



HEALTH AND WELLBEING BOARD

Date: THURSDAY, 7 MARCH 2019 at 3.00 pm

**Council Chamber
Civic Suite
Catford SE6 4RU**

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MEMBERS

Mayor Damien Egan	London Borough of Lewisham
Councillor Chris Best	Community Services, London Borough of Lewisham
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
Dr Faruk Majid	Lewisham Clinical Commissioning Group
Roger Paffard	South London and Maudsley NHS Foundation Trust
Dr Simon Parton	Lewisham Local Medical Committee
Dr Danny Ruta	Public Health, London Borough of Lewisham
Sara Williams	Directorate for Children & Young People, London Borough of Lewisham



INVESTOR IN PEOPLE

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Lewisham



INVESTOR IN PEOPLE

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.

MINUTES OF THE HEALTH AND WELLBEING BOARD

Thursday, 1 November 2018 at 3.00 pm

PRESENT: Mayor Damien Egan (Chair); Dr Faruk Majid (Vice Chair); Cllr Chris Best (Deputy Mayor, Cabinet Member for Health, Wellbeing and Older People); Aileen Buckton (Executive Director for Community Services, LBL); Val Davison (Chair of Lewisham & Greenwich Healthcare NHS Trust); Michael Kerin (Healthwatch Representative); Roger Paffard (Chair, South London and Maudsley NHS Foundation Trust); Dr Danny Ruta (Director of Public Health, LBL); and Sara Williams (Executive Director for Children & Young People, LBL)

IN ATTENDANCE: Kenneth Gregory (Joint Commissioning Lead for Adult Mental Health, LCCG & LBL); Martin Wilkinson (Chief Officer, Lewisham Clinical Commissioning Group); Salena Mulhere (SGM Inter-agency, Service Development and Integration) and James Bravin (Clerk to the Board, LBL).

APOLOGIES: Patricia Duffy (Health Intelligence Manager, Public Health, LBL); Gwen Kennedy (NHS England Representative); Tony Nickson (Director, Voluntary Action Lewisham); Dr Simon Parton (Chair of Lewisham Local Medical Committee);

1. Minutes of last meeting and matters arising

- 1.1 The Chair welcomed Dr Faruk Majid to the Health and Wellbeing Board in his role of Vice Chair. Dr Faruk Majid has replaced Dr Marc Rowland as new Chair for NHS Lewisham Clinical Commissioning Group (CCG).
- 1.2 The Chair noted the omission of a referral from Healthier Communities Select Committee in the dispatch of the papers for the November HWB meeting. The SGM Inter-agency, Service Development and Integration apologised for the error and said that this issue was being dealt with and actions taken to ensure that it didn't happen again.
- 1.3 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. BAME Health Inequalities: Mental Health

- 3.1 Mayor Egan noted that Lewisham is one of the most diverse populations in the world and it said that it is concerning that there are significant health inequalities in the borough.
- 3.2 Mayor Egan thanked Cllr Rathbone for helping to set up the BAME Mental Health Summit, in conjunction with Healthwatch, Lewisham BAME Network and the other officers.

3.3 Kenny Gregory presented this item. It summarised the findings from the BAME Mental Health Summit which was held on the 8th October 2018.

3.4 The following points were discussed:

- Kenny Gregory stressed that it was important to the BME Health Network that this was seen as the start of a longer conversation between the Health and Wellbeing Board and the Network to look at how they can work together on tackling BAME health inequalities.
- Danny Ruta said that if the HWB and BME Network wanted to start genuine co-production then it makes sense that in determining the next steps the board should come together with the BME network, rather than either group doing it on their own.
- Engagement with an academic institution to help evaluate the approach to co-production once it is developed would be useful.
- Kenny Gregory agreed and commented that at that initial meeting the key operational groups should be identified.
- Cllr Best said that she thought the BAME Mental Health Summit had been really productive and she was impressed with the enthusiasm. One of the things she noted was that there was a lack of knowledge about what different organisations were already doing in relation to mental health issues.
- That future work in this area should include young people as they had not yet been involved in the discussion.
- Funding options for future work should be explored across board member organisations.
- That there should be a stronger focus on prevention and early intervention for mental health, particularly within BAME communities.

3.5 RESOLVED: The board noted the work carried out since July and the feedback from the community regarding BAME mental health inequalities.

3.6 The board also agreed the following:

- To set up a meeting between the BAME Network and HWB to discuss approaches to sustainable co-production to support commissioning of all-age mental health services.

4. BAME Health Inequalities: Future areas of focus

4.1 Danny Ruta introduced the item explaining that in addition to Mental Health the HWB agreed at the last meeting to agree future areas of focus relating to BAME health inequalities.

4.2 Trish Duffy provided a presentation which outlined the methodology for identifying other potential areas of focus for the HWB to investigate health inequalities. Using a Public Health England guide (*Understanding Health Inequalities*) as an outline BAME health inequalities were looked at nationally, regionally and locally.

4.3 The following points were discussed:

- Mayor Egan said that the key focus should be to ensure that BAME residents have the same experience and improved outcomes in line with the rest of the population.
- Val Davison said that the Trust should be able to provide some relevant patient experience data.
- Martin Wilkinson asked how far some of the issues are condition specific e.g. are there access and awareness issues that are prevalent across multiple illnesses or are there specific issues relating to individual diseases.
- That it would be useful to find out how other HWB's in London are looking at BAME Health Inequalities.
- It would be useful to map the public/community services are already available relating to BAME health inequalities.

4.4 RESOLVED: The board noted the work carried out by the working group.

4.5 RESOLVED: The board agreed that cancer and obesity will be future areas of focus for the HWB in terms of BAME health inequalities.

5. Healthwatch Annual Report 2017-18

5.1 Michael Kerin introduced the Healthwatch Annual Report 2017-18.

5.2 RESOLVED: The Board noted the contents of the report.

The meeting finished at 3.50pm.

Agenda Item 2

Health and Wellbeing Board		
Title	Declarations of interest	
Contributor	Acting Chief Executive – London Borough of Lewisham	Item 2
Class	Part 1 (open)	7 March 2019

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)

Health and Wellbeing Board			
Title	Referral to the Health and Wellbeing Board on Lewisham and Greenwich NHS Trust's changes to the opening hours of Sexual and Reproductive Health Services in the borough.		
Contributor	Executive Director for Resources and Regeneration		Item 3
Class	Part 1 (open)	Date	7 March 2019

1. Summary

- 1.1. This report provides an overview of the error in the dispatch of the papers for the November 2018 Health and Wellbeing Board meeting, and the actions taken as a result.

2. Recommendation

- 2.1. The Board is recommended to note the report.

3. Background

- 3.1. At its meeting on 27th June 2018, the Healthier Communities Select Committee considered a report from Lewisham and Greenwich NHS Trust on its proposed changes to the opening hours of Sexual and Reproductive Health Services in Lewisham.
- 3.2. Following discussion on the item, the Committee resolved to refer its views on the communications in relation to the proposal to the Health and Wellbeing Board. The full text of the Committee's referral is copied below for information:

“The Committee notes the proposed changes to the opening hours of the Sexual and Reproductive Health service and appreciates the importance of making the changes without unnecessary delay. However, during discussions on the proposals, the members of the Committee expressed a number of queries and concerns about how service users would be made aware of the changes, if agreed, particularly those service users who may currently consider attending the outreach service at the Sydenham Green Group Practice, which would no longer be available following the proposed changes.

The Committee therefore seeks further information about the plans for communication and engagement with service users in order to be reassured that the changes will be communicated as effectively as possible and avoid any negative impact on access to sexual and reproductive health services among service users.”

- 3.3. The Committee received a response from Lewisham and Greenwich NHS Trust at its meeting on 9th October 2018, which set out the trust's communications plans for the changes. The Committee noted the response.

4. Timeline

- 4.1. Officers supporting the Health and Wellbeing Board received a draft referral from the Healthier Communities Select Committee's scrutiny manager on the 4th of September 2018. The finalised referral was received by officers on the 8th of October, along with the formal response from the Lewisham and Greenwich NHS Trust to the issues raised within the referral, (which was subsequently received and noted by the Committee on the 9th of October).
- 4.2. It was confirmed via email discussion between the scrutiny manager and relevant officers that the referral would be placed on the agenda of the next Health and Wellbeing Board (1st of November) in line with the constitutional process, and that the response already received by the Committee from the Trust would also be provided to the Board, assuming that the Committee were content with the response of the Trust.
- 4.3. The agenda for the Board meeting on the 1st of November was published on the 24th of October in line with legal requirements for the agenda and papers to be published 5 clear working days in advance of the meeting.
- 4.4. It was identified on the morning of the 25th of October that the referral had not been included on the summons and agenda as it should have been. As soon as this was identified the officer responsible took legal advice, and the Head of Law confirmed that it wasn't possible to add it to the agenda that had been published unless there were legal grounds for urgency.
- 4.5. The officer then contacted the Chair of the Committee immediately and apologised unreservedly for the error. He advised that the referral would be placed on the agenda for the next meeting of the Board (7th March 2019) to be formally received in line with the constitutional referral process, and he also offered to circulate it to the Board informally so they were aware.
- 4.6. The Mayor, Cabinet Member, Executive Director and Head of Corporate Policy and Governance were then also advised of the error on the 25th of October. Apologies were also offered to all for the officer error, an assurance given that the Chair of the Committee had been contacted as a priority and an update provided on the legal advice given and proposed course of action.
- 4.7. On the 26th of October the service manager spoke with the Chair of Overview and Scrutiny and outlined the error and offered her apologies and offered those of the officer responsible also.
- 4.8. On the 30th of October the Chair of the Committee and the Chair of Overview and Scrutiny wrote to the Head of Corporate Policy and Governance raising their shared concerns about the failure of officers to ensure the referral of the Committee was considered at the November meeting of the Board as it should have been, and also their concerns about a lack of simultaneous notification to the Chair of Overview and Scrutiny and the Mayor at the same time the Chair of the Committee was notified. The Chair's also sought an assurance that such an error would not occur again, and advised that they believed there to be an alternative solution of calling an additional meeting of the Board to receive the referral, however they were not

mind to insist on this option being taken forward, given that their concerns as outlined within the referral had already been taken into account by the Trust, as they had been assured on the 9th of October, and the additional cost an additional meeting would cause.

- 4.9. The Head of Corporate Policy and Governance responded to the Chair's letter on the 31st of October, adding his apologies for the error to those of the officer and manager, and advising that he had requested that all referrals be managed directly into the issue manager system on receipt in the future to help mitigate against such errors in the future.
- 4.10 On 3 December 2018, Healthier Communities Select Committee received a report from an appropriate officer further explaining the error in the dispatch of the papers for the November 2018 Health and Wellbeing Board meeting, and the actions taken as a result. The committee noted this report.

5. Future Actions

- 5.1. All staff have been reminded of the importance of ensuring that due process is followed and that systems are utilised for the effective management of agendas and reports. Managers will continue to support staff learning and development in this area.

6. Legal Implications

- 6.1. The Constitution provides for Select Committees to refer reports to the Executive, who are obliged to consider the report and the proposed response from the relevant Executive Director; and report back to the Committee within two months (not including recess).
- 6.2. The constitution also confirms that "No business shall be transacted at a meeting of the Council, other than that specified in the summons, subject to the provisions of Rule 25 (Urgency)".
- 6.3. Rule 25 Urgency: "Exceptionally a report on a matter of such urgency arising within a very short period before a Council meeting may be considered at a Council meeting notwithstanding that the report has not been included in the summons to the meeting. This may arise where the matter in question is of such urgency that it cannot be delayed to the next ordinary Council meeting. In such circumstances it may be submitted to the Council as an urgency report.
- 6.4. The subject of an urgency report if known, shall be included in the summons to the meeting even though the report may not be available. In such cases the report may be sent to the Mayor/members separately. The report shall contain a statement of the reasons why it needs to be considered as a matter of urgency.
- 6.5. If the report is sent so late that it is generally received less than five clear days before the Council meeting, the Chair of Council shall decide on the grounds of urgency stated, whether or not the report shall be considered or deferred to a later

meeting. If it is considered, the reasons for it being considered as a matter of urgency shall be recorded in the minutes”.

7. Financial Implications

7.1. There are no financial implications arising from this report.

Background reports:

Minutes of HCSC 27 June 2018

<http://councilmeetings.lewisham.gov.uk/ieListDocuments.aspx?CId=133&MId=5151&Ver=4>

Agenda of HCSC 9 October 2018 (draft minutes to be published on the same agenda as this report)

<http://councilmeetings.lewisham.gov.uk/ieListDocuments.aspx?CId=133&MId=5022&Ver=4>

If you have any queries regarding this report please contact Salena Mulhere 02083143380

Health and Wellbeing Board			
Title	Comments of the Healthier Communities Select Committee on the proposed changes to the opening hours of Sexual and Reproductive Health Services.		
Contributor	Healthier Communities Select Committee	Item	3
Class	Part 1 (open)	Date	7 March 2019

1. Context

1.1 Under the terms of reference of the Healthier Communities Select Committee, the Committee is able to receive referrals from Healthwatch and consider whether to make any report/recommendation in relation to such referral. The Constitution provides also for the Healthier Communities Select Committee to make reports and recommendations to the Executive/Council (including the Health and Wellbeing Board).

2. Summary

2.1 This report informs the Health and Wellbeing Board of the comments and views of the Healthier Communities Select Committee, arising from discussions held on the proposed changes to the opening hours of Sexual and Reproductive Health Services in Lewisham, considered at its meeting on 27 June 2018.

2. Recommendation

2.1 The Health and Wellbeing Board is recommended to note the views of the Select Committee as set out in this report and agree to provide a response.

3. Healthier Communities Select Committee views

3.1 At its meeting on 27 June 2018, the Healthier Communities Select Committee received a report on a proposal to change the opening hours of the Sexual and Reproductive Health Service provided by Lewisham and Greenwich NHS Trust (LGT) (attached as Appendix 1).

3.2 The Committee took oral evidence from Council and LGT officers. After questioning the witnesses and subsequent discussion, the Committee resolved to refer its views to the Health and Wellbeing Board in the following terms:

- *The committee notes the proposed changes to the opening hours of the Sexual and Reproductive Health service and appreciates the importance of making the changes without unnecessary delay. However, during discussions on the proposals, the members of the Committee expressed a number of queries and concerns about how service users would be made aware of the changes, if agreed, particularly those service users who may currently consider attending the outreach service at the Sydenham Green Group Practice, which would no longer be available following the proposed changes. The Committee therefore seeks further information about the plans for communication and engagement with service users in order to be reassured that the changes will be communicated as effectively as possible and avoid any negative impact on access to sexual and reproductive health services among service users.*

3.3 The members of the Committee understand that it is likely that the proposed changes will have been made by the time the Health and Wellbeing Board considers this referral. The committee wished to see the final communication and engagement plans in order to be reassured that service users were informed as effectively as possible.

4. Financial implications

4.1 There are no financial implications arising out of this report, but there may be financial implications arising from carrying out the action proposed by the Committee.

5. Legal implications

5.1 The Constitution states that 'the Council has appointed the Healthier Communities Select Committee to carry out, among other things, the scrutiny of health bodies under the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 and other relevant legislation in place from time to time'. The Constitution provides for the Healthier Communities Select Committee to review and scrutinise the decisions and actions of the Health and Wellbeing Board and to make reports and recommendations to the Executive/Council. It is the duty of the Executive body to respond within 2 months of receipt of the report/recommendations.

6. Further implications

6.1 At this stage there are no specific environmental, equalities or crime and disorder implications to consider.

Background papers

[Healthier Communities Select Committee Agenda \(27 June 2018\)](#)

If you have any queries about this report please contact John Bardens (Scrutiny Manager) on ext. 49976.

HEALTH AND WELLBEING BOARD			
Report Title	BAME Health Inequalities Update		
Contributors	Executive Director for Community Services	Item	4
Class	Part 1	Date	7 March 2019

1. Purpose

- 1.1 To provide the Board with a progress update on the community-led approach to addressing BAME health inequalities.

2. Recommendations

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

- Note the work carried out by nominated officers and representatives of the Lewisham BME Network since November 2018.

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 Lewisham's Health and Wellbeing Strategy.
- 3.3 The work of the Board directly contributes to the Council's new Corporate Strategy. Specifically *Priority 5 – Delivering and Defending: Health, Social Care and Support – Ensuring everyone receives the health, mental health, social care and support services they need.*

4. Background

- 4.1 In July 2018 the HWB agreed that the main areas of focus for the Board should be tackling Health Inequalities, and as an initial priority Black, Asian and Minority Ethnic (BAME) communities Health Inequalities.
- 4.2 Additional analysis undertaken by a subgroup of the Board identified three areas where it was felt the Board might add value as systems leaders in addressing the widest gaps in health inequality. These are:

- Mental health
- Obesity
- Cancer

4.3 At the November 2018 meeting of the Board it was agreed to frame the ongoing discussion concerning BAME health inequalities around these three themes and to actively engage the Lewisham BME Network in this process.

