced domestic violence and have had, or are at risk of having, children taken into care. Although the service models differ slightly in each country, some important success factors have been identified in early evaluation work, in particular the central importance of the "women's shadow board" (effectively a service user steering group), bringing together survivors of domestic violence across the participating countries to help shape programme design and delivery.

- A range of additional interventions, mostly developed internationally, may also be considered. Many of these target women and/or families with older children who have been referred to social services. Among these is the **Triple P program**, developed in the UK and North America. This complex intervention includes streams dedicated to supporting families where the risk of physical or emotional harm to the child from parents is regarded as particularly great, including the Pathways Triple P program. The Pathways intervention, delivered by a practitioner to groups or individual parents over two to five 60-90 minute sessions supports parents to build realistic expectations of their children's behaviour, and then assist with mood management. This program is supported by evidence from two randomised controlled trials showing improvements in parent self-confidence and parent-child relationships. Monetised benefits from this program (across all forms) are 5 times greater than associated costs.[14]

- **Parents Under Pressure**,[15] developed originally in Australia, focuses particularly on multi-risk families where one or both parents were drug or alcohol users. The program is structured around 12 modules delivered intensively by trained practitioners (commonly clinical psychologists) working directly with individual parents/families. An RCT in Australia showed significant reductions in risk across a range of domains at 3- and 6-month follow-up in methadone-dependent families associated with this program. For 100 families in a methadone-dependent Australian population treated with Parents under Pressure, there would be a net present value saving of an estimated £1.7 million.[16]

Current activities and services

- As in many local authorities, the most clearly integrated service "offer" to mothers and families experiencing difficulties that may lead to children being taken into care is delivered through children's services. Lewisham's **Early Help Service** (EHS) provides various forms of support to children and young people with identified additional needs (of various kinds), but some aspects of this service are more closely tailored to work with children and families in which the risk of care proceedings may be high. For example, the **Support for Families Programme**, which forms part of the Government's wider Troubled Families Programme, has strict eligibility criteria including that (1) parents or children are involved in crime or antisocial behaviour; (2) children are identified as

[14] Early Intervention Foundation (2016). Pathways Triple P (level 5). Online at: http://guidebook.eif.org.uk/programmes-library/pathways-triple-p-level-5 [accessed on 3rd October 2015].
[15] NSPCC (2016). Pause, Children's House, Parents under Pressure, Family Drug and Alcohol Court: a set of case studies of practice. Online at: https://www.nspcc.org.uk/globalassets/documents/publications/pause-childrens-house-parents-under-pressure-family-drug-alcohol-court-case-studies-practice.pdf [accessed 4/10/16]
[16] Dalziel K, Dawe S, Harnet PH, Segal L. (2015). Cost-Effectiveness Analysis of the Parents under Pressure Programme for Methadone-Maintained Parents. Child Abuse Review, 24(5).

being in need, or subject to a Child Protection Plan; (3) families affected by domestic violence or abuse; (4) families or children affected by chronic health problems; and others. Where children are involved, many of these services are coordinated by the **Multi Agency Safeguarding Hub** (MASH) bringing together Children's Social Care, the EHS, Health and Police Public Protection Desk.

- Some council programmes offer integrated support directly to families with children in response to identified needs. These include **Targeted Family Support**[17], which provides wide-ranging support including parenting and role-modelling advice to families with children in Lewisham aged 0-19.

- A variety of dedicated programmes are offered in Lewisham to support women and/or families according to the specific presenting social issue. For example, support for those experiencing domestic violence and other forms of violence against women & girls (VAWG)[18] is offered through the **Athena Service** (up to and including refuges), with signposting to third sector organisations providing other forms of support also offered. The Council's **Serious Violence Team** supports families for which gang-related crime (either involvement of children or parents) is an issue.

- There is particularly broad-ranging support for people with substance misuse problems. Lewisham Lifeline's **The Hub** offers dedicated support to children and young people aged between 11 and 25 who have substance misuse problems; they offer a broad range of services including sexual health and, as identified above, have a number of clients who have previously experienced one or more removals. For adults, there are two core service providers in Lewisham: **CGL New Directions** and **Blenheim CDP**. CGL New Directions offer a complex needs service in the community to those aged 18 and over who misuse substances. This service can support people with multiple, overlapping needs, and incorporates an Independent Domestic Violence Adviser (IDVA), an addictions psychiatrist and nursing staff besides core project workers. Blenheim CDP provide substance misuse services in primary care settings, based primarily from a network of participating GP practices across the borough. Both services work with parents who currently have children in their care. Specialised services are also available for specific populations. For example, the **Liaison Ante-Natal Drug Service (LANDS)** offers support to pregnant women with substance misuse problems, in a partnership between CGL New Directions and maternity services at Lewisham Hospital.

- Overall, of the programmes listed above, only Support for Families and Targeted Family Support provide service offers well-tailored to families at risk of having children taken into care. Many of the other services described face issues in (1) identifying families who may be at risk at a suitably early stage to enable impactful intervention; and (2) strengthening collaboration around the needs of individual families. Many of those affected have multiple, overlapping needs that cannot readily be addressed by individual services although some (e.g. The Hub and CGL New Directions) do offer support for complex needs.

Local views

- Service user perspectives were gathered for this needs assessment through key informant interviews with a selection of women who would likely have been eligible for a dedicated service.

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[17] Targeted Family Support website: http://www.targetedfamilysupport.co.uk/ [accessed on 4th October 2016]
[18] VAWG is the widely recognised umbrella term for all forms of violence perpetrated towards women, because of their gender.

Case vignette: service needs

Jane

Contact with public services to address each of Jane's needs (specifically: domestic violence, unstable housing and employment support) has been sporadic, and Jane feels that much of the initiative to address these has come from herself. She favours individualised, keyworker or befriender support, with access to that support on an ongoing basis even if contacts are minimal for periods when her personal circumstances are more stable.

- Views on limitations of the current service offer in Lewisham (and indeed elsewhere in London) were clear. In general, support to birth parents was felt to be limited with a particular deficit before, during and after care proceedings (especially where a court decision is taken to remove a child) when parental need for emotional support can be high. Service users reported weakly coordinated contacts with specialist services in other areas of need (substance misuse, mental health and so forth). This is problematic for a population of women many of whom have chaotic lifestyles and for whom difficulties engaging consistently with public services are common.
- The main service need identified was for individualised **keyworker or befriender support**, to help advocate for affected women, to inform them on what to expect during and after care proceedings, and to support contact with specific services (e.g. housing support, substance misuse services). One service user felt that grief counselling could be helpful depending on the circumstances of the client, but that in many cases long-term issues associated with the removal of children are unlikely to be resolved.
- Importantly, **support needs to be ongoing**, or at least sensitive to time-points when vulnerability is increased (e.g. birthdays for previously removed children). Service users envisaged low burden contact methods such as text messaging or emails from service providers at these times to check in with clients, with the option to escalate the level of support if needed. Women would need to have the option of re-engaging fully with maximal support from the service at short notice.
- There were mixed views on whether group support would be appropriate. One service user felt anxious about exposure to the extended social networks of other women who had experienced repeat removals, on the grounds that these networks often perpetuate damaging behaviours and make expose other women in the group to harmful influences.
- In summary, potential service users favoured a keyworker support model, with opportunities for ongoing contact tailored to changing levels of need over time, and support in signposting them to specialist services (mental health, substance misuse and so on) as appropriate.

What is this telling us?

What are the key gaps in knowledge and/or services?

Gaps in services

- The main finding from this needs assessment is that there is an **important gap in service provision for birth parents who have experienced repeated removals**, with a pressing need for an integrated service to advocate for these individuals and help them access specialist services. In many instances, the complex patterns of need are managed independently by a range of different services (mental health, substance misuse and so on), with no integrated support.

- There are **particular needs for social and emotional support** to women and families as they are going through, and then exiting, care proceedings which are not currently addressed by services locally. This was identified as a shortfall that could be addressed through a keyworker support model, with the intensity of contacts tailored according to clients changing needs at different points in time.
- There are **particular challenges around access to sexual health services including contraception**. It is not clear what proportion of women in this cohort are ever offered long-term contraception, even if they are in regular contact with services. This deficit heightens the risk of women becoming locked in cycles of pregnancy, birth, and then child removal. The cost implications of support for children born to women in this cohort are substantial. The integrated models of support being offered to women in some other Local Authorities (e.g. the Pause Program in Hackney) are perhaps best approximated in Lewisham by the Lifeline service, but this works only with young people up to the age of 25.
- Gaps in provision within specific services (e.g. mental health, substance misuse) were not identified by this HNA – partly because the diversity and complexity of needs among women in this group is so great that common themes between them are difficult to draw out. Specific service gaps may however be identified in follow-on work.

Gaps in knowledge

- A significant problem when profiling needs for women who experience repeated removals in Lewisham is that the affected population are hidden and information on their health and social service support needs are captured variably by existing data systems. **Data are often fragmented across team and service boundaries**, increasing the risk of duplication (i.e. double-counting) in assessment of needs among this group. At present, the most comprehensive dataset on women who experience repeat removals is collated by social workers in Children's Social Care – but there is a risk that this dataset may not be maintained if there are internal re-organisations or members of staff change roles.
- Additionally, data are commonly collected from the perspective of the children, with **incomplete information recording regarding birth parents** unless specific parental factors (e.g. substance misuse) are identified that directly affect the wellbeing of the child. In many instances parental information is collected without differentiating between those issues that concern the birth mother, and the father.
- **Detailed health information is commonly not available** for this cohort. Data analysed for this HNA was aggregated (e.g. "mental health problem") and there was very little information available on the nature and intensity of non-communicable disease in this group.
- **Costings** reported in this HNA are approximate and based on generic estimates for legal fees and care placements in London that may not fully reflect local costs in Lewisham. There is a need to strengthen information gathering on costs associated with care proceedings and taking children into care to better inform these estimates for the future.
- Finally, **there may a larger population of women at risk of repeat removal (e.g. women who have had one child previously removed) about whom we can say very little**, based on the data available for this report. A truly preventive approach to reducing the risk of repeat removal will need to engage with ways of identifying the size and nature of this population in Lewisham.

What is coming on the horizon?

- National interest in this area is rising – and particularly in the potential of the Pause model developed in Hackney. The Department for Education has provided pump priming funding to enable Pause to launch nationally, with the intention of increasing the number of practices operating in local authorities around the country. The Government Spending Review and Autumn Statement 2015 announced that a £15 million annual fund, equivalent to the VAT raised each year on sanitary products, would support women's charities. From this fund, £500,000 of additional funding for Pause was also announced in the March 2016 budget, with further rounds anticipated to be administered through the Cabinet Office. A national unit has also been established to support expansion in the work of FDACs nationwide. A preliminary evaluation of this initiative was published in January 2017.[19]
- While there is some justification to taking a national approach to a population that is often mobile across local authority boundaries, at present the focus of project development remains local and driven by local need.

What should we be doing next?

- Given the scale and scope of need among women in this population in Lewisham, and the cost to services associated with child removal and placement, a dedicated new service may be expected to deliver significant improvements in outcomes and savings to the Council. Scoping work is currently underway to investigate options in setting up a new service to support women who experience repeated removals in Lewisham, possibly in partnership with other existing services in London. Various models are being explored with a view to building a business case.

Recommendations

- In light of findings presented above, a pressing need for an integrated service to advocate for women who experience repeated removals and help them access specialist services in Lewisham has been identified. To help meet this need, the following recommendations are made:

For all stakeholders:

- Targeted support for women who experience repeat removals should **emphasise social and emotional support needs during care proceedings, and integrated, tailored support afterwards** (or between rounds of care proceedings) to ensure adequate continuity for this vulnerable group.
- In light of funding constraints, **commissioners may wish to prioritise consideration of a slim-line model for a new service for women in this cohort** (either as jointly-delivered service in partnership with a neighbouring borough, or modelled on the 3-member of staff model developed by Positive Choices/MPower in Suffolk.
- **Services should consider adopting a "Making Every Contact Count" approach to sexual health** screening and offers of contraception to women in this cohort to ensure uptake.

For Public Health:

[19] Roberts et al (2017). Family Drug and Alcohol National Unit: independent evaluation research report. Children's Social Care Innovation Programme Evaluation Report 12. Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/585193/Family_drug_and_alcohol_court_national_unit_evaluation.pdf [accessed 8/2/17].

- **The Public Health Team should support planning for a potential new service by developing a business case that outlines service design options** ranging from light footprint (potentially a jointly-delivered service in partnership with a neighbouring borough) through to a full model with up to 5 members of staff that replicates the approach used by Pause.
- The Public Health Team can support implementation of a new service by **advising on development of a robust set of measurable performance indicators for monitoring and evaluation**.
- As a result of stakeholder engagement work to date, the Public Health Team is well placed to **advise on recruitment to a steering committee for a new service**. It is crucial to the success of any future service that this committee includes a cross-section of practitioners and in particular, strong representation from service users.

For Children's Social Care:

- **Mechanisms for strengthening information collection and analysis on women who fall into this cohort should be put in place to ensure accuracy and completeness**. This could be achieved through periodic (potentially quarterly) data audits to bring together information on affected women from different sources (children's social care, adult social care, domestic violence, substance misuse and health services) where information governance and confidentiality considerations permit this.

Young People in Contact with the Criminal Justice System in Lewisham

Joint Strategic Needs Assessment – June 2017

DRAFT

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LONDON BOROUGH OF LEWISHAM | PUBLIC HEALTH TEAM

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Executive Summary

- This Joint Strategic Needs Assessment (JSNA) document has been produced in response to findings from a Full Joint Inspection of Youth Offending work in Lewisham by Her Majesty's Inspectorate of Probation (HMIP) in late 2016. The inspection noted areas of strength in mental health provision for Youth Offending Service users, but recommended improvements in assessment and management of their physical, and speech, language and communication needs.
- For the purposes of this report, physical health needs encompass acute and chronic health conditions such as asthma and diabetes, sexual health problems, and physical disabilities including hearing and visual impairments. Speech, Language and Communication Needs (SLCNs) encompass a range of receptive and expressive difficulties.
- There are well recognised links between physical ill-health and particularly SLCNs and offending among youth populations. The burden of SLCN among young offenders nationally may be as high as 60% based on survey results, compared with 10% in the general population. However, case recognition especially for SLCNs in youth offending populations is poor; SLCNs in particular are difficult to diagnose and may be effectively masked by young people themselves.
- An audit of 55 young offenders under the management of the Lewisham Youth Offending Service (YOS) from January-February 2017 carried out for this report revealed that 9% had diagnosed physical health conditions, and 13% SLCNs. There was no observed overlap in physical ill-health and SLCNs in this cohort, although one individual had overlapping SLCN and a diagnosed mental health problem. These figures likely significantly underestimate the true burden of need in this cohort. Rates of SLCN are some way below estimates from national surveys.
- There were significant challenges to data analysis and interpretation in the case audit. 18% of the young people did not have a current, completed Asset+ assessment, although in 70% of these cases this was because they had previously had an Asset assessment completed or their criminal justice outcome meant that no YOT intervention was required. Documentation of sexual health status was very limited. In five cases (9%), case workers documented significant concerns about undiagnosed SLCN or special educational needs (SEN) but no onward referral was documented or further clinical assessment was awaited.
- Lewisham YOT practitioners identified a range of challenges in assessment and management of physical health and SLCNs among young offenders. To help address these, they argued for improved data sharing between service partners (and especially with schools), and strengthened specialist input to support assessment and management of health needs by YOS staff.
- This report makes recommendations in two areas:
    - **Strengthening initial assessment and referral**: through dedicated YOT staff training in assessment and recognition of physical health needs and SLCN/SENs and increased expert support for physical health and SLCN/SEN assessment and interventions for YOS users. There are opportunities to strengthen expert input through work in partnership with the newly commissioned Young People's Health and Wellbeing Service in Lewisham.
    - **Improving data completion** through, for example, audit work to improve record completion in Asset+.

Section 1: Introduction

Purpose

1. The purpose of this Joint Strategic Needs Assessment (JSNA) is to examine rates of physical health, and speech, language and communication needs (SLCNs) among children and young people (CYP) who come into contact with Youth Justice Services (YJSs) in the London Borough of Lewisham, and to outline both current practice in Lewisham and best practice from elsewhere in assessment and management of these needs.

2. The report aims to support practitioners, managers, policy makers and commissioners in Lewisham in prioritising and targeting local resources effectively in future development of the service offer by Lewisham Youth Offending Team (YOT).

Definitions and methodology

3. The definitions of physical health and SLCN used in this report are as follows:

    a. Physical health needs in young people encompass well-recognised chronic conditions such as asthma and type 1 diabetes (both of which are quite common in children and adolescents), episodes of acute illness, and long-term physical disabilities – which may include visual or hearing impairments, or mobility problems requiring support up to and including wheelchair use.

    b. SLCN is a broad term that includes a range of receptive and expressive difficulties. Put simply, speech refers to saying sounds accurately and in the right places; language refers to understanding and making sense of what people say; communication refers to how we interact with others and to adapt this to suit different situations. SLCNs can exist in isolation, alongside other disabilities or indeed as a part of them. It is important to note that people diagnosed with Autism Spectrum Disorders (ASD) and learning difficulties will always have some form of SLCN and there is an increased risk of SLCN within young people with Attention Deficit Hyperactivity Disorder, Conduct Disorders, Social Emotional Behavioural Difficulties and dyslexia.

4. This document outlines findings from an evidence review of current physical health and speech, language and communication needs in the YOS cohort in Lewisham. Data were drawn from a number of different sources to support this, including:

    a. A desk review of literature on youth offending nationally and in Lewisham. This included both peer-reviewed academic literature (drawn from academic journals) and non-peer reviewed grey literature reports from national bodies (such as the Ministry of Justice, Youth Justice Board, Centre for Mental Health and others), and local organisations (including Lewisham Council, and papers produced by the Lewisham YOT).

    b. An in-depth review of case records held by the Lewisham YOT on 38 repeat offenders in contact with the service over January and February 2017. This group of young people has now been established as a "cohort", and their records will be regularly reviewed over time to provide a clearer picture of risk factors for offending and repeat offending in the borough.

    c. Focus group discussions with a selection of Lewisham YOT practitioners, to better understand the working pressures they operate under, and seek views on potential solutions to these.

Section 2: what is the policy context to this report?

National policy context

5. Youth offending teams (YOTs) are multi-agency partnerships that deliver youth justice services locally and require local partner cooperation to coordinate the provision of local youth justice services. YOTs are specifically tasked with reducing offending or re-offending among young people, and bring together stakeholders from the local authority, police, probation and health services.

6. YOTs were originally established under the terms of the Crime and Disorder Act 1998, with national oversight for both community and custodial sentences provided by the Youth Justice Board (YJB). In recent years there has been a shift towards reduced central oversight and reporting to the YJB in favour of greater local autonomy in youth justice provision, but this has coincided with broad-ranging cuts to funding, and healthcare delivery in this context has for some time been identified as an area for improvement across localities[1].

7. There is also broad recognition among policymakers of the need to redesign services around an early intervention, prevention and family-based model and an acknowledgement that to be effective, YOTs must bridge the criminal justice system and wider children and young people's services to bridge service gaps between the two. This approach has been a recurrent theme in national policy documents since the publication of the Government's *Healthy Children, Safer Communities* strategy in 2009[2].

Local context

8. In September 2016, Her Majesty's Inspectorate of Probation (HMIP) carried out a Full Joint Inspection of Youth Offending work in Lewisham[3]. The inspection report noted that while "the provision of mental health services was good…physical health and speech, language and communication needs were not being adequately met" in Lewisham.

9. The inspection team made a series of recommendations, primarily that the Youth Justice Management Board in the borough should redouble its efforts to improve outcomes for children and young people, aiming for a reduction in reoffending rates, better management of the risk of harms to others, and strengthened protection of vulnerable children and young people who have offended in the past. In relation to health specifically, they recommended that:

    a. "The delivery of health services to YOS children and young people reflects the needs identified in The Joint Strategic Needs Assessment 2014…including physical health, and speech, language and communication needs" (Recommendation 8);

    b. "Information sharing with health, substance misuse and social care partners is improved" (Recommendation 9).

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[1] See the three Healthcare Commission/CQC and HMIP reports on this topic released between 2006 and 2011: Let's Talk About It: A review of healthcare in the community for young people who offend (Healthcare Commission, 2006); Actions Speak Louder : A second review of healthcare in the community for young people who offend (Healthcare Commission and Her Majesty's Inspectorate of Probation, 2009); Re: actions: A third review of healthcare in the community for young people who offend (Care Quality Commission, 2011)

[2] Department of Health, Department for Children, Schools and Families, Ministry of Justice, Home Office (2009). Healthy children, safer communities - a strategy to promote the health and well-being of children and young people in contact with the youth justice system. London: TSO.

[3] HMIP (2016). Full Joint Inspection of Youth Offending Work in Lewisham: an inspection led by HMI Probation. December. London: HMIP.

10. Stakeholder observations and findings from the previous JSNA in this area[4] support the view that there is scope for improving primary health provision for this cohort. This includes better management of physical health needs (including sexual health) and speech, language and communication needs.

11. In May 2017, a new Young Person's Health and Wellbeing Service was launched in Lewisham supporting CYP aged 10-19 years old (up to 25 years old for Learning Difficulties), addressing needs such as sexual health, substance misuse and mental health. The service is offered via a 'hub and spoke' model including in-reach to support the YOS cohort with their health needs. The service reflects an emergent move nationally towards outreach-based models of clinical services for young people to improve access. New models of care have been developed with a focus on greater accessibility, multi-agency working and integrated offer services in the community e.g. one-stop shops (hubs) and outreach clinics (spokes). Among other objectives, the Lewisham service aims specifically to:

    a. Provide a universal and targeted early help, prevention and early intervention offer in accessible settings;

    b. Provide a mobile holistic assessment and intervention service focused on the three main risk predictors of teenage ill-health (substance misuse, risky sexual behaviour and poor mental health);

    c. Provide support to young people to develop healthy relationships, including managing their own sexual health needs for contraception and STI testing.

12. Alongside this, Lewisham YOS has embarked on a 'trauma-informed' approach, endorsed by the Mayor's Office for Policing and Crime, and coordinated by the London Resettlement Consortium. This approach emphasises awareness of possible trauma in the background of young people, and an understanding of the ways in which this can affect behaviour and service engagement.

Section 3: why do physical health and SLC needs among young people in contact with the criminal justice system matter?

13. Young offenders are often highly marginalised and there are significant challenges to healthcare provision for this group. The research evidence is clear that young offenders have higher rates of physical and mental ill-health, sexually transmitted disease, early pregnancy, injury and speech, language and communication problems than the general population[5].

14. These health problems rarely exist in isolation. Health needs identified above often sit alongside high rates of tobacco use and alcohol dependency, as well as concurrent substance misuse and mental ill-health (sometimes referred to as "dual diagnosis" by service providers)[6]. And there are

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[4] London Borough of Lewisham (2014). Joint Strategic Needs Assessment (JSNA): Young people in contact with the criminal justice system. August.

[5] Dolan, M., Holloway, J., Smith, C. & Bailey, S. (1999) Health status of juvenile offenders: a survey of young offenders appearing before the juvenile courts. Journal of Adolescence 22 137–144.

[6] Dolan, M., Holloway, J., Smith, C. & Bailey, S. (1999) Health status of juvenile offenders: a survey of young offenders appearing before the juvenile courts. Journal of Adolescence 22 137–144; Ritakallio, M., Kaltiala-Heino, R., Kivivuori, J. & Rimpelä, M. (2005) Delinquent behaviour and depression in middle adolescence: A Finnish community sample. Journal of Adolescence 28 155–159; Galahad SMS Ltd. (2004) Substance Misuse and Juvenile Offenders. London: Youth Justice Board; Galahad SMS Ltd. (2009) Evaluation of the substance misuse project in the young person's secure estate. London: Youth Justice Board.

overlaps between these factors and educational underachievement, young parenthood and adolescent mental health problems. Risk factors cluster together in the lives of the most disadvantaged children and the chances of offending behaviour increases with the number of risk factors. YOT practitioners identify lifestyle, thinking and behaviour and statutory education as risk factors for offending; young offenders also cite lack of training and qualifications and neighbourhood.

Physical health problems

15. Links between physical ill-health and offending behaviour will usually be indirect, but they are often connected with issues of self-esteem and emotional well-being that may have a significant impact on behaviour. For example, poorly controlled type 1 diabetes may lead to alterations in cognitive function and even aggressive behaviour in extreme situations, resulting in disruptive behaviour. In a school setting this may ultimately result in exclusion.

16. The prevalence of sexually transmitted infection among young offenders is high, but detection in Youth Justice facilities and in the community for this group is generally poor despite positive attitudes towards testing among young people[7], and the proven cost effectiveness of early intervention for these infections. This is problematic because many of the most common infections – chlamydia for example – are readily detectable using simple tests; failure to diagnose chlamydia promptly increases the risk of onward infections, and can result in long-term health problems including chronic pelvic pain and infertility in women, in addition to issues of self-esteem and emotional wellbeing.

Speech, language and communication needs

17. There is an extensive literature highlighting correlations between SLCNs, poor educational levels and literacy as risk factors for offending. We also know that the prevalence of SLCNs among youth offending populations nationally is very high. National surveys report rates of SLCNs among young people in contact with YJSs from around 40% to up to 60%, compared with 10% in the broader population. Around 30% of service users in the youth justice sector in a recent survey were thought to have SLCNs as their primary need[8]. Presence of SLCNs directly affect the ability of young people to engage in verbally-mediated interventions, putting them at risk of non-compliance, reduced engagement, and in turn, re-offending. Young people with SLCN are also more vulnerable to abuse than those without[9], making them a deliberate target for some perpetrators of abuse.

18. However, SLCN diagnosis rates are poor. Reports show only 5% of young offenders had their SLCN identified prior to their entry to the YJS and identification in YJSs remains low despite high prevalence rates nationally[10]. This may be because:

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[7] Buston K, Wight D. Self-reported sexually transmitted infection testing behaviour amongst incarcerated young male offenders: findings from a qualitative study. Journal of Family Planning and Reproductive Health Care. 2010 Jan 1;36(1):7-11.

[8] University of Sheffield, Birmingham City University and the Communication Trust (2015). The Special Educational Needs and Disability Reforms and Speech, Language and communication Needs in the Youth Justice Sector: Findings from a Survey of Youth Justice Services in England

[9] Snow, P. (2009) Child maltreatment, mental health and oral language competence: inviting speech-language pathology to the prevention table, International Journal of Speech-Language Pathology, 11(2), pp. 95-103 (see p. 99); Stalker, K. and McArthur, K. (2010) Child abuse, child protection and disabled children: a review of recent research, Child Abuse Review (see p. 2 and p. 14).

[10] Bryan K, Freer J and Furlong C. (2007) Language and communication difficulties in juvenile offenders. *International Journal of Language and Communication Disorders*, 42, 505-520.

a. SLCNs can be difficult to identify: young people can become proficient in masking their problems by avoiding engagement or being disruptive so as to distract from their difficulties. Detection may be particularly difficult where social, emotional and behavioural difficulties co-exist[11].

b. YOS staff do not feel adequately qualified either to identify SLCN with confidence, or to make the appropriate onward referrals for support where necessary: nearly half of those YOS practitioners surveyed in recent national research indicated that service users locally did not typically have a Statement of Special Educational Need (SEN) or an Education and Health Care Plan (EHP) put in place if a SCLN was identified [12].

Section 4: physical health, SLC needs and service provision among youth offenders in Lewisham

Characteristics of the population of children and people in Lewisham in general

19. The spectrum of need among children and young people in Lewisham is broad, with deteriorations in some important outcome measures in recent years. In 2014, 26.5% of the population of CYP under the age of 16 in Lewisham lived in poverty (a small increase compared with 2013), compared with a national average of 20.1%. The crude rate of looked after children (who are at greater risk of contact with YJSs than the general population) aged 16 and over in the borough increased from 192 per 10,000 in 2014/15 to 235 per 10,000 in 2016/17, both figures being well above both pan-London and national rates.

20. In physical health terms, the new STI diagnosis rate rose from 2,022 per 100,000 in 2012 to 2,131 per 100,000 in 2015 – again well above both pan-London and national rates[13]. There have also been increases in hospital admission rates due to substance misuse among young people aged 15-24, and hospital admission rates for some chronic diseases (e.g. asthma in those aged under 19).

21. Collectively, these figures suggest that the burden of health need among the population of young people in Lewisham who might potentially come into contact with the YOS is changing in ways that may place new demands on services in the borough.

Characteristics of young people in contact with Lewisham YOS

General features of the population of young people in contact with the YOS

22. The YOS cohort includes all children aged 10 to 18 who have committed an offence and receive either a reprimand (warning) or are charged to appear in court. Rates of contact with youth offending services in Lewisham are high, in part because the borough is one of the most deprived in the country (48th most deprived Local Authority in England). To date in 2016/17, 270 young people have been on the Lewisham YOS caseload. Of these, 60 settled with out of court disposal,

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[11] Gregory J, Bryan K. Speech and language therapy intervention with a group of persistent and prolific young offenders in a non-custodial setting with previously undiagnosed speech, language and communication difficulties. International Journal of Language and Communication Disorders. 2010;46(2):202-15.

[12] University of Sheffield, Birmingham City University and the Communication Trust (2015). The Special Educational Needs and Disability Reforms and Speech, Language and communication Needs in the Youth Justice Sector: Findings from a Survey of Youth Justice Services in England

[13] These figures exclude new diagnoses of chlamydia in people under the age of 25.

20 were in custody (7.4%), 10 in remand, and 180 were given community orders. Of this total of 270 young people, 40 (15%) were looked after children.[14]

23. Importantly, there is evidence that the complexity of cases in contact with Lewisham YOS may be increasing over time. In 2016-17, there has been a 20% reduction in First Time Entrants (FTEs[15]) – the highest reduction in London over the same time period (the average reduction in FTEs across London over the same time period was 6.5%) – but this is partly offset by a 10.4% increase in frequency rate[16], and an increase in the custody rate[17] to 45 for the year. The increase in re-offences and the high number of custodial sentences suggest that a small number of young people locally are committing a high number of offences, often resulting in custody.

24. Ongoing monitoring of information in respect of YOS cohort entrants has until recently been challenging. However, a Youth Justice Board "Live Tracker" has now been set up, identifying 55 young people who received an Order between 1st January and 28th February 2017. These young people will now be tracked over the year, not only to extract and analyse outcomes but also to influence decisions when case managers assess that a risk of re-offending has increased.