4.4 The Lewisham BME Network is a community development project, managed by the Stephen Charitable Lawrence Trust and funded by the London Borough of Lewisham. The Network is comprised of over 120 BAME stakeholder groups, all working to support Lewisham's BAME community organisations and the communities they serve. The Network includes a BAME Health subgroup which meets monthly.

5. Informal workshop for members of the Health and Wellbeing Board and the Lewisham BME Network

5.1 A meeting between representatives from Public Health, Adults Joint Commissioning, Corporate Policy and the Network's BAME Health subgroup took place on 19th December 2018.

5.2 The purpose of this meeting was to discuss how best to set up an initial informal workshop session between members of the Health and Wellbeing Board and the Lewisham BME Network.

5.3 The intention is for this workshop to set the tone for co-production going forward and identify a 'programme of work' to deliver shared, agreed priority actions regarding BAME health inequalities.

5.3 At a follow-up planning meeting on 17th January 2019 it was agreed that experienced and independent third-party facilitation was key to the success of the initial workshop session. A tender specification document, to procure this expertise, was drafted in adherence with Council guidelines.

5.4 A budget of £1,500 was allocated by Adults Joint Commissioning in support of this workshop and the tender specification advised that bids with a value higher than this would not be considered.

5.5 The specification was sent out on 30th January 2019 with a submission deadline of the 5th February 2019.

5.6 Only one bid was received but this could not be considered since the cost of their proposal was too high.

5.7 On the 20th February, the Lewisham BME Network, Adults Joint Commissioning and the Executive Director for Community Services met to agree the next steps. It was determined that an extended meeting of the

Health and Social Care Leader's Forum on the 7th March should be used for the joint working session with the Lewisham BME Network.

5.8 A revised tender specification was sent out on 22nd February. This set out the following outcomes for the proposed workshop:

- a. An interactive first conversation between statutory organisations and Lewisham BME Health Network.
- b. Develop a common understanding of systems change (policy, processes and behaviour).
- c. Reminds attendees of what the issues are e.g. Experience of Mental Health services, disparity between crisis and voluntary access to mental health provision, etc.
- d. Develop a common vision (important for steering ongoing dialogue and action).
- e. Agree principles underpinning how we work together.
- f. For Health and Wellbeing members to consider where applicable respective contributions to the health inequalities improvement programme budget.

5.9 A written report is to be produced with observations and outcomes from the workshop session including a set of recommendations. This will come to a future meeting of the Board for review and decision-making.

6 Financial implications

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

7. Legal implications

7.1 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 it 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.
- 7.2 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.
- 7.3 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.
- 7.4 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.
- 7.5 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/>
- 7.6 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

- 7.7 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/>

8. Crime and disorder implications

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

9. Environmental implications

- 9.1 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

Agenda Item 5

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	7 March 2019
Strategic Context	See body of the report		

1. Purpose

- 1.1 To update the board on the progress of the Joint Strategic Needs Assessment.

2. Recommendation/s

Members of the Health and Wellbeing Board are recommended to:

- 2.1 Note progress and comment on completed JSNAs.

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.lewishamsna.org.uk. The current content will shortly be transferred to the Lewisham Observatory where it will sit alongside wider demographic information to be a data hub for Lewisham intelligence.

[Croydon](#) have a well-established site providing the same service. The Picture of Lewisham, first published in March 2018 has now been updated for March 2019. It describes the population in terms of the key health and socio-demographic characteristics, including mortality, morbidity, ethnicity and inequalities.

- 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 now well-established and meets bi-monthly. The group has representation from Public Health, Lewisham CCG, Voluntary Action Lewisham, Children and Young People's Commissioning, the Local Medical Committee and Lewisham and Greenwich Trust. South London and Maudsley have also been identified as a membership need.

- 5.1.2 The group have approved the following JSNA Topic Assessments and refreshes to be signed off by the board:
- Parenting
 - Refresh of Tobacco Control
 - Refresh of Immunisations

5.2 JSNA Topic Assessments

- 5.2.1 The Parenting JSNA looks at the breadth of services provided in the borough and more in-depth at Domestic Violence, Mental Health and Substance misuse, the so called toxic trio.
- 5.2.2 The refresh of the Tobacco Control JSNA Topic Assessment updates data on smoking prevalence within the borough but also considers key groups such as pregnant women and people with mental health conditions. Furthermore the assessment outlines current stop-smoking services within Lewisham.
- 5.2.3 An Immunisations JSNA Refresh has also been completed. This now incorporates adult vaccinations such as flu for pregnant women and those aged 65+ and the Shingles vaccine.
- 5.2.4 A JSNA Topic Assessment on Short-term Supported Housing is nearing completion, the impetus of this was the then proposed changes to funding, which were subsequently withdrawn. A topic assessment on

Mental Health, encompassing common mental health disorders, (depression and anxiety), as well as serious mental health and dementia is underway, as is a Respiratory JSNA, which is focusing on COPD and Asthma. Refreshes of the Sexual Health and Falls JSNAs are also taking place. These will all be presented at future HWBB meetings.

- 5.2.5 Previously approved topic assessments are available on the site for information and reference.

5.3 Picture of Lewisham 2019

- 5.3.1 The Picture of Lewisham has been refreshed with up to date data. Of note, life expectancy for females has continued to improve but for males has decreased fractionally. Population projections for the borough have also been revised down.

6. Financial implications

- 6.1 There are no specific financial implications. The Public Health team will have to allocate the appropriate human resources to manage and coordinate the JSNA process. This will be funded from the ring fenced Public Health Grant. Relevant commissioners will also be required to allocate appropriate human resources to support the relevant JSNA Topic Assessments. 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 further embedded in strategic planning.

If you have any difficulty in opening the links above or those within the body of the report, please contact Stewart Weaver-Snellgrove (Stewart.Weaver-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***

Parenting JSNA

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Introduction

The impact of parenting on children's life chances is well documented, this has been shown in studies of those in early childhood, right through to adolescence^{1, 2, 3}. Research has found that it is not a particular family structure that is important but rather, *"responsible, committed and stable parenting by people who genuinely care about the child"*⁴.

The government guide '[Working together to safeguard children](#)' highlights that local authorities have an overarching responsibility for safeguarding and promoting the welfare of **all** children and young people in their area. Hence the need to look at parenting within a needs assessment. The above guide identifies that professionals should be alert to the potential need for early help for a child who has risk factors including those living in a family circumstance presenting challenges for the child, such as substance abuse, domestic violence and adult mental health problems (often called the toxic trio). As Lewisham has high prevalence rates of these risk factors, this JSNA has focused on these three issues.

Furthermore there has been growing emphasis on the term [Adverse Childhood Experiences](#) (ACES) to describe a wide range of stressful or traumatic experiences that children can be exposed to whilst growing up, which then increase the risk of experiencing a range of health conditions in adulthood. ACEs range from experiences that directly harm a child (such as suffering physical, verbal or sexual abuse, and physical or emotional neglect) to those that affect the environment in which a child grows up (including parental separation, domestic violence, mental illness, alcohol abuse, drug use or incarceration). By having services and programmes in place to minimise the number and impact of ACEs the greater the reduction in health and societal inequalities.

Focus Areas

Substance Misuse

Alcohol and drugs use has a major impact on health, anti-social behaviour, crime and other important social issues, including the well-being and development of children and young people. It is also a well-known risk factor for abuse and neglect. The National Drug Strategy 2017 states:

'Parental drug and alcohol dependence can have a significant impact on families, particularly children, and can limit the parent's ability to care for their child(ren). Parents are role models for their children and parental dependence increases the likelihood of children misusing drugs and alcohol themselves. It can also mean that children take on inappropriate caring roles for their parents.'

¹ Geddes, R., Haw, S. and Frank, J. Interventions for Promoting Early Child Development for Health, MRC, SCPHRP, 2010

² Shonkoff, P., Phillips, D.A (2000) From Neurons to neighbourhoods: The Science of Early Childhood Development.

³ Steinberg, L. (2009), A Behavioural scientist looks at the science of adolescent brain development. Brain and Cognition, 72, 1, 160-164

⁴ [The Good Childhood Report 2012. The Children's Society](#)

Domestic Violence

Living with domestic abuse can affect a person's ability to parent. Given this, parents' needs as adult victims must be seen alongside their needs as the parents of (often traumatised) children⁵. The World Health Organisation has also highlighted that women who experience domestic violence are more likely to experience depression. The guilt mothers may feel as a result can inhibit them from seeking help when their children do display signs of distress, because they fear their children will be removed by social services. This is a threat often made by perpetrators of domestic violence⁶.

Adult Mental Health

The impact of a parent or carers mental health issue will depend on their circumstances and the support they receive. However various studies have shown impacts; babies of mothers who experience perinatal mental illness are at an increased risk of being born prematurely with a low birth weight⁷. Post-natal depression can affect parents and carers bonding with their baby and have a negative impact on the baby's intellectual, emotional, social and psychological development.⁸ For older children the risks are increased for developing behaviour problems such as physical aggression by the time they reach school age and for children developing mental health problems themselves.

Parenting Support

A wide variety of programmes and services are delivered across Lewisham with a key focus on offering parenting support and increasing the opportunity for parenting to become a positive protective factor in a child's life. Where the service is not specifically targeted on the three stands above it has been listed as parenting support.

⁵ Jaffe, P. G., and Crooks, C. V. (2005). *Understanding women's experiences parenting in the context of domestic violence: Implications for community and court-related service providers*. Washington, DC: Violence Against Women Online Resources.

⁶ Humphreys, C. and Stanley, N. (2006) (eds.) *Domestic violence and child protection: directions for good practice*, London: Jessica Kingsley Publishers.

⁷ All Party Parliamentary Group (APPG) for Conception to Age 2 (2015) [Building Great Britons: conception to age 2: first 1001 days \(PDF\)](#). [London]: All Party Parliamentary Group (APPG) for Conception to Age 2

⁸ Hogg, S. (2013) Prevention in mind: All Babies Count: spotlight on perinatal mental health. [London]: NSPCC.

Facts and Figures

Summary

Lewisham has high prevalence of a number of risk factors for parents which can result in poor outcomes for children.⁹ The combination of higher levels of substance misuse, domestic violence and serious mental health issues in the adult population are likely to make the challenges of parenting greater in Lewisham than other localities. Research has found that high-risk health behaviours of smoking, illicit drug use, alcohol use, sexually risky behaviour and, in some studies, obesity are all seen to be detrimental to the quality of parent-child relationships.

These issues are compounded by other wider problems such as higher than average deprivation and a difficult housing economy. These data findings should be used to advice the planning and commissioning of parental services. Further contextual data is available in Appendix A.

Lewisham Families

The total population estimate for Lewisham in 2017¹⁰ was 301,300, which includes a young age bias and extensive ethnic diversity. There are estimated to be 39,660 families with dependent children in Lewisham¹¹. The 2011 Census provided more detailed information about households and counted 13,239 lone parent families. At 11.5% of households this was a larger proportion than in neighbouring boroughs and notably above the London (8.5%) and national levels (7.1%). Additionally there were 7,674 households with dependent children where at least one person had a long-term health condition or disability. This equates to 5.1% of households, again higher than England but in line with London and neighbouring boroughs.

Substance Misuse

Alcohol and drugs can have a major impact on the development and well-being of children and young people, as a well-known risk factor for abuse and neglect. Parental alcohol dependency is associated with child maltreatment and poor outcomes¹². Nationally between 2011 and 2014 parental alcohol misuse was recorded as a factor in 37% of cases where a child was seriously hurt or killed and 38% for drug misuse¹³. Furthermore children of parents with a substance dependency are more likely to become dependent themselves in later life¹⁴. An estimated one in three people who are in contact with drug and/or alcohol treatment population services in England has a child living with them at least some of the time.

⁹ Every Child Matters identified the five outcomes that are most important to children and young people: be healthy, stay safe, enjoy and achieve, make a positive contribution, achieve economic well-being.

¹⁰ Office for National Statistics 2017 Mid-Year Population Estimates

¹¹ Greater London Authority Datastore, 2017

¹² Burton, R., Henn, C., Lavoie, D., Wolff, A., Marden, J. and Sheron, N. (2016) The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: an evidence review, London: Public Health England

¹³ Sidebotham P, Brandon M, Bailey S, Belderson P, Dodsworth J, Garstang J, Harrison E, Retzer A, Sorensen P. Pathways to harm, pathways to protection: A triennial analysis of serious case reviews 2011 to 2014. Department for Education; 2016

¹⁴ Hidden Harm: responding to the needs of children of problem drug users. Advisory Council on the Misuse of Drugs 2003

Adults with Substance Misuse Issues who are living with Children

The Diagnostic Outcomes Monitoring Executive Summary (DOMES) report identifies what proportion of treatment users live with children under the age of 18. Lewisham levels are lower than the national figures (01/01/2016 to 31/12/2016):

Table 1: Proportion of Lewisham Treatment Users living with children under 18 (2016)

	Latest period		National average
	(%)	(n)	
Opiate	17.2%	132 / 768	27.3%
Non-opiate	19.0%	30 / 158	23.8%
Alcohol	16.2%	52 / 321	24.0%
Alcohol and non-opiate	14.0%	31 / 222	22.0%

However this is still a notable number of treatment users, indicating that there was still be a considerable number of children in the borough who live with substance misuse at home, as shown in Table 2.

Table 2: Annual met treatment need estimates, alcohol dependency 2014/15 to 2016/17

Adults with an alcohol dependency	Lewisham			Benchmark	National
	Prevalence	Treatment	% met need	%	%
Total number of adults with a dependency who live with children	615	831	14%	22%	21%
Total number of children who live with an adult with a dependency	1,178	1,701	14%	21%	21%

For particularly vulnerable groups of children, nationally, analysis indicates that 7% of young carers are looking after a parent or relative with drug or alcohol use problems. Of these, 28% had received an assessment and 40% were missing school, or had other indicators of educational difficulties¹⁵. Furthermore the Department for Education's Children in Need census showed that in 2016/17, drug use was assessed as a factor in 19.7% of cases and alcohol use a factor in 18%.

Domestic Violence

Domestic violence and abuse is defined by the Home Office as a pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, psychological, physical, sexual, financial and emotional abuse. Across the UK it is estimated that around one in five children have been exposed to domestic violence¹⁶.

¹⁵ [Dearden, C. and Becker, S. Young Carers in the UK: The 2004 Report London: Carers UK. 2004](#)

¹⁶ Radford, L. et al (2011) Child abuse and neglect in the UK today.

The Early Intervention Foundation state that the damaging impact that witnessing or experiencing domestic violence and abuse can have on children can cast a long shadow over their adult lives. The cyclical nature of the problem can mean that the fear, pain and suffering it causes are transmitted from generation to generation¹⁷. Research indicates that women with experience of extensive physical and sexual violence are more likely to have an alcohol problem or be dependent on drugs, compared to women with little experience of violence and abuse¹⁸.

Domestic Violence in Lewisham¹⁹

- 4th highest rate of domestic violence in London
- 20 recorded incidents per 1,000 population
- 2 domestic homicides in-borough since 2014

Domestic Violence Multi-Agency Risk Assessment Conference (MARAC)

A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors. Any frontline agency representative (e.g. Police officer or health professional) that undertakes a risk assessment with a victim, and thereby determines that their case meets the high risk threshold, can refer a victim's case to a local MARAC.

To give further context to the domestic violence levels in Lewisham we can analyse the number of referrals to the Lewisham MARAC. In 2017 the service received 410 referrals, almost a quarter (23%) of which were repeated referrals. In addition, a count of assessment factors from the Council's children's social care information management system, presented in 2016/17, showed that:

- There was a 13% increase in referrals for Children's Social care to the MARAC
- 55% of all child protection cases involved domestic abuse
- 244 (1.4%) of all assessment concerns, related to a child being subject to domestic violence;
- 698 (3.9%) of assessment concerns, related to a child's parent or carer being subject to domestic abuse;
- 123 (0.7%) of all assessment concerns, related to another person living in the household being subject to domestic abuse.