Characteristics of the "Live Tracker" cohort

25. Of the 55 young people in the Live Tracker from January-February 2017, 17 (31%) were first time entrants (FTE) into the criminal justice system; the remaining 38 (69%) were repeat offenders. Data presented in the following sections relate to all young people in the live tracker (i.e. both FTEs and repeat offenders).

26. A large majority of young people in the repeat offending cohort were male (84%), and of Black African, Black British or Black Caribbean ethnicity (60% across all three of these ethnic groups). This is in contrast to overall figures on the ethnic makeup of the population of young people in Lewisham: in 2017, Black African, Black British and Black Caribbean young people account for around 27% of the population aged 10-18 in the borough[18], meaning that these groups are disproportionately represented in the cohort. In age terms, the vast majority of young people (71%) were aged 16-18. It is not possible from this cross-sectional analysis to give a sense of how the age distribution of young people in contact with the YOS is changing over time.

27. The range in intensity of offending varied markedly within the repeat offending group. Most offending occurred at relatively low rates: 38 (69%) of the cohort had committed 3 or fewer offences. At the upper end, however, 2 cohort members had committed over 40 offences each since their first point of contact with the Lewisham YOS.

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[14] This percentage figure is likely a conservative estimate given that some of those in contact with the YOS will previously have been looked after children out of borough.

[15] FTEs have no record of previous offences and no prior contacts with YJSs.

[16] This is calculated by dividing the number of re-offences across the borough by the number of young people re-offending. It has historically been used as a standard measure of re-offending rates.

[17] Defined as the proportion of young offenders given custodial – as opposed to community-based – sentences. Custodial sentences are usually reserved for more serious offences.

[18] Estimate derived from Greater London Authority 2015 round ethnic group population projections, available here: https://data.london.gov.uk/dataset/2015-round-ethnic-group-population-projections (accessed 22/5/17)

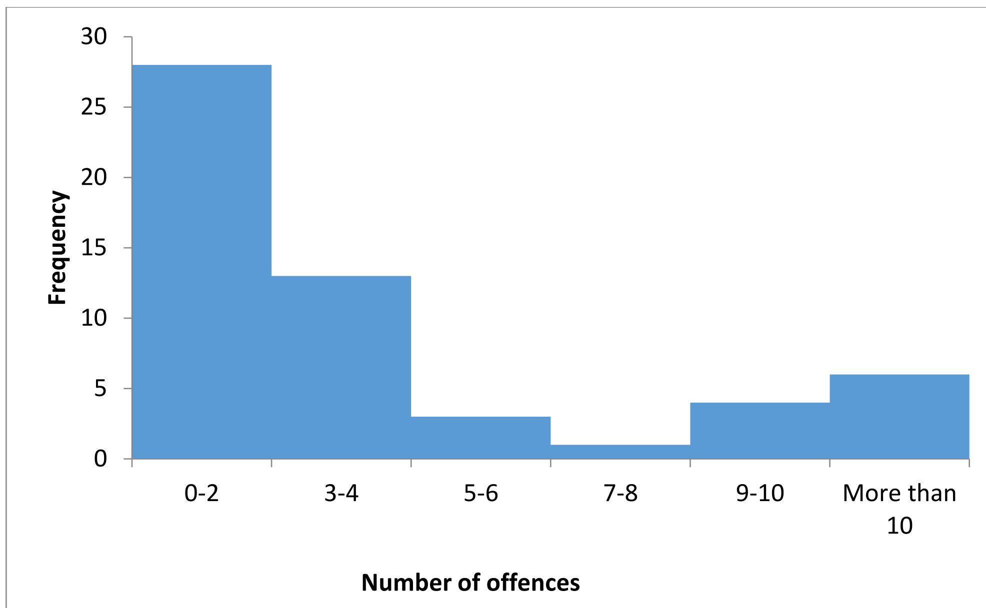

Figure 1. volume of offences by young offenders in the YOS cohort – showing that a majority of young people in this group have offended 4 times or less.

Health needs among the “Live Tracker” cohort

28. In physical health terms, 5 (9%) members of the cohort had a diagnosed physical health condition – including asthma, migraines, epilepsy and sickle cell anaemia. Three of these individuals were on regular medication at the time of their Asset+ assessment. It is difficult to benchmark these figures because data on physical health needs from other localities is not comprehensively gathered.

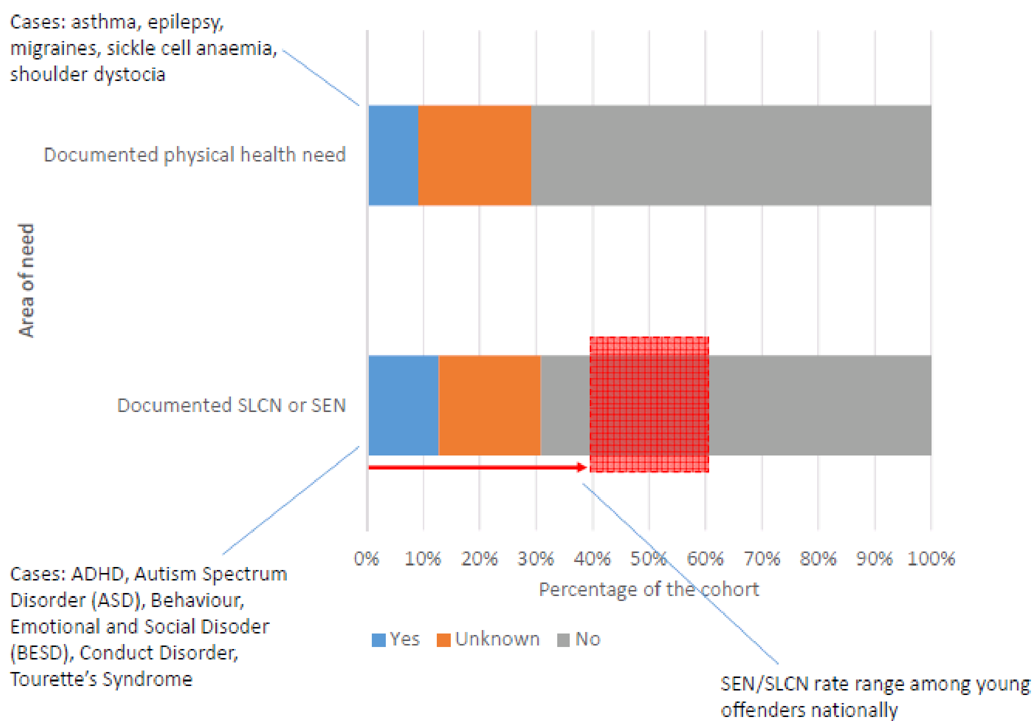

Figure 2. Documented physical health and/or SLCN/SEN needs among the cohort of repeat offenders in the Live Tracker. These figures exclude those individuals for whom there was evidence of a physical health or SLCN need in the free text of the record, but who were not explicitly coded as having one of these needs.

29. The extent to which physical health needs are being met under current arrangements within the YOS is uncertain. Of the 55 young people in the cohort, 16 (29%) were documented as registered with a General Practitioner. A further 10 young people were also in Looked After Care (LAC) for which specific physical health screening and management systems are in place. The registration status of the remaining 29 young people is unclear.

30. Turning to speech, language and communication, and special educational needs, 7 young people (13%) had recognised SENs (ADHD, Tourette's syndrome, conduct disorder and emotional or behavioural disorders across these cases) – a rate well below figures for the burden of SEN in this cohort nationally, which range from 40-60%. In a further 5 cases (9%), YOS workers identified significant concerns over SLCN and/or SEN needs but there was no formal diagnosis or the young person in question was awaiting clinical assessment at the time Asset+ assessment was completed.

31. Importantly, none of those young people with documented physical health needs in this cohort also had overlapping SLCN or SEN needs. One individual with documented SLCN or SEN needs also had an overlapping mental health condition for which they were receiving treatment.

Assessment processes and data completion

32. The case audit revealed some shortfalls in data completion in IYSS, and difficulties in case record interpretation are a significant problem for this cohort. 45 (81%) of case records had an accompanying Asset+ assessment recorded on IYSS, but 10 young people (18%) had no Asset+ assessment documented on the system. Of those young people without a completed Asset+ assessment, this was either because an assessment had previously been completed using the old Asset system (2 cases), the young person would not comply with the assessment (2 cases), or an assessment was not required because of the nature of the outcome of criminal justice proceedings (3 cases)[19]. In the remaining three cases, it was unclear why an Asset+ assessment had not been completed.

33. For physical health among repeat offenders, only 4 of the 5 individuals with known diagnoses were explicitly coded as such in Asset+ (details for the fourth were obtained from accompanying free text). Recording of sexual health issues was very limited across all case records. The case audit found no evidence that sexual health screening (in the form of targeting questioning) was performed during contacts with young people in the YOS, although information on child sexual exploitation was given, and contraceptive use among female young offenders was occasionally recorded in free text. Alcohol consumption was in general poorly recorded – 4 of the cohort (7%) were recorded as active consumers of alcohol (alongside cannabis in each case) but no data on volume of consumption was recorded and there is no evidence that assessments of alcohol-related harms are carried out for young people in contact with the service. Just 1 of the 55 young people in the cohort was coded as being a current or past user of opiates. For SLC needs, the case notes show that 4 of 7 young people with diagnosed SENs were not coded in the Asset+

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[19] Outcomes for which a YOT intervention (and therefore an Asset+ assessment) are not required include: a caution; a deferred sentence; absolute or conditional discharge; a bind over; a fine; or a compensation order. Further details are given in the Youth Justice Board's data recording guidance for 2016/17: https://yjresourcehub.uk/yjb-effective-practice/youth-justice-kits/item/448-yot-data-recording-requirements-2017-18.html [accessed 1st June 2017]

assessment – including ADHD and Conduct Disorders severe enough to interfere with daily activities.

34. For both documented physical health and SLCNs, a significant proportion of case records had no definitive coding (i.e. "unknown" status). Information on onward referrals was not available on IYSS so it was not possible to determine how assessment results had been acted upon.

35. Finally, there were discrepancies between documented SEN or SLCN status with the YOS and Lewisham Council's Special Educational Need and Disabilities (SEND) services, which support children and young people in the borough with needs in this area. Of the 5 young people in the repeat offending cohort with document SENs, 2 were known to the Council's SEND services. A further two young people were listed on the SEND caseload who were in contact with the YOT but did not have a formal SEN documented in their Asset+ assessments.

Practitioner perspectives on needs, assessment and service provision in Lewisham

36. A focus group was conducted with Lewisham YOS staff to explore practitioner perspectives on needs among young people in contact with service, methods of assessment and what an effective service to meet physical and SLCNs might look like.

37. Participants identified some overarching challenges relating both to the circumstances of CYP in the service, tools available to them to do assessments, and ways of working to better serve young people in contact with the YOT:

    a. **The circumstances of some young people in contact with the service are particularly challenging, and assessments sometimes do not identify the extent of these needs**. Particular mention was made of CYP in the cohort who are themselves carer (e.g. for parents), and those with undiagnosed autism, ADHD or sexual health problems that are particularly vulnerable to exploitation.

    b. Staff felt they were still **adapting to Asset+ as a tool for supporting assessments**. Some viewed the Common Assessment Framework for Children and Young People as a better tool for gathering information on physical health and family circumstances than Asset+.

    c. All agreed that **sharing of information between services is essential** for effective assessment, and to facilitate a preventive rather than reactive way of working. Existing arrangements allowing YOS workers access to social care information on service users through the Integrated Children's System (for children on the Child Protection Register) were highlighted as an example of how information sharing could make a very positive contribution to care.

    d. In view of well-recognised **training needs in recognition of SCLNs and SENs in particular,** participants favoured having **a permanent, in-house health practitioner** to oversee assessment and initial management of health needs. A school pupil referral unit nurse was identified as potentially good candidate for this role in view of their knowledge of this cohort from the community.

    e. Participants emphasised the central importance of **improved links with schools** especially as young people leave the care of the YOS. Better links are needed not just to enable information exchange, but also to ensure that long-term follow-up plans for young people are put in place and acted on once they leave the YOS' care.

38. Participants also identified some practice issues and solutions specific to each of the main health domains of interest in this report – as outlined below:

Domain	Issues	Potential solutions
Physical health	• Young people cannot be forced to register a GP if they do not see value in it • There is a perception among service users that they are seeing the YOT mainly about their offence – not about health needs • Parent's lack of understanding of importance of health disclosure is a factor in low recognition of physical health needs	• Some localities (e.g. Enfield) have a nurse present at triage for new entrants into the YOT to ensure that physical health needs are recognised at this early stage • In-house capacity would better support identification of health needs
Sexual health	• Asset+ assessments offer opportunities to open this topic, but how far it is pursued depends on each case worker's experience and comfort	• Specialist, in-house support would assist with identification of sexual health needs
Speech, language and communication needs	• CYP often compensate for SLCNs – making identification more difficult • SENs are under-diagnosed and often interpreted simply as "bad behaviour" • There are particular concerns about assessment and management of dyslexia and dyspraxia. Case workers reported low levels of confidence in assessing needs for these young people • Referrals from the YOT for SLCN interventions are not yet happening	• Regular training for case workers would improve confidence in needs assessment • Letters to families need to be pictorial with less technical jargon – this area is unfamiliar to many people • A commissioned service is likely to be needed to ensure appropriate management of SLCNs identified by the service.

Table 1. Issues identified and potential solutions from participants in the Lewisham YOT practitioner focus group discussion.

Section 5: healthcare and SLCN provision for young offenders– what works?

Literature evidence on alternative models of healthcare provision

39. Various models for health care provision for YOS users have been developed, distinguished by the extent of health worker integration into the YOT (table 2). Most of these have been developed to support mental health care provision, but they illustrate some of the ways in which wider health provision – including physical health and SLCNs – could support the YOT's work, ranging from fully integrated health teams, to teams operating completely independently of the YOT but inputting directly into its work.

Case studies of good practice from other localities

40. Case studies in this section have been chosen on the basis of discussions with practitioners in the Lewisham YOS and with input from the Youth Justice Board.

Lambeth

41. In Lambeth[20], a YOS Health Co-ordination Group and YOS Health Action Plan was initiated in 2013, providing for a General Practitioner role to be commissioned to offer cover for one afternoon every two weeks in the YOS, alongside a youth worker to perform general physical health screening (using Asset+, as in Lewisham), sexual health screening (including discussions regarding sexually transmitted infections and condom use). The purpose of commissioning two linked roles was to improve referral rates into health services. This basic service has since been upgraded into

[20] Information in this case study is derived from an interview with the YOS Head of Service in Lambeth.

a full, co-located YOS Health Team comprising: the Child and Adolescent Mental Health Service (CAMHS), Assessment, Intervention and Moving on (AIM), SLT, Substance Misuse and GP service (all provided in partnership with the Well Centre, a youth centre in the borough).

42. This service offers (through the youth worker): group work programmes on various topics including healthy relationships, identifying and managing negative emotions, alcohol, cannabis, Multi Systemic Therapy (MST) in partnership with Troubled Families, Come Correct condom distribution service and single-person Intervention and Brief Advice (IBA) for alcohol use.

Greenwich

43. In Greenwich[21], a service has been developed that combines assessment and referral support by a nurse with speech and language therapy input. A Band 7 practice nurse is commissioned 3 days a week to provide support on health matters. The nurse is integrated within the YOT and their post sits under children's services. They have access to the Safeguarding records for CYP at risk or looked after. The nurse recruited to this post developed their own assessment tools based around Asset+ and CHAT, findings from which they discuss with the allocated caseworker for each service use. They will action all the points or allocate any needs picked up to the caseworker – such as a need to address incomplete vaccination schedules.

44. A Speech and Language Therapist is employed in-house in the YOS, partly in response to concerns among caseworkers about missing SLCNs for which they felt they had little training to complete meaningful assessments. The therapist now does the screening, and works with the caseworkers and help develop assessment skills within the team, and improve knowledge on appropriate follow-up. If high level needs are picked up then the service user is referred to specialist services.

Durham

45. County Durham YOS have developed an innovative approach based around a comprehensive strategy to address SLCNs among young people in contact with them, and their approach is evolving over time[22]. The strategy, originally launched in 2014, combines staff training across the service with integrated SLCN expertise in the form of a Speech and Language Therapist (SLT) sitting within the service. This post is full-time and is funded jointly by the YOS and North Tees and Hartlepool NHS Foundation Trust. The service is now expanding to incorporate specialist SLT assessments and interventions, and has also developed a range of communication-friendly tools to support young people who offend (ClearCut Communication).

[21] Information in this case study is derived from an interview with the YOS Head of Service.

[22] Durham County Council (2017). County Durham Youth Offending Service Speech, Language and Communication Needs Strategy. Report to the Health and Wellbeing Board, 31st January 2017. Online at: https://democracy.durham.gov.uk/documents/s71294/Item%206%20-%20CDYOS%20SLCN.pdf (accessed 22/5/17).

Model	Description	Advantages	Disadvantages
Health team within the YOT Example: Lewisham Adolescent Resource and Therapy Sevice (ARTS)	• The Lewisham ARTS team is located in the YOT itself and includes a clinical psychologist, team manager, two mental health substance misuse nurses, a consultant psychiatrist, an administrator, a mental health liaison and diversion worker for young people – all funded through the South London and Maudsley NHS Foundation Trust (SLAM). • Cases are generally managed in-house by the ARTS forensic team, although some referrals are made to other services. • A speech and language worker based elsewhere provides consultation and training for YOT caseworkers, schools, parents and magistrates.	• Better joint working with YOT caseworkers because of co-location • No waiting lists for assessments • Good opportunities for shared clinical learning and professional development • Availability of a broad range of skills onsite.	• Risk of the young people remaining in YOT 'silos' and not making use of the full range of mainstream community services • Risk of staff becoming isolated from developments in mainstream services.
Lone health practitioner within the YOT Example: Enfield	• Some YOTs operate a service model involving a single health practitioner working full-time within the service and operating alongside a multi-disciplinary team • Most services operating in this way integrate workers with a mental health background (usually from CAMHS).	• Ability to attract energetic and enthusiastic workers • Caseworkers value having expertise on-site to see advice informally	• Risk of professional isolation and weakened links into "mainstream" services • Ability to identify needs limited by the individual practitioner's training and experience
Foot in, foot out Example: Lambeth, Newcastle	• Health practitioner has a presence in the YOT and good clinical and operational links with a specific local health team	• Ability to maintain connections with both the YOT and other teams • Improved opportunities for health worker professional development	• Few identified by practitioners elsewhere
Virtual locality health team model Example: Sheffield, Bradford	• Extends the foot in, foot out model – health workers see themselves as having shared responsibility for all CYP across the local area, in partnership with colleagues outside the YOT • Health workers are located in the YOT, but have strong clinical and operational links outside it	• Sense of shared ownership improves strategic coordination of services • Access to good quality clinical supervision and peer support for the health worker • Good continuity of care for YPs when they exist the YOS	• Some gaps in provision reported in areas operating this model
Outreach consultative model	• Clinical teams located outside the YOT provide direct services to very high risk or vulnerable YPs, but also provide supervision and/or telephone support to workers in the YOT and in custodial settings	• The main advantage of this approach is easy access to expertise and support for young people in YOTs (often via telephone contact)	• Uncertain sustainability in funding terms because of the cost of contracting specialists in this way

Example: Northumberland, Islington	• After screening young people for general health and mental health needs, the health practitioner checks that young people are registered with GPs, before dealing with general health and sexual health needs and delivering lower threshold mental health support (such as anger management sessions or brief interventions)		
External YOT health one-stop shop Example: Head 2 Head Nottinghamshire	• A team of health practitioners assembled to support the YOT, with a health manager located within the YOT to provide coordination • Contacts with service users are outreach-based and available (in this case) 7 days a week	• Ability to offer broad ranging expertise and intensive support, with often quicker responses to referrals • Some of those areas in which the model operates are able to provide 7-day cover • Strong links to other services	• High cost of providing broad-ranging support of this nature • Perceived constraints on access to health support and advice because workers are not co-located.

Table 2. Six potential service models for physical health and SLCN support provision in or working with the YOT[23]. Some of these describe service models for mental health needs rather than physical health or SLCN/SEN, but broad principles regarding the degree of integration with YOTs remain relevant.

[23] Details of these models are derived mainly from: Khan and Wilson (2010). You just get on and do it: healthcare provision in Youth Offending Teams. London: Centre for Mental Health. Online at: http://www.ohrn.nhs.uk/resource/policy/Justgetonanddoit.pdf (accessed on 22/5/17)

Conclusions and recommendations

Summary of main findings

46. The HMIP inspection identified important areas of strength in the YOS offer in Lewisham, not least the comprehensive nature of mental health support. However, both the inspection report and this needs assessment have identified important areas for further development, including:

    a. **Issues around the collection of data on the physical health and SLCNs of young people using the service remain**, as evidenced by the data audit, and there are some areas in which it appears that almost no information is gathered (e.g. sexual health) – although trade-offs between the need to build a rapport with young people at initial consultations, and the need for detailed information gathering is acknowledged. Overall, this means that it is difficult to be certain whether the reported burden of physical health and SLCN/SEN needs given earlier in this report truthfully describes needs among the young people in contact with Lewisham YOS, or reflects under-recognition and under-reporting.

    b. **There is some uncertainty as to how information on physical health and speech, language and communication needs gathered through Asset+ is acted on.** The data audit found little information on onward referrals where needs are suspected, and management of those with documented needs is also uncertain. The Lewisham YOT is currently developing an algorithm to support case workers in identifying the most appropriate lines of action when physical, mental health or SEN/SCLN needs are identified.

    c. There was broad agreement on the value of **sharing information on young people in the YJS across other services**. Concerns were raised that services work in isolation and because of confidentiality were often unable to share information on individual children. Findings from the data audit show that availability of accessory information on Asset+ around physical health is limited. Case workers typically will not have access to health information unless the young person or their family agrees to share clinical letters with them; access was generally better for young people in LAC – for whom information could be verified against social care data systems. In addition, it appears that some young people in the YOS known to have SEN/SCLN needs are not then accessing the Council's SEND service, and vice versa.

    d. **Training around speech and language for YOS staff** was seen as a priority by workshop participants. Practitioners felt lack of confidence contributed to low levels of SLCN/SEN recognition among staff, and low reporting in case records.

    e. However, there was also **agreement that increasing specialist speech and language input to the service would be an advantage**. This could be in the form of a SLT based at the YOS – either part or full time – by re-purposing existing specialist input to provide the necessary support, or by linking in with the new Young People's Health and Wellbeing Service. The potential for support in recognition and management of learning disability from clinical psychologists working for CAMHS in the YOT was identified as one means of bringing in necessary expertise without significant cost implications.

    f. **Various models of good practice elsewhere** have been identified in this report which could form the basis of a service model to support physical health and SLC needs locally. The particular shape of the service ultimately developed will depend on availability of resources locally.

Recommendations

47. In light of the findings outlined above, the following recommendations are made:

Recognition and initial assessment of needs

a. Greater attention to **information gathering around potential sexual health needs among young people** presenting to the YOS should be considered, possibly through the addition of screening questions to the existing Asset+ assessment. There are a number of short screening questionnaires or proformas in use in General Practice in the UK on which these questions could be modelled.

b. **Dedicated YOT staff training in assessment and recognition of physical health needs and SEN/SLCN should be supported** to improve knowledge and awareness. There are a number of providers who could fulfil this function, locally and nationally and discussions are already underway in the YOS in this area.

c. **Existing expertise within the service could be involved in assessment and management of need in new ways** – particularly for SEN/SLCN through, for example, involvement of clinical psychologists (with CAMHS) in assessment and initial management of young people with learning disabilities.

Management of physical health and SEN/SLCNs

d. **Existing pathways for referral of young people with identified needs to specialists should be strengthened**. Some of this work is already underway. An algorithm to guide case workers in appropriate course of action when particular needs are identified by Asset+ assessments is currently in development in the YOS. Implementation of this approach should be supported, to ensure referrals are completed.

e. **Strengthening expert support for physical health and SLCN/SEN assessment and interventions for YOS users should be a priority**. There are now opportunities to achieve this through work in partnership with the newly commissioned Young People's Health and Wellbeing Service in Lewisham, a holistic service with a strong preventive focus that includes capacity for assessment and brief intervention for substance misuse, sexual health problems and mental ill-health including self-harm. The specification for this new service includes conditions requiring the provider to co-locate services with key partners in the borough – including the YOS. The service model was being finalised at the time of this JSNA and included developing the in-reach offer to the YOS. However, further discussion will be needed with key local partners including primary care to ensure young people can access the full range of physical health services (including immunisations for example)

Data completion, audit and information sharing between partners

f. **Mechanisms for strengthening information collection and analysis through Asset+ should be put in place to ensure accuracy and completeness** – by, for example, conducting regular case audits to ensure high levels of completion, and by ensuring that accessory documents are regularly uploaded by case workers.

g. **Opportunities for sharing information between key stakeholders working with the YOS should be maximised**, through regular meetings and if necessary reciprocal agreements or memoranda of understanding to ensure that service user confidentiality is maintained.

Appendix 1: exploring risk factors for first contact with the Youth Justice System in Lewisham

- Alongside the JSNA refresh outlined above, a broader needs analysis that focuses upstream on young people who are not in contact with the criminal justice system but who are at risk of being so due to their challenging behaviour is also underway. This work includes an assessment of LBL's wider children and youth services, and ways in which these can be further developed to support prevention. This falls outside the scope of the recommendations from HMIP's inspection in Lewisham. It aims to complement and build upon three Safer Lewisham Partnership reports:
    - Local area profile on serious youth violence
    - JSNA on domestic violence affecting under 25 year olds
    - Report on CSE and radicalisation
- Results presented in this appendix are preliminary. Work is ongoing to understand the range and nature of risks for first time entry into the YJS in Lewisham.

Conceptualising young people's involvement with the criminal justice system: what are the key risk factors?

48. Key risk factors for youth offending are well recognised in the research literature[24]. Broadly speaking they fall into four categories: those associated with the family, with school, with the community, and finally those which are individual and related to peer-group experiences.

    a. ***Family-related risk factors*** include poor parental supervision and discipline, a history of criminal activity within the family, and parental attitudes that condone anti-social behaviour and criminality. More broadly, the associations between poor housing, low family income and criminal behaviour among young people are recognised.

    b. ***School-related risk factors*** include a disorganised school environment, but mainly provide early indicators of a move towards offending behaviour. For example, low academic achievement, aggressive behaviour (including bullying) and lack of commitment to school work and activities (up to and including truancy) can all be indicators of a move towards offending.

    c. At ***community-level***, risk of youth offending is increased in disadvantaged neighbourhoods, those with high population turnover and low levels of social attachment, and those where drugs are widely available.

    d. The literature on ***individual-level risk factors*** has tended in the past to focus on personal characteristics (e.g. hyperactivity, impulsivity, low intelligence and/or cognitive impairment), attitudes (principally those condoning antisocial behaviour or criminality), early involvement in crime and disorder, and peer relationships – in particular those with individuals who are already actively involved in crime and/or drug misuse.

49. In the analysis that follows, we have tried to identify and quantify proxies for the family-, school-, community- and individual-level risk factors identified above where possible.

[24] Among many research papers and summary reports on this topic, see for example: Youth Justice Board (2005). Risk and Protective Factors. London: Youth Justice Board; Farrington, Ttofi and Piquero (2016). Risk, promotive, and protective factors in youth offending: Results from the Cambridge study in delinquent development. Journal of Criminal Justice 45 (2016) 63–70.

Characterising the cohort of first-time entrants in Lewisham

50. Of the 55 young people in the Live Tracker from January-February 2017, 17 (31%) were first time entrants (FTE) into the criminal justice system; the remaining 38 (69%) were repeat offenders. Data presented in the sections that follow explore risk factor patterns among the FTE and repeat offending groups. Direct comparisons between these groups should be treated with caution, for two reasons. First, the number of young people in the Live Tracker cohort is small, and simple statistical testing showed that only a minority of the observed differences between FTE and offender groups were significant[25]. Second, this audit presents a cross-sectional analysis of risk factors (i.e. at a fixed point in time) – so it is not possible to say whether the risks identified *explain* contact with the youth justice system or are simply associated with it.

- From a demographic perspective, FTEs were (perhaps surprisingly) in general of a similar age to repeat offenders in the Live Tracker cohort. The vast majority (15 – or 88%) were male. The distribution of ethnicities in this group was more diverse than among repeat offenders in the cohort, but Black African, Black British and Black Caribbean young people were again disproportionately represented by comparison with the population of Lewisham as a whole (47% of all records reviewed).
- Examination of risk factors for contact with the criminal justice system revealed a mixed pattern. At community level, the proportion of both FTEs and repeat offenders living in areas of high deprivation was predictably high. It was not possible from the data available to gather information systematically on other community-level risk factors.

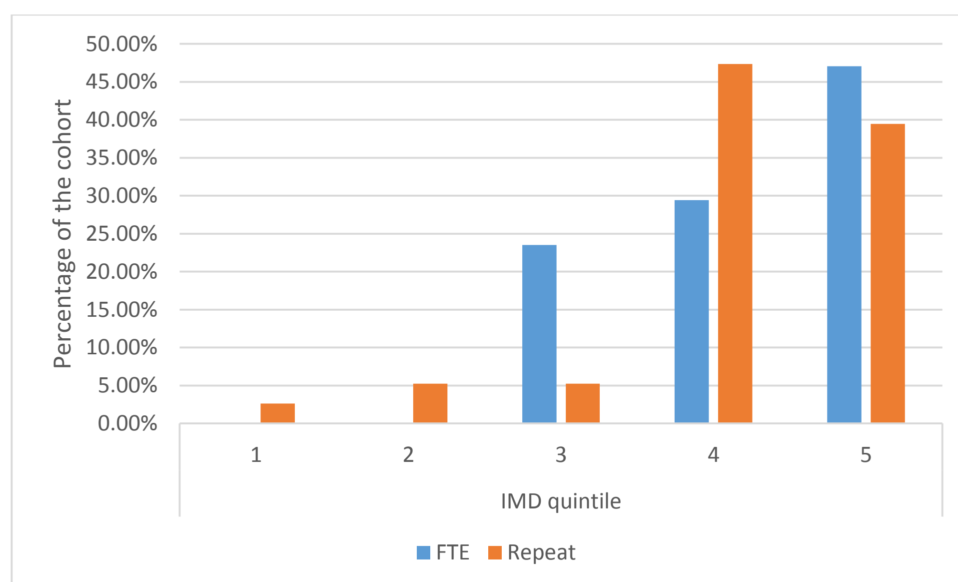

Figure 3. Distribution of young people in the cohort by index of multiple deprivation quintile. If a young person is in quintile 5, they live in one of the most deprived areas of the borough; if they are in quintile 1, one of the least deprived areas.

- The prevalence of key family risk factors was generally lower among the FTE group. For example, the proportion of young people who were looked after or in foster care was lower than the repeat offending group (12% among FTEs compared with 32% among repeat offenders). Similarly, documented domestic violence (either current or historical) prevalence in families of FTEs was

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[25] Crude univariate analyses were carried out by calculating 95% confidence intervals for the difference in the proportion of young people in each group documented to have each risk factor.

12% compared with 26% among repeat offenders. Neither of these differences was statistically significant, however.

- There were important differences in prevalence of school-related risk factors between the two groups. The proportion of repeat offenders with poor school attendance was 39%, and 26% with evidence of aggressive behaviour in school, compared with 6% for both groups among FTEs. Both of these differences were statistically significant.
- On an individual level, documented gang affiliation was more common among repeat than FTEs (26% and 12% respectively), as were previous episodes in which the young person had themselves been a victim of crime (18% and 12% respectively – most commonly assault). Perceived negative peer group influences were common in both groups (55% among repeats, 47% among FTEs). None of these differences were significant however.
- In health terms, the prevalence of diagnosed physical conditions was comparable with the repeat offenders group (12% compared to 11% in the repeat offending group). One of the FTE group was identified as having SLCN or SEN needs, and one with a mental health diagnosis. There was a marked discrepancy in the prevalence of current or past substance misuse between the two groups however; the prevalence of substance misuse in the repeat offending group was 63% compared with 12% among the FTE group. This was statistically significant.

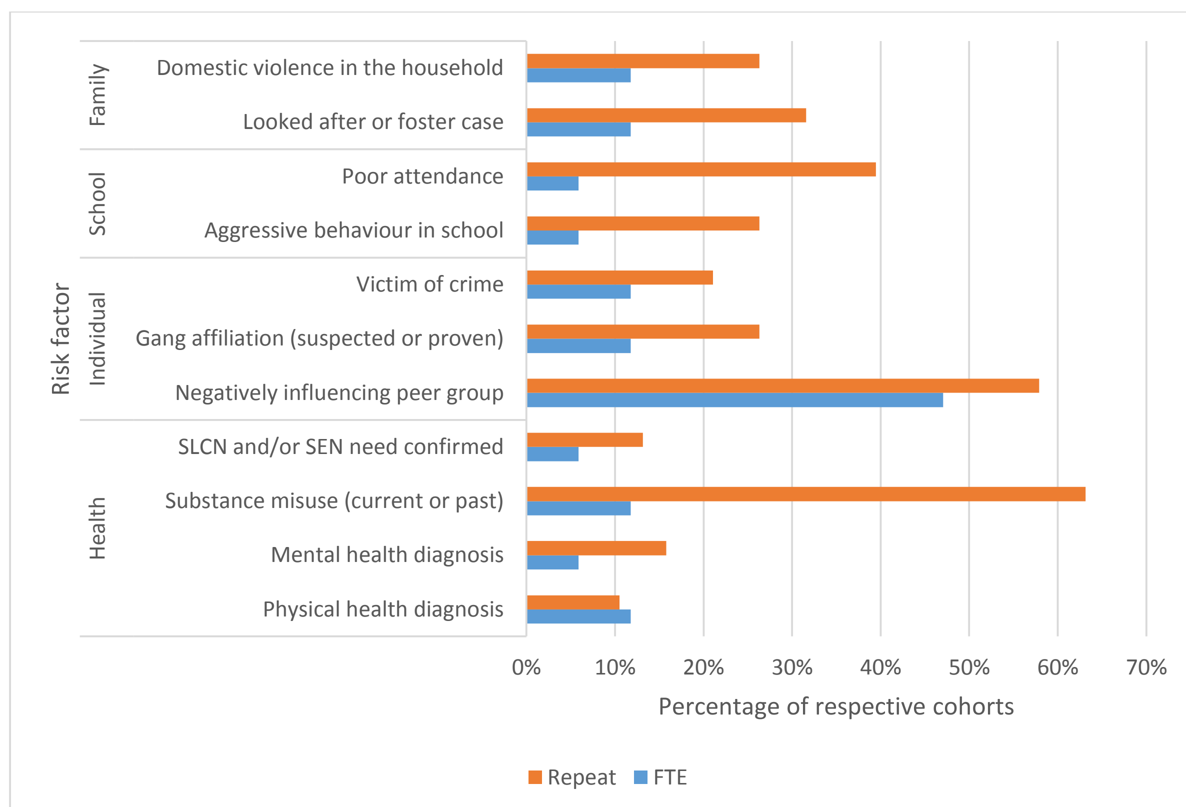

Figure 4. Proportion of the cohort with documented evidence of a series of family, school, individual and personal health risk factors, across first time entrants, and repeat offenders.

- **On the basis of these figures, the clearest risk factor for FTE contact with the youth justice system appears to be exposure to a negatively influencing peer group**. The documented prevalence of other risk factors for youth offending was generally low in this group (no more than 12%). Work is ongoing to further characterise needs among this group and to understand differences in risk factor profile between FTEs and young people who repeatedly offend.

Appendix 2: Asset+ assessment proformas for physical and mental health, and SLCN needs

Physical health

Physical Health and Development Screening Tool

Young Person ____________________

Please indicate whether the following apply to the young person:

	Question	Response
Q1	Has a diagnosed physical health condition?	☐ Yes ☐ No ☐ Yet to clarify
Q2	Experiencing current physical health symptoms? e.g. breathing problems, chest pains, seizures	☐ Yes ☐ No ☐ Yet to clarify
Q3	Currently taking prescribed medication for a physical illness?	☐ Yes ☐ No ☐ Yet to clarify
Q4	Has any current contact with GP or hospitals in relation to a major physical illness?	☐ Yes ☐ No ☐ Yet to clarify
Q5	Is pregnant or could be pregnant?	☐ Yes ☐ No ☐ Yet to clarify
Q6	Health is being put at risk through his/her own behaviour?	☐ Yes ☐ No ☐ Yet to clarify

Further exploration:
Please provide as much detail as possible here:

Note any positives, and/or any other concerns that require further investigation, referral or action.

(including registration with GP, lack of access to appropriate services, concerns expressed by the young person and parents/carers etc).

Mental health

Mental Health and Emotional Development Screening Tool

Young Person ______________________________

Please indicate whether the following apply to the young person:

Q1	Any formal diagnosed mental health condition? (current/previous)	☐ Yes ☐ No ☐ Yet to clarify
Q2	Any contact with mental health services?	☐ Yes ☐ No ☐ Yet to clarify
Q3	Any prescribed medication for mental health problems? (current/previous)	☐ Yes ☐ No ☐ Yet to clarify
Q4	Has current feelings of sadness, anxiety/stress or irritability?	☐ Yes ☐ No ☐ Yet to clarify
Q5	Feels constantly in low mood?	☐ Yes ☐ No ☐ Yet to clarify
Q6	Feels hopeless about the future?	☐ Yes ☐ No ☐ Yet to clarify
Q7	Has flashbacks of past traumatic events?	☐ Yes ☐ No ☐ Yet to clarify
Q8	Experiencing unsual thoughts?	☐ Yes ☐ No ☐ Yet to clarify
Q9	Sees or hears things that other people cannot?	☐ Yes ☐ No ☐ Yet to clarify
Q10	Has longstanding symptoms of overactivity, inattention and impulsivity in multiple settings? (e.g. home, school etc.)	☐ Yes ☐ No ☐ Yet to clarify
Q11	Has history of deliberate self-harm?	☐ Yes ☐ No ☐ Yet to clarify
Q12	Has previously attempted suicide?	☐ Yes ☐ No ☐ Yet to clarify
Q13	Has current thoughts to self-harm or wish to commit suicide?	☐ Yes ☐ No ☐ Yet to clarify
Q14	Looks depressed or is behaving unusually?	☐ Yes ☐ No ☐ Yet to clarify
Q15	Risks/ concerns from others (family/professionals) about young person's mental health?	☐ Yes ☐ No ☐ Yet to clarify

Further exploration:

Please provide as much detail as possible here including: the events/circumstances; nature of emotions arising (anger, grief, fear etc); impact on young person's life etc.

SEN/SLCN

Speech, Language, Communication and Neuro-disability Screening Tool

Young Person ____

Please indicate whether the following apply to the young person:

Speaking

Q1	Have difficulty thinking of the words he/she wants to say?	☐ Yes ☐ No ☐ Sometimes
Q2	Only use very simple vocabulary?	☐ Yes ☐ No ☐ Sometimes
Q3	Have difficulties explaining things? Eg do they leave out important details or give information out of sequence?	☐ Yes ☐ No ☐ Sometimes
Q4	Is their speech difficult to understand? Eg do they stammer/stutter or find it hard to say long words; do they mispronounce words frequently?	☐ Yes ☐ No ☐ Sometimes

Understanding spoken language

Q5	Have difficulty remembering things people say?	☐ Yes ☐ No ☐ Sometimes
Q6	Have difficulty following spoken instructions or only follow part of them?	☐ Yes ☐ No ☐ Sometimes
Q7	Have difficulty understanding the meaning of words?	☐ Yes ☐ No ☐ Sometimes

Non-verbal

Q8	Have difficulty using non-verbal communication? Eg too little or unusual eye contact, body language, facial expression	☐ Yes ☐ No ☐ Sometimes
Q9	Have difficulties showing emotions? Eg do they smile or laugh at the right times?	☐ Yes ☐ No ☐ Sometimes

Social skills difficulties (inc Autistic Spectrum Disorders)

	Question	Response
Q10	Have difficulties initiating and/or maintaining friendships?	☐ Yes ☐ No ☐ Sometimes
Q11	Is socially awkward and inappropriate?	☐ Yes ☐ No ☐ Sometimes
Q12	Appear frustrated or anxious when there is no obvious cause?	☐ Yes ☐ No ☐ Sometimes
Q13	Have difficulty thinking about the thoughts/feelings of others?	☐ Yes ☐ No ☐ Sometimes
Q14	Has been diagnosed with social communication difficulties? (e.g. Autistic Spectrum Disorder)	☐ Yes ☐ No ☐ Yet to Clarify
Q15	Has a professional/ family member expressed concerns about social communication skills?	☐ Yes ☐ No ☐ Yet to Clarify

Education needs & Learning Disability

	Question	Response
Q16	Have problems with reading or writing?	☐ Yes ☐ No ☐ Sometimes
Q17	Have difficulties with time concepts? Eg telling the time, using a calendar, understanding date and time concepts such as 'day after tomorrow'?	☐ Yes ☐ No ☐ Sometimes
Q18	Needs support in daily living skills? e.g. washing, getting ready for school, cooking etc.	☐ Yes ☐ No ☐ Sometimes
Q19	Have any Special Educational Needs been identified?	☐ Yes ☐ No ☐ Yet to Clarify

Further exploration:
Please provide details of special educational needs here:

Identified SEN	Responses to identified SEN
☐ Specific Learning Difficulty (SpLD) ☐ Moderate Learning Difficulty (MLD) ☐ Severe Learning Difficulty (SLD) ☐ Profound and Multiple Learning Difficulty (PMLD) ☐ Behaviour, Emotional and Social Difficulty (BESD) ☐ Speech, Language and Communication Needs (SLCN) ☐ Autistic Spectrum Disorder (ASD) ☐ Visual Impairment (VI) ☐ Hearing Impairment (HI) ☐ Multi-Sensory Impairment (MSI) ☐ Physical Disability (PD) ☐ Other (please specify)	

Q20	Has a professional/ family member expressed concerns about learning needs?	☐ Yes ☐ No ☐ Yet to Clarify

Traumatic Brain Injury

Q20	Head injury that caused him/her to be knocked out or dazed or confused?	☐ Yes ☐ No ☐ Yet to Clarify

Further exploration:

Please provide as much detail as possible here: e.g. is there something unusual about the way the individual communicates? Please give examples such as 'difficult to have a conversation with them/fixed smile/reluctant to talk'.

Air Quality

Joint Strategic Needs Assessment (Refresh) - February 2018

DRAFT

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Joint Strategic Needs Assessment (JSNA): Air Quality

Introduction

The quality of the air in the local environment has an impact on the health of the public and ecosystems. There are several different gases which can occur in ambient air and which have been identified as having health impacts. These include nitrogen dioxide (NO_2), sulphur dioxide (SO_2) and ground-level ozone (O_3). In addition, very small particles of dust can be inhaled and reach the inner airways and lungs.

Breathing in polluted air is linked to respiratory illnesses including Chronic Obstructive Pulmonary Disease (COPD)[1], asthma[2] cardiovascular disease[3] and neurological impairments[4]. In June 2012, the International Agency for Research on Cancer (IARC) confirmed that fumes from diesel engines are carcinogenic[5].

A study in 2013 has shown association between early exposure to traffic pollution and several childhood cancers[6]. Links have also been reported to diabetes and premature and low birth weight babies[7]. This can lead to restricted activity, hospital admissions and even premature mortality.

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What do we know?

Facts and Figures

- The Committee on the Medical Effects of Air Pollutants (COMEAP) speculated that it is reasonable to consider that air pollution may have made some contribution to the earlier deaths of up to 200,000 people in the UK (the number dying of cardiovascular causes) with an average loss of life of about two years per death affected, though that actual amount would vary between individuals.[8]

- Air pollution is estimated to reduce life expectancy of every person in the UK by an average of 7-8 months with estimated equivalent health costs of up to £15 billion each year, within a range of £8-£17 billion.[9]

- It has been estimated that 116 deaths (aged 25+ years) in Lewisham in 2010 were attributable to long-term exposure to small particles. This figure is based upon an amalgamation of the average loss of life of those affected of 12 years. [10].

- COMEAP estimate that for every $10\mu g/m^3$ increase in $PM_{2.5}$, there is a 6% increase in annual all-cause death rates. Based on this estimate, there would be an additional 153 early deaths within the London Borough of Lewisham for every such rise.[8]

- Some 40 million people in the 115 largest cities in the European Union (EU) are exposed to air exceeding WHO air quality guideline values for at least one pollutant.[11]

  Children living near roads with heavy-duty vehicle traffic have twice the risk of respiratory problems as those living near less congested streets.[12]

- Persons between the ages of 0-14 years and 65-80+ years and those with pre-existing lung or heart disease are more vulnerable to the effects of air pollution.[13]

- Epidemiological studies on acute exposure to air pollution increases chances of premature mortality, cardiovascular hospital admissions, exacerbated asthma and other respiratory symptoms. This is particularly the case for fine particles (PM_{10} and $PM_{2.5}$) and ozone. For these pollutants, the relationships revealed by these studies are widely accepted as causal.[13]

- Chronic exposure to air pollution has been shown to have a more profound effect (measured through changes in life expectancy) than acute exposure. Increasing evidence is showing that association between NO_2 and impact on health is not strong enough to be quantified and is not used widely.[13]

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Trends

The UK Air Quality Standards Regulations 2000, updated in 2010, sets standards for a variety of pollutants that are considered to be harmful to human health and the environment. These are based on EU limit values and are for a range of air pollutants, listed below:

- Benzene
- Benzo(a)pyrene
- Carbon monoxide (CO)
- Lead
- Nitrogen dioxide (NO_2)
- Oxides of nitrogen (NO_x)
- Particulate matter (PM_{10} & $PM_{2.5}$)
- Sulphur dioxide (SO_2)
- Ozone

Of the pollutants included in the Air Quality Standards Regulations, monitoring of the following has been carried out within London Borough of Lewisham for several years:

- Carbon monoxide (CO) – monitoring site closed in 2010
- Nitrogen dioxide (NO_2)
- Ozone (O_3) – since 2016 no longer monitored
- Particulate matter (PM_{10}) i.e. particles with a diameter <10 microns
- Sulphur dioxide (SO_2) – since 2016 no longer monitored

Monitoring of particulate matter ($PM_{2.5}$) began at one location in 2012.

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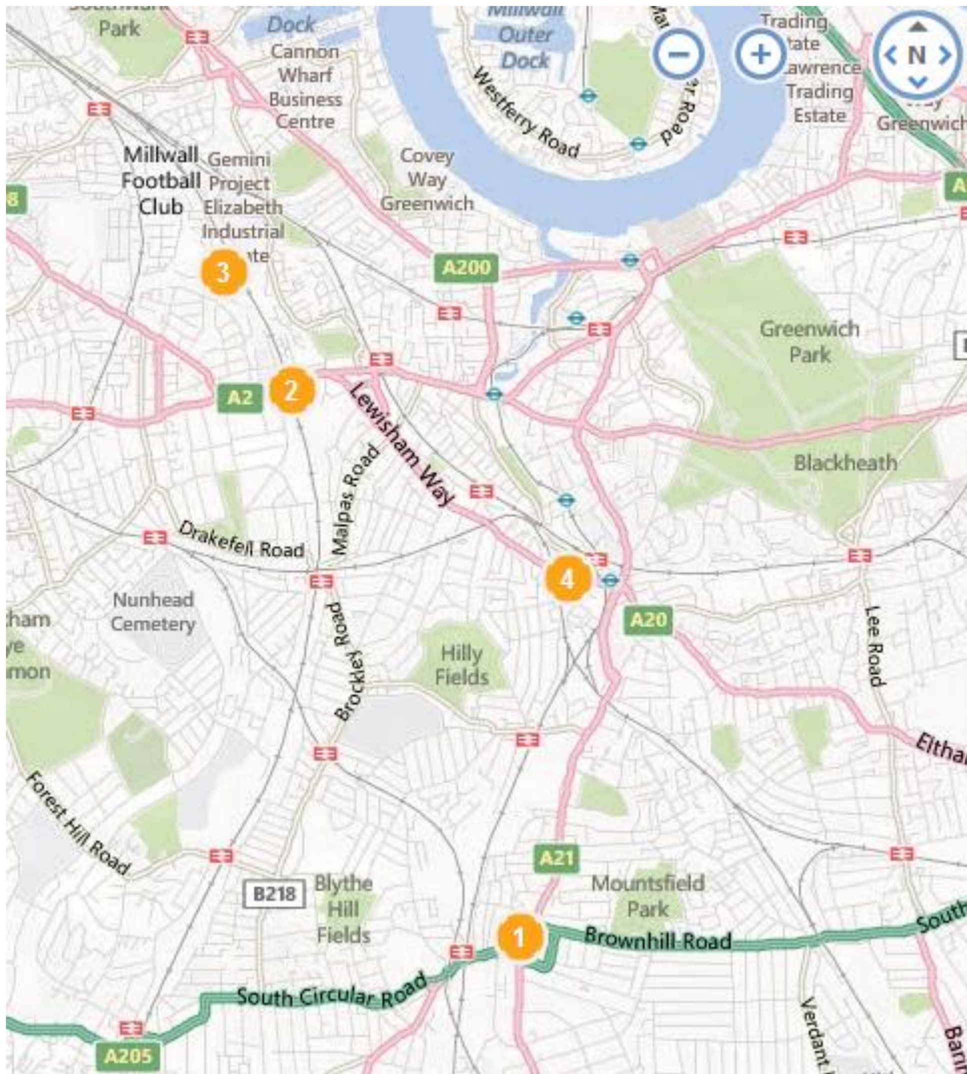
The map below shows the locations where automatic monitoring of air pollutants has taken place within the London Borough of Lewisham:



Map 1: Locations of automatic Air Quality Monitoring Stations in London Borough of Lewisham

1 = Broadway Theatre, Catford (UB)   2 = New Cross Road (Roadside)
3 = Mercury Way (site closed in 2015)   4= Loampit Vale (Roadside)

Monitoring site 3 in Mercury Way started collecting data between 2010 and 2015 and monitoring site 4 in Loampit Vale opened in 2012. A further site, located in Crystal Palace Parade, is just outside the borough boundary but was a collaborative project with neighbouring boroughs. This site was closed in July 2010 but data from the site up until this date has been included in this report.

Carbon monoxide

Carbon monoxide monitoring was only carried out at the Crystal Palace site which closed in 2010. In 2010, prior to its closure, the maximum 8-hour running mean was 1.2mg/m^3 compared to a target of **10**mg/m^3 set in the National Air Quality Objectives. This period of monitoring confirmed that the air quality objective for Carbon Monoxide was achieved.

Location		2008	2009	2010
Crystal Palace 1, Crystal Palace Parade	Max 8 Hour	1.6	1.5	1.2
	Annual mean	0.4	0.4	0.4
	Max 1 Hour	3	2	1.8
	Data capture %	86	89	56

Table 1: Carbon monoxide monitoring data (Crystal Palace 1)

Nitrogen dioxide (NO_2)

The National Air Quality Objective for the NO_2 annual average is **40**µg/m^3. The graph below shows the annual averages measured at automatic monitoring sites within the borough for the years where data is available (see Map 1 for locations of monitoring sites).

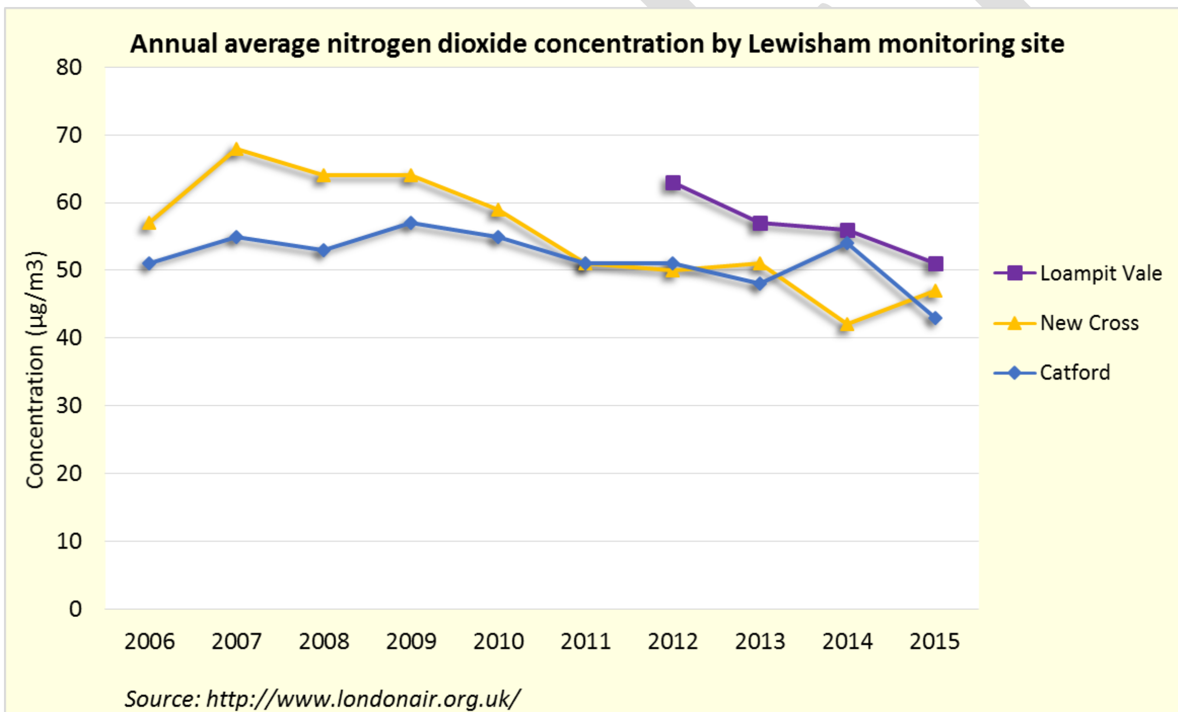


Fig 2: Trends in nitrogen dioxide annual averages

In addition to the automatic monitoring sites, London Borough of Lewisham also gather data on NO_2 concentrations using diffusion tubes which are passive monitors. These have a lower degree of accuracy than the automatic monitors but provide indicative data that is used to calculate annual averages. Data is collected at 34 different locations around the borough, some close to busy roads (roadside) while others are located in residential areas or parks (background). The tables/graphs below show the annual averages for NO_2 at both roadside and background locations.

Ozone is not included in the system of Local Air Quality Management owing to its trans-boundary nature.

Background Site id	2009	2010	2011	2012	2013	2014	2015	2016	Trend
LW1 CM	56.0	55.0	51.0	50.0	48.0	54.0	43.0	45.0	
L2			29.7	31.0	29.6	29.2	28.1	27.0	
L3			34.7	37.9	37.1	35.9	34.3	32.0	
L4			37.2	34.9	37.3	34.9	34.4	30.0	
L6			35.9	37.5	38.3	36.0	35.2	31.0	
L12			30.7	33.7	34.9	30.5	26.9	25.0	
L13		34.9	29.7	32.3	33.3	28.3	27.3	24.0	
L14	35.7	33.3	33.5	34.5	34.7	31.2	29.9	28.0	
L22	37.9	33.1	35.4	34.3	33.5	32.2	30.3	28.0	
L24	30.8	33.4	29.0	35.1	36.3	35.6	32.4	31.0	
L25	27.1	30.8	28.3	28.3	27.5	25.5	23.3	22.0	
L31	28.7	30.7	23.2	25.4	29.6	25.7	23.5	23.0	
L32	33.0	35.3	29.7	29.6	31.6	30.6	28.6	29.0	
L33	60.7	54.7	47.1	51.4	51.0	44.6	41.8	40.0	
L34	34.3	32.7	27.6	30.4	34.0	31.8	27.0	25.0	

Fig 3: Trends in nitrogen dioxide annual averages at background sites (diffusion tubes)

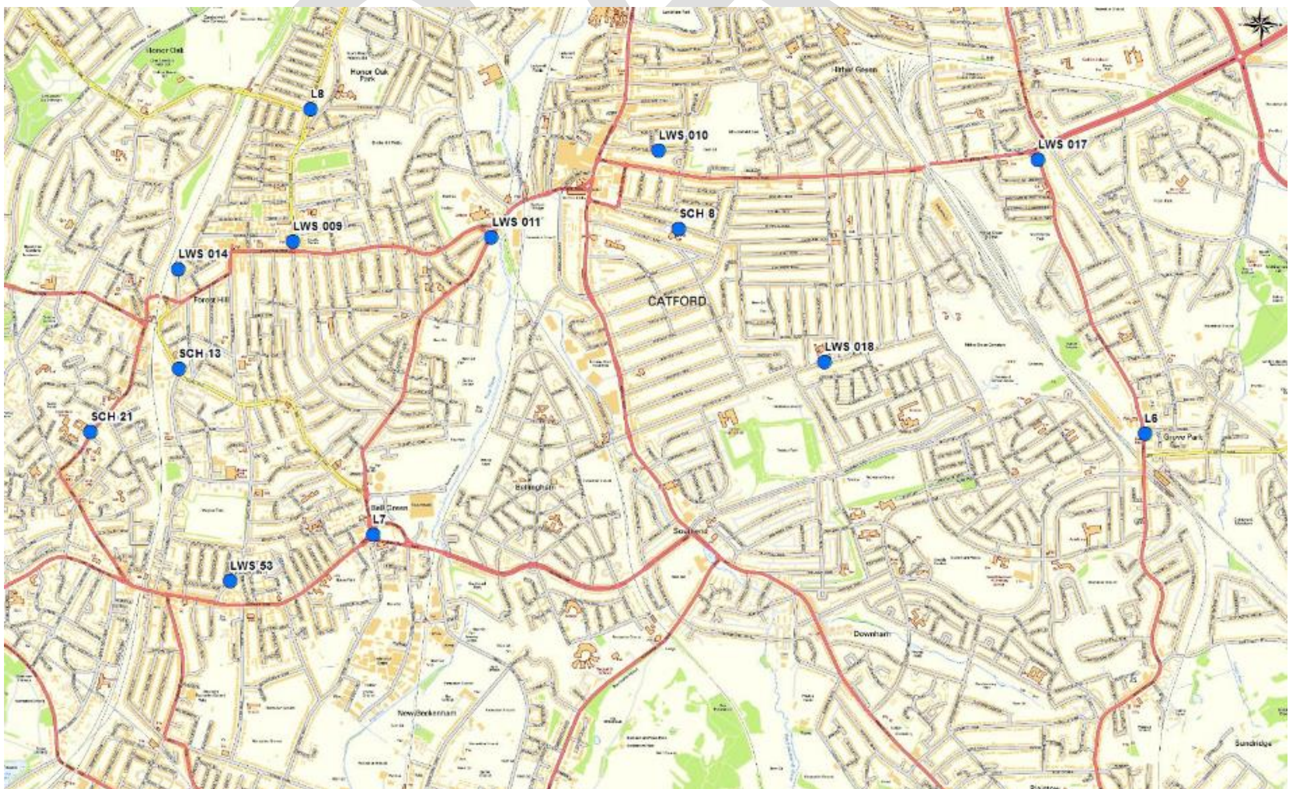
Roadside Site id	2009	2010	2011	2012	2013	2014	2015	2016	Trend
LW2 CM	63.0	59.0	51.0	50.0	51.0	42.0	47.0	47.0	
LW4 CM				64.0	57.0	56.0	51.0	45.0	
L1			36.4	37.8	38.6	38.0	33.1	31.0	
L5			36.6	39.0	43.3	37.7	33.4	32.0	
L7			48.3	53.4	53.8	55.4	48.3	44.0	
L8			44.5	44.8	48.6	42.2	42.2	38.0	
L9			39.9	40.6	40.5	40.8	37.5	35.0	
L10			43.2	44.0	46.2	40.3	39.4	37.0	
L11			44.9	40.0	47.4	38.6	36.1	33.0	
L15	49.2	47.8	43.6	44.3	47.6	46.5	46.6	41.0	
L16	59.4	61.3	48.7	55.0	58.6	52.5	48.7	49.0	
L17	72.8	75.2	75.4	59.2	53.7	49.1	50.6	52.0	
L18	73.1	75.2	75.4	59.2	53.7	51.1	49.1	31.0	
L19	71.2	75.2	75.4	59.2	53.7	49.6	49.7	47.0	
L20		54.1	42.4	45.4	44.7	43.6	43.2	38.0	
L21	56.6	60.9	52.6	54.0	54.0	54.6	50.3	46.0	
L23	57.1	56.1	54.0	56.5	59.9	55.1	51.8	45.0	
L26	60.0	53.8	49.7	48.0	51.9	53.7	47.2	41.0	
L27a* previous site	40.5	38.5	34.6	37.3	37.2	36.2			
L27b* new site							57.1		
L28	49.1	60.7	51.9	59.3	61.9	51.0	58.6	52.0	
L29	31.3	35.1	29.9	32.1	33.3	33.0	28.6	27.0	
L30	31.0	33.0	27.8	31.1	34.3	31.3	32.3	28.0	
L33	60.7	54.7	47.1	51.4	51.0	44.6	41.8	40.0	