Adult Mental Health

Nationally over 2 million children are estimated to be living with a parent who has a common mental health disorder²⁰. In Lewisham prevalence of depression is 7.5%, this is higher than London but lower than England (2016/17).²¹ The ONS Annual Population Survey has found

¹⁷ <http://www.eif.org.uk/domestic-violence-and-abuse/> (Accessed 03.09.2018)

¹⁸ Scott, S and McManus, S. (2016) *Hidden Hurt violence, abuse and disadvantage in the lives of women*. DMSS research for Agenda. Available at: <http://weareagenda.org/wp-content/uploads/2015/11/Hidden-Hurt-full-report1.pdf> Accessed 6 July 2017.

¹⁹ Mayor's Office of Police and Crime 2016-17

²⁰ <https://doi.org/10.1186/1471-2458-9-377>

²¹ General Practice Quality Outcomes Framework (2016/17)

that one in five (20.7%) Lewisham residents self-reported as having a high anxiety score²². The GP Patient Survey found that Lewisham residents are more likely to have a Long-term mental health problem than the London or England average.²³

Crucially mental health problems do not happen in isolation but are interlinked with negative or stressful life experiences such as poverty, unemployment, physical illness, disability, social isolation, relationship breakdown or childhood abuse or neglect²⁴.

A recent (2018) JSNA Topic assessment was conducted on [Maternal Mental Health](#). 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.

Table 3: Estimated number of women affected by common MMH disorders in Lewisham²⁵

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

Table 3 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)²⁶ 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.

²² [PHE Fingertips](#)

²³ [PHE Fingertips](#)

²⁴ [Cleaver et al \(2011\) Children's Needs – Parenting Capacity1](#)

²⁵ <http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=66&geoTypeId=#iasProfileSection5>

²⁶ <https://www.gov.uk/government/statistics/birth-summary-tables-in-england-and-wales-2016>

Current Activities and Services

This section will outline the overall services available to parents in relation to the four focus areas – substance misuse, domestic violence, adult mental health and parenting support. It also outlines a number of relevant cross-cutting services that provide a holistic approach to meeting the needs of parents and their families. The Parenting Services commissioned by the council have been mapped for the Parenting Strategy in Appendix B. Relevant key data is recorded in the following targets and performance section. Appendix C provides the triangle of need diagram which illustrates Levels of Service. A guide for information on services is currently being collated by the Family Information Service.

Substance Misuse

Hidden Harm Service

The Hidden Harm Service was created in response to the issue of parental substance misuse. It is led by a coordinator and places an emphasis on services working together to protect children and safeguard their health and wellbeing. The approach was developed in 2009 and builds on the Hidden Harm agenda, which supports and protects the children of drug-using parents.

The service works with vulnerable families in Lewisham to ensure early entry into treatment for parents and an improved understanding of what needs to change to make a positive difference for children. Referrals are accepted from universal children's services when there are known/suspected parental substance misuse issues. The parent or carer can be visited at home and a wide-ranging support plan formulated considering the identified concerns with the parent and shared with the professionals from children's services. Direction is offered to other agencies around how to best support the needs of the family and facilitate change. The service has been quoted by Public Health England as a best practice example.

Adult Substance Misuse Services

Lewisham's current approach to treatment was reconfigured in April 2015 in order to better meet the needs of the following groups:

- Alcohol users
- Young people under the age of 25
- People who wish to access services in primary care settings
- People who come into contact with the criminal justice service
- Minority groups who do not wish to access mainstream integrated drug services

The system therefore consists of four main commissioned substance misuse services and a range of associated activity delivered via the council's Prevention, Inclusion and Public Health Commissioning Team, GPs, Pharmacists and the providers of detoxification and rehabilitation services.

Core Adults and Integrated Offender Management (IOM)

These services are provided by Change, Grow, Live (CGL). The Core Adults service delivers interventions for adults aged 18 years and over with complex needs including poly-drug use and dual diagnosis (with Mental Health conditions). It provides support, treatment and

rehabilitation programmes that promote recovery and encourage individuals to maintain their recovery through engagement in positive activities such as employment and training. The service provides prescriptions for opioid substitute medications such as Methadone as well as managing the interface with health services including hospitals and pharmacies. The IOM service provides the interface with the Criminal Justice System and is funded via Mayor's Office for Policing and Crime (MOPAC).

Primary Care Recovery Service (PCRS)

PCRS is delivered by Blenheim Community Drugs Project (Blenheim CDP) and provides a recovery-orientated model offering support, advice and treatment options for people living in Lewisham whose drug and/or alcohol use is stable enough for them to receive services via General Practice. The service is delivered in partnership with GPs and pharmacists and includes opioid substitute therapy, nurse led community detoxification and a range of other psycho-social recovery interventions.

The young person's element of the substance misuse service is now part of the Compass Lewisham Young People Health and Wellbeing Service. The service is delivered in partnership with Kooth Online Counselling and helps young people in Lewisham to make achievable and sustainable lifestyle changes that improve their long term health, resilience and emotional wellbeing. The multidisciplinary team delivering the service, consisting of Health and Well-being workers, Health and Well-being nurses, Health and Well-being Counsellors & Support Workers.

The service works with young people aged 10-19, (up to 25 with evidenced additional needs) and offers support to any young person in Lewisham needing help or advice with emotional wellbeing, sexual health or substance misuse. The service emphasis is on prevention and Early Help, focusing on reducing harm and protecting and safeguarding young people, but with capacity to offer more targeted and specialist treatment or make appropriate referrals if higher levels of support are needed. The service has a focus on the identification and prevention of harmful and toxic risk factors affecting young people. In particular to improve sexual health and sexual relationships; decreased levels of substance misuse and improved emotional wellbeing.

Table 4: Adult Substance Misuse Services in Lewisham

Service Type	New Direction	Primary Care Recovery Service	Aftercare	Young People
Organisation	Change, grow, live (CGL)	Blenheim CDP	Blenheim CDP	Compass
Age Range	<ul style="list-style-type: none"> 18+ for prescribing (PX) clients 18+ for all other clients 	<ul style="list-style-type: none"> 18+ for all clients 	<ul style="list-style-type: none"> 18+ for all clients 	<ul style="list-style-type: none"> Up to 19 (and on to 25 where SEND applies).
Alcohol Clients	<ul style="list-style-type: none"> Drinking more than 200 units per week Daily alcohol consumption Unable to engage in treatment offered within GP services 	<ul style="list-style-type: none"> Drinking less than 200 units per week Daily alcohol consumption Binge drinking Able to engage in treatment offered within GP services 	<ul style="list-style-type: none"> Abstinent No OST 	<ul style="list-style-type: none"> Up to 19 (and on to 25 where SEND applies).
Stimulant Clients	<ul style="list-style-type: none"> All aged 18+ 	<ul style="list-style-type: none"> All aged 18+ Non-complex co morbidity issues 	<ul style="list-style-type: none"> Abstinent 	<ul style="list-style-type: none"> Up to 19 (and on to 25 where SEND applies).
Cannabis Clients	<ul style="list-style-type: none"> All aged 18+ 	<ul style="list-style-type: none"> All aged 18+ Non-complex co morbidity issues 	<ul style="list-style-type: none"> Abstinent 	<ul style="list-style-type: none"> Up to 19 (and on to 25 where SEND applies).
NPS Clients	<ul style="list-style-type: none"> All aged 18+ 	<ul style="list-style-type: none"> All aged 18+ Non-complex co morbidity issues 	<ul style="list-style-type: none"> Abstinent 	<ul style="list-style-type: none"> Up to 19 (and on to 25 where SEND applies).
Opiate Clients	<ul style="list-style-type: none"> Poly-substance misuse Complex co-morbidity issues Clients using on top of PX Unable to engage in treatment offered within GP services IV Opiate Users (specifically neck and groin use or those at risk of significant harm) Please refer to the Joint Working Protocol between CRI, Blenheim CDP and Compass for additional guidance 	<p>Clients for whom it is agreed are suitably stable or are best placed to have their needs met in shared and primary care setting, this might include but is not restricted to:</p> <ul style="list-style-type: none"> Clients stable in education/employment Able to engage in treatment offered within GP services Those who do not wish to engage in SM specific services and meet criteria above Non-IV Opiate Users or those with no current problematic use (no neck or groin injecting) 	<ul style="list-style-type: none"> Abstinent 	<ul style="list-style-type: none"> Psychosocial support Up to 19 (and on to 25 where SEND applies). <p>Additionally the following points to be considered for exclusion:</p> <ul style="list-style-type: none"> Significant/chaotic substance use IV Opiate use (specifically neck and groin use or those at risk of significant harm) Significant physical or mental health co-morbidity Pregnancy

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Criminal Justice Clients	<ul style="list-style-type: none"> Assessments will be carried out on all appropriate clients within custody/court/probation/prison and referrals made to the appropriate service according to criteria above Any that meet the criteria outlined above 	<ul style="list-style-type: none"> Any that meet the criteria outlined above 	<ul style="list-style-type: none"> Any that meet the criteria outlined above 	<ul style="list-style-type: none"> Any that meet the criteria outlined above
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Domestic Violence

Community Groups Programme

The Pre-School Learning Alliance in Lewisham run a number of programmes for children and parents across the borough as well as a number of Children's Centres. Key within this is the Community Groups Programme. It is a therapeutic programme for women and their children who no longer reside with the perpetrator and are not in crisis.

The programme runs for 12 weeks, working with both a child and typically the mum. Children must be aged between 4 and 11 and sessions are grouped into age categories. A dedicated team of 8 volunteers provide the training, who themselves have been trained by AVA (Against Violence and Abuse).

A short questionnaire is asked at the beginning and end of the programme to monitor outcomes. In-house training on domestic violence is also provided in-house by PSLA.

Freedom Programme

Lewisham Health Visitors run the Freedom Programme, for women who have experienced domestic violence. There are currently two intakes a year. The group is for women living in Lewisham with children under 5 years. The course consists of 8 weekly half day session, each week they look at the warning signs and tactics of the dominator. The areas that are covered in the programme are as follows:

- The bully
- The bad father
- The effects of DVA on children
- The head worker
- The jailer
- The sexual controller
- The king of the Castle
- The liar
- The persuader

The programme is delivered at the Ladywell and Donderry Children's Centre, (crèche facility is available). The majority of referrals come from within the Health Visiting service, along with additional referrals from GP's, Children Centre staff and Children's Social Care. The facilitator of the group is required to have undertaken specific *Pat Craven* training.

Athena Service

The Athena service began in 2015, providing Violence against Women & Girls services and refuge provision in Lewisham. The service is run by Refuge and provides confidential, non-judgmental support to those living in Lewisham who are experiencing gender-based violence. It supports women and girls aged 13 and over, and men aged 16 or over, including those who are lesbian, gay, bisexual, or are unsure of their sexuality. As of February 2019, a service review is underway. The service is currently commissioned until early 2020.

Support for children

Athena's child support workers are based in the refuge and run play sessions and homework clubs. Most of the children staying in the refuge accommodation have experienced some form of direct or indirect abuse and the sessions are designed to give them the opportunity

to explore their experiences, learn and develop in a safe environment. The child support workers have links with local schools and children's centres, meaning children arriving at a refuge can access local education as soon as possible. Older children also have access to a computer to ensure that they do not fall behind in school as a result of moving home.

Adult Mental Health

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

Lewisham and Greenwich Trust have a specialist midwifery team, Indigo, within the Maternity Service. Jointly with the Specialist Perinatal Mental Health (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, Family Nurse Partnership, health visitors and Improving Access to Psychological Therapies. 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

The Maternity Service employs a Specialist PMH Midwife in a 0.4 part time role. Many of the key national strategies on PMH call for this role to be in place in every Maternity Service in the UK⁵⁹. 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.⁵⁹

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

Further perinatal mental health services include the 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.

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.

Health Visiting - Understanding Your Baby

Lewisham Health Visiting are currently running a pilot for the Solihull Approach "Understanding your Baby". This programme is delivered weekly over an eight week period and provides a two-hour session for up to eight mothers and their babies. The postnatal plus parenting group is intended for parents who may be experiencing difficulties that may affect their relationship with their baby. The group aims to provide a framework of thinking about parent / baby relationships, which can be developed into a lifelong skill. Themes covered:

- Exploring parents feelings about having a baby and becoming a parent.
- How parents are feeling, and how their baby may be feeling.
- Getting parents to think about who can be helpful in supporting them now.
- An outline on ways to relax.
- Information on baby brain development (emotional).
- Parents getting in tune with their baby.
- Understanding and responding sensitively to baby's crying, feeding and sleeping.
- Understanding a baby's development and play needs.
- Parents thinking about their own needs in relation to support for the future.
- A time to think about how parents experience being separate from their baby and how this might feel.
- An opportunity to reflect on what they have learnt and how they would like to develop their relationship with their baby in the future.

The criteria for the pilot programme were: (referrals only being accepted from Health Visiting service)

- women with an infant less than 9 months old and are willing to fully engage in the course.
- The group is not suitable for women with severe perinatal mental illness who require intensive support from the Specialist Perinatal mental health team.

Mindful Mums

The Mindful Mums (MM) Project runs in Lewisham to provide emotional support to women during the perinatal period. The project began in the borough of Bromley in 2016, and received funding to expand into Lewisham in 2017. The aim of the free 5-week group course is to enhance the emotional wellbeing and resilience of the participants by providing them with specific tools to deal with the unique stresses and anxieties of pregnancy and early motherhood. The groups are run by volunteer facilitators, each of them local mothers with lived experience of perinatal mental health issues. The group work content was co-produced by these peer facilitators. The groups are run in Children & Family Centres. Mothers sign up to the course themselves.

Child Adolescence Mental Health Service (CAMHS) Parental Wellbeing Service

The service has been running since 2016 and consists of one psychologist working 2.5 days per week, solely with parents, however a referral can be made to family therapy. The service

particularly aims to work with parents with a mental health need, although they do not formally have to be receiving mental health support. Typical patients have co-morbidity and difficult interpersonal skills and can struggle to engage with services. On average a client will have two to three appointments. The service aspires to build an alliance between Adult Mental health and CAMHS.

The service offers assessments but the clinician also has a treatment caseload as well as offering counselling; cognitive therapy and couple's therapy. There is also a signposting role of how patients can be linked into support and acts as a consultancy role on other cases. The bulk of services' referrals are from CAMHS. Areas for expansion include outreach work, with GPs considered to play a crucial role as gatekeepers.

Adult Improving Access to Psychological Therapies (IAPT)

Primarily for treatment of adult anxiety disorders and depression, providing evidenced based psychological therapies. In Lewisham the service is run by SLAM. It is available at many GP surgeries and other clinics around Lewisham. Increasingly Lewisham patients are self-referring into this service. The service may be appropriate for women experiencing mild to moderate depression. IAPT services do not provide complex interventions to treat substance use problems but drug and alcohol use should not be an automatic exclusion criterion for accessing psychological therapy.

CAMHS Lewisham Young People's Service (LYPS)

LYPS supports young people with enduring mental health issues, such as psychosis and personality disorder. Based in this service is a specific Early Intervention Services (EIS) clinical post who works across adult's and children's mental health services, with a key focus to aid transition to adults. This provision is well established and has been recognised as a gold standard model. This practitioner is based in CAMHS and has clinical accountability across the boundary between CAMHS and Adult Mental Health (AMH), they hold cases in CAMHS and remain the care co-ordinator as they transition to AMH Services. At age 18 there is a Transition Care Programme Approach and psychiatric responsibility transfers to AMH. The EIS Practitioner remains care co-ordinator until a suitable time when AMH can take on the case fully and this is usually between 1-3 years post 18.

As highlighted in the CAMHS Transition Policy, all young people transitioning to AMH have a CPA six months prior to their 18th birthday, targets against this have consistently been met by the CAMHS service.

Parenting Support

Health Visiting Service

The Health Visiting Service leads on the delivery of the National Healthy Child Programme (HCP), providing a universal home visiting service to all families from pregnancy up until the child is 5 years old. Through health assessments, the service delivers universal interventions to families to ensure the continued development of the child physically and emotionally. Additional targeted and specialist support is offered to more vulnerable families.

MECSH

The Maternal Early Childhood Sustained Home-visiting (MECSH) program is a structured program of sustained nurse home visiting for families at risk of poorer maternal and child

health and development outcomes. It was developed as an effective intervention for vulnerable and at-risk mothers. In summary the MECSH program:

- Provides the sustained, structured MECSH home visiting program by trained nurses*, commencing with families antenatally and continuing until the child is 2 years old.
- Supports the continuity of a home visitor with each family in the program.
- Adheres to the theoretical and practice underpinnings of the program.

Family Nurse Partnership (FNP)

The Family Nurse Partnership (FNP) is a home-visiting structured support programme for first time young parents aged 19 and under (with local adaptation to support vulnerable mothers aged 19 -22 years) until the child reaches the age of two. FNP is an evidence-based, preventive programme for first time young mothers. FNP is a targeted programme which complements the HCP, the universal clinical and Public Health programme for all children and families from pregnancy to 19 years of age. It can also be an integral part of Lewisham's Early Help offer. Participation in the FNP programme is voluntary. When a mother joins the FNP programme, the HCP is delivered by the Family Nurse (up until and including the 2-2½ year review ensuring continuity of care) instead of by Health Visitors as part of delivering the FNP programme.

Family Action - Young Carers Service

Family Action support young carers and their families through a range of activities including:

- one to one mentoring
- group activities
- health and wellbeing workshops
- holistic family support

The service aims to:

- Increase the support available to the young carer and their family to improve young carer emotional health and wellbeing and build resilience
- Support the young carers' engagement in schools and their education
- Support the young carer to pursue their interests
- Improve relationships within the family, to support the development of young carer resilience and to develop the capacity of the family to prioritise the needs of the young carer.

The service deliver the following core activities:

- 18 families/young carers (8yrs – 18yrs) each year matched with a mentor.
- Mentoring fortnightly or three weekly for 6-9 months, facilitating the young carer to identify and follow their interests
- 6 group activities a year (A range of activities – theatre, outdoor sport activities, BMX; Swimming, Ice Skating, tennis, badminton, Zoo, Science museum and cycling.

Caring and Supporting Parenting Programme

The programme is for parents whose children have been removed by Children's Social Care and are currently in assessment proceedings to have their children returned. Referral to the programme is therefore within the Children's Social Care service. The programme lasts for six weeks and has been re-adapted from the Incredible Years Programme to create a secure and supportive learning environment for parents. The ethos is that parents put themselves in the shoes of their children, through a process of mentalisation underpinning the work, using

interactive activities, discussion, role play, video footage and homework and is adapted dependant on parent's learning styles, their needs and experiences. The programme is very specific and designed to meet the issues that the parent are facing. Facilitators call the group members weekly to provide motivation and encouragement. Information and observation of progress or concerns can be shared with the child's social worker to help with decision making within the assessment process.

Groups are run three times a year, comprising of six to eight people. Attendance is good, believed to be because the groups are small. If co-parents both wanted to attend this would be done in separate groups. Sessions are held in a contact centre, that the parents are already familiar with. The programme has been running since 2012, when it was identified that this group was too vulnerable to be seen in universal services such as Children's Centres. Runs for parents of children aged 4 to 12. A similar service 'Baby Fab' runs for parents of younger children. Assessments with parents are undertaken at the beginning, mid-point and end of the programme. Parents also self-assess and together this information can be used as supporting evidence in court proceedings.

Parent Support Group (PSG)

The main purpose of this service is to support the parents and carers of children who have involvement with crime, gangs, anti-social behaviour, drug-use, teenage pregnancy, unemployment, poor school attendance or who have been diagnosed with behaviour difficulties. This support will increase parent and carer capacity to be protective factors in their child's lives.

PSG provide the following services:

- Parent sessional counselling and support service
- Drop in sessions from key locations

The intended impact is to improve family relationships in Lewisham (through person specific counselling and support) and reduce entry into tier 4 services by building emotional wellbeing and resilience to help prevent family breakdown, school exclusion and risk of entry into the Criminal Justice System.

PSG train and support volunteer counsellors, active within local communities, who are managed internally and receive external monthly clinical supervision. The clinical supervisor is qualified to level 3 Safeguarding and all counsellors are BACP registered. However, the counselling offer is not a clinical offer and focuses on emotional and practical support so operates more as an advocacy service. The support provided is not time-limited (but each service is reviewed every 6 weeks) and focuses on the holistic emotional wellbeing of all concerned; in turn, this supports each young person to overcome challenges, rebuild relationships and fulfil their potential.

Youth Offending Service (YOS) Parenting Worker

The YOS also have a Parenting Officer, initially this post was in place to oversee Parenting Orders. However there are currently no orders in place and Magistrates rarely use them. Not having contact made statutory fits with the ethos of the Lewisham YOS, instead they offer a support package and a collaborative approach is taken in working with parents, which can happen before or after or separate to a family working with FFT. The YOS team have undertaken Non-violence resistance programme training provided by Oxleas NHS

foundation Trust, which is embedded across all the work they do. This has been found to be more effective in working with the Lewisham population.

The Parenting Worker has a caseload of approximately 20 families at any one time, at a variety of intensities. Work will typically take place in three to six months chunks, this lines up with the majority of young people's orders so work can be co-ordinated. Average involvement with a young person is around 6-9 months, unless the offence is more serious. The Parenting Worker also undertakes direct relational and communications work with parents and families but also practical support. This is particularly crucial as many of the families they work with have multiple needs including illness or debt.

The Lewisham YOS as a team is working to build relationships with the voluntary sector, including food banks to be more joined up and provide better outcomes for families. The service is concerned that the young people they work with are stigmatised due to the way their children manifest behaviour, leading other people to be fearful. The team considers they would benefit from increased capacity and more partnership working. A key goal is supporting parents to self-refer, for example going to the GP or IAPT, or referrals to charities such as 1 in 4 (who support people who have experienced child sexual abuse and trauma of sexual exploitation).

Triple P Group Programme

The Triple P – Positive Parenting Programme is a parenting and family support system designed to prevent, as well as treat, behavioural and emotional problems in children and teenagers. It aims to prevent problems in the family, school and community before they arise and to create family environments that encourage children to realize their potential. It is currently run in a number of Children's Centres across the borough. It is delivered at three of Lewisham's Children's Centres.

Parents as Partners Programme

A free evidence based 16-session parents group designed to improve the relationship between co-parent's and to increase children's success and well-being. Its aim is to support and strengthen the family unit and to make family relationships more effective. It offers chaotic and vulnerable families a chance to foster better family relationships. The programme is run by Family Action.

Education Champions

The Virtual School and Children's Social Care have nominated two foster carer champions for education who are in post to provide advice to other foster carers and parents around how to support looked after children's learning within the home. The role of the education champion includes:

- Engaging foster carers with the education of their children
- Helping foster carers understand their role in the educational outcomes of their looked after children

Attending Personal Education Plan meetings with foster carers to help them in being more assertive about what they feel the child needs.

Parent Champions

The Parent Champions programme is based on the idea that parents are the best people to support other parents to find out about childcare and early years services. Parent Champions are parent volunteers who give a few hours a week to talk to other parents about the local services available to them. There are currently two Parent Champions schemes in Lewisham, which are in their infancy. They are administered by the Family Information Service (FIS) and aligned to the Family and Childcare Trust national programme. One scheme is being set up to promote the 30 hours and other childcare offers. The programme have partnered with the Early Years Quality and Sufficiency Service and will be training Parent Champions in November 2018. Alongside the programme there is a separate scheme helping families with complex needs who require early intervention services, where Parent Champions have just been trained and will begin their activity in autumn 2018. Future developments to share health messages are also proposed.

Community Parents Hub

The hub is a partnership between London & Quadrant (L&Q) Housing, Parents 1st, Creative Homes & Therapy4Healing to create a Community Parents Peer Support programme. L&Q Housing are undertaking some research around the needs of particularly single parents of primary school or below, age group, though others can be involved. The hub is currently still in the development stage undertaking workshops and establishing a steering group.

Parent Resilience Training

The primary aim of the Parent Resilience Training is to work in partnership with Parent ENGage, Bromley, Lewisham and Greenwich MIND (BLG MIND) and schools to deliver introductory parent resilience workshops to help to promote and develop resilience in Lewisham parents. Work will take place for a period of 6 months (commencing September 2018) to train up volunteer parent facilitators and support them to deliver two workshops for 20-30 parents. The workshops will focus on an introduction to resilience and tools and techniques parents can use. The workshops will be universally available to parents of the school population.

Cross Cutting Services

Early Help & the Multi-Agency Safeguarding Hub (MASH)

The Multi-agency Safeguarding Hub (MASH) provides a single point of access for all professionals to report safeguarding concerns to children's social care. Professionals can also request commissioned targeted family support through the multi-agency early help panel. The MASH is a consent-based model. Professionals dealing with suspected child neglect, abuse or need for support, will endeavour to work in partnership with parents. This means the professional will:

- be open and honest with parents about the concerns they have about a child(ren)
- explain to parents, before making a referral, how the MASH team will share information about the child and family to get the best possible picture about the child's circumstances.

Resident's and other members of the public are also able to refer into the MASH. Once a referral has been accepted the family will be referred on to relevant services.

Creative Homes

Run group sessions to help families connect and support each other on a local level to strengthen communities and our pathways service helps families to access further support around them. In Lewisham they are working with Lewisham Homes and L&Q Housing.

Lewisham Safer Stronger Families (Family Support Service)

This service is commissioned by the CYP Joint Commissioning Team and provided by Core Assets. The service provides intensive, practical support to families within their own home via a 12 week intervention programme (followed by a 10 week step-down period). Support is focused on three evidence-based delivery approaches (Triple P Level 4, Solution Focused Brief Therapy and Team Parenting), which enable children and families to build resilience, set achievable goals and develop positive relationships. Referral is via the Early Help process. The service is funded by the Troubled Families Programme. The service is now also offering a special service with referrals directly from Family Social Work (Level 4).

Functional Family Therapy

Functional Family Therapy (FFT) is an evidence-based family therapy intervention which is targeted at families who have a young person (aged 10-17) engaging in persistent anti-social behaviour, youth offending and/or substance misuse. The criteria has now increased so that the young person must be deemed 'at risk' of offending.

The young person and his/her parents attend a one-two hour session with a FFT therapist on a weekly basis for as long as the family needs. The programme content reflects the needs of the family, impacting positively on family conflict, communication, parenting and youth problem behaviours. It has been running since 2014/15 but from 1st March 2017, the management of FFT transferred from CAMHS to the Youth Offending Service which coincided with the project's third developmental phase, Generalisation. This has created an opportunity for FFT to become an integral and embedded part of the YOS's intervention to identified families.

The team comprises an FFT Site/Clinical Supervisor and two FFT Therapists which is the minimum number of staff for a viable FFT team. As well as from the YOS, FFT accept referrals from CAMHS, identified schools (Abbey Manor College, New Woodlands, Deptford Green/Addey and Stanhope, Prendergast Ladywell Fields and Sedghehill) and Children's Social Care (CSC). The management move to the YOS has stimulated an increase in referrals from the YOS. Between March 2017 and October 2018, 90 young people were referred to FFT, 78 of whom were accepted. 36% completed the programme successfully.

Working with Men

This service is focussed on supporting positive father engagement. It employs 1 WTE (father's development worker or FDW) and the key targets and aims for delivery are to:

- Work intensively with 40 young fathers in Lewisham
- Implement a strategic work plan to provide where appropriate a 'one to one' support package for E/YFs, and their children with the key aim of moving the E/YF into positive achievements and outcomes for themselves, their children and healthy relationships, within the extended family.
- Promote the positive image of Young Fathers.
- Continue to build on the strong working relationship built with partner agencies, stakeholders, organisations, agencies and services in Lewisham, and to sit on the

Early Help Panel for Lewisham in relation to safeguarding children and supporting families.

- Continue to build on supportive and engaging relationships with each E/YF and families.
- Develop and execute regular workshops, group sessions and forums with YFs and professionals, for E/YFs and service.
- Increase numbers of referrals through outreach and partnership working in the community and through the EHP, outreach, promotions and drop-in sessions

The support offered by the FDW includes; informal legal advice and support in family court sessions as a McKenzie Friend; advocacy and empowering YFs within CP /RCPC and CGMs, as well as partnership working and development of, in need and appropriate programs, and forums which promote the positive outcomes for family issues raised by the professional services for Lewisham, and generally for the families being supported.

CYP-IAPT

In 2013 PSLA became the Lewisham VCS partner in the National Children and Young People's Improved Access to Psychological Therapies Programme (CYP IAPT). They deliver either the 14 week Incredible Years Parenting Programme to groups of parents or 1:1 Personalised Intensive Parent Training (PIPT) programme to a parent and child.

Both of the above programmes offer the support/intervention recommended within NICE guidelines for treatment of children with ODD/Conduct Disorder. Currently we are the only provider working within the CYP IAPT framework to offer this intervention²⁷.

Youth First

Youth First is a community benefit society that spun out of Lewisham Council's youth service in September 2016. It provides Lewisham's young people with a universal open door youth offer of:

- Safe places to go
- Fun things to do and learn
- Help, support and early intervention from professional and passionate youth workers

Youth First works with over 11,000 young people, delivered by over 50 staff, working from five adventure playgrounds and five youth centres.

²⁷ <https://www.nice.org.uk/guidance/cg158/chapter/1-Recommendations>

Targets and Performance

This section shows the key relevant data that is collected against each focus area and where possible performance against target. It is important to highlight that these are often high level snapshots and that more detailed data reporting will sit behind each commissioned service.

Substance Misuse

The Hidden Harm Service provided information on levels of referrals for one month in spring 2018. Within this time frame, 41 parents or expectant parents were referred. The majority of referrals had multiple children living in the home, and just over half were categorised at Level 4. Just under half of referrals related to more than one substance, i.e. Alcohol and Cannabis.

Domestic Violence

As of May 2018 there were 68 children on the waiting list for the Community Groups Programme which indicates the high levels of need in Lewisham.

Of the 942 referrals Athena received between February 2016 to August 2017, 546 (58%) reported that Domestic Violence was the primary element or formed a part of abuse. Table 5 presents a detailed breakdown of issues experienced by clients seen in Quarter 2, 2016/17.

Table 5: Athena Clients (Quarter 2, 2016/17)

Issue experienced	Number
Experiencing domestic violence	294
Clients experiencing stalking (intimate partner)	62
Clients experiencing sexual violence (intimate partner)	89
Clients experiencing honour based violence	12
Clients experiencing sexual violence (non-intimate partner)	13
Clients experiencing child sexual exploitation	16
Total referrals for the quarter	339

Adult Mental Health

Mindful Mums

Between September 2017 to June 2018, 161 Lewisham women joined the Mindful Mums programme. There were 12 groups run across the school year, each lasting five weeks with one session per week. 91 women completed a full evaluation of the programme, which used the Mind Resilience Tool, including pre and post-programme measures. This evaluative model is based on evidence showing that resilience is affected by three key areas – wellbeing, social capital, and psychological coping strategies. 93% of women showed improved resilience scores - 58% of women increased in all three outcome areas, 25% increased in two areas, and 10% increased in one area.

Women were also asked questions on their enjoyment of the programme, confidence and learned skills. 100% enjoyed the programme and would recommend it to a friend, 100% said that they learnt skills that they can take away and use, 99% said they had improved confidence, 86% said that they felt better able to cope, 82% felt happier and more positive, and 79% felt less isolated since attending the groups.

As of July 2018, six Mindful Mums groups have run, with 89 participants. Almost nine in ten respondents (89%) of mums attending improved their resilience scores in at least one area after attending the course.

Specialist Perinatal Mental Health Service (SLaM)

Between April 2018 - October 2018, the average caseload for the Specialist Perinatal Mental Health Service was 227 Lewisham women, all of whom were in the perinatal period with moderate to severe mental health needs. The service works with women with a range of mental health needs, including depression, anxiety, psychosis, borderline personality disorder, post-traumatic stress disorder, obsessive-compulsive disorder, and eating disorder. As of September 2018, the average waiting time for treatment was two weeks, and the average length of stay in the service was 8 months.

Health Visiting - Understanding Your Baby

A pilot of the Understanding Your Baby Postnatal Group was delivered by the Lewisham Health Visiting Service between April - June 2018. Seven women attended the session. Pre and post-course screening was completed using recognised screening tools - the PHQ9 for depression, GAD7 for anxiety and the Karitane Parenting Confidence Scale. The results showed a decrease in anxiety and depression and an increase in parenting confidence. Following the success of the pilot, a second group is being run in autumn 2018, and three new groups will be run in 2019.

Parenting Support

Table 6: Functional Family Therapy Service Data (2017/18):

Source of Referral	Number of referrals	Number allocated and currently engaged	Number awaiting allocation	Number not accepted
Youth Offending Service	7	3	3	1
CAMHS	4	3	1	0
Schools	5	1	2	2
Children's Social Care	4	0	2	2
Total	20	7	8	5

On average a family will begin therapy two to three months after being referred and the therapy will last between four to six months. As of May 2018 the FFT service was engaging 23 families.