Fig 4: Trends in nitrogen dioxide annual averages at roadside sites (diffusion tubes)

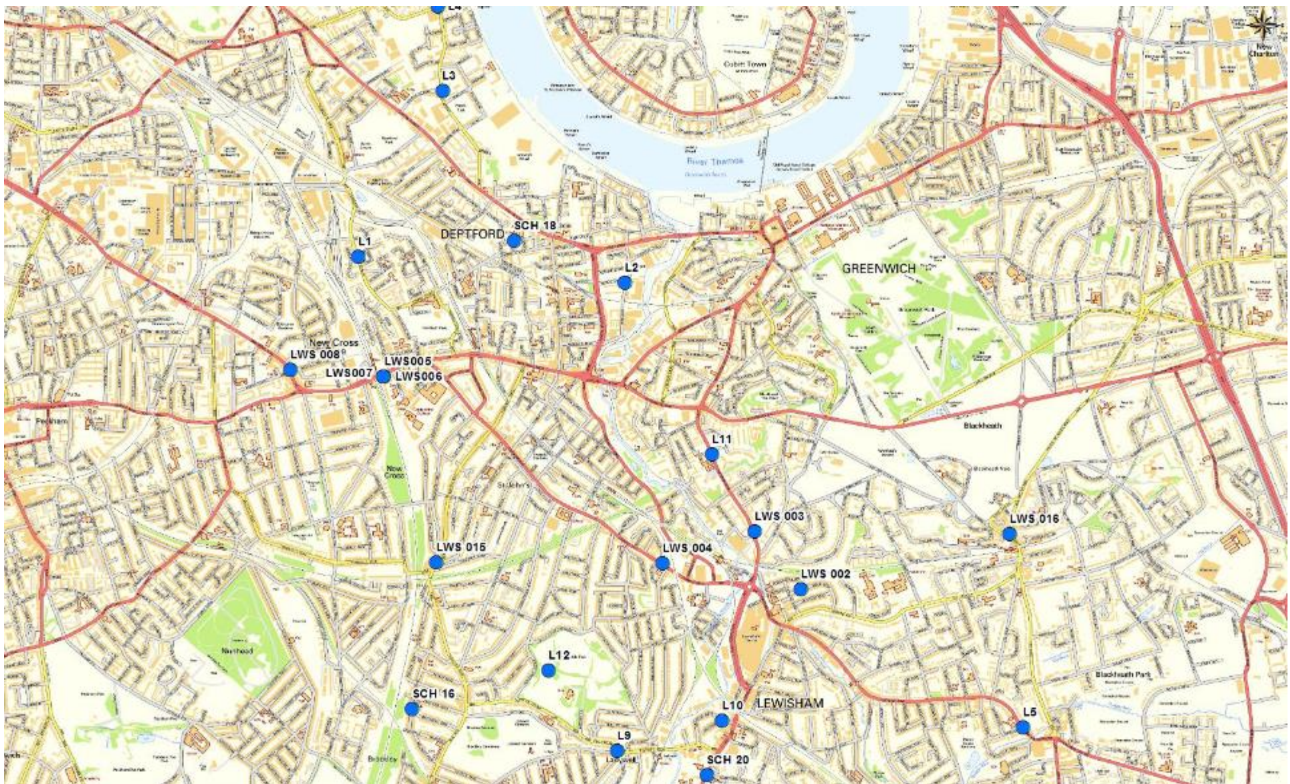
NOTE: Data for 2016 in both the above tables uses Bias Adjusted Factor of 0.92

Background Sites		Roadside Sites	
LW1 CM	Catford	LW2 CM	New Cross
L2	Bronze Street, SE8	LW4 CM	Loampit Vale
L3	Grove Street, SE8	L1	Chubworthy Street, SE14
L4	Plough Way, SE8	L5	Lee High Road, SE12
L6	Le May Avenue, SE12	L7	Bell Green, SE6
L12	Hilly Fields, SE13	L8	Stondon Park, SE23
L13	Mayow Road, SE26	L9	Ladywell Road, SE13
L14	Boyne Road, SE13	L10	Whitburn Road, SE13
L22	Ringstead Road, SE6	L11	Sparta Street, SE10
L24	Hazelbank Road, SE6	L15	Lewisham Road, SE13
L25	Stanstead Road, SE23	L16	Loampit Vale, SE13
L31	Howson Road, SE4	L17-L19	New Cross Road, SE14
L32	Clyde Street, SE8	L20	Hatcham Park Road, SE14
L34	Dartmouth Road, SE26	L21	Brockley Rise, SE23
		L23	Catford Hill, SE6
		L26	Shardloes Road, SE14
		L27	Lawn Terrace, SE3
		L28	Baring Road, SE12
		L29	Sangley Road, SE6
		L30	Perry Vale, SE23
		L33	Lewisham High St, SE13

Table 2: Showing names of both Background and Roadside sites



Map 2 showing Diffusion Tube Monitoring Locations in LB of Lewisham: Diffusion Tube Network (South) in 2016



Map 3 showing Diffusion Tube Monitoring Locations in LB of Lewisham: Diffusion Tube Network (North) in 2016

Particulate Matter (PM_{10})

The National Air Quality Objective for the PM_{10} annual average is **40**µg/m^3. The graph below shows the annual averages recorded at the borough's monitoring sites for those years where data is available.

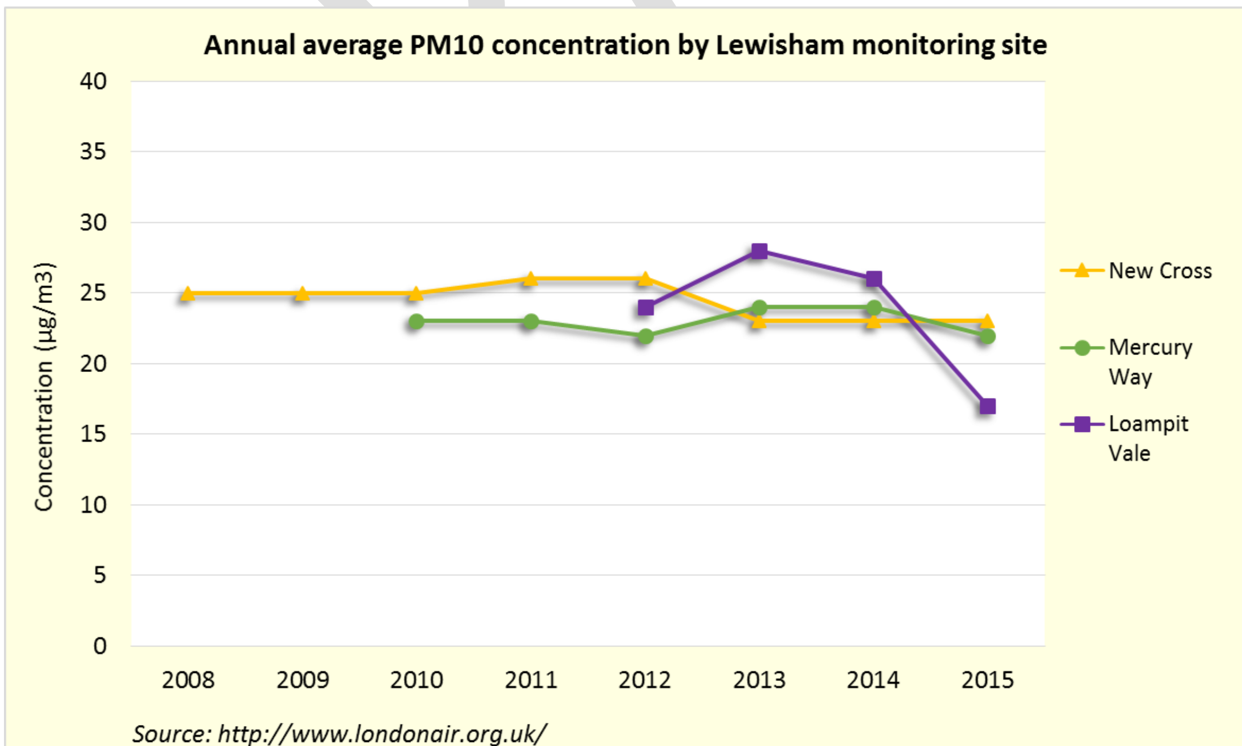


Fig 5: Trends in PM_{10} annual averages

Targets

The European Union has issued an air quality Directive that sets standards for a variety of pollutants that are considered harmful to human health and the environment. These standards, which are based on WHO guidelines, include limit values, which are legally binding and must not be exceeded. The EU Directive, including the emission concentration limit values, has been transposed into English law by the Air Quality Standards Regulations and a national strategy developed. The table below shows the objectives that are set in the UK National Air Quality Strategy for the different pollutants that occur in ambient air:

Pollutant	Concentration	Averaging period	Legal nature	Permitted exceedances each year
Fine particles ($PM_{2.5}$)	25 µg/m³***	1 year	Target value entered into force 1.1.2010 Limit value enters into force 1.1.2015	n/a
Nitrogen dioxide (NO_2)	200 µg/m³	1 hour	Limit value entered into force 1.1.2010	18
	40 µg/m³	1 year	Limit value entered into force 1.1.2010*	n/a
PM_{10}	50 µg/m³	24 hours	Limit value entered into force 1.1.2005**	35
	40 µg/m³	1 year	Limit value entered into force 1.1.2005**	n/a
Lead (Pb)	0.5 µg/m³	1 year	Limit value entered into force 1.1.2005 (or 1.1.2010 in the immediate vicinity of specific, notified industrial sources; and a 1.0 µg/m3 limit value applied from 1.1.2005 to 31.12.2009)	n/a
Carbon monoxide (CO)	10 mg/m³	Maximum daily 8 hour mean	Limit value entered into force 1.1.2005	n/a
Benzene	5 µg/m³	1 year	Limit value entered into force 1.1.2010**	n/a
Arsenic (As)	6 ng/m³	1 year	Target value enters into force 31.12.2012	n/a
Cadmium (Cd)	5 ng/m³	1 year	Target value enters into force 31.12.2012	n/a
Nickel (Ni)	20 ng/m³	1 year	Target value enters into force 31.12.2012	n/a
Polycyclic Aromatic Hydrocarbons	1 ng/m³ (expressed as concentration of Benzo(a)pyrene)	1 year	Target value enters into force 31.12.2012	n/a

Table 3: Air Quality Objectives included in Regulations for the purpose of Local Air Quality Management in England.

Note: Ozone and SO_2 are no longer being monitored so are not included in the above table

* Under the new Directive the member State can apply for an extension of up to five years (i.e. maximum up to 2015) in a specific zone. Request is subject to assessment by the Commission. In such cases within the time extension period the limit value applies at the level of the limit value + maximum margin of tolerance (48 µg/m³ for annual NO_2 limit value).

** Under the new Directive the Member State was able to apply for an extension until three years after the date of entry into force of the new Directive (i.e. May 2011) in a specific zone. Request was subject to assessment by the Commission. In such cases within the time extension period the limit value applies at the level of the limit value + maximum margin of tolerance (35 days at 75μg/m^3 for daily PM_{10} limit value, 48 μg/m^3 for annual Pm_{10} limit value).

*** Standard introduced by the new Directive (http://ec.europa.eu/environment/air/quality/legislation/directive.htm)

These National Air Quality Objectives have been set in regulations which implement European Union Directives on ambient air quality. The EU Directives set limit values for the pollutants which take into account relevant World Health Organisation standards, guidelines and programmes. The limit values are legally binding on the member states and must not be exceeded.

A new European Union directive on ambient air quality and cleaner air entered into force in June 2008. This merges together four earlier directives and one Council decision.

Performance

2015 Data from http://www.londonair.org.uk/:
Concentrations of each of the pollutants included in the Air Quality Standards Regulations have been monitored and/or estimated then compared to the relevant standards (objectives).

Pollutant	**Lewisham site**	**Capture rate**	**Concentration**	**Target**	**Measure**	**Achieved in LBL (Y/N)**
Nitrogen dioxide (NO_2)	Catford	82%	0 μg/m^3	200 μg/m^3 not to be exceeded more than 18 times a year	1 hour mean	n/a*
			43 μg/m^3	40 μg/m^3	Annual mean	n/a*
	Loampit Vale	84%	0 μg/m^3	200 μg/m^3 not to be exceeded more than 18 times a year	1 hour mean	n/a*
			51 μg/m^3	40 μg/m^3	Annual mean	n/a*
	New Cross	92%	7 μg/m^3	200 μg/m^3 not to be exceeded more than 18 times a year	1 hour mean	y
			47 μg/m^3	40 μg/m^3	Annual mean	n
Particulate matter (PM_{10})	Loampit Vale	96%	1 μg/m^3	50 μg/m^3 not to be exceeded more than 35 times a year	24 hour mean	y
			17 μg/m^3	40 μg/m^3	Annual mean	y
	Mercury Way	92%	16 μg/m^3	50 μg/m^3 not to be exceeded more than 35 times a year	24 hour mean	y
			22 μg/m^3	40 μg/m^3	Annual mean	y
	New Cross	92%	8 μg/m^3	50 μg/m^3 not to be exceeded more than 35 times a year	24 hour mean	y
			23 μg/m^3	40 μg/m^3	Annual mean	y
Particulate matter ($PM_{2.5}$)	New Cross	88%	16 μg/m^3	25 μg/m^3	Annual mean	n/a*

* n/a applies to sites that do not meet the capture rate requirement of 90%

Table 4: List of each of the pollutants with the relevant objective and whether or not the objective was met in the most recent year for which data was available (2015)

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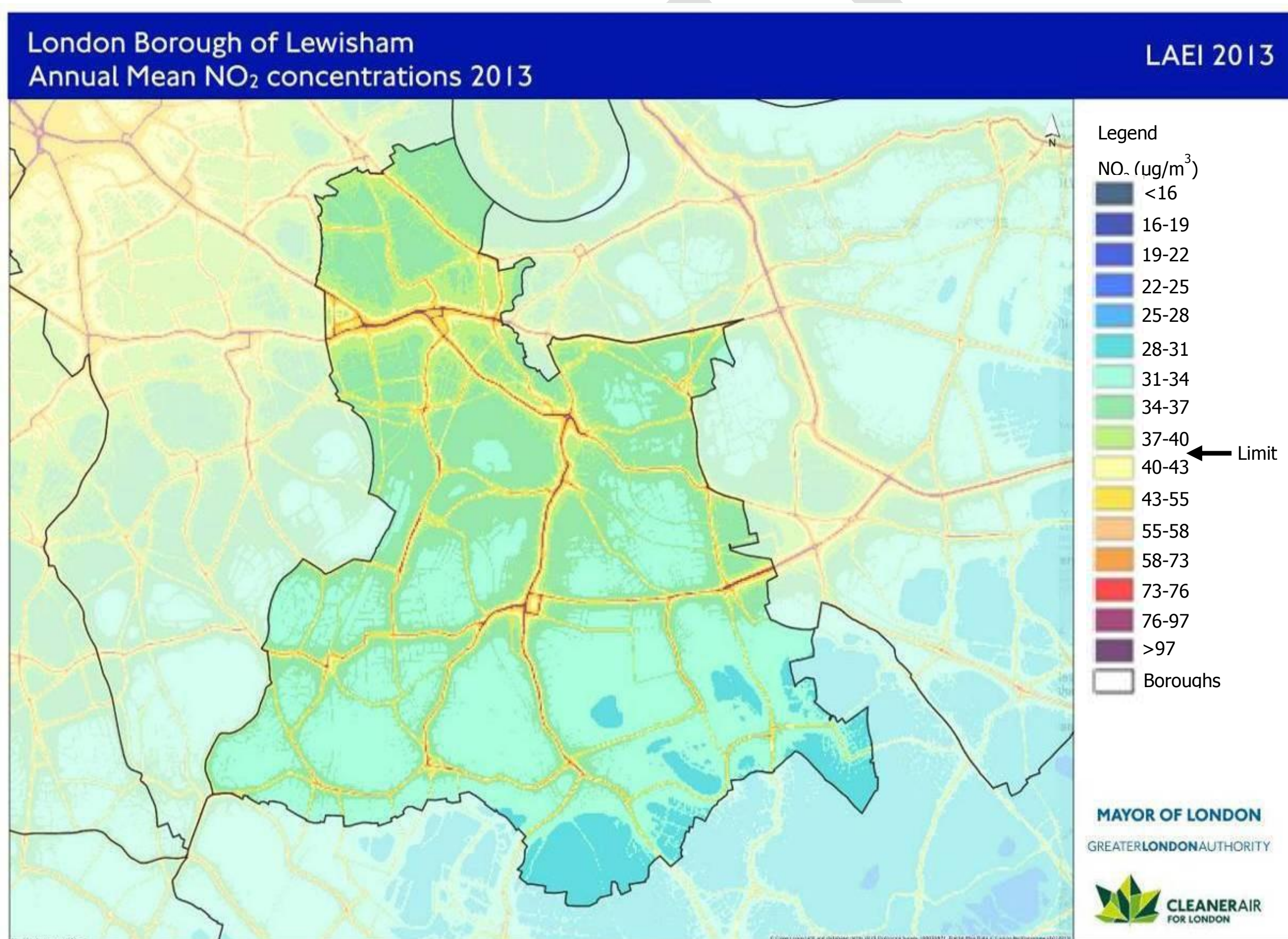
From the above table, it can be seen that the objectives were not met for only one of the pollutants; NO_2. These are called 'exceedances'. Exceedances of the annual average objective occur at many roadside locations within the borough while exceedances of the 1-hour mean objective only occur adjacent to those roads that are the most busy and congested. All background sites where monitoring of nitrogen dioxide is undertaken show compliance with both objectives.

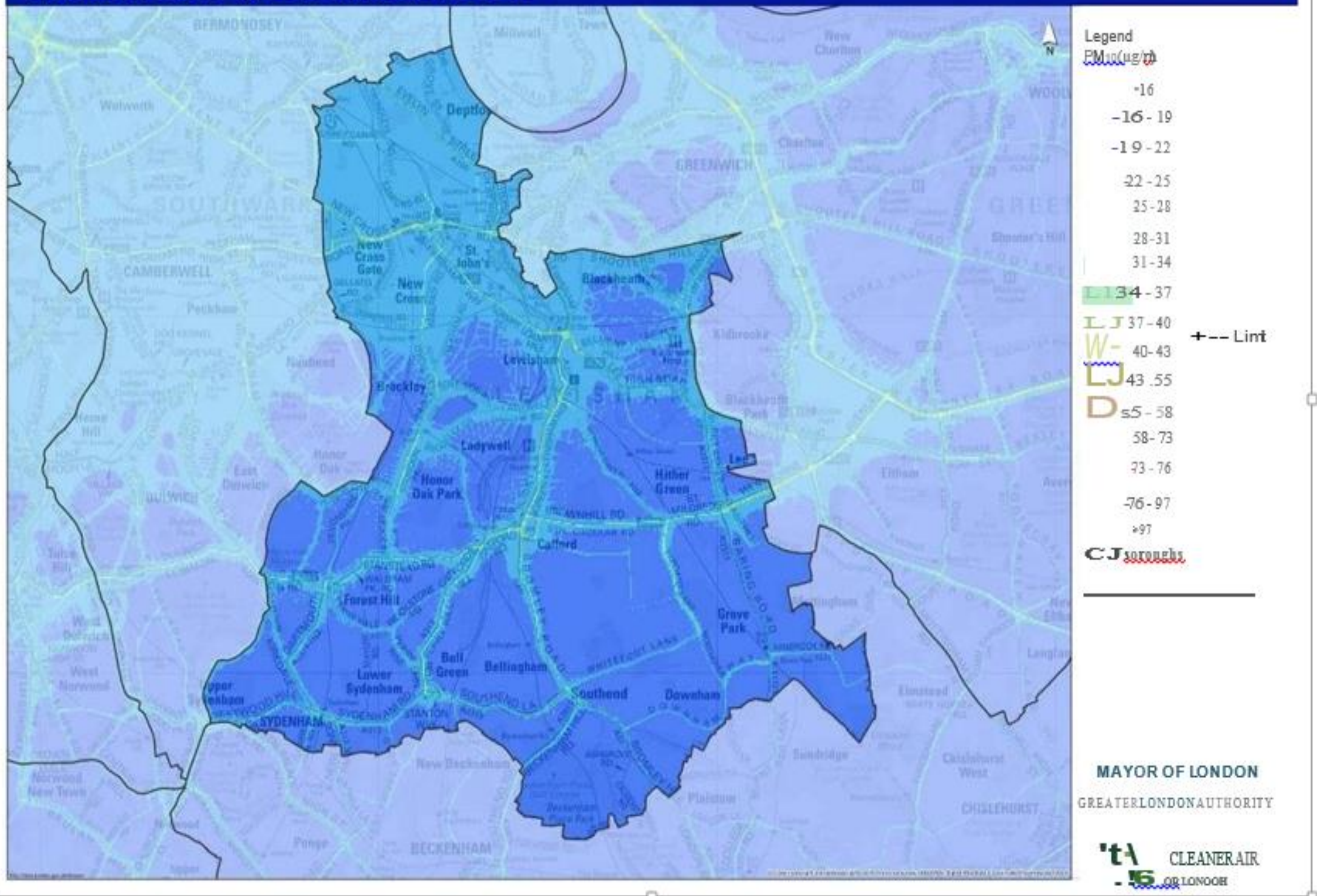
To help put the situation in Lewisham in a regional context, the highest annual mean for NO_2 measured at the New Cross monitoring station in 2015 was 47µg/m^3. The highest reading recorded at any monitoring station in London was 135µg/m^3.

Exceedances of the 24-hour mean objective for PM_{10} have occurred previously but not since 2003.

The maps below show the modelled concentrations of nitrogen dioxide and PM_{10} for 2013 within the borough of Lewisham.



Map 4: NO_2 concentrations in London Borough of Lewisham 2013



Map 5: PM_{10} concentrations in London Borough of Lewisham 2013

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Local Views

Air quality is of significant concern to many local people and the subject often generates headlines in the national and local media. The 2010 Londoner Survey[14] found that pollution from traffic was the top environmental concern for Londoners.

There is no measure of local attitudes towards air quality within the borough that is carried out on a regular basis. Progress on air quality is reported to DEFRA and the GLA on an annual basis and these reports are available for viewing on the Lewisham Council website (https://www.lewisham.gov.uk/myservices/environment/air-pollution/Pages/Air-quality-reviews.aspx). These reports are required to be produced according to a prescribed template and the content is fairly technical. Possibly as a result of this, they rarely generate feedback from members of the public. However, from conversations and calls to the local authority, we know that people are concerned about local air pollution.

Local views are gathered through consultation on specific issues and/or during community engagement events. A consultation on parking regulations within the borough was carried out in 2012 which included questions on public attitudes towards encouraging low emission vehicles using fiscal incentives. In addition, a local consultation was carried out within the Crofton Park / Forest Hill area on the designation of a new Air Quality Management Area. The responses from the latter consultation showed overwhelming support for a larger geographical area to ensure that air quality could be managed on a wider scale.

Another consultation was held 2016 for the Air Quality Action Plan (AQAP) 2016-2021, 303 residents responded to this consultation. The highlights of the consultations are as follows:–

Over 50% of respondents felt that Air Quality had got worse compared to a year ago.

- Nearly all respondents saw traffic as being a main source of the problem and 70% of respondents identifying construction as a source, with industry and domestic/commercial fuel use identified as a source but to a lesser extent.

Traffic was identified as a main priority for the AQAP with emissions specifically from commercial delivery vehicles and freight being particularly important for consideration.

- In relation to emissions from developments and buildings; Localised solutions; Public health and awareness raising 40-50% respondents identified these as being ‘Very Important’ in relation to emissions from developments and buildings.

Over 69% of respondents were likely or very likely to introduce further energy efficiency measures within their home.

- Respondents were asked whether they wished to receive information on Boiler Cashback information and 60 respondents replied requesting information.

Over 16% of respondents have diesel cars that are older than September 2014, pre-Euro 6 engines, required when the Ultra-Low Emission Zone is introduced.

- Nearly 20% of those that had this aged diesel car answered that they are very likely or quite likely to purchase a more environmentally friendly car if cheaper resident parking and controlled parking zone parking was introduced for cars that complied with modern pollution standards.

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If discounted parking meter charges were introduced for zero-emission cars, how likely would you be to purchase a zero-emissions car in the future? Question responses: 286 (94.70%)

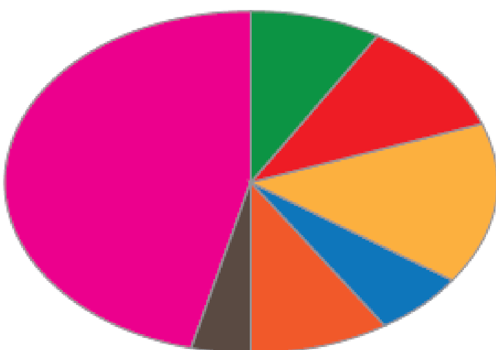
		% Total	% Answer	Count
Very likely		10.93%	11.54%	33
Quite likely		13.91%	14.69%	42
Neutral		25.50%	26.92%	77
Unlikely		15.56%	16.43%	47
Very unlikely		17.88%	18.88%	54
Don't know		10.93%	11.54%	33
[No Response]		5.30%	--	16
	Total	100.00%	100.00%	302

When asking whether respondents currently have a motor vehicle, 62.58 % said YES, with 36.09 replying NO and 1.32% with no response.

- Only 1.66% owned a zero emission vehicle. The main reason for not purchasing one was the cost and the availability of the infrastructure i.e. electric charging points.

If discounted parking meter charges were introduced for zero-emission cars, nearly 25% indicated that they were very likely or quite likely to purchase a zero-emissions car in the future.

- If yes to 'Do you have a diesel car that is older than September 2014': If cheaper resident parking and controlled parking zone parking was introduced for cars that complied with modern pollution standards, would you be likely to purchase a more environmentally friendly car? Question responses: 163 (53.97%)



		% Total	% Answer	Count
Very likely		8.61%	15.95%	26
Quite likely		10.93%	20.25%	33
Neutral		15.23%	28.22%	46
Unlikely		6.29%	11.66%	19
Very unlikely		8.94%	16.56%	27
Don't know		3.97%	7.36%	12
[No Response]		46.03%	--	139
	Total	100.00%	100.00%	302

Over 85% of respondents thought the introduction of night-time deliveries, where noise disturbance to residents can be minimised, was a very good or good idea. 43% of respondents reported that there was someone in their household that has a health condition affected by poor air quality.
101 respondents requested further information about AirText, a free text and phone application service which provides alerts where high levels of pollution are forecast and relevant health advice for those with breathing conditions. Nearly 80% of respondents were not aware of the free service available.

The Lewisham Cyclist Group felt that the consultation questionnaire focused on questions around the motor car and didn’t consider alternative active modes of travel such as walking and cycling, particularly as significant numbers of Lewisham residents and households do not have access to a motor car. The cyclist group would have liked a question that might have identified how many people would choose to cycle if they had somewhere secure to store cycles. The Lewisham Cyclist Group stated that, they are currently working with the council in the preparation of a cycling strategy which considers pollution and public health. We would welcome the opportunity to discuss this issue further with council officers.

The Air Quality Action Plan (AQAP) 2016-21 was developed based on the responses received from this consultation including identifying actions to reduce emissions, particularly Nitrogen Dioxide.

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National and local strategies

The National Air Quality Strategy

The Environment Act 1995 put into legislation a requirement for a national strategy to be developed to tackle poor air quality and thereby reduce the associated risks to human health and the environment. Consequently, on March 12th 1997, the National Air Quality Strategy was published, with commitments to achieve new air quality objectives throughout the UK by 2005. A review of the Strategy was published in January 2000 and the most recent version was produced in July 2007.

The National Air Quality Strategy aims to protect health and the environment without imposing unacceptable economic or social costs. It sets out standards and objectives for the 8 main health-threatening air pollutants in the UK. The standards are based on an assessment of the effects of each pollutant on public health. They are based on recommendations by the Expert Panel on Air Quality Standards, The European Union Air Quality Daughter Directive and the World Health Organisation. Local Authorities are responsible for seven of the eight air pollutants under Local Air Quality Management (LAQM).[15] The pollutant that is not covered by LAQM is ozone which is tackled at a national level.

Mayor's Air Quality Strategy

The Mayor of London is also required to keep under review an Air Quality Strategy for the Greater London area. The most recent version of the Mayor's Air Quality Strategy entitled 'Cleaner Air for London' was published in July 2015[16]. The Strategy contains policies and proposals that aim to improve air quality across the Greater London area and thereby seek to ensure that the limit values for all pollutants in the area are achieved.

Lewisham Air Quality Action Plan

Although the London Borough of Lewisham does not have an Air Quality Strategy for the borough, much of the area has been declared an Air Quality Management Area. Where an Air Quality Management Area is declared, the local authority is required to develop an Action Plan containing measures that seek to address the particular air quality problems identified. As outlined above, London Borough of Lewisham published a new Air Quality Action Plan (2016-2021) in December 2016 containing 43 measures that will help to reduce the levels of NO_2 and PM_{10} within the 6 Air Quality Management Areas declared. Although the Action Plan is for these 6 Air Quality Management Areas, the measures implemented will deliver air quality benefits across the whole of the borough.

Current Activity and Services

For the Lewisham areas declared as Air Quality Management Areas, a single Air Quality Action Plan is in place. This details all the measures that London Borough of Lewisham Environmental Protection Team are implementing or intending to do so in order to reduce the levels of NO_2 and PM_{10}.

However, many of the measures will not tackle solely the Air Quality Management Areas since any improvements to air are likely to benefit a much wider area.

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A Progress Report is submitted to DEFRA each year (to the GLA from 2016) outlining the progress made with each of the measures in the Action Plan. These reports are available to view on the Air Pollution pages of the Lewisham Council website. The measures which have been targeted within 2016-21 are as follows:

- Measures to increase awareness on air quality issues including promotion of the air pollution alert service AirTEXT and methods to help people reduce their exposure such as Walkit.com;
- Measures to Encourage the Use of Cleaner Technology and Alternative Fuels through the promotion of the uptake of electric vehicles and installation of infrastructure to support their recharging;
- Promotion of Walking through improvements to the walking environment including signage, lighting and surfacing;
- Promotion of Cycling through cycle training, security marking and repair workshops.
- Measures to Manage Parking through a review of the Parking Strategy including consideration of financial incentives for low emission vehicles.
- Measures to Reduce Emissions from Domestic Buildings through offering energy efficiency measures and advice.

In addition, London Borough of Lewisham is looking at ways to improve community engagement and provide information to residents about air quality and is developing a phone app that will assist residents in finding least polluted travel routes and will provide air quality alerts and information to assist in engagement.

The Lewisham Mayor launched an Air Quality Campaign in July 2016, to help bring about behavioural change by all whilst providing a focused approach with children, schools, transport and infrastructure projects coupled with an evidence-based approach, drawing on available research to maximise effectiveness of actions and to build new knowledge through research partnerships with academic units investigating air quality issues. It is working at encouraging residents to sign a pledge of actions to improve air quality.

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What is this telling us?

What are the key inequalities?

Air pollution can often travel some distance away from the source of emissions. Particulate matter, especially, can travel substantially so that concentrations within London are affected by emissions from mainland Europe as well as dust from the Sahara. However, the largest source of emissions within the borough of Lewisham are motor vehicles and, consequently, the areas of poorest air quality are adjacent to the busiest roads.

As the properties alongside busy roads tend to be cheaper and/or rented accommodation, it tends to be those from the lowest socio-economic groups who live in these areas and are, therefore, exposed to higher levels of air pollution. A close link has been shown between areas of high deprivation and pollution.

A recent study by the think tank Policy Exchange sought to quantify the inequalities experienced. The research found the following:

- 5-10 year old children living in the 10% of areas with the lowest air quality in London are nearly 50% more likely than the London average to be on free school meals.

- People living in the 10% of the areas with the lowest air quality are over 25% more likely than the London average to be on income support.

As highlighted in the 2010 Marmot Review[17], individuals in deprived areas experience more adverse health effects at the same level of exposure compared to those from less-deprived areas. This is, in part, because of a higher prevalence of underlying cardio-respiratory and other diseases, as well as greater exposure to air pollution as a result of homes being situated nearer to busy congested roads and with fewer green spaces.

Studies also show that the greatest burden of air pollution usually falls on the most vulnerable in the population, in particular, the young and elderly. The link between health inequalities and pollution is complex.[18]

Individuals particularly at risk also include those with existing respiratory problems and chronic illnesses such as asthma and chronic obstructive pulmonary disease (COPD). There are approximately 690,000 asthma sufferers in London and 230,000 individuals suffering from COPD.[19]

The Health Effects Institute (HEI) panel concluded that the evidence is sufficient to support a causal relationship between exposure to traffic-related air pollution and exacerbation of asthma. It also found suggestive evidence of a causal relationship with onset of childhood and asthma, non-asthma respiratory symptoms, impaired lung function, total and cardiovascular mortality, and cardiovascular morbidity, although the data are not sufficient to fully support causality.[20]

What are the key gaps in knowledge and/or services?

Although we have information on the current levels of air quality and studies demonstrate a link between air pollution and ill-health, there are still a number of gaps in our knowledge.

The main areas in which further information is needed are:

- the effects of different types of air pollution on hospital admissions and mortality
- the quantitative impacts on pollutant concentrations from individual measures in order to identify those that are the most effective.

What is coming on the horizon?

The move of Public Health into Local Authorities facilitates the integration of considerations of the wider determinant of health into the planning and delivery of local authority services. The Public Health Outcomes Framework is a set of indicators compiled by the Department of Health to measure how effectively the activities of each local authority are addressing the determinants of health. Within four domains, there are a total of 68 indicators. One of these indicators is Air Pollution.

Following on from a recent "Review and Assessment" of air quality within the borough, a Detailed Assessment was carried out which involved modelling the concentrations of NO_2 within an area around Crofton Park and Forest Hill. This area was identified as having concentrations of NO_2 above the limit values in the Air Quality Standards Regulations, being an area where members of the public are exposed and which had not already been declared as an Air Quality Management Area. Consequently, a new Air Quality Management Area was declared to cover the areas of exceedances as a minimum. Officers from the Environmental Protection Team presented a draft order to Mayor and the Cabinet on 10 April 2013 which was approved.

Following the declaration of the new Air Quality Management Area, an Action Plan has been put in place setting out the measures that will be implemented to reduce concentrations of NO_2 in this area.

What should we be doing next?

The aim is to ensure that public health is protected by ensuring that no individuals are exposed to unhealthy levels of air pollution concentrations.

Therefore, we need to reduce exposure to air pollution but, more importantly, reduce emissions at source. While LB Lewisham aims to ensure that we achieve compliance with the prescribed limit values for all pollutants, we will strive to go beyond this and continue to improve air quality in all areas. In this way, we aim to protect even the most vulnerable individuals from the potential health impacts from air pollution.

No one measure is going to deliver the necessary reductions so a package of measures need to be implemented which requires co-operation and input from a variety of stakeholders. Furthermore, as some pollutants are brought into the borough from outside our area of jurisdiction, there are limitations to what can be achieved.

However, we need to ensure that the sources of air pollution that are emitted within the borough area and, therefore, within our remit, are controlled.

Therefore, we need to:

- Reduce emissions from transport by providing a range of sustainable alternatives with readily available information on the options, leading by example to promote

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cleaner technology and alternative fuels and using fiscal options to encourage cleaner vehicles while deterring the most-polluting;
- Reduce emissions from industry through providing advice and information to industrial operators while taking appropriate enforcement action where necessary;
- Reduce emissions from heating by supporting the uptake of energy-efficiency measures;
- Ensure that new developments do not result in increased air pollution nor place people in areas of poor air quality;
- Educate, encourage and advise people to change polluting modes of behaviour and reduce their exposure to harmful levels of air pollution.
- Work with schools to raise awareness and reduce exposure to pollution.

Certain measures to improve air quality have significant co-benefits for health. These are listed below:

Motor traffic is responsible for air pollution and so measures that encourage people to use sustainable transport, such as walking and cycling would have the following benefits:

- Create an environment that is more pleasant to walk and cycle, hence increasing physical activity levels
- Reduce risks of injury and death from road traffic collisions
- Reduce noise pollution which also enables people to open windows to buildings thus reducing the costs of air conditioning
- Reduce community severance, increase community cohesion and social interactions
- Contribute to reducing the urban heat island effect (This effect is explained by the Met Office). [21]

Greater number of trees and vegetation:

- Reduce risks from localised flooding
- Contribute to urban cooling and help to contribute to reducing the urban heat island effect
- Provide shade to enable people to keep cool and out of direct sunlight in sunny weather
- Improve mental health and wellbeing
- Improve resilience to climate change. Information on climate change is available at the Met Office website. [22]

Improving the energy efficiency of homes would reduce emissions from heating systems, which would have the additional benefits of:

- Reducing fuel bills, thus reducing fuel poverty (which is the situation where households are required to spend more than 10% of their income to heat their homes to an appropriate temperature)
- Reduces likelihood of damp and mould occurring, which aggravate respiratory disease
- Reduce the number of falls in the home (falls are more likely to occur in cold homes due to poor blood circulation).

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Indoor Air Pollution

Research indicates that people may spend up to 90% of their time indoors, so in addition to consideration of the air quality outside, indoor air quality of our homes and workplaces is also important. [23]

In the UK, sources of indoor air pollution include domestic gas combustion from cooking and heating, cleaning agents, tobacco smoke, mould, condensation and asbestos. Tobacco smoke is an important source of indoor air pollution, exposure to second hand smoke can cause lung cancer in adults who do not smoke. It can also cause asthma in children who have not shown symptoms of asthma before.[24]

In urban areas outdoor air pollution may affect indoor air quality. Indoor air quality can be improved through source control, filtration and ventilation.[25] It is possible to install filtration to reduce ingress of outdoor air pollution. There are European standards for filtration applicable for non-residential buildings. At home individuals can improve indoor air quality by not smoking at home, and other actions such as keeping types of houseplants known to improve air quality and ensuring there is adequate ventilation and extraction when cooking and using cleaning products.

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Appendix 1: Health impacts of air pollution

Health effect of particulate matter (PM)

- PM that have diameters between 0.1 and 1 μm can be suspended in the atmosphere for days or weeks and are hence subject to long-range trans boundary air transport.[26]

- PM consists of sulphates, nitrates, ammonia, sodium, potassium, magnesium, calcium, chlorine, carbon, transition metals that include cadmium, copper, nickel, vanadium and zinc, and polycyclic aromatic hydrocarbons (PAH). Allergens and microbial compounds have also been detected in PM.[26]

Impact on morbidity

Exposure to air pollution can exacerbate existing health conditions including cardiovascular and respiratory disease.

Short-term Impacts:

Short-term exposure to air pollution can cause several immediate health problems:

- Air pollution can worsen respiratory symptoms in those with pre-existing lung disease and asthma.[27] Gaseous pollutants (NO_2, SO_2, O_3), particulate matter ($PM_{2.5}$ and PM_{10}) and traffic-related air pollution have all been implicated. Exposure to elevated concentrations of these pollutants has been linked with a range of respiratory symptoms, including decreases in immune defence leading to increased susceptibility to respiratory infection.[28, 29]
- Air pollution can also have immediate impacts on cardiovascular events: Short-term exposure to traffic-related pollution has been associated with increased risk of myocardial infarction for several hours after exposure. One meta-analysis found that admission to hospital or mortality from stroke was strongly associated with increased short-term exposures of SO_2, CO, NO_2, $PM_{2.5}$ and PM_{10}.[30]
- Use of health services can increase after periods of strong air pollution: PHE's Real Time Surveillance System Team found an increase in GP consultations for respiratory problems immediately following an episode of Saharan air pollution in 2014.[31]

Long-term impacts

Long-term exposure to air pollution can also contribute to increased risk of onset of several diseases and health problems, as summarised below:

Cardiovascular disease
There is abundant evidence air pollution, particularly PM, contributes to the risk of cardiovascular disease, including: coronary artery disease, myocardial infarction, heart failure, and stroke.[32]

Cancer
Long-term exposure to outdoor air pollution, particularly PM, is associated with incidence of and deaths from lung cancer.[33] The International Agency for Research on Cancer (IARC) has classified PM and NO_2 from diesel engines as Group 1 carcinogens.[34]

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Reduced lung function
Air pollution has detrimental effects on normal lung function growth in children;[35] while for adults there is emerging evidence that air pollution accelerates decline in lung function.[36,37]

Respiratory disease
Evidence for air quality's contribution to COPD onset is inconclusive,[38,39] however studies have shown that exposure to air pollution increases risk of progression to "asthma-COPD overlap syndrome" three-fold.[40]

Low-birth weight
Exposure during pregnancy is linked to low birth weight, which itself is a risk factor for several diseases during adulthood. The evidence is strongest for PM, though NO_2, CO and O_3 have also been linked.[41]

Development of asthma
A meta-analysis[42] of 19 studies on the effect of traffic-related air pollution and asthma in children concluded that increased exposure to NO_2 was associated with a higher prevalence (OR 1.05) and incidence (OR 1.12) of childhood asthma.

Pre-term delivery
Some evidence suggests that the gaseous pollutants SO_2 and O_3 as well as particulates, are associated with pre-term delivery.[43]

Hypertension
A recent cohort study found long-term exposure to $PM_{2.5}$ air pollution and high traffic load to be positively associated with incident self-reported hypertension.[44]

Type II Diabetes
There is moderate evidence that new-onset Type 2 diabetes in adults is associated with exposure $PM_{2.5}$, PM_{10} and nitrogen oxides, thought causality is not clear.[45]

Table 4 below shows the mortality and hospital admissions data for some of the key diseases which have been associated with, or shown to be exacerbated by, air pollution in Lewisham. It also shows, mortality and hospital admission rates of COPD, cardiovascular disease and lung cancer are all worse in Lewisham compared to London and England. As mentioned earlier, poor air quality is associated with each of these diseases. This local picture highlights the importance of tackling air quality's health effects within the Borough.

Table 5: Prevalence of key air quality-related conditions in Lewisham

Condition	Indicator	Lewisham	London	England
Chronic Obstructive Pulmonary Diseases (COPD)	4.07i. Under 75 mortality per 100,000 from respiratory disease (2014-16)^	39.6	30.3	33.8
	Emergency hospital Admissions for COPD per 100,000 population (2015-16)*	497	405	411
Cardiovascular Disease (including heart disease and stroke)	4.04i. Under 75 mortality rate per 100,000 (2014-16)^	81.8	74.9	73.5
Asthma	Hospital admissions for asthma under 19 years per 100,000 population (2015/16)*	305.4	194.9	202.4
Lung cancer	Registration rate per 100,000 for lung cancer (2013-15)*	85.7	77.3	78.5
	Mortality from lung cancer per 100,000 population (2014-16)**	61.3	53.4	57.7

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^ https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/1/gid/1000044/pat/6/par/E12000007/ati/102/are/E09000023
* http://fingertips.phe.org.uk/tobacco-control#page/1/gid/1938132888/pat/6/par/E12000007/ati/102/are/E09000023
** http://fingertips.phe.org.uk/tobacco-control#page/1/gid/1938132887/pat/6/par/E12000007/ati/102/are/E09000023

Impact on mortality

- There is good evidence of the effects of short-term exposure to PM_{10} on respiratory health, but for mortality, and especially as a consequence of long-term exposure, $PM_{2.5}$ is a stronger risk factor than the coarse part of PM_{10} (particles in the 2.5–10 μm range). All-cause daily mortality is estimated to increase by 0.2–0.6% per 10 $\mu g/m^3$ of PM_{10}. Long-term exposure to $PM_{2.5}$ is associated with an increase in the long-term risk of cardiopulmonary mortality by 6–13% per 10 $\mu g/m^3$ of $PM_{2.5}$. [26]
- Susceptible groups with pre-existing lung or heart disease, as well as elderly people and children, are particularly vulnerable. [26]
- DEFRA has estimated that in 2008, artificial $PM_{2.5}$ reduced life expectancy of people in the UK by 6 months.[46] The burden of particulate air pollution in the UK in 2008 was estimated to be equivalent to nearly 29,000 deaths at typical ages and an associated loss of population life of 340,000 life years lost.[47]
- Across the UK, one pollutant alone ($PM_{2.5}$) has been estimated to have an effect equivalent to 40,000 deaths a year.[48]

It is possible to estimate the proportion of mortality attributable to pollutants in the air and this forms an outcome indicator in the Public Health Outcomes Framework (PHOF) which will enable to prioritise action on air quality in Lewisham to help reduce the health burden from air pollution.[49]

The indicator is named as ‘Fraction of mortality attributable to particulate air pollution’ which is defined as ‘Fraction of annual all-cause adult mortality attributable to anthropogenic (human-made) particulate air pollution (measured as fine particulate matter, $PM_{2.5}$ – which means the mass (in micrograms) per cubic metre of air of individual particles with an aerodynamic diameter generally less than 2.5 micrometers. $PM_{2.5}$ is also known as fine particulate matter)’. This is attributed to mortality burden associated with long-term exposure to anthropogenic particulate air pollution at current levels, expressed as the percentage of annual deaths from all causes in those aged 30+.[49]

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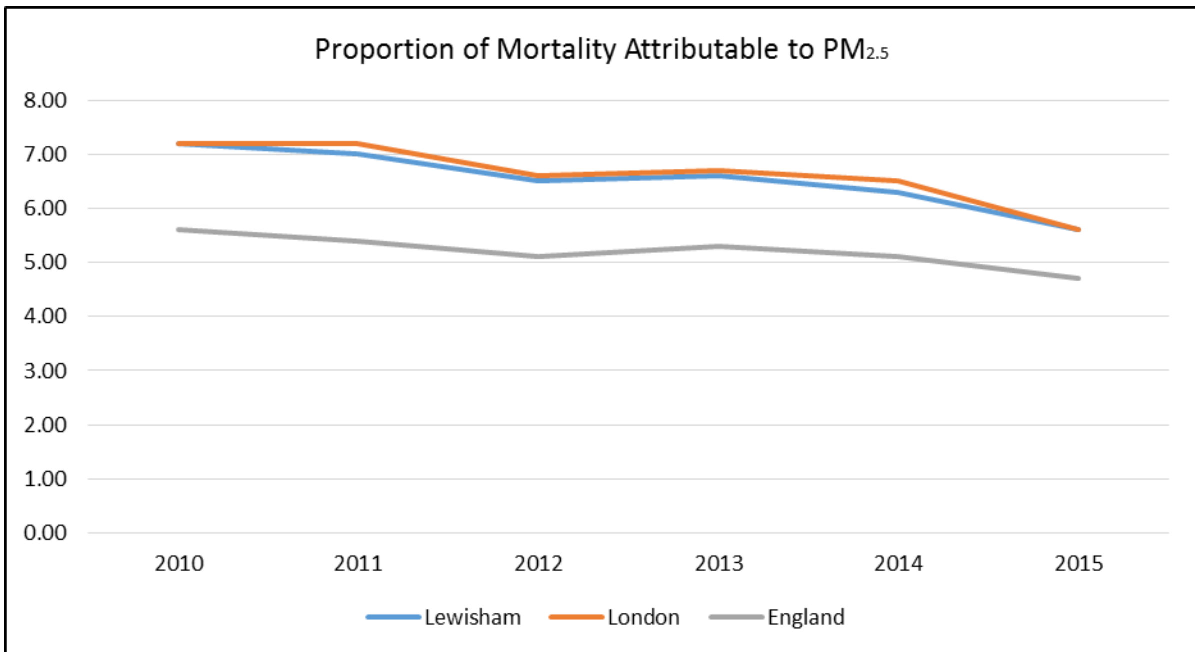

Fig 6: Proportion of mortality attributable to $PM_{2.5}$
Source: Public Health Outcomes Framework (PHOF)[49]

Lewisham has similar proportion to London, however, England has a much lower proportion indicating air quality in London inlcuding Lewisham needs a lot of attention.

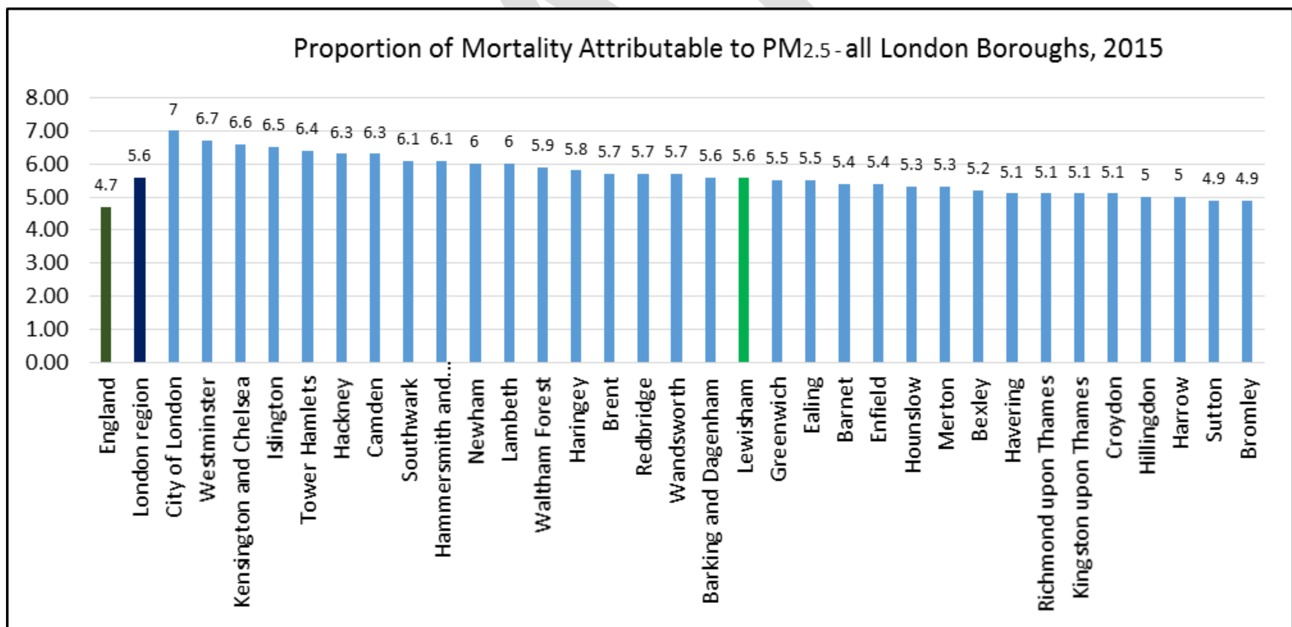

Fig 7: Proportion of mortality attributable to $PM_{2.5}$ – all London Boroughs, 2015
Source: Public Health Outcomes Framework (PHOF)[49]

The above figure shows how Lewisham compares with other London Boroughs in terms of the proportion of mortality that can be attributed to poor air quality. Lewisham's proportion is similar to that of London as a whole, and little higher than our neighbouring borough, Greenwich. Estimates for the overall burden of mortality attributable to $PM_{2.5}$ in Lewisham show this pollutant contributing a significant amount to the overall mortality in the area. For comparison, this compares with England-wide estimates of 6% of mortality in 1998 due to obesity, and 10% due to smoking.[50]

References

[1] Peacock JL, Anderson RH, Bremner SA, Marston L, Seemungal TA, Strachan DP, Wedzicha JA. Outdoor air pollution and respiratory health in patients with COPD. Thorax. 2011 Jul;66(7):591-6. doi: 10.1136/thx.2010.155358. Epub 2011 Apr 1. http://www.environment-health.ac.uk/publications/outdoor-air-pollution-and-respiratory-health-patients-copd

[2] EPUK, 2010, COMEAP Revises Air Quality and Asthma Position http://www.environmental-protection.org.uk/news/detail/?id=2701
http://www.envirotech-online.com/news/air-monitoring/6/breaking_news/main_roads_are_a_main_cause_of_asthma_in_children/22125/

[3] Tze Wai Wong et al, 1999, Air Pollution and Hospital Admissions for Respiratory and Cardiovascular Diseases in Hong Kong published in Occup Environ Medicine 1999;56:679-683 http://oem.bmj.com/content/56/10/679.full.pdf+html

[4] http://www.epa.gov/region7/air/quality/health.htm

[5] http://press.iarc.fr/pr213_E.pdf

[6] Childhood Cancer and Traffic-Related Air Pollution Exposure in Pregnancy and Early Life. Heck et al. (2013) Envion Health Perspect 121:1385-1391. Available at http://ehp.niehs.nih.gov/1306761/

[7] ClientEarth, The Health Impacts of Air Pollution http://www.clientearth.org/health-environment/clean-air/the-health-impacts-of-air-pollution-1427

[8] The Mortality Effects of Long-Term Exposure to Particulate Air Pollution in the United Kingdom: A report by the Committee on the Medical Effects of Air Pollutants
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304641/COMEAP_mortality_effects_of_long_term_exposure.pdf

[9] Air Quality Information for Public Health Professionals – City of London.
https://www.london.gov.uk/sites/default/files/air_quality_for_public_health_professionals_-_city_of_london.pdf

[10] Estimating local mortality burdens associated with particulate air pollution, 2014
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/332854/PHE_CRCE_010.pdf

[11] World Health Organisation, http://www.euro.who.int/en/health-topics/environment-and-health/air-quality/data-and-statistics

[12] World Health Organisation, http://www.euro.who.int/en/health-topics/environment-and-health/air-quality/data-and-statistics

[13] http://cleanair.london/wp-content/uploads/CAL-294-ULEZ-HIA_Final_ULEZ-consultation_Reduced-size.pdf

[14] The Annual London Survey carried out in early 2010, https://www.london.gov.uk/get-involved/annual-london-survey/annual-london-survey-2010

[15] Taken from www.air-quality.org.uk

[16] Cleaner Air for London: Progress report on the delivery of the mayor's Air Quality Strategy. July 2015
https://www.london.gov.uk/sites/default/files/gla_migrate_files_destination/MAQS%202015%20Progress%20Report%20FINAL%20FOR%20PUBLICATION_0.pdf

[17] Sir Michael Marmot. Fair Society Healthy Lives. http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

[18] Air Quality and Social Deprivation in the UK: an environmental inequalities analysis – Final Report to Defra, June 2006. http://uk-air.defra.gov.uk/reports/cat09/0701110944_AQinequalitiesFNL_AEAT_0506.pdf

[19] www.london.gov.uk/publication/mayors-air-quality-strategy

[20]
http://www.comeap.org.uk/images/stories/Documents/Statements/asthma/does%20outdoor%20air%20pollution%20cause%20asthma%20-%20comeap%20statement.pdf

[21] Met office, Urban Heat Islands, http://www.metoffice.gov.uk/services/climate-services/case-studies/urban-heat-islands

[22] Met office, What is Climate Change, http://www.metoffice.gov.uk/climate-guide/climate-change

[23] P511 (2001) Polluton: Causes, Effects and Control Eds Roy M Harrison .
http://opac.vimaru.edu.vn/edata/EBook/TNBook/TL%20tong%20hop/Control/0854046216.pdf

DRAFT

[24] United States Environmental Protection Agency, Second hand smoke and the health of your family
[25] Air Quality in Lewisham: A guide for Public Health Professionals, Mayor of London 2012.
[26] World Health Organization 2013. Health effects of particulate matter: Policy implications for countries in Eastern Europe, Caucasus and central Asia.
http://www.euro.who.int/__data/assets/pdf_file/0006/189051/Health-effects-of-particulate-matter-final-Eng.pdf
[27] Guarnieri M and Balmes JR (2014). Outdoor air pollution and asthma. *The Lancet*. 2014 May 9;383(9928):1581-92.
[28] Schindler C et al, (2009). Improvements in PM10 Exposure and Reduced Rates of Respiratory Symptoms in a cohort of Swiss Adults (SAPALDIA). Am J Respir Crit Care Med Vol 179. pp 579–587
[29] McConnell R, Berhane K, Gilliland F, Molitor J, Thomas D, Lurmann F, Avol E, Gauderman WJ, Peters JM. Prospective study of air pollution and bronchitic symptoms in children with asthma. American journal of respiratory and critical care medicine. 2003 Oct 1;168(7):790-7.
[30] Shah AS, Lee KK, McAllister DA, Hunter A, Nair H, Whiteley W, Langrish JP, Newby DE, Mills NL. Short term exposure to air pollution and stroke: systematic review and meta-analysis. bmj. 2015 Mar 24;350:h1295.
[31] Morbey R et al (2015). The application of a novel 'rising activity, multi-level mixed effects, indicator emphasis' (RAMMIE) method for syndromic surveillance in England.
https://www.evernote.com/Home.action#n=f011df62-45ff-4237-8a67-fb8ed84d79bc&ses=4&sh=2&sds=2&
[32] Newby DE, Mannucci PM, Tell GS, Baccarelli AA, Brook RD, Donaldson K, Forastiere F, Franchini M, Franco OH, Graham I, Hoek G. Expert position paper on air pollution and cardiovascular disease. European heart journal. 2014 Dec 8:ehu458.l care medicine. 2014 Oct 15;190(8):914-21
[33] Raaschou-Nielsen O, Andersen ZJ, Beelen R, Samoli E, Stafoggia M, Weinmayr G, Hoffmann B, Fischer P, Nieuwenhuijsen MJ, Brunekreef B, Xun WW. Air pollution and lung cancer incidence in 17 European cohorts: prospective analyses from the European Study of Cohorts for Air Pollution Effects (ESCAPE). The lancet oncology. 2013 Aug 31;14(9):813-22
[34] International Agency for Research on Cancer. Outdoor air pollution a leading environmental cause of cancer deaths. Lyon/Geneva. 2013 Oct 17
[35] Chen Z, Salam MT, Eckel SP, Breton CV, Gilliland FD. Chronic effects of air pollution on respiratory health in Southern California children: findings from the Southern California Children's Health Study. J Thorac Dis. 2015 Jan;7(1):46-58. doi: 10.3978/j.issn.2072-1439.2014.12.20
[36] Lepeule J, Litonjua AA, Coull B, Koutrakis P, Sparrow D, Vokonas PS, Schwartz J. Long-term effects of traffic particles on lung function decline in the elderly. American journal of respiratory and critical care medicine. 2014 Sep 1;190(5):542-8
[37] Schindler C et al, 2009. Improvements in PM10 Exposure and Reduced Rates of Respiratory Symptoms in a cohort of Swiss Adults (SAPALDIA). Am J Respir Crit Care Med Vol 179. pp 579–587
[38] Schikowski T et al, 2014. Ambient air pollution: a cause of COPD? European Respiratory Journal 2014 43: 250-263. 54
[39] Marino E, Carusso M et al, 2015. Impact of air quality on lung health: myth or reality? Therapeutic Advances in Chronic Disease September 2015 vol. 6 no. 5 286-298
[40] To T et al, 2015. Progression from Asthma to Chronic Obstructive Pulmonary Disease. Is Air Pollution a Risk Factor? AJRCCM Vol. 194, No. 4 | Aug 15, 2016
[41] Lamichhane DK, Leem J-H, Lee J-Y, Kim H-C. A meta-analysis of exposure to particulate matter and adverse birth outcomes. Environmental Health and Toxicology. 2015;30:e2015011. doi:10.5620/eht.e2015011.
[42] Gasana J, Dillikar D, Mendy A, Forno E, Ramos Vieira E. Motor vehicle air pollution and asthma in children: a meta-analysis. Environ Res. 2012 Aug;117:36-45. doi: 10.1016/j.envres.2012.05.001. Epub 2012 Jun 6
[43] Lamichhane DK, Leem J-H, Lee J-Y, Kim H-C. A meta-analysis of exposure to particulate matter and adverse birth outcomes. Environmental Health and Toxicology. 2015;30:e2015011. doi:10.5620/eht.e2015011.

DRAFT

[44] Fuks KB et al, 2016. Long-term exposure to ambient air pollution and traffic noise and incident hypertension in seven cohorts of the European study of cohorts for air pollution effects (ESCAPE). *Eurpean Heart Journal 37:42*
[45] Eze IC, Hemkens LG, Bucher HC, Hoffmann B, Schindler C, Künzli N, Schikowski T, Probst-Hensch NM. Association between ambient air pollution and diabetes mellitus in Europe and North America: systematic review and meta-analysis. Environmental Health Perspectives (Online). 2015 May 1;123(5):381
[46] Defra (2010) *Air Pollution: A Changing Climate.* London: Defra. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/69340/pb13378-airpollution.pdf
[47] Public Health Outcomes Framework. https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/3/gid/1000043/pat/6/par/E12000007/ati/102/are/E09000023/iid/30101/age/230/sex/4
[48] Royal College of Physicians (2016). *Every breath we take: the lifelong impact of air pollution. Report of a working party*. London: RCP. https://www.rcplondon.ac.uk/projects/outputs/every-breath-we-take-lifelong-impact-air-pollution
[49] Public Health Outcomes Framework (PHOF) https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/1/gid/1000049/pat/6/par/E12000007/ati/102/are/E09000023
[50] National Audit Office, 2001. Tackling Obesity in Britain. London: NAO, 2001 https://www.nao.org.uk/wp-content/uploads/2001/02/0001220.pdf

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Serena Patel (GP Trainee) and Charly Williams (CYP Commissioner), April 2018

Joint Strategic Needs Assessment (JSNA): Maternal Mental Health in Lewisham

Executive summary

Aim

The aim of this JSNA is to explore and establish the mental health and well-being needs of women in Lewisham in the 1001 days from the conception of their child until the child is two years old (the 'Maternal Mental Health' period), review how well these needs are met, identify any gaps and make recommendations for improvements in service provision.