Core Assets Safer Stronger Families Service

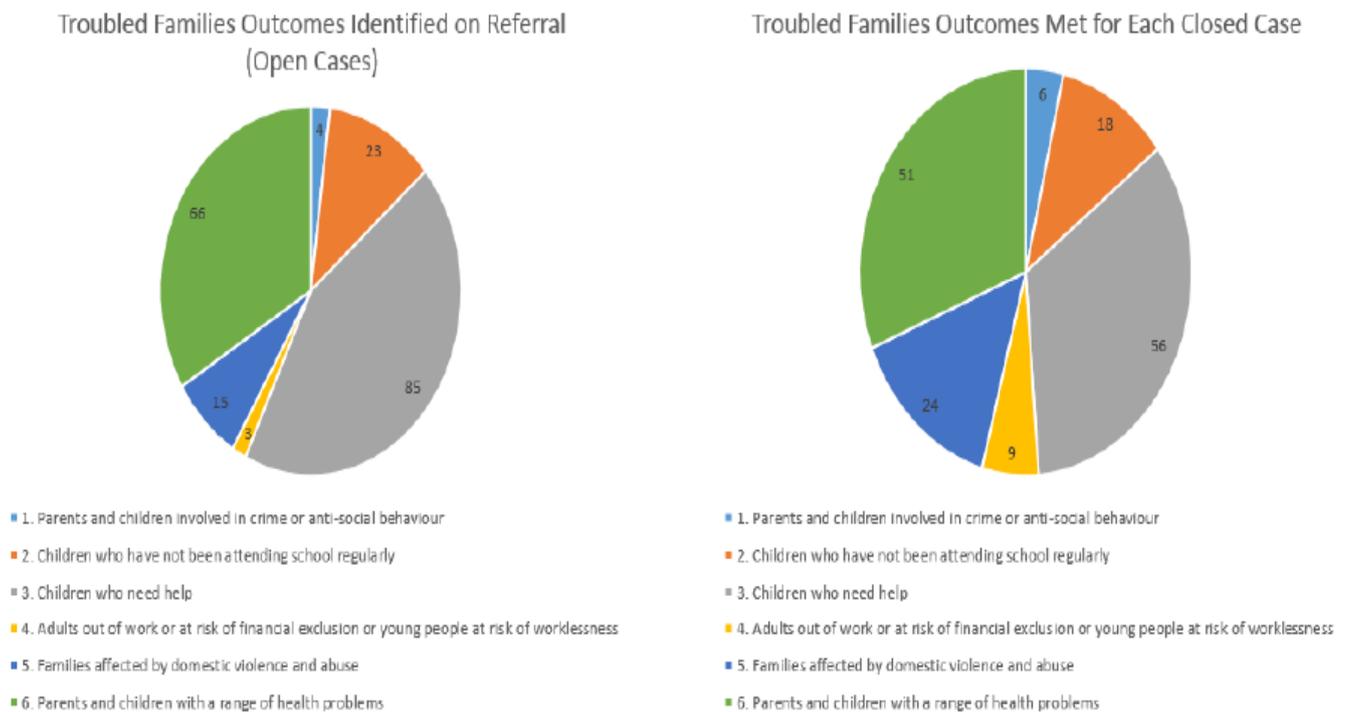
As the service is funded by the Troubled Families (TF) programme, which works on a Payment by Results model, service data is used to measure TF outcomes. Data below is for Q2 (July, Aug, and Sept) 2018-19 unless stated.

Referrals

From the cases heard at the Early Help (EH) Panel during this quarter, Core Assets accepted 87 cases and 75 cases were allocated to other services. It took 10 days on average to undertake the initial Team Around the Family (TAF) meeting, which is within the 15 day target set.

For open cases actively being worked on, TF outcome 3 (Children of all ages who need help) was the most frequently identified (85 cases), followed by 6 (Parents and children with a range of health issues - 66 cases). The least frequently identified was outcome 1 (Parents and children involved in crime or anti-social behaviour - 4 cases). Proportionately, the TF outcomes most frequently met were also 3 and 6 (56 outcomes and 51 outcomes respectively).

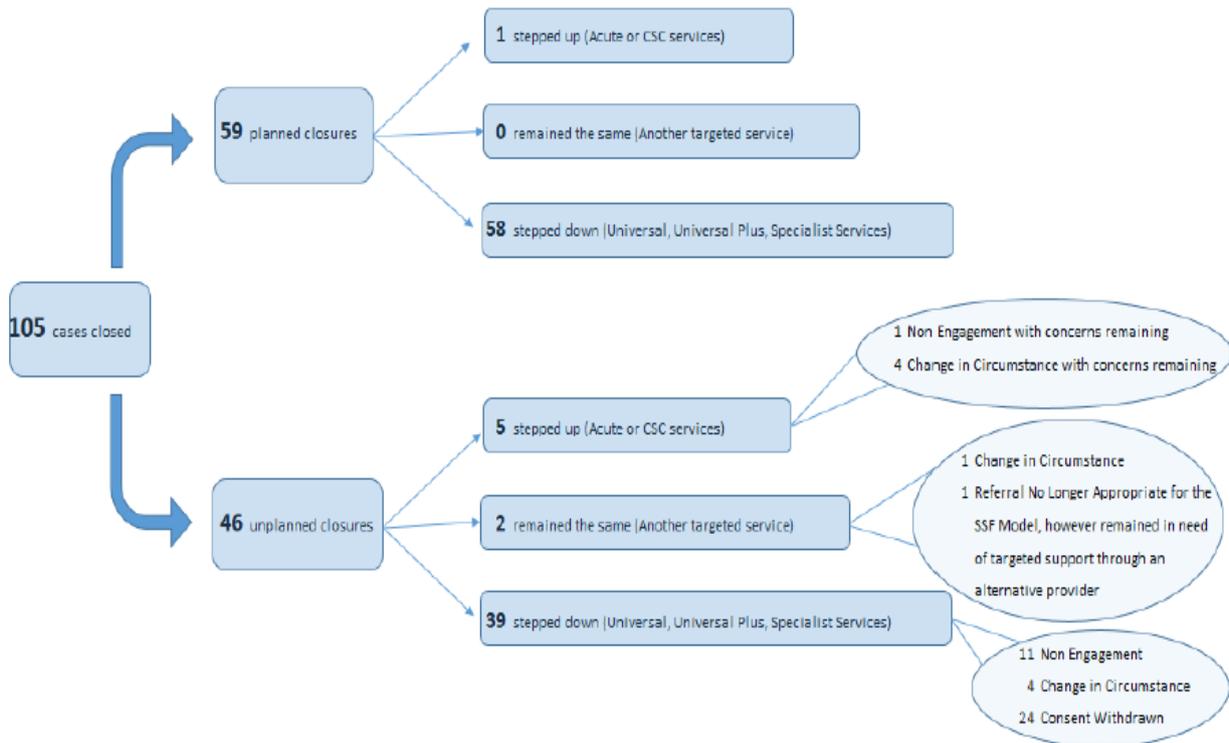
Figure 1: Safer Stronger Families Service - Troubled Families Outcome Data



Closures

105 cases closed during this quarter, of which 59 were planned and 46 were unplanned closures. The majority of the cases closing (both planned and unplanned) this quarter were stepped down to Universal / Universal Plus level (92%). For unplanned closures, the rate of stepdown was slightly lower due to safeguarding concerns for the case remaining.

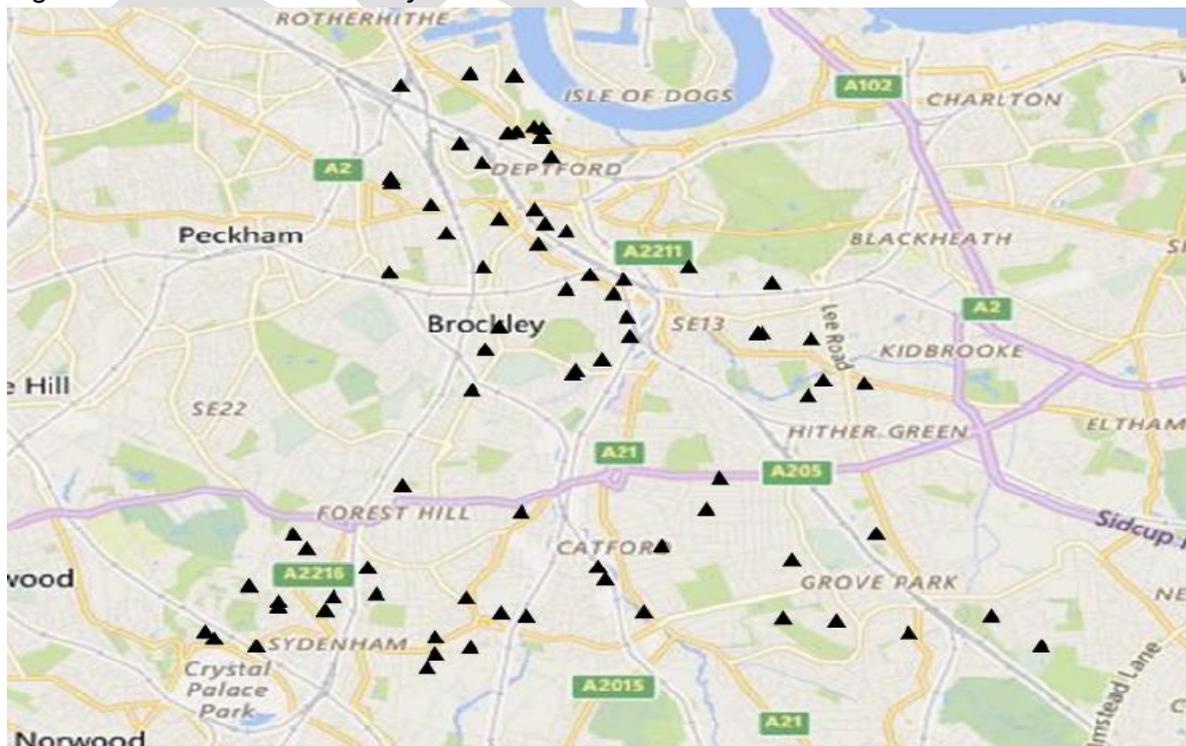
Figure 2: Reasons for closures and associated level of need



Service User Location

Of the 87 cases accepted this quarter, there are variations in service user intake across the borough shown in Figure 3. There are higher levels of referral intake particularly from the northern wards (Deptford area) but also from the south-west wards (Sydenham area). This is likely to be reflective of levels of poverty (which in turn may affect levels of crime and need), in these areas and higher volumes of social housing.

Figure 3: Service user intake by location



Demographics

Just over half (53%) of the 196 service users were aged between 12-17. The service has been delivered to slightly more males than females this quarter, 54% male and 46% female. The Core Assets intake of service users from a wide variety of ethnic backgrounds is reflective of the diverse borough of Lewisham. Religion was not stated for the majority of service users.

Outcomes

The 'Family Star' questionnaire is completed with all parents, asking them to reflect on where they feel they currently are within different categories. The scores in October show improvement in all but one of the areas, the greatest improvement was in the areas of Education and Learning, Meeting Emotional Needs, Your Well-being and Progress to work.

The 'My Star' questionnaire is completed by the young person. The questions / categories are reflective of those faced by young people. The scores for cases closing during this month show improvement in all areas. The greatest improvement is reflected for Feelings and Behaviour category, followed closely by the Confidence and Self Esteem category. The lowest improvements were in the "Where you Live" and "Being Safe" categories, this was due to a family moving out of borough which impacted on the young person's view of their living situation.

Figure 4: Family Star Plus Outcomes - October 2018



CYP-IAPT

Table 7 shows the number of families using the CYP-IAPT service in recent years.

Table 7: CYP-IAPT Outputs

Year	Total Referrals	Total Families Engaged	Breakdown Group	
			Incredible Years Group	Personalised Intensive Parent Training
2014-15	49	15	1 group 8 parents	7 families
2015-16	37	12	1 group 7 parents	5 families
2016-17	104	42	3 groups 29 parents	13 families
2017-18	57	28	3 groups 18 parents	10 families

Outcomes

A requirement of the CYP IAPT programme is use of routine outcome measures when working with parents/children. The minimum data set used with parents includes:

- Initial Strengths & Difficulties Questionnaire (parent)
- Current View (EET)
- IAPT Goal Progress Chart
- IY Parent Weekly Evaluation Form
- Brief Parental Self Efficacy Scale (BPSES)
- Session Feedback Questionnaire (SFQ)

This is an extremely robust way of measuring the programme impact, parental confidence, understanding and engagement of the sessions, and how the practitioners themselves are delivering and meeting parent expectations.

Strengths and Difficulties Questionnaire's (SDQ)

The SDQ breaks down the clinical data into different areas:

- Conduct Disorder: Measures defiance and behavioral problems in relation to other children of their age
- Emotional Problems: Potential emotional issues that could underlie the behavioural problems of the child and could indicate potential Mental Health issues
- Impact: Impact that the child's behaviour has on a family
- Help: Level of help & support experienced by families from programme engagement
- BPSES: This measures the parent's confidence in their parenting skills and understanding of strategies they can use to help address issues and behaviours.

For emotional/conduct/impact a third of service users reported improvements. For 'Help' the scores indicated that all parents feel the programme had an impact with 50% reporting a great amount. For BPSES Just over 2/3 of the group showed a reliable increase in confidence in their parenting ability as a result of the group.

National and Local Strategies

National Strategies

The section below sets out key national strategies in each of our focus areas.

Substance Misuse

[Drug Strategy \(2017\)](#)

The overall aims of the Home Office's Drug Strategy are to:

- Reduce illicit and other harmful drug use
- Increase the rates recovering from their dependence

The approach to achieving this is divided over four key objectives:

- Reducing Demand
- Restricting Supply
- Building Recovery
- Global Action

Specific to parenting and families the strategy acknowledges that parental drug and alcohol dependence can have a significant impact on families, particularly children, and can limit the parent's ability to care for their child(ren). Parents are role models for their children and parental dependence increases the likelihood of children misusing drugs and alcohol themselves. It can also mean that children take on inappropriate caring roles for their parents. Crucially the strategy acknowledges that there are families where substance misuse is just one of a number of other complex problems. Actions were identified for Public Health England to:

- PHE will also work with Family Drug and Alcohol Courts and local public health teams to help them to work together to improve outcomes for families and children.
- PHE will review the evidence and provide advice on the estimated number of children likely to be affected by the drug and/or alcohol use of their parents, and provide advice to national and local government on where action could have the greatest impact on improving children's outcomes.

Domestic Violence

[Ending Violence Against Women and Girls Strategy \(2016-20\)](#)

Builds on the original plan from 2010 which had four pillars of prevention, provision of services, partnership working and pursuing perpetrators as its framework. The vision of the updated strategy is that by 2020 the below objectives are met:

- There is a significant reduction in the number of VAWG victims, achieved by challenging the deep-rooted social norms, attitudes and behaviours that discriminate against and limit women and girls, and by educating, informing and challenging young people about healthy relationships, abuse and consent;
- All services make early intervention and prevention a priority, identifying women and girls in need before a crisis occurs, and intervening to make sure they get the help they need for themselves and for their children;
- Women and girls will be able to access the support they need, when they need

it, helped by the information they need to make an informed choice;

- Specialist support, including accommodation-based support, will be available for the most vulnerable victims, and those with complex needs will be able to access the services they need;
- Services in local areas will work across boundaries in strong partnerships to assess and meet local need, and ensure that services can spot the signs of abuse in all family members and intervene early;
- Women will be able to disclose experiences of violence and abuse across all public services, including the NHS. Trained staff in these safe spaces will help people access specialist support whether as victims or as perpetrators.

Specific to parenting the strategy identifies that effective multi-agency responses are also critical in managing adolescent to parent violence.

Adult Mental Health

[No Health without Mental Health - \(2011\)](#)

A cross government outcomes strategy, sets out six shared objectives to improve mental health, wellbeing and outcomes for people with mental health problems:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Specific actions to be taken include

- prioritise early intervention across all ages;
- take a life course approach, with objectives to improve outcomes for people of all ages;
- tackle health inequalities, and ensure equality across all protected characteristics, including race and age, in mental health services;

The strategy acknowledges some parents will require additional support to manage anxiety and depression during pregnancy and the child's early years, which can have an adverse effect on their child's development. States plans to work with Health Visitors and School Nurses to ensure that these staff are properly equipped to identify and help parents, infants, children and young people who need support with their emotional or mental health.

Advocates for adolescents, multi-systemic interventions that involve young people, parents, schools and the community have been shown to reduce conduct disorder, improve family relationships and reduce costs to the social care, youth justice, education and health systems. Further acknowledgement that families often experience multiple problems, such as substance misuse or mental health problems, parenting problems, child neglect and behaviour problems in school, or involvement in offending. Evaluation of family intervention has shown reductions in mental health problems, drug or substance misuse and domestic violence.