Needs analysis

It is estimated that approximately 1,019 women (20%) in Lewisham develop a mental health problem in pregnancy or within a year of giving birth. Serious perinatal mental disorders are associated with an increased risk of suicide. Suicide is the leading cause of maternal mortality in the UK. Maternal mental health (MMH) issues do not just affect the mother, but also the wider family. For the child, the period of the first 1001 days – from conception to the age of two, is widely recognised as a critical developmental period. There are a number of risk factors for developing MMH issues, and in Lewisham, the high prevalence of many of these factors, indicates a high risk population. As such, MMH is an important priority for the borough.

Service provision

Lewisham has a Specialist Perinatal Mental Health (PMH) Service, provided by South London and Maudsley (SLaM) NHS Foundation Trust, for women with moderate to severe mental health issues, including those who require inpatient care. The borough also has provision for women with mild to moderate mental health needs throughout the MMH period, including support from GPs, Health Visitors, Midwives and the Voluntary and Community Sector (VCS). There are several service developments currently in motion to improve MMH support in the borough, in line with national and local policies. However, gaps have been identified in the provision, knowledge and ease of access to preventative, early intervention services. There are also gaps in workforce training and development, support for partners/fathers and support for parents and practitioners around the parent-infant relationship.

Recommendations

The recommendations of this JSNA include ensuring that the JSNA findings are widely shared and jointly owned to maximise impact; undertaking additional research into the latest evidence based practice and the specific needs of partners/ fathers in relation to PMH; ensuring multi-agency input into an integrated PMH care pathway; increasing PMH training opportunities across the sector; promoting access to, and considering development opportunities for, early intervention services in PMH; prioritising plans to achieve continuity of midwifery care and ensuring families can easily access existing services that address the wider determinants of mental health.

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2. Needs analysis....................p.4

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1. Aim of JSNA

1.1 Maternal Mental Health (MMH) problems pose a huge human, social and economic burden to women, their families and the wider population, constituting a major public health challenge. This JSNA explores the mental health and well-being needs of women in the 1001 days from conception until their child is two years old and aims to:

- Provide an overview of the epidemiology of maternal mental illness in Lewisham and nationally.
- Review the evidence and recommendations for effective management of maternal mental illness and quality care services.
- Identify current service provision.
- Identify gaps in current knowledge and services, and make recommendations for local planning and strategy formulation.

1.2 Please note, although this JSNA covers MMH (the period from conception until a child is two years old), much of the currently available data and research relates primarily to the perinatal period (conception under the child is one), partly because this period presents some very particular needs and risks for women. The JSNA recognises the lack of data and research on MMH as a gap for future development. Nevertheless, the perinatal research is still relevant and applicable, allowing useful conclusions to be drawn, but with the caveat that more research into the wider MMH period is ultimately needed.

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2. Needs analysis

National data

2.1 The World Health Organisation (WHO) defines health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’[1]. The positive dimension of mental health is stressed within this definition – good mental health is not merely the absence of mental illness, but a positive attribute. You can have a mental health diagnosis and still work towards mental well-being. Using this framework of mental health, the prevention of mental illness and the promotion of well-being and self-help are equally as important as treating a mental health diagnosis.

2.2 During pregnancy and after birth, women can be affected by a number of different mental health problems. Nationally, it is estimated that up to 20% of women are affected by a mental health problem during their pregnancy or in the first year after having a baby[2]. It is also estimated that over 50% of those who meet diagnostic criteria for psychological disorders are not identified[3] due to problems not being disclosed, recognised or effectively treated. This means that only around half of the pregnant or postnatal women who develop a psychological disorder may present to primary care mental health services each year. PMH disorders include anxiety disorders, mood disorders, psychotic disorders, eating disorders, substance use disorders and puerperal psychosis. These disorders can range from mild to severe in nature and require different kinds of treatment and care.

2.3 Despite being common, mental illness in general is underdiagnosed. The mental health problems that pregnant women and new mothers can experience are the same as those that can affect people at other times, however these problems can be experienced differently by pregnant women and new mothers and, for various reasons, are particularly important to address. These include the effect they can have on the mother’s physical health. Maternal mental illness, particularly if left untreated, can have devastating impacts on women and their families[4]. Serious perinatal mental disorders are associated with an increased risk of suicide, with suicide being the leading cause of maternal mortality in developed countries[5].

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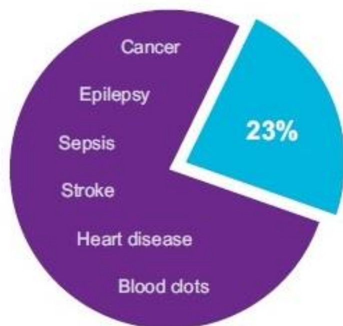
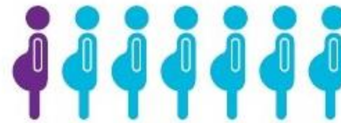
[1] WHO (2017) Constitution of WHO: Principles: http://www.who.int/about/mission/en/ (accessed on 18/10/2017)
[2] Lewisham Strategic Partnership Website, Lewisham’s Public Health Information Portal: http://portal.lewishamjsna.org.uk/Demography.html
[3]https://cdn.movember.com/uploads/files/2015/Misc/Promoting_MentalHealth_&_Wellbeing_FINAL%5b2%5d.pdf
[4] MBBRACE-UK (2016) Saving Lives, Improving Mothers’ Care: Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity, 2009–14.
[5] Nonacs R, Cohen LS. (1998) Postpartum mood disorders: diagnosis and treatment guidelines. The Journal of Clinical Psychiatry. 59:34–40.

Figure 2: Infographic illustrating maternal mortality rate[6]

Mental health matters



Almost **a quarter** of women who died between six weeks and one year after pregnancy died from **mental-health related causes**



1 in 7 women died by **Suicide**

2.4 The effects of MMH problems are often felt by the wider family, particularly partners/ fathers. For example, maternal depression is the strongest predictor of paternal depression during the postpartum period and studies into postnatal depression in men suggest that 1 in 10 may suffer from depression after becoming fathers[7]. However, data on mental issues in new fathers is limited, partly because of under-diagnosis. Recent research by The Centre for Men's Health[8], highlighted high rates of undiagnosed mental health problems in men that are not being adequately identified or supported through current service provision. This emphasises the importance of addressing MMH issues in order to support partners/ fathers as well as mothers.

2.5 It is also pertinent to note the impact of wider family support on MMH. There is evidence that mothers who perceive stronger social and emotional support from their partner mid-pregnancy have fewer symptoms of post-partum depression and anxiety after giving birth. Furthermore, their newborns are less sensitive to stress, indicating that they too benefit from the support provided by their mother's partner[9].

2.6 MMH problems can have a direct effect on a women's developing foetus and/or newborn baby[10]. Stress hormones are raised during maternal mental illness and may have physical effects on the mother predisposing her to high blood

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[6] https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202015%20-%20Infographic.pdf
[7] https://www.nct.org.uk/parenting/postnatal-depression-dads
[8] Robertson S, White A, Gough B, *et al.* (2015) Promoting Mental Health and Wellbeing with Men and Boys: What Works? Centre for Men's Health, Leeds Beckett University, Leeds: https://cdn.movember.com/uploads/files/2015/Misc/Promoting_MentalHealth_&_Wellbeing_FINAL%5b2%5d.pdf (accessed on 10/11/2017)
[9] Stapleton LR, Schetter CD, Westling E, et al. (2012) Perceived partner support in pregnancy predicts lower maternal and infant distress. Journal of Family Psychology, 26(3), 453-463.
[10] NSPCC (2012) Prevention in mind: All Babies Count: Spotlight on PMH – NSPCC

pressure, pre-eclampsia and an early and difficult labour[11]. Babies may also be small for age. Healthy social and emotional development in babies and toddlers is important as it is the building block for good physical and psychosocial health in the future, and helps to prevent behavioural problems and mental illness. The first 1001 days of a child's life, from conception to the age of two, is now widely recognised as a critical developmental period[12]. During this time solid psychological and neurological foundations are laid that will affect social, emotional and physical health, and educational and economic achievement. It is the time when a baby's brain is developing fastest and he or she is most susceptible to forming strong bonds of attachment with his/ her primary care giver. MMH is a key determinant of the quality of that relationship, and is also a key factor in safeguarding children from abuse and neglect[13]. Unwanted or teenage pregnancy can increase the chance of childhood mental health problems, along with use of tobacco, alcohol and drugs in pregnancy[14].

2.7 A key risk factor for the poor social and emotional development of infants is a poor relationship between the child and his or her primary care giver – referred to as attachment. The National Institute for Health and Care Excellence (NICE) defines attachment as 'a secure relationship with a main caregiver, usually a parent, allowing a baby or child to grow and develop physically, emotionally and intellectually'[15]. If attachment needs are unmet this 'may lead to social, behavioural or emotional difficulties, which can affect the child's physical and emotional development and learning'.

2.8 MMH problems, if left unaddressed, can compromise parent-infant attachments, often with serious long term consequences[16]. Studies have shown that infants of chronically depressed mothers show less sociability with strangers, fewer facial expressions, smile less, cry more and are more irritable than infants of well mothers[17]. Children do not perform as well on thinking and intelligence tests at 18 months, and they are more distractible, less playful and less social up to the age of 5. Effects on older children have been shown to include neglect, abuse, slower social, emotional and cognitive development and higher rates of school and behavioural problems[18].

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[11] Maternal Mental Health and Child Health and Development: www.who.int/mental_health/prevention/suicide/MaternalMH/en/index.html
[12] Wave Trust (2013) Conception to age 2 – the ages of opportunity: https://www.wavetrust.org/sites/default/files/reports/conception-to-age-2-full-report_0.pdf (accessed 21/09/2017)
[13] Horowitz JA, Bell M, Trybulski J, et al. (2001) Promoting responsiveness between mothers with depressive symptoms and their infants. Journal of Nursing Scholarship, 33, 323–329.
[14] http://fnp.nhs.uk/
[15] London: National Institute for Health and Clinical Excellence (2010) Looked-after children and young people. Public health guideline [PH28].
[16] Jablensky AV, Morgan V, Zubrick SR, et al. (2005) Pregnancy, delivery, and neonatal complications in a population cohort of women with schizophrenia and major affective disorders. The American Journal of Psychiatry 162, 79–91.
[17] Horowitz JA, Bell M, Trybulski J, et al. (2001) Promoting responsiveness between mothers with depressive symptoms and their infants. Journal of Nursing Scholarship, 33, 323–329.
[18] Maternal Mental Health and Child Health and Development: www.who.int/mental_health/prevention/suicide/MaternalMH/en/index.html

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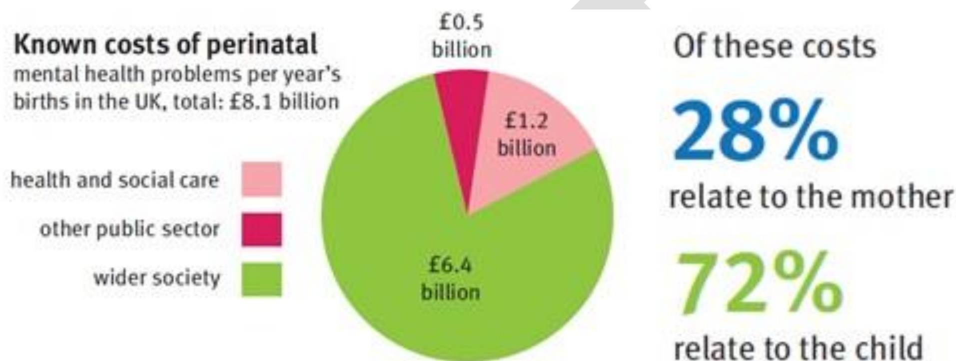
2.9 The partner/ father-infant relationship is also very important to infant mental health, significantly influencing social, emotional and physical long term outcomes. Severe depression in fathers has been found to be associated with high levels of emotional and behavioural problems in their infant children, particularly boys[19].

2.10 MMH issues carry a heavy economic cost. Economic modelling of the costs associated with perinatal mental ill-health, including the adverse effects on the child as well as the mother, was published by the London School of Economics and the Centre for Mental Health in 2014[20] and is set out below.

Figure 3: Infographic illustrating the costs of PMH problems[21]



Local data

2.11 Lewisham is home to approximately 297,325 residents from a diverse range of communities, neighborhoods and localities. Over the next two decades Lewisham is forecast to see the second fastest rate of population growth in inner London and eighth fastest in London, with a further 9,000 people by 2018.

2.12 The most widely adopted measure of deprivation in England is the Index of Multiple Deprivation (IMD). Using this measure, Lewisham is the 48th most deprived of all 326 local authorities in England, meaning that it remains within the top 20% most deprived local authorities in the country[22]. There are areas of

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[19] Robertson S, White A, Gough B, *et al.* (2015) Promoting Mental Health and Wellbeing with Men and Boys: What Works? Centre for Men's Health, Leeds Beckett University, Leeds: https://cdn.movember.com/uploads/files/2015/Misc/Promoting_MentalHealth_&_Wellbeing_FINAL%5b2%5d.pdf (accessed on 10/11/2017)

[20] Centre for Mental Health, LSE Personal Social Services Research Unit. (2015) The costs of PMH problems: https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=07afd94b-92cb-4e47-8439-94cbf43548d8 (accessed on 11/09/2017)

[21] http://everyonesbusiness.org.uk/wp-content/uploads/2014/12/Embargoed-20th-Oct-Summary-of-Economic-Report-costs-of-Perinatal-Mental-Health-problems.pdf

[22] Department for Communities and Local Government (2015) The English Indices of Deprivation 2015 Statistical Release:

significant deprivation in the north, central and southern parts of the borough. The populations of these areas experience many of the problems associated with poverty: poor health and educational outcomes, unemployment, homelessness, low pay and inequality.

2.13 There is currently no locally available data on the specific MMH period from conception until a child is two. Local trends have been reviewed using data on PMH (until the child is one), which is based on national estimates. Although more accurate local data specifically on MMH is identified as an area for future development, useful and relevant conclusions can still be drawn from the available data on PMH.

2.14 The table below shows the estimated number of women affected by the most prevalent mental health disorders antenatally and postnatally in Lewisham. These figures are calculated by applying the national prevalence rates of these disorders to Lewisham's live birth rate (4,721 births in 2016)[23] to produce local estimates. It should be noted that one woman might present with more than one perinatal psychiatric disorder; therefore a total estimate of women with a PMH condition cannot be obtained by simply adding the separate estimates together.

Table 1: Estimated no. of women affected by common PMH disorders in Lewisham[24]

Mental health disorders during pregnancy and after childbirth	National prevalence estimate (per 1,000 deliveries)	Estimated no. of women affected in Lewisham each year
Postpartum psychosis	2	10
Chronic serious mental illness	2	10
Severe depressive illness	30	140
Mild-moderate depressive illness and anxiety (lower – upper estimate)	100 – 150	465 - 695
Post-traumatic stress disorder	30	140
Adjustment disorders and distress (lower – upper estimate)	150 – 300	695 – 1,385

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/465791/English_Indices_of_Deprivation_2015_-_Statistical_Release.pdf (accessed 20/11/2017)
[23] Office for National Statistics (2017) Birth summary tables in England and Wales: 2016. Available at: https://www.gov.uk/government/statistics/birth-summary-tables-in-england-and-wales-2016 (accessed on 16/10/2017)
[24] http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=66&geoTypeId=#iasProfileSection5

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2.15 The table below shows the number of women estimated to suffer from the 'baby blues[25]' and postnatal depression[26] in Lewisham. Baby blues, although not an official medical definition, is very common, especially in the first week after giving birth, when mothers may find themselves weepy and irritable. The baby blues are thought to be linked to the changes in chemical and hormone levels two to four days after giving birth. Postnatal depression[27] may present in the same way as the baby blues but lasts longer. It is thought to be experienced by 10-15% of all women, in the first year after giving birth.

Condition	Estimated prevalence	Estimated no. of women affected in Lewisham each year
'Baby blues'	80%	3,776
Postnatal depression	10% - 15%	472 – 708

Table 2: Estimated prevalence of 'baby blues' and postnatal depression

2.16 Any woman may develop mental health problems during pregnancy, but NICE guidance[28] identifies a number of risk factors associated with the development of mental health problems during this time which include: social isolation, economic status, housing and personal history (including drug and alcohol use, domestic violence, childhood sexual and physical abuse), family history and psychiatric history. The guidance also recognises that women with complex social factors may be less likely to access or maintain contact with antenatal care services, which can affect outcomes for both mothers and babies.

2.17 A number of the risk factors for MMH issues, and their prevalence in Lewisham[29],[30],[31] are set out below.

- *Previous mental health issues* - Prevalence figures from 2015/16 show a higher prevalence of depression and severe mental illness in Lewisham than the London average. Therefore, it is reasonable to assume there will be a higher level of MMH problems as well.
- *Poverty* - Lewisham is amongst the 20% most deprived local authority areas in England.

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[25] https://www.nct.org.uk/parenting/baby-blues
[26] https://www.nhs.uk/conditions/post-natal-depression/
[27] http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/postnataldepression.aspx
[28] NICE (2007), Antenatal and postnatal mental health. London: National Institute for Health and Clinical Excellence.
[29] Lewisham Mental Health and Emotional Wellbeing Strategy Children and Young People "It's Everybody's Business" 2015-2020. Available at: https://www.lewisham.gov.uk/mayorandcouncil/aboutthecouncil/strategies/Documents/Mental%20Health%20and%20Emotional%20Wellbeing%20Strategy%20for%20Children%20and%20Young%20People.pdf
[30] Lewisham Clinical Commissioning Group (2016) Lewisham Public Mental Health and Wellbeing Strategy 2016-2019. Available at: https://www.lewisham.gov.uk/mayorandcouncil/aboutthecouncil/strategies/Documents/PublicMentalHealthAndWellbeing2016.pdf (accessed on 11/09/2017)
[31] Lewisham Children and Young People's Plan 2015-18: https://www.lewisham.gov.uk/myservices/socialcare/children/cypp/Pages/default.aspx

- *Non-secure accommodation* - 4.7 in every 1,000 households in Lewisham are homeless households with dependent children or pregnant women compared to 3.6 in London and 1.7 nationally. The current London housing market, rising rents and the impact of welfare reforms have added additional strains on the housing circumstances of many families.
- *Unemployment* - 25.1% of children in the borough live in jobless homes compared with 26.4% in Inner London and 18.2% nationally (2015).
- *Domestic violence* - Lewisham has one of the highest rates of domestic violence in the country. The rate of domestic abuse incidents recorded by the police in Lewisham is higher than the national rate.
- *Lone parent households* - Lewisham has a higher proportion of lone parent households (11.5%) compared to (8.5%) London and (7.1%) England in 2011.
- *Drug abuse* - 12.4 in 1000 Lewisham residents are opiate or crack cocaine users compared to 8.4 nationally and 9.55 in London (2011).
- *Crime* - In 2016, 518 per 100,000 10-17 year olds receive a first reprimand, warning or conviction in Lewisham, compared to 407 in London and 327 in England as a whole. 95% of imprisoned young offenders in the UK have mental health problems.
- *Teenage pregnancy* - In 2013 Lewisham had the second highest teenage pregnancy rate in London. There has been a fall in the under 18 year old conception rate since then and in 2015, there were 107 conceptions recorded among under 18s in Lewisham which was down from 152 in 2013.
- *Having child(ren) with special educational needs and/ or disabilities (SEND)* - In 2016, 5557 children and young people in Lewisham were classified as receiving SEND support.

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3. National and local policy

National policy

3.1 The Five Year Forward View for Mental Health[32], National Maternity Review[33], Future in Mind[34], the Chief Medical Officer Report[35] and the Healthy Child Programme[36] all emphasise the strong link between maternal / paternal mental health, children's mental health and the importance of good mental health during pregnancy and after birth. There is a national drive for prevention of mental health problems and the promotion of good mental health. This is highlighted in The Prevention Concordat for Better Mental Health[37] which emphasises the importance of a shift towards prevention-focused leadership.

3.2 The Five Year Forward View for Mental Health states that by 2020/21 there will be increased access to specialist PMH support in the community or in-patient mother and baby units, allowing at least 30,000 more women to access evidence-based specialist mental health care during the perinatal period. Public Health England published a rapid review of evidence for the Healthy Child Programme[38]. This highlighted best practice on PMH in reference to NICE guidelines.

3.3 The National Maternity Strategy[39] highlights that due to the historic underfunding and provision of perinatal mental healthcare, there is now a significant need for investment, both in the community and in specialist care. This should involve training and sharing of best practice to ensure a standardised approach nationally.

3.4 NICE issued updated clinical guidance in 2014 on the treatment and management of women with mental illness in the antenatal and postnatal period[40]. It recommends that women are asked about their emotional well-being at every contact throughout pregnancy and postnatally, using the Whooley

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[32] The Mental Health Taskforce (2016). The Five Year Forward View for Mental Health: www.england.nhs.uk/mentalhealth/taskforce (accessed 22/09/17)
[33] NHS England (2016). The National Maternity Review Report: www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf (accessed 22/09/17)
[34] Department of Health (2015). Future in Mind: www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf (accessed 22/09/17)
[35] Department of Health (2015). Annual Report of the Chief Medical Officer 2014: Women's Health: www.gov.uk/government/publications/chief-medical-officer-annual-report-2014-womens-health (accessed 22/09/17)
[36] http://healthychildprogramme.com/
[37] Public Health England (2017) Policy paper: Prevention Concordat for Better Mental Health: https://www.gov.uk/government/publications/prevention-concordat-for-better-mental-health-consensus-statement/prevention-concordat-for-better-mental-health (accessed on 20/11/2017)
[38] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/429740/150520RapidReviewHealthyChildProg_UPDATE_poisons_final.pdf
[39] NHS England (2016). The National Maternity Review Report: www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf (accessed 22/09/17)
[40] https://www.nice.org.uk/guidance/cg192

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questions[41] and the 2-item Generalised Anxiety Disorder (GAD-2)[42] questions. These questions act as a screening tool to identify women who may be mentally unwell, or at risk, during or after their pregnancy, which will allow them to be properly monitored and managed.

3.5 NICE guidance states that specialist PMH community services and inpatient psychiatric mother and baby units should be available to support women with moderate to severe mental health problem in pregnancy or the postnatal period – it is the only NICE guidance that specifies a particular service, rather than a treatment. It also states that there should be a range of community-based early intervention services that promote metal well-being amongst pregnant and new mothers.

Local policy

3.6 Local policies in Lewisham emphasise PMH and MMH as key priorities for the borough. Lewisham's Children and Young People's Plan (CYPP) 2015-18[43] describes how partners will work together to improve outcomes and life chances of children and young people in the borough. Of particular relevance to MMH are the following priorities within the plan: 'Optimising the outcomes of pregnancy and the first 1001 days, including reducing toxic stress for children and securing attachment', and 'identifying and developing the perinatal workforce over the period 2015-2020'.

3.7 The Lewisham Mental Health and Emotional Wellbeing Strategy[44] highlights five priority areas for the next four years, all of which are relevant to MMH:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

3.8 As part of this strategy, Lewisham CCG is using CAMHS Transformation Funding[45] to develop better PMH services in the borough in order to achieve the following aims:

- Create better, clearer, more responsive care pathways to enable improved access into appropriate services
- Embed resilient practice in community settings, to help people be better equipped to cope when faced with adversity

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[41] http://whooleyquestions.ucsf.edu/
[42] http://www.corc.uk.net/outcome-experience-measures/generalised-anxiety-disorder-assessment/
[43] Lewisham Children and Young People's Plan 2015-18: https://www.lewisham.gov.uk/myservices/socialcare/children/cypp/Pages/default.aspx
[44]https://www.lewisham.gov.uk/mayorandcouncil/aboutthecouncil/strategies/Documents/Mental%20Health%20and%20Emotional%20Wellbeing%20Strategy%20for%20Children%20and%20Young%20People.pdf
[45]https://www.lewisham.gov.uk/mayorandcouncil/aboutthecouncil/strategies/Documents/NHSLewishamCTRefresh2January2018Final.pdf

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- Increase awareness of mental health and emotional well-being and provide guidance regarding where to go for support

3.9 The Lewisham Public Mental Health and Wellbeing Strategy 2016-2019[46] provides a framework for mental ill health prevention and promotion of mental well-being in Lewisham. In developing this strategy, local stakeholders highlighted issues for families, including the need for 'support around maternity' and a 'shift in focus from crisis management to prevention for mental health and well-being'. Specifically related to MMH, the strategy commits to raising awareness amongst the public and professionals of the impact of maternal stress during pregnancy, promoting the Royal College of General Practitioners (RCGP)[47] online toolkit for PMH and supporting the local Maternity Voices Partnership (MVP) campaign, 'It's ok not to feel ok'. The MVP have voted PMH as one of their key priorities for the last 3 years.

3.10 The approach taken to commissioning and delivering PMH/ MMH services in Lewisham is consistent with the Council's 'Shaping Our Future: Lewisham's Sustainable Community Strategy' and its corporate priorities. In particular, it is aligned with the Council's priorities regarding Young People's Achievement and Involvement, the Protection of Children, Community Leadership and Empowerment and Inspiring Efficiency, Effectiveness and Equity.

3.11 The Our Healthier South East London (OHSEL) programme has mapped PMH services across South East London. This exercise identified key areas for improvement in terms of PMH, including the information available to women regarding psychiatric medication in pregnancy, staff training on PMH and greater access to psychological therapies.

3.12 The SEL Better Births Implementation Plan has PMH as a key strand. It aims to improve early detection of PMH issues, by ensuring that all maternity staff have the necessary skills to recognise mental illness and detect new onset and deterioriation, especially in women at greater risk of suicide. The plan also calls for an expansion in the Improving Access to Psychological Therapies (IAPT) programme across South East London.

3.13 Lewisham is part of the South London PMH Network which is a multidisciplinary network accountable to the London Mental Health Strategic Clinical Network. PMH networks provide a concentration of expertise on PMH, seeking to improve outcomes and increase patient satisfaction on PMH services across the region. The networks organise and facilitate training, education and awareness raising on PMH, and provide specialist expertise for primary, secondary and social care services[27].

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[46] Lewisham Public Mental Health Strategy: http://councilmeetings.lewisham.gov.uk/documents/s46392/Item%207a%20-%20Draft%20Public%20Mental%20Health%20and%20Wellbeing%20Strategy%2015%2011%2016.pdf
[47] Royal College of General Practitioners (2016) Position statement about PMH: http://www.rcgp.org.uk/clinical-and-research/a-to-z-clinical-resources/perinatal-mental-health.aspx (accessed 06/11/2)

3.14 Domestic abuse and its role in MMH is a critical issue, especially as Lewisham has the 3rd highest rate of reported domestic abuse incidents in London (joint with Tower Hamlets and Hounslow at a rate of 20 per 1,000 population, October 2016 – September 2017)[48]. Evidence shows that high levels of symptoms of perinatal depression, anxiety, and post-traumatic stress disorder are significantly associated with having experienced domestic abuse[49]. Living in a household where domestic abuse is occurring is also a risk factor for poor mental health in babies and toddlers: 'The impact of living in a household where there is a regime of intimidation, control and violence…has an impact on their mental, emotional and psychological health, social and educational development'[29].

3.15 In Lewisham, whilst analysis of key linked offences involving non-familial forms of violence against females show decline, the rising number of domestic violence offences more than offsets this downward trend. Given the gravity of crime and the largely hidden harm caused to children and families, the Safer Lewisham Partnership continue to prioritise this area and a Violence Against Women and Girls (VAWG) 2013-2017 Plan[50] has been produced in Lewisham. Close work between key agencies in Lewisham continue to address this issue in line with the plan.

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[48] Mayor's Office for Policing and Crime (2017) Domestic and Sexual Violence dashboard London City Hall: https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-statistics/crime%20/domestic-and-sexual (accessed 30/11/2017)

[49] The Safer Lewisham Partnership's Reducing Violence Against Women and Girls Plan 2014-2017:https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&cad=rja&uact=8&ved=0ahUKEwjlivXQqLHXAhWSpKQKHfxHBM4QFgg3MAM&url=http%3A%2F%2Fcouncilmeetings.lewisham.gov.uk%2Fdocuments%2Fs27461%2FAppendix%2520-%2520Draft%2520Safer%2520Lewisham%2520VAWG%2520Plan.pdf&usg=AOvVaw3s_Wy_XJR0X9zsviIIEp9E (accessed 09/11/2017)

[50] https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwiWt_6jo7HXAhWCCewKHQPqChsQFggmMAA&url=https%3A%2F%2Fwww.lewisham.gov.uk%2Fmyservices%2Fsocialcare%2Fchildren%2Fkeeping-children-safe%2FDocuments%2FLewishamDVMARACPoster.pdf&usg=AOvVaw1L_7oZS-lEVlmiRvc6ZEi9

4. Current service provision

4.1 Services/ interventions to support women and families with MMH/ PMH issues, are divided below into universal access services and targeted services. Targeted services include specialist PMH services, such as the service provided by SLaM, but also services that are targeted at a wider cohort, e.g. teenage parents, but which include a key focus on MMH/PMH. Some of the listed services/ interventions provide targeted support within a universal service, such as the Specialist PMH Health Visitor and Midwife posts. Such services/ interventions are listed under targeted services. The latest integrated care pathway for PMH is included as appendix 1.

Universal services/ interventions

GPs, Lewisham Clinical Commissioning Group (CCG)

4.2 GPs are often the first professional a women will talk to regarding MMH issues. It is therefore critical that they are able to respond effectively, supporting women themselves or referring them to other sources of support where appropriate. Many women are reluctant to disclose MMH issues. However, if they do, this is a ‘red flag’ for GPs, meaning it is especially important that the GP explores this in detail before reassuring or normalising the women’s feelings[51].