[Five Year Forward View for Mental Health](#)

This national strategy, which looks at both adults and children, was published in February 2016, following the establishment of a Mental Health Taskforce in March 2015. It aimed to take a strategic approach to improving mental health outcomes across the health and care system. It set out three main aims:

- Making it easier for everyone to access high quality services
- Bringing mental health care and physical health care together
- Promoting good mental health and stopping people from having mental health problems

Parenting

England does not have a Parenting Strategy, however Scotland published theirs in October 2012: *Making a positive difference to children and young people through parenting*²⁸. The strategy sought to champion the importance of parents to Scottish society, by strengthening the support on offer to parents and by making it easier to access that support.

Cross-cutting strategies

[Troubled Families Programme](#)

The Troubled Families Programme aims to help families overcome multiple and complex problems, many of whom would previously have been let down by services that focused on the specific problems of individual family members rather than the whole family's overlapping needs. The programme is working with families to address a number of problems including: domestic abuse, physical and mental health problems, crime, worklessness and debt.

The current programme (2015-2020) now specifically supports families with younger children and those with a broader range of problems, such as substance misuse, domestic abuse or mental health issues.

Local Strategies

Substance Misuse

[Lewisham Alcohol Delivery Plan \(2015-17\)](#)

The plan is divided into four strands:

- Prevention
- Treatment and Recovery
- Co-ordination and enforcement of existing powers against alcohol-related crime, disorder and anti-social behaviour
- Intelligence

The Alcohol Delivery Group, works in partnership across the borough to oversee the plan.

²⁸ <https://beta.gov.scot/binaries/content/documents/govscot/publications/publication/2012/10/national-parenting-strategy-making-positive-difference-children-young-people-through/documents/00403769-pdf/00403769-pdf/govscot:document/>

Domestic Violence

[Violence Against Women and Girls Plan 2017-2021](#)

VAWG brings together eight strands of policy under one umbrella:

- Domestic violence and Abuse
- Stalking
- Female Genital Mutilation
- Crimes said to be committed in the name of 'honour.'
- Trafficking for Sexual Exploitation
- Sexual Violence and Rape
- Prostitution
- Forced Marriage

The strategic priorities of the plan are Protecting and Educating; Deliver the Right Support; Working Together and Ensure that perpetrators are held to account.

Adult Mental Health

[Maternal Mental Health Action Plan](#)

A Maternal Mental Health JSNA was carried out in March 2018, which produced a set of recommendations and corresponding action plan. Mental health in the perinatal period (from conception to one year after birth) is an issue that is of concern to a wide range of services and commissioners, and the Maternal Mental Health Action Plan was developed and carried forward in partnership between the Maternity Service, Health Visiting Service, CYP and Adults MH commissioners, Children's Social Care and Early Help and GPs.

Perinatal Mental Health remains a priority for the CCG across Maternity and Mental Health commissioning, and is included within the 2019/20 Mental Health Commissioning Intentions, 2019/20 CAMHS Transformation Plan and Maternity Better Births Implementation Plan for the STP. There is a strong network of Perinatal Mental Health professionals in Lewisham, including a specialist midwife and health visitor and a number of perinatal mental health clinicians, that work together to achieve the recommendations of the JSNA and Action Plan.

[Lewisham CAMHS Transformation Plan \(October 2018\)](#)

One of the plans priorities is 'Care for the most vulnerable', which has the sub-section 'Enhancing preventative and integrated support for perinatal mental health'. The plan include details of the Perinatal Mental Health Pathway, current services offered and details on performance, as well as future objectives:

- Seek to enhance prevention, early intervention and integrated approaches to perinatal mental health support.
- Evaluate and review the Specialist Perinatal Mental Health Team in response to the Community Service Development Funding coming to an end in March 2019.
- Build a closer partnership approach to perinatal mental health commissioning, across Children's and Adults Mental Health and Maternity Commissioning.
- Raise awareness of perinatal mental health and provide further training opportunities for local GPs.
- Share and raise awareness of the Integrated Perinatal Mental Health Pathway, including responsibility for mental health screening, amongst Health and Social Care Professionals.

Cross-cutting strategies

[Children and Young People's Plan \(2015-18\)](#)

The Lewisham Children and Young People's Strategic Partnership has identified four key areas to improve outcomes for children and young people. This work is to be taken forward through our Children and Young People's Plan 2015-18. The priority areas are:

- Build child and family resilience
- Be healthy and active
- Raise achievement and attainment
- Stay safe

Lewisham aims to work across the partnership to ensure that the right of every child to live in a safe and secure environment, free from abuse, neglect and harm is protected. Joint working will identify and protect children and young people at risk of harm and ensure that they feel safe. The Children and Young People's Partnership Board, chaired by Cllr Barnham, oversees the progress of the plan.

[Early Help Strategy \(2016-20\)](#)

The strategy was published in the understanding that providing early help is more effective in promoting the welfare of children than reacting later in life. The five key objectives of the strategy are:

- 1) To understand and respond in a timely way, apply the revised continuum of need document and assess needs of children, young people and families
- 2) To develop appropriately targeted early help services and support prevention, early intervention and crisis intervention
- 3) To create a clear 'menu' and pathway of support across all partner agencies so that families and professionals understand what support is available and how it can be accessed
- 4) To support families to be resilient and effectively address issues they are facing to stop their needs from escalating
- 5) To embed resilient practice in community settings, which will enable families to be appropriately supported in these settings as soon as issues arise

Progress on the objectives is monitored by the Early Help Board.

Local Views

During the preparation of this JSNA, we consulted with local parents both in an online survey and in focus groups. Key themes identified by parents during the consultation around this strategy and through other recent consultations have been highlighted below.

Lewisham Parenting Strategy Consultation

An online survey was undertaken in May 2018, to look at how the council supports parents in the borough. It aimed to gain insight on the challenges parents face, how services meet the needs of those who use them and how services could be planned to meet needs in the future. The survey was completed by 203 parents. The survey [link](#) was distributed via schools, Lewisham and Greenwich Trust, service providers and community and voluntary organisations. The key findings were:

- Lack of knowledge about what is on offer was listed as the main barrier to accessing support. Other barriers included time of service, waiting lists and childcare.
- Different parents want different types of support. The consultation highlighted that there needs to be a wide range of types of support available as different parents prefer different types of support.
- There is a need to involve fathers and partners in services. We currently do not engage well with fathers and partners evidenced by the fact that only 7% of responses for the online consultation were from fathers. Few fathers will present at parenting support as it often targeted to mothers.
- The majority of parents who have accessed parenting support previously felt it had impacted positively on their parenting and on their children.
- We engage well with parents of children with SEND. 31% of respondents reported having at least one child with Special Educational Needs and Disabilities which is an over-representation compared to the demographic of Lewisham.
- From their experiences of bringing their children up in Lewisham, parents are concerned about crime and gangs, education and mental health.
- At a 'Thrive LDN' Lewisham Community Workshop held in March 2018, the need to educate and empower parents to effectively deal with issues arising throughout childhood was highlighted. This event also highlighted the importance but lack of parenting support.

Focus groups

The views of parents with alcohol or substance misuse issues are often not heard in the development of strategies and plans. In May 2018, two focus groups were undertaken with parents attending the CGL Women's Group and Aftercare Group. The aim of the focus groups was to gain insight on the specific challenges parents who had been in receipt of services for alcohol and/or drug abuse and how they felt they could be better supported. A total of 18 individuals (both male and female) attended the two focus groups. The key findings were:

- Parents in aftercare felt that thresholds for accessing services was their biggest barrier to accessing support. They felt if services were more pro-active rather than reactive their children may not have needed as much input from social services. The main factor was knowing where to go for support and how to access it.

- Parents felt that there should be more psychological support for children who are exposed to addiction. This could help to break the cycle of addiction and propose methods for children to understand and handle their emotions.
- Parents wanted more support around understanding their rights and the rights of a social worker when contact is initiated. There were suggestions that this could take the form of an information pack given to parents at the first contact or that they could have support from advocates.
- Parents in treatment suggested that childcare was the main barrier to support. Groups held before the school run worked best but their children are their priority.
- Parents can feel stigmatised at general parenting groups or workshops. Parents voiced that they felt they couldn't be honest with "normal mums at other groups".
- Parents would value more follow up after attending courses and groups. It was highlighted that often after a few months of an activity when it stops you are alone again.
- Parents would value more activities for their children to do after school. This would help them spend more time to focus on their own health and wellbeing.

Views of parents with young children were captured at the end of a Mindful Mums session and a focus group was held at the Maternity Voices Partnership. The key findings from these parents were:

- Parents have worries about accessing childcare and unclear about the processes for accessing free childcare. They do not find the information on either the Government or Lewisham website clear and would value having professionals or knowledgeable peers to talk to.
- Parents would like more parenting groups in the evenings and at weekends so that working partners have the chance to attend.
- Parents would like a variety of support. Parents acknowledged that it is nice to come to groups such as Mindful Mums with their babies but at other times it would be nice to leave their child at home and focus on themselves. They also spoke about sometimes offering groups in other venues that were outside of the child environment so they could focus on their own needs.
- Parents would value seeing the same midwife and health visitor to help them to establish relationships and to have consistency in the service and information provided.
- Parents would value a consistency in information during and after their pregnancy. Parents felt that messages from Health Professionals were inconsistent including the roles of the groups of professionals.

What Works?

As described Lewisham currently has a variety of parenting services provided across the partnership. In order to understand where resource could be focused in future a review of relevant research and evidenced parenting programmes was undertaken.

The Joseph Rowntree Foundation carried out a number of research projects on parenting. It summarised these in its 2007 publication *'Parenting and the different ways it can affect children's lives: research evidence'*, which pulled together findings from seven separate research projects on parenting. Recurring themes were:

- Differences in child temperament, among other factors, demonstrate that **flexible, adaptable parenting** is more likely to be effective than a 'one size fits all' approach.
- The quality of parent-child relationships shows considerable stability over time. **Some dimensions of parenting are important in children's lives irrespective of age**, especially whether relationships are warm and supportive or marked by conflict.
- **Warm, authoritative and responsive parenting is usually crucial in building resilience.** Parents who develop open, participative communication, problem-centred coping, confidence and flexibility tend to manage stress well and help their families to do the same.
- Young children's relationships with their mothers typically affect their development more than father-child relationships. But **teenagers' relationships with their fathers appear especially important to their development and achievement in school.**
- Children's perspectives show that what young people 'think' is not necessarily what parents 'think they think'. **Parents tend to underestimate their own influence**, but are also prone to take insufficient account of children's feelings at times of emotional stress.
- There is no clear-cut, causal link between poverty and parenting. However, **poverty can contribute to parental stress**, depression and irritability leading to disrupted parenting and to poorer long-term outcomes for children.
- **Policy, practice and research on parenting have made simplistic assumptions about parenting in black and minority ethnic communities.** Stereotyped misunderstandings about 'tradition' and 'culture' have contributed to failures to protect children from abuse.
- **Parents most in need of family support services are often the least likely to access them.** Evidence suggests that engagement can be improved by: accessible venues and times for service delivery; trusting relationships between staff and users; a 'visible mix' of staff by age, gender and ethnicity; involving parents in decision-making; and overcoming prejudices concerning disabled parents, parents with learning difficulties and parents with poor mental health.

Any review of commissioned services should consider these factors within their selection framework.

Research conducted for the [Scottish Parenting strategy](#) (2012) found that **parents wanted clear, concise and consistent information at every stage** of being a parent from conception to teenage years. The most commonly recurring obstacles to finding this information were:

Finding relevant information when it's needed - including the different stages of children's development, how to manage behaviour and how to respond to the challenges of the teenage years. Information needs to be clear to avoid confusion.

Not knowing where to turn for help - Many parents said they do not know where to go or who to ask, leading to feelings of isolation and being left to cope alone.

Cultural differences - The language barrier was one commonly cited reason for parents of different cultures not asking for help, along with a lack of understanding by services and agencies of their culture.

In summary the dissemination of accurate information and understanding where to find it are key. This reinforces finding from the Lewisham Parenting Strategy survey. Overcoming potential barriers such as are also key, particularly relevant in such a diverse local authority as Lewisham.

Older Children

As part of the development of the Scottish Parenting Strategy, a review of interventions to [support parents of older children and adolescents](#) (pre-dominantly children aged 7-19) was conducted. Many findings overlapped with general parenting, which were: Reducing stigma, making services accessible and understanding what will support parents engaging with a parenting programme increase its success. Its key points are summarised below:

1. Family-centred help-giving approaches are successful

Give families choice regarding involvement and provision of services and parent/professional collaboration and partnerships. Services need to be characterised by practices that treat families with respect and dignity; and which share information.

2. Parents' experiences and perceptions of parenting programmes

The most successful programmes are ones which allow parents to acquire knowledge, skills and understanding along with feelings of acceptance and support from other parents. This may enable parents to regain control and feel more able to cope with their parenting role.

3. Address the Support needs of mothers, fathers and carers

It was found that the support needs of parents are often not sufficiently addressed in designing services. Parents and children's views should be taken into account through effective evaluation. Parents seek a certain type of support from professionals. Parents require support in the form of advice and practical skill development, emotional support, personal and social skills support, family relationship-building skills, opportunities to learn, education and training and financial support. Support can be preventative or treatment; some families may require both forms of support.

4. Community-based interventions and removing stigma associated with parenting programmes

The findings suggest that community-based parenting skills programmes have the potential to improve child behaviour, welfare, and reduce the amount of time spent in care and levels of juvenile crime. Addressing the barrier of negative stigma and ensuring that parents feel comfortable in receiving help through non-judgemental, empathic support from staff is a key facilitator to engaging parents.

5. School-based interventions

School-based interventions that involve parents and carers can improve child behaviour, school attendance, relationships, prevent or reduce substance misuse and potentially increase educational attainment. Offering support through a single point of contact for parents can improve both parental engagement and child outcomes. Studies have indicated that service provision in a school setting is less stigmatising and can facilitate engagement. Making access to support as easy as possible through convenient locations and providing childcare. Fathers and ethnic minority parents face particular barriers to access which should be considered as part of service design and delivery.

6. Policy initiatives

Policy initiatives that provided financial supplements or incentives to parents had no effect or a potentially negative effect on child outcomes. However the limited evidence was drawn from the US.

Potential Programmes to Utilise

There are a wealth of existing parenting programmes in addition to those currently running in Lewisham, with varying degrees of evidence base behind them. A number with a strong evidence base are described below:

Strengthening Families Programme (SFP)

The [SFP](#) is an evidence-based family skills training program found to significantly improve parenting skills and family relationships, reduce problem behaviours, delinquency and alcohol and drug abuse in children and to improve social competencies and school performance. Child maltreatment also decreases as parents strengthen bonds with their children and learn more effective parenting skills. The programme was originally developed in the 1980s in the US for high-risk and general population families. This programme has been deemed by the UK Faculty of Public Health as having a strong evidence base. The original programme consisted of 14 sessions, a seven session programme was then developed for low risk children. The programme continues to be developed and adapted to widen its reach and impact. In London the programme has been implemented in Kingston and Richmond, utilising Troubled Families funding.

A number of evidence reviews have been conducted in the UK, including work by the [Early Intervention Foundation](#) and Oxford Brookes University, detailing its effectiveness in 10-14 years olds.

Family Links Programmes

[Family Links](#) has been working throughout the UK for over 20 years to support children, parents and teachers with their emotional health and wellbeing, with an emphasis on early intervention. As well as working with children and parents, they provide other training to professionals such as social workers and those in health care. Again the UK Faculty of Public Health has deemed their work to have a strong evidence base.

The organisation has a *Talking Teens* programme that works specifically with parents of teenagers, or soon-to-be teenagers. The four week parenting programme was [evaluated](#) in 2018 and found that there was a statistically significant improvement in all measures,

showing significant improvements in parenting self-efficacy and aspects of family life. Wirral Council's Family Intervention Service is an example of the programme.

Supporting Father's Involvement Programme

Supporting Father's Involvement is a programme being trialled in the UK that was originally designed to reduce couple conflict but has recently been shown to have secondary preventative application for couples at risk of low severity domestic violence and abuse. It is a couples, group based approach particularly concerned with improving fathers' involvement in family life within low income families with relatively high levels of conflict. The [Early Intervention Foundation](#)'s 2014 report on Domestic Violence and Abuse found that the programme required further testing but was 'an example of a promising and innovative approach'.

Families with current reported domestic violence and abuse concerns, or current child protection involvement are excluded from participation but the programme has been shown to reduce future domestic violence and abuse incidents. The intervention has been subject to a US Random Control Trial involving more than 270 low-income families, which showed that a 16-week couples group, led by trained mental health professionals, resulted in a reduction in parenting stress, an increase in father involvement in the tasks of child care, maintenance of couple relationship satisfaction, and stable children's problem behaviours (in contrast with increasing problems in the control group) over an 18 month follow up period. A benchmarked non-controlled second study of another 270 low income couples participating in Supporting Fathers Involvement not only maintained the levels of couple relationship satisfaction seen in the original RCT, but also significantly reduced parenting stress, reduced violent behaviours (including hitting and screaming), reduced children's aggressive behaviour and increased father involvement in the family.

Child First

[Child First](#) is a US national, evidence-based, two-generation model that works with very vulnerable young children and families, providing intensive, home-based services. The programme was identified by the Early Intervention Foundation as meeting several criteria of the Troubled Families Programme²⁹. However it has not yet been used in the UK.

Evaluation work has been conducted on outcomes between 2010-2017 in conjunction with the Research and Evaluation Team at the University of Connecticut Health Centre. It found that following participation within the programme 78% of children and families showed improvement in at least one area, 56% in at least two areas, and 35% in at least three areas.

Child First data analysis has continued to show strong outcomes in the following areas:

- Improvement in child language development
- Improvement in child social skills
- Decrease in child behavioural problems
- Decrease in maternal depression
- Decrease in parent stress
- Strengthening of the parent-child relationship

²⁹ Children of all ages who are identified as in need or are subject to a Child Protection Plan; Families affected by domestic violence and abuse and Parents identified with mental health problem

What should we be doing next?

It has been difficult to collect some service data for this JSNA, due to a number of the parenting support offers being provided by small organisations who have limited capacity to performance manage. Therefore it is not always possible to understand the reach and impact of the numerous programmes working with families. Data collection and analysis is an area for expansion to ensure that outcomes can be quantified and value for money realised. Related to this is equalities monitoring information. As the borough continues to grow, it is set to increasingly diversify. Hence it is crucial to understand if use and uptake of services is representative, to mitigate any potential inequalities between groups.

The mapping exercise of services is extremely helpful to understand what is available however this work needs to be developed further with pathway diagrams created to enable both parents and professionals to know where to seek help or make referrals. As reflected in both the literature (particularly research conducted for the Scottish Parenting Strategy) and the Lewisham Parenting Strategy Consultation, knowing where to find information is crucial. It is encouraging that a directory of services is currently being produced by the council, however it is vital that this is widely publicised and kept up to date. It also needs to be accessible for the wide ranging audience it must reach, so be useable by residents who do not speak or read English; have learning difficulties or another impairment. Greater awareness should also mean that the right referral is made, this is particularly important when there are multiple issues, for example an underlying condition needs to be successfully addressed before further parenting support is offered to ensure it is not counter-productive and that the parent is well enough to consistently apply the techniques or learning. This would then have the knock-on effect of less repeat or inappropriate referrals happening. The Hidden Harm service is an excellent example of this principle in practice.

As well as a *Parenting Support* offer, specific services are in place around *Substance Misuse, Domestic Violence and Adult Mental Health* but again access could be improved by services working in a more joined up way and adapting their offer, which was a key finding from the Parenting Survey. Mapping pathways as mentioned above should also assist. This is particularly relevant, as discussed, the toxic trio issues do not happen in isolation. This links back to ACES and the aim to reduce the number of traumatic experiences children go through.

Underserved groups include fathers, older children and younger parents (where the Family Nurse Partnership is not applicable). These areas should be addressed, particularly engagement with fathers. Transition is a further area that would benefit from further examination, both transition from primary to secondary school and from children to adults services.

Recommendations Summary

- Use mapping/directory of services to create pathways document(s). This could be done by level of need and/or by issue, e.g. Domestic Violence.
- The Family Information Service is currently in its infancy, explore how it will be expanded to include details of services that parents can self refer into
- Co-ordination and amalgamation of commissioned service monitoring data, including equalities monitoring, to help build a clear picture of need across the borough

- Attempt to better understand non-commissioned provision in the borough
- Consider how to access more information on dads and older children
- The development of an overarching Parenting Strategy with a connected Action Plan would provide a framework to take the learning from this needs assessment alongside continual improvement and review of parenting support across the borough.
- Consideration of our parenting offer to be included in the early help review

DRAFT

Appendix A - Additional Indicators of Parenting Capacity in Lewisham

Social Care

Examining social care data gives us an understanding of the level of children living in an area who need help or protection.

Children in Need (excluding Looked After Children and those with a Child Protection Order)

Children in need are defined in law through the Children Act 1989, as children who are aged under 18 and:

- need local authority services to achieve or maintain a reasonable standard of health or development
- need local authority services to prevent significant or further harm to health or development
- are disabled.

In 2017/18 there were 1,526 Children in Need in Lewisham. Information on gender was available for 1,461 of these children, 55% were male and 45% were female. Black African and White British were the largest groups (both 21%), however this is an over-representation for Black African child who make up just 15% of the 0-18 population and an under-representation for White British children who comprise 26% of the 0-18 population. Black Caribbean children were also over-represented within the Children in Need cohort.

Children with a Child Protection Plan

There were 327 Lewisham children with a Child Protection Plan in 2017/18, with an almost even gender split. Whilst White British children comprised the biggest ethnic group, it was Black Caribbean children who were most over-represented at 19%, (this ethnic group comprise 10% of the population).

Looked After Children

There were 480 Looked After Children in 2017/18, again split evenly by gender. As seen with Child Protection Plans, White British children were most numerous, yet Black Caribbean children were over-represented at 19% of all Looked After Children. In Lewisham children are more likely to become looked after due to abuse or neglect, rather than due to family stress or dysfunction or absent parenting. The same pattern was seen for Children in Need.

Table 8: Children's Social Care Data (Data for 2017)

	Rate per 10,000 children under 18		
	Lewisham	London	England
Children who started to be looked after due to abuse or neglect	24.8	14.3	16.2
Children who started to be looked after due to family stress or dysfunction or absent parenting	3.4	11.6	9.3
Children in Need	392.8		
Children in need due to family stress or dysfunction or absent parenting	69.0	97.9	93.8
Children in need due to abuse or neglect	241	166.3	172.9

Teenage Pregnancy

Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poor quality housing and are more likely to have accidents and behavioural problems.³⁰

In Lewisham in 2016, 100 young women aged under 18 years conceived, (22.1 per 1,000 population)³¹. Whilst this is a 40% reduction since 2009 the borough remains the 7th highest in London but similar is to the national average (18.8 per 1,000 population). In 2016, 12 girls became pregnant under 16 years, a rate of 2.8 per 1,000 population; the national rate was 3.0. Of under 18 conceptions in Lewisham in 2016, 59.0% led to abortion, compared with the national average of 51.8%.

Deprivation

In relative terms, Lewisham remains amongst the most deprived local authority areas in England. In the overall Index of Multiple Deprivation or IMD (the combined score from all the indices), Lewisham's average score was 28.59, which puts Lewisham as the 48th most deprived of all 326 Local Authorities (one being the most deprived). This means that Lewisham is within the 20% most deprived Local Authorities in England³².

The percentage of dependent children aged under 20 in relative poverty (living in households where income is less than 60 per cent of median household income before housing costs) was over one in five (22.7%) in 2015³³.

The percentage of children eligible and claiming free school meals in 2017 was 17.6%, a rate that was higher than London (16.5%) and the national figure (13.9%). Furthermore Long term claimants of Jobseeker's Allowance in 2016 was also higher than England and seventh highest of any London borough. In terms of income Average weekly earnings (2017) at £520.60 Lewisham residents were lower than comparable neighbours.

Housing

The housing charity Shelter³⁴ states the major influences on a child's life as: family income, effective parenting, and a safe and secure environment - are all directly or indirectly influenced by a family's housing conditions. Furthermore poor housing conditions increase the risk of severe ill-health or disability by up to 25% during childhood and early adulthood. Lewisham faces significant and increasing housing challenges. The Family homelessness

³⁰ Public Health England, 2016 <https://www.local.gov.uk/good-progress-more-do-teenage-pregnancy-and-young-parents>

³¹ ONS, 2017

<https://fingertips.phe.org.uk/search/teenage#page/4/gid/1/pat/6/par/E12000007/ati/102/are/E09000023/iid/20401/age/173/sex/2>

³² Department of Communities and Local Government (2015)

³³ HMRC, 2018

³⁴ https://england.shelter.org.uk/__data/assets/pdf_file/0016/39202/Chance_of_a_Lifetime.pdf

rate at 5.2 per 1,000 households (2016/17) was notably higher than London and more than double the national average. The number of people on the housing waiting list in Lewisham is increasing. In 2016/17 there were 1,864 households in Temporary Accommodation.

Schools Data

School Absence³⁵

Ensuring all children and young people fulfil their potential requires regular school attendance in order to benefit from the developmental opportunities offered by schools. Missed learning opportunities increases the risks of falling behind academically and socially. Children and young people who attend school regularly and punctually are less likely to be at risk, both in terms of engaging in anti-social behaviour and in terms of their own health safety and welfare. Children with low levels of attendance tend to achieve less in both primary and secondary schools.

It is therefore encouraging that overall school absence in Lewisham for 2016/17 was 4.5% (Primary 3.9% and 5.2% for secondary). The overall absence rate for pupil enrolments known to be eligible for and claiming free school meals (FSM) was 7.0%, compared to 4.1% for non FSM enrolments. The percentage of FSM eligible enrolments that were persistent absentees was 21.6%, compared to 8.2% of pupil enrolments that were not eligible for free schools meals. The overall absence rate for Lewisham Children Looked after is 7.9% (authorised is 5.2% and unauthorised is 2.7%). 70% of the cohort have over 95% attendance, there are no Children Missing Education, however 19.9% of the cohort are persistently absent. The report data not give data by gender or ethnic group.

School Exclusions

In the academic year 2016/17 there were 67 permanent exclusions from Lewisham schools, 22% (11 pupils) less than 2015/16. There were an additional 16 Lewisham residents excluded from secondary schools outside of the borough. Persistent disruptive behaviour was the main reason for exclusion in Lewisham schools, with verbal/ physical assault on another pupil and offensive weapons / knives being the other two main causes.

Table 9: Exclusion reasons - Lewisham schools only

Reason	2016/17	2015/16
Drugs	6	6
Offensive weapons / knives	13	23
Persistent disruptive behaviour	25	28
Verbal/ Physical assault on another pupil	15	21
Verbal / physical assault on an adult	2	0
Sexual misconduct	4	0
Racist abuse	1	0
Damage	1	0

³⁵ Access, Inclusion and Participation: Attendance Annual Report 2016/17

Excess weight

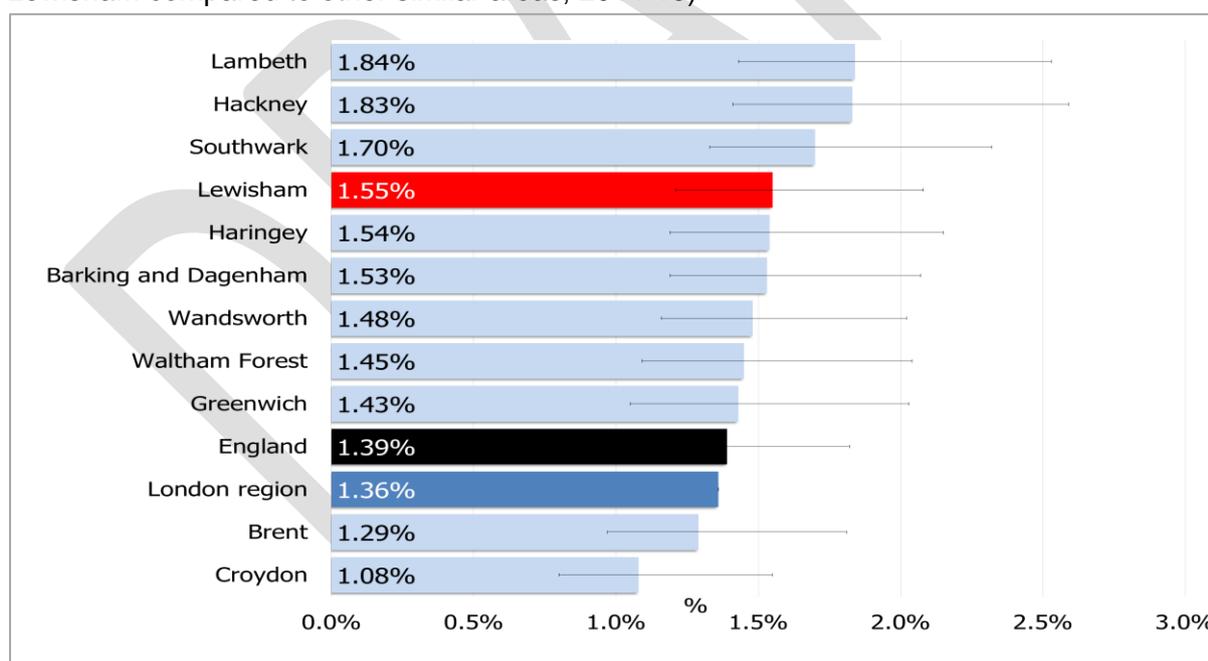
A number of studies, including the Joseph Rowntree Foundation found that parental obesity had an impact on the quality of parent-child relationships³⁶. Adult excess weight in Lewisham is 57.8%, (childhood levels range from 22% in Reception to 39% in Year Six). All ages are above the national average illustrating the additional challenges Lewisham faces in tackling obesity and its many associated problems. Maternal obesity also increases the risk of poor pregnancy outcomes and is a risk factor for childhood obesity. Data from Lewisham Hospital for 2017-18 indicates that 47.6% of women attending their maternity booking appointment (at around 13 weeks of pregnancy) had excess weight. Within this group, 40% were either obese or morbidly obese. Benchmarking data is not available for this indicator, as areas are not required to report the data.

Substance Misuse Contextual Data

Adults - Alcohol

Alcohol is the leading risk factor for deaths among men and women aged 15 to 49 in the UK. Whilst Lewisham performs 'well' against the national average for alcohol related hospital admissions, the alcohol specific mortality rate is increasing (12.8 deaths per 100,000 population) and is now highest out of all similar boroughs, this is also compared to a flat national figure (10.4 per 100,000 population)³⁷. This appears to be driven by mainly by premature mortality for men from liver disease and is an indication of higher alcohol misuse.

Chart 1: Dependent Drinkers aged 18+ (Estimated % with 95% Confidence Intervals. Lewisham compared to other similar areas, 2014-15)



Lewisham is seen to have more adult dependent drinkers than most similar areas and England, however the confidence intervals for this indicator are particularly wide, this has a potential impact if parents are heavily represented within this group.

³⁶ Parenting and the different ways it can affect children's lives: research evidence (2007) <https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/2132-parenting-literature-reviews.pdf>

³⁷ Public Health England, 2018

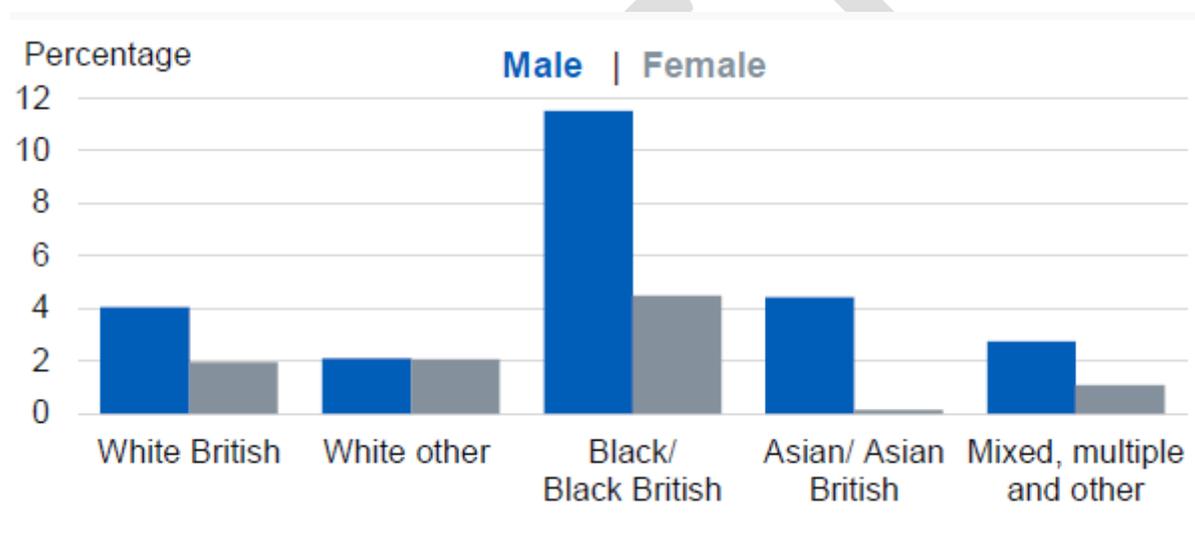
Drug Users - Adults³⁸

Across England in 2016/17, 8.5% of adults used an illicit drug at least once. Whilst it is not possible to ascertain what proportion of this group were parents we do know that the 25 to 34 age range saw the highest level of hospital admissions with a primary diagnosis of poisoning by illicit drugs.