4.3 There are 42 GP practices across the borough, including some online services and an extended hours service. GPs work closely with acute and specialist NHS settings, the local authority, voluntary and community sector (VCS) and other key public services. The Royal College of General Practitioners (RCGP) has identified PMH as a clinical priority. Currently there is no mandatory training for GPs on PMH, but the RCGP has produced a PMH Toolkit[52] to assist GPs in the care of women with PMH needs. It is set of tools and resources to support members of the primary care team to deliver the highest quality care to women with mental health problems in the perinatal period. The Toolkit also provides details of additional learning for individual practitioners as well as resources for women and their families.

Health Visiting Service, Lewisham and Greenwich NHS Trust (LGT)

4.4 The Health Visiting Service is a workforce of specialist community public health nurses who provide expert advice, support and interventions to families with children under 5. In Lewisham, it is provided by LGT and commissioned by the local authority, via the CYP Joint Commissioning Team. MMH is a key component of the service. Health Visitors screen all new mothers for MMH issues at all core contacts using the Whooley depression and GAD-2 anxiety screening tools. This helps to identify mothers who need further support, including referral to other services. The service also offers ‘listening visits’ for women with MMH. These are extra home visits for up to 12 weeks to support mental health and wellbeing. Screening tools are repeated at these visits to monitor and review

[51] http://www.rcgp.org.uk/clinical-and-research/clinical-resources/perinatal-mental-health.aspx
[52] http://www.rcgp.org.uk/clinical-and-research/toolkits/perinatal-mental-health-toolkit.aspx

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progress. Health Visitors work closely with, and refer regularly to, the Specialist PMH Service, and the IAPT programme.

4.5 The service also provides breastfeeding support for new mothers which can help with MMH issues, for example, by encouraging women to develop supportive peer networks as part of breastfeeding support groups. These groups take place regularly across the borough in a range of accessible community locations, including CFCs. The service operates a Breastfeeding Friendly Scheme, designed to make it easier for mothers to feel comfortable breastfeeding in public across Lewisham. The Health Visiting Service has been awarded UNICEF Level 3 Baby Friendly status[53] which demonstrates its excellence in promoting and supporting breastfeeding. This includes work on strengthening mother-baby and family relationships for all babies, not only those who are breastfed, which has a direct impact on MMH issues.

Maternity Service, LGT

4.6 The Maternity Service delivers antenatal, intrapartum and postnatal care for all women and their families who chose to book with LGT. The service is provided by LGT and commissioned by Lewisham CCG (via the CYP Commissioning Team). Promoting maternal well-being and identifying and supporting women with PMH issues is an important element of the service. The service has a clear care pathway for the detection, identification and treatment of PMH in line with NICE guidance. This includes Midwives asking women at every antenatal and postnatal appointment about their mental health, using Whooley and GAD-2 screening tools, and putting in place extra support as needed. All Midwives receive PHM training as part of their annual mandatory training package. The service has a Specialist PMH Midwife and a Specialist Midwifery team which supports women with PMH amongst other vulnerabilities. These elements are described under targeted services.

4.7 Central to the Maternity Service's strategy for improving PMH support is a drive to increase the number of women who receive continuity of midwifery care as this has been demonstrated to have a positive impact on PMH amongst other key pregnancy and birth outcomes, including stillbirths, pre-term births and women's experience of care. Continuity of midwifery care is defined as a women seeing the same midwife for most, or all, of her antenatal, intrapartum and postnatal contacts. Currently this model of care is available only for women with specific vulnerabilities, including those at risk of pre-term birth via the POPPIE research trial. The future plan is to expand this model to many more women, including those at risk of, or experiencing PMH issues. The service is also trialling an initiative called 'Centering in Pregnancy' whereby antenatal care is delivered in groups by the same midwife rather than on a one to one basis. This is likely to impact positively on MMH due to the continuity of care offered as well as the peer networks formed between the women taking part.

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[53] Lewisham CCG (2016) Lewisham is awarded baby friendly status: http://www.lewishamccg.nhs.uk/news-publications/Pages/Lewisham-is-baby-friendly.aspx (access 06/11/2017)

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Children and Family Centres (CFC), Pre-School Learning Alliance (PSLA) in partnership with Clyde, Kelvin Grove and Eliot Bank, and Downderry Children's Centre

4.8 CFCs are delivered by a partnership of VCS and school providers and are commissioned by the local authority (CYP Commissioning Team). CFCs provide a range of activities and services across the borough that support families with children under 5. These include services that promote emotional well-being and health, improve parent-child attachment and prevent escalation of needs. For example, there are programmes such as 'Five to Thrive' and 'Beautiful Babies, Beautiful Brains' which promote healthy attachment and child development, counselling sessions are available in some centres and all centres provide open-access play sessions. Clyde Early Childhood Centre offers a programme of yoga, mindfulness and games for families, combining physical activity with mental health support. Mindful Mums, described below, is offered in CFCs across the borough.

Mindful Mums, Bromley and Lewisham MIND

4.9 Bromley and Lewisham MIND are commissioned by the CCG to deliver the 'Mindful Mums' programme - a community based, universally accessible, early intervention programme targeting maternal wellbeing (up to one year after birth). The programme has funding for two years, until March 2019, from the CAMHS Transformation Fund. Peer support groups, of pregnant women and new mothers, are led by trained volunteers with lived experience of MMH issues, offering the opportunity for women to connect with, and support one another, during the perinatal period.

4.10 Lewisham Mindful Mums is the second Mindful Mums programme to run in London, with the Borough of Bromley piloting the first. Evaluation from the Bromley Mindful Mums pilot in 2016/2017 showed that, of the 118 women who participated in the programme, all improved in at least one of three areas (wellbeing, feeling positive and social support) after attending the group, with 67% showing an improvement in all three[54]. Bromley Mindful Mums has now expanded their service to include more targeted programmes and a Befriending Service. These options could be explored for Lewisham in future. The Lewisham programme began in September 2017. Early performance data is promising, with 100% and 96% respectively, of women attending (and completing the feedback form) so far, stating that the course improved their confidence and had a positive impact on their family.

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[54] Bromley and Lewisham Mind (2017) Annual Review 2017. Available at: https://www.blmind.org.uk/wp-content/uploads/2017/10/Annual-Review-2017-Bromley-Lewisham-Mind.pdf (accessed on 03/11/2017)

Working with Men

4.11 Working with Men is a VCS organisation commissioned by the local authority (CYP Commissioning Team) to provide support and advice to fathers under 25 years of age (or up to 35 where there is evidenced need), living in Lewisham. They provide one-to-one support for expectant and young fathers, including parenting advice, employment advice, group activities and mediation. Although not specifically a mental health service, the support and advice offered can help new fathers with their mental health and well-being both directly and indirectly.

Other VCS services

4.12 Other non-commissioned VCS services available to support MMH in Lewisham, include NetMums, Mummy's Gin Fund and PANDAS (online peer support groups), Mum's Aid (one-to-one counselling) and The Birth Trauma Association (for families who have experienced a difficult birth). A free smart phone/ tablet application called 'mush' helps link up new mothers in their local area. At a recent 'Loneliness amongst Parents' focus group held in November 2017, feedback from service users highlighted how valuable these VCS services are, especially in helping women and families stay emotionally healthy[55].

Others services/ activities that promote emotional well-being during pregnancy and after birth

4.13 Exercise is known to be an effective way to improve mental health. Numerous research demonstrates a positive link between physical activity and a reduction in stress, depression and anxiety[56]. In Lewisham, the Wavelengths Leisure Centre has a low-cost crèche, the Glass Mill and Bridge Leisure Centres offer parent and baby swimming classes and there are combined exercise and mindfulness classes offered at some of the CFCs. A 'Healthy Walks' programme currently operates in Lewisham which involves volunteer-led walks across the borough to promote health and social interaction. The MVP are seeking to expand this programme to include peer-led walks specifically for pregnant and new mothers, both to support physical health but also mental health and social networking amongst women. Lewisham's libraries offer free sessions for parents and babies under five, such as 'Baby Bounce' and 'Toddler Tales'. Again, these activities can help to promote mental health and well-being, social interaction and parent-infant attachment amongst new parents.

National Healthy Start Scheme

4.14 The national Healthy Start Scheme is a means-tested programme which provides vouchers for parents of children under 4 to use at certain retailers to buy basic healthy foods such as milk and fruit. Evidence[57] suggests that, in addition to physical health benefits, such schemes can help to ease economic stressors that may be a risk factor for poor mental health amongst some new parents. Despite

[55] Loneliness amongst Parents Focus Group, Jo Cox Loneliness Commission
[56] https://www.cambridge.org/core/product/identifier/S1368980099000567/type/journal_article
[57] http://www.gov.scot/Publications/2016/03/7301/6

national guidance stating that the scheme should be promoted to all pregnant women, uptake of this scheme in Lewisham is not as high as it should be.

Targeted services/ interventions

Maternal Early Childhood Sustained Home-Visiting Programme (MECSH), Health Visiting Service, LGT

4.15 MECSH is a structured programme of home visits for vulnerable families that sits within the Health Visiting Service. Health Visitors make additional visits to families' homes before and after a child is born (for up to two years post birth). The programme is targeted at families at risk of poor maternal and child health and development outcomes. It is based on the best available evidence on the importance of the early years, child health and development, parent-infant interaction and parental mental health. MECSH is commissioned as part of the Health Visiting Service.

Specialist Perinatal Mental Health Health Visitor, Health Visiting Service, LGT

4.16 There is a Specialist PMH Health Visitor within the Health Visiting Service. The role involves education, training, advice and awareness raising for Health Visitors and other early years services involved in PMH care; acting as a strategic point of contact for the wider early year's workforce on PMH; acting as a champion and advocate for affected families, including clinical practice with these families, and driving quality improvements and integrated care across the service. This role is commissioned as part of the Health Visiting Service.

Solihull Postnatal Support Group, Health Visiting Service, LGT

4.17 The Health Visiting Service have developed a new postnatal support group which will run for 8 sessions from April 2018. The group is based on the Solihull model[58] which aims to support women in the perinatal period who are experiencing mild to moderate anxiety, depression and/or other mental health disorders. IAPT practitioners will be attending for two sessions. The sessions will be delivered in CFCs across the borough.

Family Nurse Partnership (FNP), LGT

4.18 FNP is a nurse led home visiting programme for under 19 year old first time mothers from early pregnancy until their child is two years old. The programme is delivered by LGT and commissioned by the CYP Joint Commissioning Team within the local authority. The team is made up of five family nurses and a line manager. The evidence base for FNP is robust, with three high quality US trials demonstrating a wide range of positive outcomes for mothers and children over the short, medium and long term. The programme supports young mothers to have a healthy pregnancy, improve their child's health and development and plan a positive future for themselves and their child.

[58] https://solihullapproachparenting.com/

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4.19 The FNP team are notified of all first time mothers under 20 who book for antenatal care. In 2010, this was 170 a year, reducing to 124 in 2017 due to a fall in the under 18 conception rate. FNP have since extended their service offer to 20-22 year olds with additional vulnerabilities and they make up 12% of the caseload. The team is commissioned for 115 places at any one time. In October 2017, 42% of the caseload had a recent or current mental illness, which included self-harm, eating disorder, anxiety and depression, personality disorder, bi-polar disorder and schizophrenia, 16% were receiving specialist mental health services and 29% had been physically or sexually abused within the last year.

Specialist Midwifery Team ('Indigo'), Maternity Service, LGT

4.20 There is a specialist midwifery team, Indigo, within the Maternity Service. Jointly with the Specialist PMH Service, this team care for vulnerable women, including those with moderate to severe mental health issues, victims of domestic abuse and sex trafficking, women with learning disabilities and teenage parents. Women are referred by GPs, midwives, obstetricians, the Specialist PMH Service, FNP, health visitors and IAPT. Women's care is tailored according to individual needs, with outreach and home visiting offered for women less likely to engage. Continuity of midwifery care is provided antenatally and postnatally until 28 days. The overall focus is on reducing health inequalities for women and babies. The typical caseload of a full time midwife in the team is 30 women.

Specialist Perinatal Mental Health Midwife, Maternity Service, LGT

4.21 The Maternity Service employs a Specialist PMH Midwife. Although the role sits within the Maternity Service, it is commissioned separately by the CCG as it is funded through a separate funding stream, the CAMHS Transformation Fund. Many of the key national strategies on PMH call for this role to be in place in every Maternity Service in the UK[59]. LGT's PMH Midwife has a crucial role to play in effective PMH care, helping to drive local efforts to ensure that women with perinatal ill-health are identified early and get the best possible care within the Maternity Service and the wider service system. The role involves education, training, advice and awareness raising for maternity staff and staff from other services; acting as a strategic point of contact for all professionals involved in the delivery of PMH care; acting as a champion and advocate for families affected by perinatal mental illness, improving the quality of services, promoting integrated care and providing direct support to a small number of women affected by mild to moderate PMH issues. From June 2018, the role will become part time (two days a week) rather than full time, as currently.

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[59] Health Education England (2016) Specialist Health Visitors in Perinatal and Infant Mental Health. What do they do and why they matter. Available at: https://hee.nhs.uk/sites/default/files/documents/Specialist%20Health%20Visitors%20in%20Perinatal%20and%20Mental%20Health%20FINAL%20low%20res.pdf (accessed 06/10/2017)

Specialist Perinatal Mental Health Service, South London and Maudsley NHS Trust (SLaM)

4.22 Lewisham has a Specialist PMH Service, provided by SLaM and commissioned by the CCG. The service is for women with existing and previous moderate to severe PMH needs. Any health professional can refer a woman to the team. The service received additional funding from NHSE in 2017 to significantly expand its capacity and workforce. From one nurse practitioner and one part time consultant, the service now has a psychologist, a psychiatric consultant, a psychiatric registrar, a practitioner team leader, three specialist PMH nurses, an occupational therapist, a nursery nurse, a social worker and a specialist midwife. Increased capacity means an enhanced service offer and many more women seen, including home visits for patients, more psychological interventions covering the whole range of PMH disorders, organisation and facilitation of care programme meetings and pre-birth planning meetings, attendance at pre-discharge meetings and ward reviews, and future care management and planning.

4.23 Approximately four women per 10,000 births require admission to a specialist unit pre or postnatally for severe mental illness. The Specialist PMH Service work closely with the nearest local mother and baby unit (MBU) which is The Bethlem Royal Hospital in Beckenham, Kent. It is a 13 bedded unit that accepts referrals from consultant psychiatrists or community mental health teams from across the country. The mother and baby unit specialises in the treatment of antenatal and postnatal mental illnesses, predominantly for women who develop or have a relapse of serious mental illness during pregnancy, and women who develop postnatal depression, puerperal psychosis or have had a relapse of serious mental illness following the birth of their baby. The Bethlem MBU was recently awarded funding from NHSE to provide additional training for staff and improve facilities within the unit.

Child and Adult Mental Health Service (CAMHS), SLaM

4.24 CAMHS is an NHS service that assesses and treats children and young people with emotional, behavioural or mental health difficulties. Lewisham CAMHS is delivered by SLaM and is commissioned by the CCG and local authority. In relation to PMH, work is currently underway to clarify the care pathway for under 18 year olds with PMH needs who require specialist support. These clients remain the responsibility of CAMHS as they are under 18 but they require input from the Specialist PMH Service as CAMHS do not offer this specialism in-house. The care pathway proposed is that under 18 year olds with PMH issues should be referred to CAMHS. CAMHS will then co-ordinate the support needed by the client from the Specialist PMH Service but will remain the lead professional. This ensures that there is continuity of care for the client. This care pathway will need to be shared widely and kept under review.

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Improving Access to Psychological Therapies (IAPT), SLaM

4.25 IAPT is a national programme designed to increase the availability of 'talking therapies' on the NHS[60]. The programme is primarily for people with moderate mental health difficulties, which are too complex for primary care intervention. Conditions include depression, anxiety, phobias and post-traumatic stress disorder, and are treated using a variety of therapeutic techniques, including cognitive behavioural therapy, interpersonal therapy and couples therapy. The programme is open to any adult registered with a Lewisham GP. The service accepts self-referrals and referrals from GPs and other services. Appointments take place in a range of community settings, including GP surgeries and other clinics around Lewisham. In Lewisham, IAPT is provided by SLaM and commissioned by the CCG.

4.26 Within the service, there is a PMH lead who has been in place since 2015. This role came about through the Pan London PMH Network 'London IAPT Perinatal Leads Project', aiming to increase the number of perinatal women being seen in London IAPT services. The IAPT PMH lead receives training via the Pan London Network and organises training for other therapists within IAPT, with the intention of building PMH competencies across the team. Through this role, IAPT has developed strong links with the Specialist PMH Service, the Maternity Service and the Health Visiting Service, and is currently working with these services to develop shared care pathways. IAPT prioritise PMH referrals, seeing these women within two weeks of a referral, in line with NICE guidelines. Treatment for these women is also prioritised.

Service user feedback and input

4.27 Lewisham have a Maternity Voices Partnership (MVP); an independent partnership committee in which service-users, healthcare professionals, and commissioners works collaboratively to monitor and improve maternity services in the borough. Via this group, the voices of women who are currently, or have recently, used local maternity services are heard and used to shape, design and plan the commissioning and provision of maternity services. This work feeds into the work of the South East London Local Maternity System (LMS).

4.28 Lewisham MVP were involved in the development of this JSNA, welcoming the focus on this topic as it is one of their key priorities. Focus groups facilitated by the MVP, were held with women who have lived experience of MMH issues to inform the JSNA. The MVP also played a key role in the establishment of Lewisham Mindful Mums and led the local campaign, 'It's ok to not feel ok'[61]. Other parent forums will need to be engaged and consulted on the implementation of recommendations within this JSNA.

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[60] https://www.england.nhs.uk/mental-health/adults/iapt/
[61] www.lewisham.gov.uk/notfeelingok

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5. Current workforce training and development

5.1 The below describes the workforce training and development that is currently available to support professionals working with women and families experiencing MMH issues.

Specialist Perinatal Mental Health Midwife and Health Visitor

5.2 The Specialist PMH Health Visitor and Midwife have an important role to play in educating and training both their own services and the wider workforce, on PMH issues. For example, the PMH Midwife has recently conducted an audit of staff training needs and is working to ensure these needs are met, through access to specialist training, online training, training for new midwives and obstetricians and sharing learning materials through an online knowledge hub. The PMH Health Visitor trains new and existing Health Visitors, and raises awareness of PMH amongst the wider early year's workforce.

Specialist Perinatal Mental Health Service

5.3 The Specialist PMH Service provides training on PMH to all midwives once a year as part of their mandatory training requirements. In addition, they recently started offering reflective practice sessions to specialist midwives in the Indigo team, to support them in their care for women with mental health issues. The service also has a role to play in training and workforce development for the wider service system, including Health Visitors and GPs. SLaM provide a PMH simulation course that is free of charge to all NHS staff in South London. The course is suitable for any healthcare professional involved in PMH care, bringing together different services to share learning and build confidence and skills in working with women with PMH needs.

Public Health Department and Lewisham Community Education Provider Network (CEPN)

5.4 Lewisham's Public Health team work in partnership with CEPN to run training courses on public health issues for any organisation that has face to face contact with the public[62]. These include courses on 'Mental Health First Aid' and 'Young People's Wellbeing Toolkit' which explores the theory and physical effects of stress, trauma and poor mental health on the mind and body of young people. The courses are free and openly accessible.

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[62] https://www.lewisham.gov.uk/myservices/socialcare/health/improving-public-health/Pages/Health-improvement-training.aspx

6. Gaps in knowledge and service provision

6.1 Based on the needs analysis, mapping of current provision and the views of service users, providers and professionals in the field, this JSNA identifies gaps in the following areas:

A clear shared understanding of local need

6.2 Whilst we are closer to achieving a shared understanding of local need in relation to MMH as a result of this JSNA, there are still some gaps. There is a lack of data and knowledge on the whole MMH period (i.e. beyond the perinatal period), on the specific needs of particular groups, including partners/ fathers, LGBTQ women and women with additional vulnerabilities, such as young parents, women experiencing domestic violence and women with learning disabilities, and on the wider determinants of parental mental health and parenting as a whole. These gaps could and should be addressed through a wider parenting JSNA and resultant strategy. It is important that the learning from this JSNA is widely disseminated, applied and built upon.

A clear care pathway that is widely understood and consistently applied

6.3 It is important that there is a clear care pathway in place for all women with mild to severe maternal mental illness, covering prediction, prevention, detection and treatment. This should include specific pathways for vulnerable groups and those with additional needs, as well as an acute/ emergency pathway for women in and out of hours.

6.4 Until recently, each service had its own pathway (or no specific pathway) for MMH/ PMH. Where pathways were in place, they frequently overlapped and sometimes contradicted, the pathways of other services. Women did not always get the support they needed at the right time and in the right place, and often had to tell their stories multiple times to multiple professionals. However, the Specialist PMH Service are currently developing an integrated PMH pathway which joins up the various different pathways being used by different services. This is being developed in partnership with other services, including the Maternity and Health Visiting Service.

6.5 To date, Children and Adult Social Care have not been involved in the development of the PMH pathway but need to be given the important links with these services. Lewisham's Early Help Panel[63] also needs to be included, as a multi-agency decision making forum for families requiring targeted support, which could include support with MMH issues. Interventions to support parent-infant attachment should also be included. The next steps are to ensure that the new integrated pathway is well understood and widely applied, including through training and ongoing monitoring. As part of a planned Parenting Strategy, consideration should be given to extending this pathway beyond the PMH period.

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[63] https://www.safeguardinglewisham.org.uk/assets/1/finalearlyhelpstrategy.pdf

High quality training and awareness raising for the wider workforce

6.6 MMH training should be available, and where possible, mandatory, for all practitioners who work with families in this period, including those in Maternity Services, General Practice, Health Visiting, CFCs, Children's Social Care, CAMHS, Adult Mental Health and the VCS. Training should be delivered by a professional with accredited training expertise and experience. Ideally, different services should be trained together, to learn from one another and to ensure a consistent approach.

6.7 Training opportunities in MMH are currently limited in Lewisham. This JSNA identifies particular gaps in training for GPs and the VCS. At a focus group[64] of service users with lived experience, many felt that their GPs were not able to provide the specific support they needed, either directly or through signposting to other services. When consulted on the JSNA[65], GPs themselves reported that they lacked up to date training and information on mental health in general, let alone MMH and PMH specifically. Other frontline practitioners[66], including VCS staff, reported limited knowledge of the training available to them and how to access it. They also reported barriers to accessing training, including time and money.

6.8 Specialist Midwives and Health Visitors who work with women with high levels of mental health needs requested more support with reflective practice from the Specialist PMH Service, as well as more training and support in general. Reflective practice sessions are now in place for Specialist Midwives but not Health Visitors. With regards to wider MMH training, Specialist Midwives do not currently receive any additional training beyond the one hour a year mandatory training delivered to all Midwives. Health Visitors also do not currently receive specialist PMH training. This is recognised as a gap.

Evidence-based universal services promoting maternal mental health and preventing escalation

6.9 The MMH service offer in Lewisham is disproportionately weighted towards women with moderate to severe mental health needs; there is an insufficient focus on community-based, early intervention services for women with lower level needs. Whilst programmes like Mindful Mums (Bromley and Lewisham Mind) and Five to Thrive (CFCs) are very valuable in promoting MMH, they cannot reach all those who need them. In addition, there is a lack of knowledge locally about what works in promoting MMH and preventing needs from escalating.

6.10 Nationally, there is a drive towards more community-based, preventive work in this area, with peer support increasingly recognised as having great value in the context of mental health, often playing a key role in recovery and maintenance of wellbeing. Feedback from service users stresses the importance of social

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[64] MVP meeting, October 2017
[65] Healthy Child Programme Board, October 2017
[66] *Ibid.*

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interaction; a women who experienced postnatal depression stated that, 'getting out of the house every day and having some kind of social contact was important for me and for my children…[it was] helpful to share and normalise what a stressful time of life this can be'[67].

6.11 At a 'Loneliness amongst Parents' event in Lewisham, service users spoke about the importance of easily accessible information about available services and how to access them. They felt that this was currently lacking, both amongst service users and amongst professionals. Social isolation and fear of stigma can present barriers to accessing services.

Sufficient understanding of the needs, and support for, partners/ fathers

6.12 There should be a range of universal and targeted services available to promote the mental health of expectant or new partners/ fathers and to support them in protecting the mental health of new mothers. Currently, there is a limited service offer for partners/ fathers in Lewisham, and we do not understand enough about their specific needs. Working with Men supports young fathers and CFCs, Health Visitors and Midwives work with both men and women to promote good mental health, but this is not enough. This gap is especially problematic given that men are generally less likely than women to seek help for mental health issues[68]. Addressing the needs of partners/ fathers and the wider families, as well as mothers, should be standard practice according to NICE guidelines[69] and national policies which all reference family centred care[70].

Sufficient understanding of the needs, and support for, LQBTQ parents

6.13 LGBTQ (lesbian, gay, bisexual, transgender, queer or questioning) parents are disproportionately affected by negative health outcomes compared to heterosexual parents, however, little is known about their specific needs, both generally, and in relation to mental health[71]. The knowledge gap for this group needs to be addressed, with support put in place to address their specific needs in relation to MMH.

[67] 'Loneliness amongst Parents' event, Jo Cox Loneliness Commission, November 2017
[68] https://www.nimh.nih.gov/health/publications/men-and-depression/index.shtml
[69] London: National Institute for Health and Clinical Excellence (2014) Antenatal and postnatal mental health: clinical management and service guidance. Clinical guideline [CG192]
[70] Department of Health (2009). Healthy Child Programme – Pregnancy and the First Five Years of Life. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf (accessed 22/09/17)
[71] MIND (2013) LGBTQ Mental Health. Available at: https://www.mind.org.uk/information-support/guides-to-support-and-services/lgbtq-mental-health/#.Wg69ff67IdW (accessed 17/11/2017)

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A joint commissioning strategy for Parental Mental Health

6.14 It is useful to consider MMH within the context of overall parental mental health. As maternal, and wider parental, mental health span several different service areas, it is important to have an integrated commissioning strategy which bring together these different strands, and set out an overall vision and agreed outcomes. This should be underpinned by the findings of this JSNA and the planned parenting JSNA.

Continuity of care across the maternity pathway

6.15 Evidence suggests that improved continuity of care across the maternity pathway may improve the detection, prevention and treatment of PMH/ MMH issues[72]. Women are more likely to mention concerns to someone they trust and it is easier for Midwives to detect problems in a women they have come to know[73]. Currently continuity of care is available only for a small number of women with specific vulnerabilities, including teenage parents and women at risk of pre-term birth via the POPPIE research trial which is exploring the link between pre-term birth and continuity of care. Continuity of care needs to be rolled out across the Maternity Service, for as many women as possible. This work is being taken forward by the LMS; with continuity of care planned for vulnerable women first, before being extended to as many other women as possible.

Clarity of future arrangements and role for the Specialist Perinatal Mental Health Midwife

6.16 Currently, much of the work on PMH within the Maternity Service and the wider service system, is being progressed by the Specialist PMH Midwife. Funding has recently been secured to enable this (currently fulltime) role to be continued on a part time basis for a year from June 2018-19. The role needs to be re-specified given the change in hours and in line with new priorities. Funding is in place for a year, with no guarantee of further funding being available beyond 2019.

Access to Specialist Perinatal Mental Health Service for under 18 year olds

6.17 There is a need to clarify and consolidate the service offer for under 18 year olds with PMH needs who meet the threshold for the Specialist PMH Service. Currently, there is a risk that these young women may fall between CAMHS (who lack specialism in PMH specifically) and the Specialist PMH Service (who work primarily with over 18s). However, work is underway to develop a specific care pathway to address this potential gap, whereby these young women will be under the care of CAMHS but will be able to access specialist support from the Specialist PMH Service as needed.

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[72] http://everyonesbusiness.org.uk/wp-content/uploads/2014/06/Boots-Family-Trust-Alliance-report.pdf
[73] https://www.nct.org.uk/pregnancy/continuity-care

Awareness of, and interventions to support, parent-infant attachments

6.18 The importance of parent-infant attachments are stressed in local and national strategies[74],[75],[76] including Lewisham's CYPP 2015-2018, the Children and Young People's Mental Health and Emotional Well-Being Strategy and the Healthy Child Programme. Whilst there is some valuable work underway in this area, including a new Health Visitor led programme based on the Solihull approach to attachment, it was emphasised, during JSNA focus groups, that a greater focus was needed on infant-parent attachments.

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[74] The Mental Health Taskforce (2016). The Five Year Forward View for Mental Health: www.england.nhs.uk/mentalhealth/taskforce (accessed 22/09/17)
[75] NHS England (2016). The National Maternity Review Report: www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf (accessed 22/09/17)
[76] Department of Health (2015). Future in Mind: www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf (accessed 22/09/17)

7. Recommendations

7.1 Recommendations are based on addressing identified gaps and are divided by service area. The top 10 priorities are listed first, following by the remaining priorities. The remaining priorities are also important but some are already in action, while others are longer term.

Top 10 priorities

1. Ensure that the **MMH JSNA is widely shared and jointly owned,** with multi-agency commitment to the recommendations. Commissioners should use the MMH Alliance 'Mapping Perinatal Services Tool' to assist them in developing a SMART action plan for taking forward the recommendations, with specified action owners and timescales. This should be led by the CYP Commissioning Team.

2. **Undertake a wider Parenting JSNA** which includes MMH/ parental mental health as a key theme, along with other linked topics, such as domestic violence and substance misuse. This should be used to plug gaps in knowledge identified in this JSNA, particularly in relation to the needs of partners/fathers[77],[78], LGBTQ parents, parents with disabilities or with children with disabilities and parents who suffer domestic violence. Along with this JSNA, the Parenting JSNA should also be used to underpin the development of a wider **Parenting Strategy** for the borough which includes MMH as a core component. This should be led by the CYP Commissioning Team, in partnership with providers and service users.

3. Ensure that all relevant services are involved in the **development of an integrated PMH care pathway**, including Children and Adult Social Care and Lewisham's Early Help service. Once complete, actions should be taken to ensure that the pathway is widely understood, shared and reviewed regularly, for example, through inclusion in multi-agency training. This pathway is already in development, and included as appendix 1. This work is being led by the Specialist PMH Service, with multi-agency input.

[77] In advance of any service design or commissioning to support the needs of partners/ fathers, consideration should be given to the following research: Robertson S, White A, Gough B, et al. (2015) Promoting Mental Health and Wellbeing with Men and Boys: What Works? Centre for Men's Health, Leeds Beckett University, Leeds: https://cdn.movember.com/uploads/files/2015/Misc/Promoting_MentalHealth_&_Wellbeing_FINAL%5b2%5d.pdf (accessed on 10/11/2017)
[78] This should include consideration of the role of existing services, such as Working with Men and Mindful Mums.

4. **Increase multi-agency training opportunities**[79] for all professionals working with families in the MMH period, including GPs, Social Workers, the VCS workforce, Obstetricians, Midwives, Health Visitors and CFC staff. This should include:
    - **Promoting existing training opportunities** via the Specialist PMH Service, PMH Midwife and Health Visitor, Voluntary Action Lewisham, service managers, commissioners and 'PMH Champions' (see below).
    - **Reviewing the role of the Specialist PMH Service in training, upskilling and outreach to the wider workforce**, including Midwives, Health Visitors, GPs and other practitioners, with a view to extending this offer. This should be led by the Adults Mental Health Commissioning Team, in partnership with the Maternity Commissioner.
    - Ensuring take up of the places available for Lewisham practitioners to **undertake London PMH Champions Training** via the London PMH Network[80].
    - **Improving the provision and uptake of PMH training for GPs,** including promoting the Royal College of GPs PMH toolkit[81], considering short, accessible drop-in sessions for GPs and considering the inclusion of PMH within mandatory training for GP trainees; the learning from which could be disseminated amongst the trainee's host practice. This should be led by the GP Maternity Lead.

5. **Consider the feasibility of GPs asking Whooley questions to all pregnant women and new mothers.** This should be led by the GP Maternity Lead.

6. **Evaluate the effectiveness of current community-based provision** in preventing the emergence and escalation of MMH issues, with a view to supporting continuation and/or service development, if effective. This should be taken forward by the Maternity Commissioner and Early Intervention Commissioner, and should include updated research on evidence based interventions/ what works.

7. The **mental health benefits of physical activity should be promoted** to all pregnant women and new mothers by healthcare professionals. This includes CYP Partnership support for the Healthy Walks initiative, being developed by the MVP, for this group. This recommendation is the responsibility of the Public Health team.

8. **Re-specify the Specialist PMH Midwife role** for two days per week, with clear objectives, deliverables, outcomes and processes for monitoring these (based on Royal College of Midwives guidance) and **consider arrangements for the role beyond 2018/19** when the current funding expires. This should be undertaken by the Maternity Commissioner.

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[79] Ensure that training is evaluated by attendees to drive future improvements.
[80] PMH Champions are ambassadors for PMH within their local area; being involved in developing integrated PMH care pathways; acting as a central resource to colleagues; empowering colleagues to raise parity of esteem for PMH; and promoting evidenced based practice at all levels.
[81] http://www.rcgp.org.uk/clinical-and-research/toolkits/perinatal-mental-health-toolkit.aspx

9. Progress and prioritise LMS plans to **achieve continuity of care** across the maternity pathway for all women, in light of the impact this would have on MMH and other key pregnancy and birth outcomes. This is likely to require additional resources, which will be identified through the LMS. This should be led by the Maternity Commissioner, in partnership with the Maternity Service.

10. **Monitor support arrangements for reflective practice by Specialist Midwives** provided by the Specialist PMH Service to ensure these arrangements are sustained and impactful. **Review whether there is a need to extend these arrangements to other services and the commissioning implications of this.** Incorporate agreed requirements for the PMH Specialist Service in terms of reflective practice, and training and support for other services, in future service specifications and commissioning intentions for the service. This should be led by the Adults Mental Health Commissioning Team.

Other priorities

11. Ensure that the **PMH pathway includes interventions supporting parent-infant attachment**, so that families receive support for both the mother's mental health problem and the parent-infant relationship, and that these are joined-up. This should be taken forward by the Specialist PMH Service.

12. **Develop an agreed competency framework for MMH** which informs training and professional development. This should be developed by the Specialist PMH Midwife.

13. **Training providers should review the content of their training** to ensure it covers the needs of partners/ fathers, infant social and emotional development and parent-infant attachment. This is the responsibility of each training provider.

14. **Ensure that families and practitioners are aware of, and can easily access, existing services to support good mental health** and the wider determinants of health, including:
    - Continued development and promotion of the **Family Information Service** as the key source of information on services for families, including self-management of low level mental ill-health.
    - Raising awareness, and promoting take up, of the **Healthy Start Scheme**. This should be led by Public Health.

15. **Consider asking partners/ fathers the same emotional wellbeing questions** that mothers are asked, if they are present at antenatal and postnatal appointments, or through other means if they are not present. This should be explored by the Specialist PMH Midwife.

16. **Ensure that the views of partners/ fathers are routinely captured and acted upon** within the Maternity Service, Health Visiting Service and other services working with families in the maternal/ perinatal period.

17. **Review the impact of the new Health Visiting led Solihull Postnatal Support Group** on parent-infant attachment and infant mental health, with a view to

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supporting continuation if effective. This should be undertaken by the Early Intervention Commissioner.

18. **Consider how to further promote the importance of parent-infant attachment and infant mental health** to practitioners and parents (including foster carers). Commissioning opportunities in this area should be explored. This should be undertaken by the Early Intervention Commissioner.

19. **A PMH 'champion' should be identified within Children and Adult Social Care** to develop PMH specialism within these services, support quality improvement and foster links with other services. This should include involvement in local PMH clinical networks, as appropriate. This should be taken forward by the Children and Adult Social Care Teams.

20. **The PMH care pathway for under 18s requiring specialist PMH input should be finalised, implemented, shared widely and regularly reviewed**. This is a responsibility for CAMHS, in partnership with the Specialist PMH Service.

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8. Conclusion

8.1 Maternal mental ill health during pregnancy and after childbirth, especially in the first 1001 days of a child's life, can cause significant and long-lasting problems for mothers, babies and families.

8.2 In severe cases, perinatal mental illness can be life-threatening; suicide remains one of the leading causes of death for women in the UK during the perinatal period. It is especially important that a woman's mental health needs are monitored, discussed and treated in the same way as her physical health during this critical period.

8.3 Maternal mental illness can affect a child's emotional, social and cognitive development. It can have an adverse impact on the interaction between a mother and her baby, impairing her parenting abilities through anxiety, reduced confidence, motivation, self-esteem and low energy. Stigma and discrimination can discourage parents from seeking help when they need it.

8.4 Women and families living in Lewisham may be at especially high risk of being affected by MMH issues due to the high prevalence of risk factors for the illness in the borough.

8.5 Some important developments have taken place in Lewisham over the last few years to bridge recognised gaps in MMH services, including a significant expansion of the Specialist PMH Service, the development of PMH specialism within IAPT, the commissioning of a new community-based, early intervention programme for PMH; Mindful Mums, and the recruitment of a Specialist PMH Midwife and Health Visitor. However, there is still work to do and the recommendations made in this JSNA seek to address gaps that are outstanding.

8.6 The recommendations include a significant increase in training opportunities and awareness raising amongst the wider workforce; updated research on the latest in evidence based practice to inform future commissioning decisions; the ongoing development and implementation of an integrated multi-agency PMH care pathway and the promotion of existing services to support good mental health and well-being during this period, including those that address the wider determinants of mental health.

8.7 Women experiencing mental health problems during and after pregnancy need timely access to high quality local support, from universal to specialist services. Effective prevention, early identification and appropriate management of MMH problems can continue to have a positive impact on a woman's health, and that of her child and family, for years to come.

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Caroline Hirst, Joint Commissioning Team Service Manager, LBL
Michelle Florio, Lead Specialist Health Visitor in PMH, Lewisham and Greenwich NHS Trust (LGT)
Suzy Hall, Lead Specialist PMH Midwife, LGT
Helen Knower, Head of Midwifery, LGT
Giuseppe Labriola, Deputy Head of Midwifery, LGT
Lynn Bayes, Community Midwife Lead, LGT
Sarah Buck, Senior Specialist Midwife for Vulnerable Women, LGT
Kathleen Cruise, Supervisor Lewisham Family Nurse Partnership, LGT
Dr Sara Roberts, Counselling Psychologist & IAPT Lead for PMH, SLaM
Dr Angelika Razzaque, GP Maternity Lead, LGT
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Dr Omer Moghraby, Lead Clinician, Lewisham CAMHS
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Kenneth Gregory, Joint Commissioning Lead, Adult Mental Health, LBL
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Natasha Logan, Advanced Practitioner, Lewisham MASH and Early Help Service, LBL
Dr Carrie Ladd, RCGP Clinical Fellow for PMH
Toyin Adeyinka, Chair of the Maternity Voices Partnership (MVP)
Jana Smith, Maternity Voices Partnership & Mindful Mums Programme Facilitator
MVP members
Healthy Child Programme Board members
Children and Young People Joint Commissioning Team
'Loneliness amongst Parents' Focus Group meeting attendees

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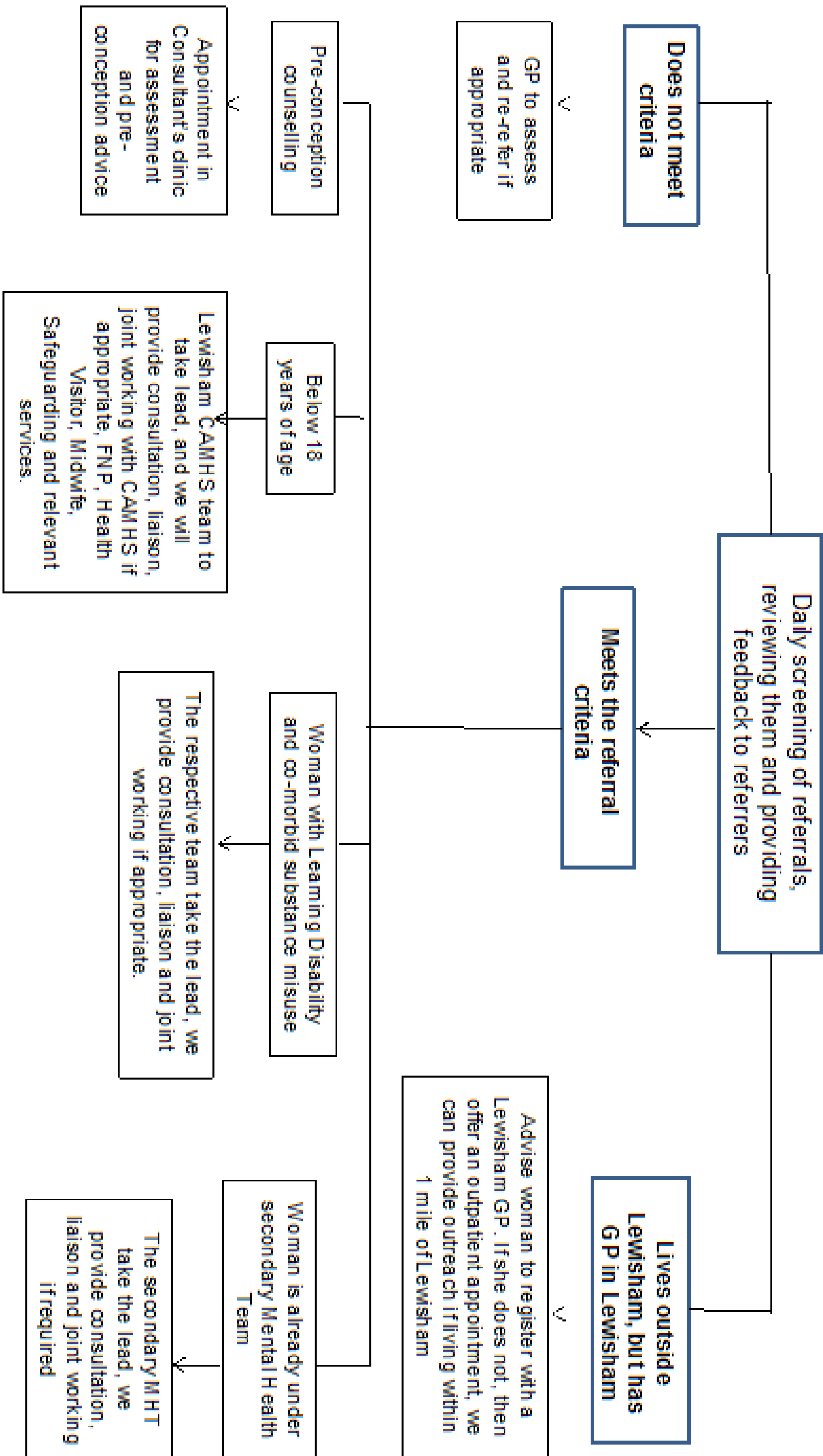
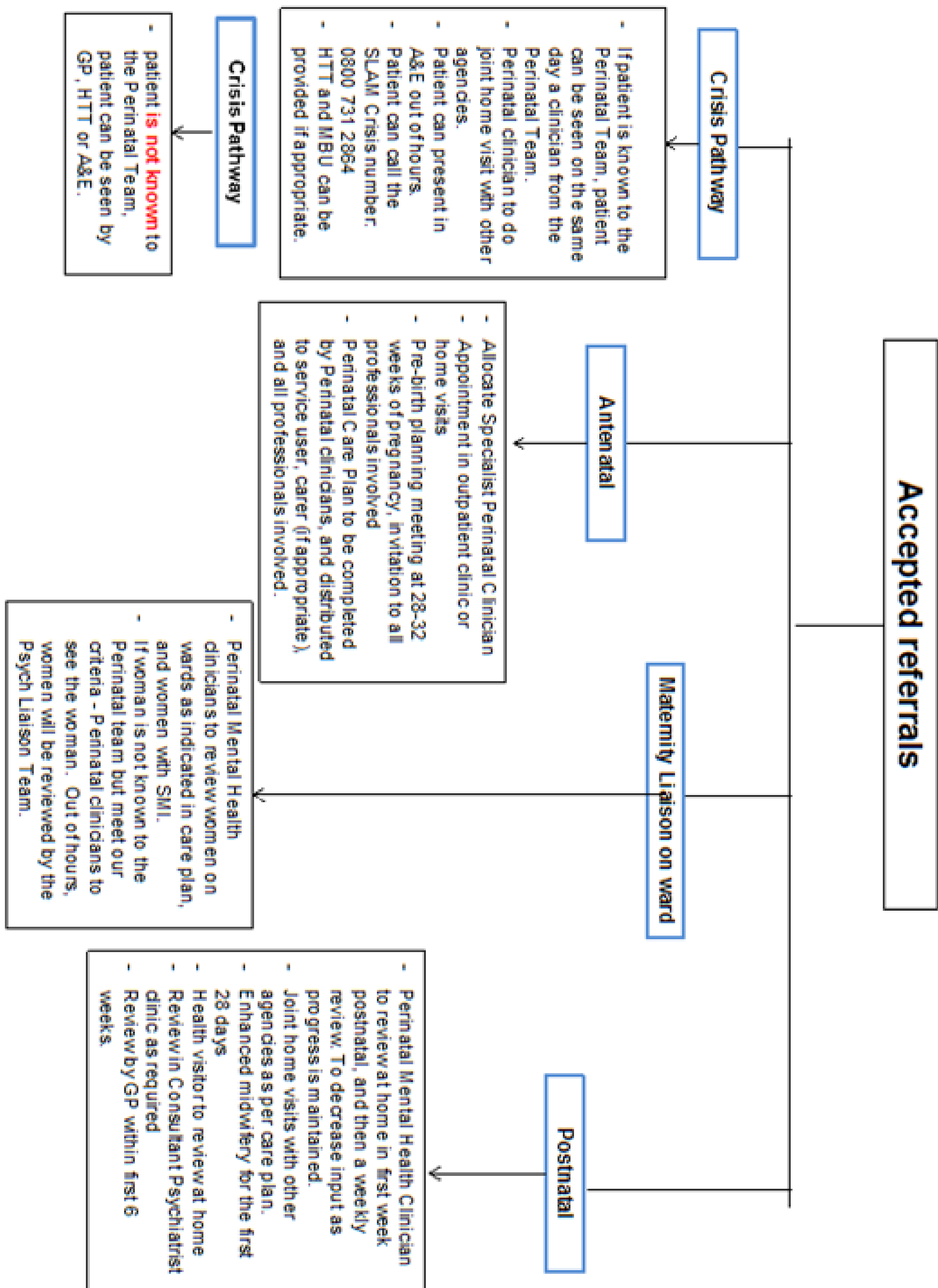
Appendix 1: Draft Lewisham Perinatal Mental Health Care Pathway (April 2018) – final version expected May 2018




Accepted referrals
Crisis Pathway
If patient is known to the Perinatal Team, patient can be seen on the same day a clinician from the Perinatal Team.
Perinatal clinician to do joint home visit with other agencies.
Patient can present in A&E out of hours.
Patient can call the SLAM Crisis number: 0800 731 2864
HTT and MBU can be provided if appropriate.
Crisis Pathway
patient is not known to the Perinatal Team, patient can be seen by GP, HTT or A&E.
Antenatal
Allocate Specialist Perinatal Clinician
Appointment in outpatient clinic or home visits
Pre-birth planning meeting at 28-32 weeks of pregnancy, invitation to all professionals involved
Perinatal Care Plan to be completed by Perinatal clinicians, and distributed to service user, carer (if appropriate), and all professionals involved.
Maternity Liaison on ward
Perinatal Mental Health clinicians to review women on wards as indicated in care plan, and women with SMI.
If woman is not known to the Perinatal team but meet our criteria - Perinatal clinicians to see the woman. Out of hours, women will be reviewed by the Psych Liaison Team.
Postnatal
Perinatal Mental Health Clinician to review at home in first week postnatal, and then a weekly review. To decrease input as progress is maintained.
Joint home visits with other agencies as per care plan.
Enhanced midwifery for the first 28 days
Health visitor to review at home
Review in Consultant Psychiatrist clinic as required
Review by GP within first 6 weeks.

Appendix 2: Maternal Mental Health JSNA Action Plan (March 2018 – Dec 2019)

ACTION	ACTION OWNER	DEADLINE	COMMENTS
COMMISSIONING, GOVERNANCE AND STRATEGY			
1. Ensure MMH JSNA is shared widely and jointly owned			
Circulate to all contributors and action owners	Charly Williams (Maternity Commissioner)	13th March	
Present and finalise at Maternity Commissioning Steering Group	Charly Williams	19th March 2018	Action plan to be monitored by Maternity Commissioning Steering Group on an ongoing basis
Secure final approval from Health and Wellbeing Board	Charly Williams	Meeting date tbc	Needs to include final version of the pathway – expected May 2018
2. Undertake wider parenting JSNA and Strategy			
Undertake wider parenting JSNA and Strategy, including MMH/paternal mental health as key theme	David McCollum (Early Intervention Commissioner); JoJo Taylor (National Management Trainee)	June 2018	Align with MMH JSNA
3. Complete PMH pathway in partnership			
Ensure PMH care pathway includes interventions supporting parent-infant attachment, under 18s pathway, Indigo Team, Adult and Children's Social Care; Early Help	Specialist PMH Service	May 2018	Final pathway meeting planned for mid May
Involve Adult and CSC in development of PMH pathway	Specialist PMH Service; Adult and CSC	May 2018	Contacts: Joan Hutton, Mary Farinha, Linda Smith for Adults; Natasha Logan/Najah Ismael for CSC/ Early Help
Once complete share the pathway widely and review it regularly	Specialist PMH Service; Suzy Hall (Specialist PMH MW)	Ongoing	Include in Specialist PMH MW Spec
WORKFORCE TRAINING AND DEVELOPMENT			
4. Increase multi-agency training opportunities on MMH/ PMH			
Promote existing training opportunities	Specialist PMH Service; Suzy Hall; Michelle Florio (PMH Health Visitor); Voluntary Action Lewisham; PMH 'Champions'	Ongoing	Includes PMH Simulation Course (SLaM); Mental Health First Aid and Young People's Wellbeing Toolkit (Public Health) and online training within RCGPs PMH Toolkit
Review training content to ensure it covers infant social and emotional development and parent-infant attachment	SLaM, Specialist PMH Service	June 2018	
En	Charly Williams	End March	Ensure that Adult and CSC each take up a place
Improve provision and uptake of PMH training for GPs	Dr Angelika Razzaque (GP Maternity Lead); Dr Charles Gosling (CD Mental Health); Dr Jim Sikorski (Chair of MHEB)	Ongoing	Promote RCGPs PMH toolkit, consider short accessible drop-in sessions and having a GP PMH Champion
COMMUNITY-BASED SERVICES (Tiers 1 & 2)			
5. Evaluate impact of current community-based PMH/MMH services and consider long-term plans			
Review impact of Mindful Mums and consider long-term plans beyond current contract, including service development	Charly Williams	Nov 2018	Current funding expires June 2019. Bromley Mindful Mums offer a Befriending Service; this could be considered in Lewisham, depending on outcomes/needs
Review impact of new Health Visiting led Solihull Postnatal Support Group and consider long-term plans	David McCollum; Michelle Florio	Sept 2018	Ensure monitoring arrangements are in place from start

Review how existing services promote parent-infant attachment and infant mental health (to parents/ carers and professionals) and consider how to better meet this need	David McCollum; JoJo Taylor	June 2018	To be considered as part of Parenting JSNA and Strategy
6. Promote mental health benefits of physical activity to pregnant women and new mums			
Consider how to promote the mental health benefits of physical activity to all pregnant women and new mums, including supporting Healthy Walks initiative (MVP led)	Pauline Cross, Public Health	June 2018	Public health to develop tangible actions to support all professionals in promoting this message.
7. Consider feasibility of GPs asking Whooley questions to all pregnant women and new mothers			
As described	Dr Angelika Razzaque; Dr Charles Gosling; Dr Jim Sikorski	June 2018	Women should be asked about their emotional health by GPs at every maternity appointment. Whooley Qs are best practice. GPs need to know what to do with results
8. Ensure existing services promoting good mental health are well promoted and easily accessible			
Develop and promote the Family Information Service (FIS)	Nikki Sealy (Early Years Manager)	Dec 2018	New website platform in development, ready by summer 2018. Work on FIS re-fresh will begin after this
Raise awareness and promote take up of the Healthy Start Scheme	Public Health	Ongoing	
9. Improve MH support offered to partners/fathers			
Review the role of Working With Men in relation to MH and consider whether this could be extended	David McCollum	June 2018	As part of Parenting Strategy
Consider asking partners/fathers the Whooley questions at maternity appointments	Suzy Hall	June 2018	
Review training content to ensure it covers needs of partners/fathers	Public Health; PMH Service	June 2018	
Ensure that the views of partners/fathers are routinely captured and acted upon	David McCollum; JoJo Taylor; Maternity Service; Health Visiting Service and other services working in maternal/perinatal MH	Ongoing	To be included in Parenting Strategy
10. Increase number of women receiving continuity of care across maternity pathway			
Progress and prioritise LMS plans to achieve continuity of care across maternity pathway for all women	Charly Williams/ Helen Knower, HOM	Sept 2018	Will likely require additional resources, identified through LMS. Plans will be developed over next 6 months.
SPECIALIST SERVICES (Tiers 3 & 4)			
11. Confirm arrangements for Specialist PMH Midwife beyond current contract			
Re-specify role based on 0.8 WTE and current priorities	Charly Williams; Suzy Hall	June 2018	Include requirement to develop an agreed competency framework for MMH.
Consider arrangements for supporting role after funding expires (May 2019)	Charly Williams	Jan 2019	
12. Review and extend role of Specialist PMH Service in training, upskilling and outreach to wider workforce			
As described	Kenneth Gregory (Adults MH Commissioner); Charly Williams	June 2018	This should include consideration of extending support with reflective practice to other services
13. Secure arrangements for reflective practice of Specialist Midwives by Specialist PMH Service			
Include reflective practice in Service Spec. for Specialist PMH Service to ensure continuation	Kenneth Gregory	Sept 2018	

HEALTH AND WELLBEING BOARD			
Report Title	Health and Wellbeing Board Work Programme		
Contributors	Principal Officer, Policy, Service Design and Analysis	**Item No.**	6
Class	Part 1	**Date:**	4 July 2018

1. Purpose

1.1 This report presents the Health and Wellbeing Board with the current work programme (included as Appendix A) for discussion and approval.

2. Recommendations

2.1 Members of the Health and Wellbeing Board are invited to:

- Review the current work programme and propose additional items to be included as appropriate.
- Note the role of the agenda planning steering group.

3. Strategic Context

3.1 The activity of the Health and Wellbeing Board (HWB) is focussed on delivering the strategic vision for Lewisham as established in *Shaping our Future* – Lewisham's Sustainable Community Strategy and in Lewisham's Health and Wellbeing Strategy.

3.2 The work of the Board directly contributes to *Shaping our Future's* priority outcome that communities in Lewisham should be Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing.

3.3 There are a number of core duties defined in the Health and Social Care Act 2012 which underpin the work of Health and Wellbeing Boards. These include:

- To encourage the integration of health and social care commissioning and provision;
- To undertake a Joint Strategic Needs Assessment (JSNA) to identify the health and wellbeing priorities of the local population;
- To develop a joint Health and Wellbeing Strategy outlining how the board intends to achieve improvements to local health outcomes.

4. Background

4.1 The work programme is a key document for the Health and Wellbeing Board. It allows the Board to schedule activity, reports and presentations across the year. It also provides members of the public and wider stakeholders with a clear picture of the Board's planned activity.

4.2 The Health and Wellbeing Board Agenda Planning Group convenes prior to each meeting of the Board with organisational representation from across the Board's members. In addition to reviewing the work programme, the Agenda Planning Group also identify new issues or emerging topics that have arisen since the Board last met.

4.5 The HWB is also required to approve the Joint Strategic Needs Assessment priorities and consider the findings and recommendations from any completed JSNA topics. These findings will inform the Board's approach to achieving improvements in local health and wellbeing outcomes.

5. Work programme

5.1 The work programme (see Appendix A), includes those items which the Board has agreed to consider over the course of the year. Board members are also requested to consider additional items to be included in the work programme as appropriate.

6. Schedule of meetings

6.1 The Board is scheduled to meet three times per municipal year (April-Mar). In 2018-19 in addition to today's meeting the Board is scheduled to meet in November 2018 and March 2019.

6.2 The requirements upon the Board to make statutory decisions, reach agreement or to be formally consulted does not always align itself with the three scheduled meetings per year. Therefore, some last minute amendments to the work programme and the scheduling of Board meetings may be required.

6.3 Workshops are scheduled for the intervening months to enable the Board to informally examine issues in more depth or to provide development opportunities for the Board.

7. Financial implications

7.1 There are no specific financial implications arising from this report or its recommendations.

8. Legal implications

8.1 Members of the Board are reminded of their responsibilities to carry out statutory functions of the Health and Wellbeing Board under the Health and Social Care Act 2012. Activities of the Board include, but may not be limited to the following:

- To encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area.
- To provide such advice, assistance or other support as its thinks appropriate for the purpose of encouraging the making of arrangements under Section 75 NHS Act 2006 in connection with the provision of such services.
- To encourage persons who arrange for the provision of health related services in its area to work closely with the Health and Wellbeing Board.
- To prepare Joint Strategic Needs Assessments (as set out in Section 116 Local Government Public Involvement in Health Act 2007).
- To give opinion to the Council on whether the Council is discharging its duty to have regard to any JSNA and any joint Health and Wellbeing Strategy prepared in the exercise of its functions.
- To exercise any Council function which the Council delegates to the Health and Wellbeing Board, save that it may not exercise the Council's functions under Section 244 NHS Act 2006.

8.2 The Equality Act 2010 (the Act) introduced a new public sector equality duty (the equality duty or the duty). 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.

8.3 In summary, 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.

8.4 The duty continues to be a “have regard duty”, and the weight to be attached to it is a matter for the Mayor, bearing in mind the issues of relevance and proportionality. It is not an absolute requirement to eliminate unlawful discrimination, advance equality of opportunity or foster good relations.

8.5 The Equality and Human Rights Commission has recently issued Technical Guidance on the Public Sector Equality Duty and statutory guidance entitled “Equality Act 2010 Services, Public Functions & Associations Statutory Code of Practice”. The Council must have regard to the statutory code in so far as it relates to the duty and attention is drawn to Chapter 11 which deals particularly with the equality duty. The Technical Guidance also covers what

public authorities should do to meet the duty. This includes steps that are legally required, as well as recommended actions. The guidance does not have statutory force but nonetheless regard should be had to it, as failure to do so without compelling reason would be of evidential value. The statutory code and the technical guidance can be found at: http://www.equalityhumanrights.com/legal-and-policy/equalityact/equality-act-codes-of-practice-and-technical-guidance/

8.6 The Equality and Human Rights Commission (EHRC) has previously issued five guides for public authorities in England giving advice on the equality duty:

1. The essential guide to the public sector equality duty
2. Meeting the equality duty in policy and decision-making
3. Engagement and the equality duty
4. Equality objectives and the equality duty
5. Equality information and the equality duty

8.7 The essential guide provides an overview of the equality duty requirements including the general equality duty, the specific duties and who they apply to. It covers what public authorities should do to meet the duty, including steps that are legally required, as well as recommended actions. The other four documents provide more detailed guidance on key areas and advice on good practice. Further information and resources are available at: http://www.equalityhumanrights.com/advice-and-guidance/publicsector-equality-duty/guidance-on-the-equality-duty/

9. Equalities implications

9.1 There are no specific equalities implications arising from this report or its recommendations.

10. Crime and disorder implications

10.1 There are no specific crime and disorder implications arising from this report or its recommendations.

11. Environmental implications

11.1 There are no specific environmental implications arising from this report or its recommendations.

If there are any queries on this report please contact Stewart Snellgrove, Principal Officer, Policy, Service Design and Analysis, London Borough of Lewisham on: 020 8314 9308 or by e-mail at stewart.snellgrove@lewisham.gov.uk

Health and Wellbeing Board – Work Programme 2017/18

1 November 2018			
Item	**Report Title**	**Lead Organisation(s)**	**Presented By**
1	**Health Inequalities**	All	
2	**The Big Question**	All	
3	**Membership of the Board**	All	
	Information Items		
3	**Safeguarding:** • **Lewisham Safeguarding Children Board (LSCB) – Annual Report** • **Lewisham Safeguarding Adults Board (LSAB) – Annual Report**	LBL	
4	**Annual Public Health Report**	LBL	

7 March 2019			
Item	**Report Title**	**Lead Organisation(s)**	**Presented By**
1	**Health Inequalities**	All	
2	**The Big Question**	All	