Drug dependence

Using age-standardised data, the proportion showing signs of dependence was highest (at 7.5%) among adults in the Black/Black British group. Despite this in previous years (2016), those in treatment were more likely to be White. This has particular implications for Lewisham with a large Black African and Black Caribbean population. It also highlights issues with access to treatment across ethnic groups. Those who were categorised as unemployed or economically inactive were more likely to be classed as drug dependent.

Chart 2: Drug Dependence by Ethnic Group – Nationally (2016/17)



Lewisham Data

Data on use of drugs is periodically produced by Public Health England at local authority level. Lewisham is considered to have higher levels of use of opiates and/or crack cocaine than London or England.

Table 10: Use of Opiates and/or Crack Cocaine in Lewisham

	Rate per 1,000 Population		
	Lewisham	London	England
Estimates of use of opiates and/or crack cocaine (2014/15) ³⁹	9.4	8.9	8.6
Estimates of injecting of opiates and/or crack cocaine (2011/12) ⁴⁰	3.05	1.97	2.49

³⁸ All data taken from NHS Digital publication <https://files.digital.nhs.uk/publication/c/k/drug-misu-eng-2018-rep.pdf>

³⁹<https://fingertips.phe.org.uk/search/drug#page/4/gid/1/pat/6/par/E12000007/ati/102/are/E09000023/iid/91117/age/182/sex/4>

⁴⁰<https://fingertips.phe.org.uk/search/drug#page/4/gid/1/pat/6/par/E12000007/ati/102/are/E09000023/iid/91118/age/182/sex/4>

The Diagnostic and Outcome Measure Executive Summary (DOMES) Report is a quarterly report that contains key treatment outcome and diagnostic data at a partnership level to assist local areas to monitor performance and compare that to national trends. Data below is taken from the Lewisham report for Quarter 3 report for 2016/17. Successful completions from substance misuse treatment, is deemed the key measure for tackling drug and alcohol dependency. Lewisham's outcomes are similar to the national average:

*Table 11: Number of Lewisham Drug Users in Treatment (Q3 2016/17)*⁴¹

	Number in Treatment
Opiate Treatment	779
Non Opiate Treatment	409
Alcohol Treatment	342

*Table 12: Lewisham Clients successfully completing Drug Treatment Services (Quarter 3 2016/17)*⁴²

	Lewisham (%)	London (%)
Opiate clients	6.5	6.6
Non-opiate clients	41.3	36.7
Alcohol clients	34.2	38.3

In the calendar year 2016, 6.3% of Lewisham opiate drug users left treatment successfully (and did not re-present to treatment within six months). For non-opiates, the figure was 42.5%. Lewisham has lower success rates compared to the best performing similar local authorities. As would be expected from the lower level of successful completions, Lewisham has a higher level of representations into treatment. At the six month review following successful completion of treatment, both opiate and non-opiate drug users in Lewisham were more likely than the national average to report a housing need (Q3, 2016/17).

Substance Misuse - Young People

Table 13: Lewisham Young People in Treatment Services

<i>Number in specialist services</i>	<i>Q4 2016-17</i>	<i>Q1 2017-18</i>
No. of young people under 18 in specialist services in the community	88	27
No. of young adults, 18-24, in 'young people only' specialist services in the community	127	45
No. of young people under 18 in specialist services within the secure estate	0	0

Contextual Mental Health Data

Nationally 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. Furthermore people in the Black broad ethnic group were the most likely to have been detained under the

⁴¹ Diagnostic Outcomes Monitoring Executive Summary, Q3 2016/17

⁴² Diagnostic Outcomes Monitoring Executive Summary, Q3 2016/17

Mental Health Act in 2016/17 - with 272.1 detentions per 100,000 Black people. People in the White ethnic group had the lowest rate of detention, at 67.0 per 100,000 White people. Again this has specific implications for the Lewisham population with its large proportion of black residents.

Severe mental illness (SMI) is a group of mental health conditions characterised by psychosis. Such illnesses tend to have poorer prognosis, are more likely to require hospitalisation, and are often comorbid with other health problems. They can cause large reduction in life expectancy, in the range of 10-20 years. It is therefore of note that Lewisham has higher rates of serious mental illness (1.31%) compared to the national average (0.92%)⁴³, although the local rate is similar to those of our neighbouring boroughs.

Lewisham has a lower prevalence of SMI in younger people, and in particular young women, possibly reflecting underdiagnoses of this age group. Converse to the national picture there is 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.

Table 14: Prevalence of SMI by age, comparing Lewisham GP Data with the Annual Psychiatric Morbidity Survey (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%

Table 15: Prevalence of SMI by Gender, comparing Lewisham GP Data with the Annual Psychiatric Morbidity Survey

	Lewisham	APMS Average
<i>Female</i>	46.5%	45.5%
<i>Male</i>	53.5%	54.5%

⁴³ General Practice Quality Outcomes Framework (2016/17)

Appendix B - Current Parenting Services

Table 16: Current parenting Services by Provider

Name of service	Provider	Commissioned by
Aftercare service	Blenheim CDP	Adults Commissioning Team
Athena	Refuge	Adults Commissioning Team
Child Sexual Assault Hub	Safer London	CYP Joint Commissioning Team
Children and family centres	PSLA, Clyde, Donderry, Kelvin Grove and Eliot Bank	CYP Joint Commissioning Team
Community Groups Programme	Childrens Centres	CYP Joint Commissioning Team
CYP IAPT	CAHMS	CYP Joint Commissioning Team
Education Champions	Virtual School	CYP Joint Commissioning Team
Expectant Fathers Programme	Working With Men	Lewisham & Greenwich Trust
Family Cooking on a Budget	Adult Learning Lewisham	Adult Learning Lewisham
Family Early Intervention Substance Misuse Support Pathway	In-house service	Adults Commissioning Team
Family Information Service	Online Directory	Early Years Quality & Sufficiency
Family Nurse Partnership (FNP)	Lewisham & Greenwich Trust	CYP Joint Commissioning Team
Family Social Work (SSF)	Core Assets	CYP Joint Commissioning Team
Freedom Programme	PSLA/Health Visiting	CYP Joint Commissioning Team
Functional Family Therapy	Youth Offending Service	CYP Joint Commissioning Team
Health Visiting	Lewisham and Greewich Trust	CYP Joint Commissioning Team
Indigo (Specialist Midwifery Team)	Lewisham & Greenwich Trust	CYP Joint Commissioning Team
Lewisham Autism Support	National Autistic Society	CYP Joint Commissioning Team
Lewisham Safer Stronger Families	Core Assets	CYP Joint Commissioning Team
Lewisham Young Carers Project	Family Action	CYP Joint Commissioning Team
Lewisham Young Carers Project	Family Action	CYP Joint Commissioning Team
Local Offer	Online Directory	CYP Joint Commissioning Team
Maths for Parents	Adult Learning Lewisham	Adult Learning Lewisham
MECSH	Lewisham & Greenwich Trust	CYP Joint Commissioning Team
Mindful Mums	MIND	CYP Joint Commissioning Team
New Direction	Change Grow Live	Adults Commissioning Team
NVR	CAHMS	CYP Joint Commissioning Team
Parent and Child Housing Service	One Support	Adults Commissioning Team
Parent Champions	Family and Childcare Trust	Early Years Quality & Sufficiency
Parent Support Group	In-house service	Attendance & Welfare
Parental Wellbeing Service	CAHMS	CYP Joint Commissioning Team
Place2be	Place2be	CYP Joint Commissioning Team
Primary Care Recovery Service	Blenheim CDP	Adults Commissioning Team
Safeguarding in Education	Lewisham Council	Attendance & Welfare
SENDIASS	KIDS	CYP Joint Commissioning Team
Understanding your baby	Health Visiting Service	CYP Joint Commissioning Team
Volunteering Service	Family Lives	CYP Joint Commissioning Team
Young Fathers Project	Working With Men	CYP Joint Commissioning Team
Aftercare service	Blenheim CDP	Adults Commissioning Team

Appendix C - Three Stage Model

Figure 5: Three Stage Model



All partners within the Lewisham Children's Partnership arrangement have agreed to work against our three stage model: universal, targeted and specialist within a single framework in which services will deliver the vision for our children and young people.

Appendix D - Academic Research Context

Much contemporary research on parent-child relationships can be traced to four dominant perspectives:

- **social learning theory** (Social learning theory is based on the assumption that children's behaviour will improve when appropriately reinforced - good behaviour is rewarded and bad behaviour is either ignored or appropriately sanctioned. Social learning theory-based programmes teach parents strategies for dealing with child misconduct, such as time out and withholding privileges, and encouraging positive behaviour through proactive reward systems, such as sticker charts and point systems.)
- **attachment theory** (is based on the notion that an infant's ability to form a strong emotional bond with their primary caregiver is a natural part of its development. The security of this bond, also known as attachment security, is largely determined by the parent's ability to respond sensitively and appropriately to their infant's bids for attention. Programmes based on attachment theory therefore aim to improve parental sensitivity by increasing parents' understanding of their children's needs and attachment related behaviours.)
- **parenting styles** (is based on research that suggests children's behaviour is directly related to their parent's child-rearing practices. Parents who combine high levels of parental warmth with high levels of supervision are more likely to have children who are more confident, more autonomous and more socially responsible. This parenting style is often referred to as an authoritative style of parenting, as it recognises the child as an individual in his or her own right and promotes personal responsibility. For this reason, many parenting programmes include elements which encourage parents to allow their children to take risks within a family environment amidst high levels of supervision.)
- **the model of human ecology** (assumes that a child's development is determined by his or her interaction within the nested environments of the individual, family, school, community and culture. Each of these environments contains elements (also known as protective and risk factors) which can either improve a child's life outcomes or place them at risk for adversity. Every family is unique in terms of the risk and protective factors influencing it. Programmes based on this model consider ways to strengthen protective factors in order to reduce or remove any ongoing risks.)

Tobacco Control

OCTOBER 2018

DRAFT

Public Health
LONDON BOROUGH OF LEWISHAM



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DRAFT

Lewisham JSNA: Tobacco Control 2018

Key Messages

- Smoking is the primary cause of premature mortality and preventable illness¹.
- Smoking kills half of all lifelong users; an average 20 years prematurely²
- People on low incomes are twice as likely to smoke as the more affluent,³ to have started younger and to be more heavily addicted
- People on the lowest incomes who smoke, spend up to 15% of their total weekly income on tobacco
- Lewisham has one of the highest rates of smoking attributable deaths in London⁴
- More than 40% of total tobacco consumption is by those with mental illness⁵
- Passive (second-hand) smoking in the home is a major hazard to the health of millions of children in the UK who live with smokers⁶
- Children with a mother or both parents who smoke are 2-3 times as likely to take up smoking themselves⁷
- Only 8% of smokers access a stop smoking service when they try to quit⁸

¹ Healthy Lives, Healthy People: A Tobacco Control Plan for England. HM Government 2011.

² Doll R, Peto, R, Boreham J & Sutherland I. Mortality in relation to smoking: 50 years' observations on male British doctors. BMJ 2004; 328: 1519 <http://www.bmj.com/content/328/7455/1519.long>

³ ONS General Lifestyle Survey 2009

⁴ PHE Fingertips (<https://fingertips.phe.org.uk/>): Local Tobacco Control Profiles for England

⁵ PHE Fingertips (<https://fingertips.phe.org.uk/>): Local Tobacco Control Profiles for England

⁶ Passive Smoking and Children: A Report by the Tobacco Advisory Group of the Royal College of Physicians March 2010

⁷ As in 6 above

⁸ Office for National Statistics (2010) Smoking and drinking among adults, 2008. ONS

WHAT DO WE KNOW?

1. Facts and figures

Tobacco is the only legally available consumer product that kills people when it is used entirely as intended.⁹

1.1 Smoking burden

Smoking is the single greatest cause of preventable illness and premature death in the UK, and is one of the main determinants of health inequalities. It is a major contributing factor to the mortality divide between the most deprived areas in England and England as a whole. It is estimated that the direct cost to the NHS for smoking attributable conditions was estimated to be £5.17 billion (5.5% of total healthcare costs) in 2005–6.¹⁰

It is a major contributor to ill health, including circulatory disease, cancer and chronic obstructive pulmonary disease (COPD). Worldwide 1 billion adults (800 million men and 200 million women) currently smoke cigarettes. This is an underestimate of total tobacco exposure worldwide, as it does not include childhood smoking, smokeless tobacco or second-hand smoke. Cigarette smoking prevalence varies widely around the world, and over 80% of the world's adult male smokers, and half of the world's adult female smokers, live in low- or middle-income countries. Tobacco use kills almost 6 million people worldwide each year, with nearly 80% of these deaths in low- and middle-income countries. Each year 600,000 non-smokers worldwide die from exposure to environmental tobacco smoke. By 2030 tobacco will kill a predicted 8 million people worldwide each year. Tobacco use caused 100 million deaths worldwide during the 20th century, and if current trends continue it will kill 1 billion people in the 21st century. About 114,513 people died last year and the tobacco related cost to economy was almost £30,424,000. Worldwide smoking prevalence is overall increasing.¹¹

In 2017, the proportion of current smokers in the UK was 15.1%, which equates to around 7.4 million in the population based on estimate from the Annual Population Survey. The latest figure represents a significant reduction in the proportion of current smokers since 2016, when 21.2% smoked.¹²

Tobacco is the largest preventable cause of death in the world.¹³ Tobacco smoking caused an estimated 105,000 deaths in the UK in 2015 - almost a fifth (19%) of all deaths from all causes; it caused an estimated 43,000 cancer deaths in the UK in 2010 - more than a quarter (27%) of all cancer deaths.¹⁴

⁹ Oxford Medical Companion 1994

¹⁰ S Allender, R Balakrishnan, P Scarborough, P Webster, M Rayner. The burden of smoking-related ill health in the UK. *Tob Control*. 2009 Aug;18(4):262-7. doi: 10.1136/tc.2008.026294. Epub 2009 Jun 9.

¹¹ World Lung Foundation/American Cancer Society. *The Tobacco Atlas*. Available from: <http://www.tobaccoatlas.org>. Accessed April 2014.

¹² Office for National Statistics. *Adult smoking habits in the UK: 2017*. 2018. [cited 03 July 2018].

¹³ World Lung Foundation/American Cancer Society. *The Tobacco Atlas*. Accessed March 2018.

¹⁴ Peto R, Lopez A, Boreham J, et al. *Mortality from smoking in developed countries 1950-2010*. Accessed April 2014.

Tobacco (both active smoking and environmental tobacco smoke) causes 3 in 20 (15%) cancer cases in the UK.¹⁵ One in every two regular smokers is killed by tobacco and half of all smokers will die before the age of 70, losing on average 10 years of life.¹⁶

In 2016/17, 484,700 hospital admissions in England are attributable to smoking which is an increase of 2% on the previous year and this represents 4% of all admissions; 22% of all admissions for respiratory diseases, were estimated to be attributable to smoking; 47% of admission for cancers that can be caused by smoking were estimated to be attributable to smoking. In 2016, 77,900 deaths were attributable to smoking, which is a decrease of 2% on the previous year, but this represents 16% of all deaths; 37% of all deaths for respiratory diseases, were estimated to be attributable to smoking; 54% of deaths for cancers (that can be caused by smoking) were estimated to be attributable to smoking.¹⁷

Smoking is the leading cause of preventable death and disease in the UK. About half of all life-long smokers will die prematurely, losing on average about 10 years of life.¹⁸ Smoking kills more people each year than the preventable causes of death combined obesity, alcohol, road traffic accidents, drug misuse, HIV infection.¹⁹

Most smoking-related deaths arise from one of three types of disease: lung cancer, chronic obstructive pulmonary disease (COPD which incorporates emphysema and chronic bronchitis) and coronary heart disease (CHD). In 2015, 16% (79,000) of all deaths of adults aged 35 and over in England were estimated to be attributable to smoking.²⁰ Of these smoking caused 27% of all cancer deaths, 35% of all respiratory deaths and 13% of all circulatory disease deaths.

1.2 Smoking prevalence

Smoking is a modifiable lifestyle risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population. Prevalence of smoking among persons 18 years and over for England was estimated to be 14.9% whereas smoking prevalence in London is 14.6% based on the Annual Population Survey (APS).²¹

1.3 Young people and smoking

Child and adolescent smoking causes serious risks to respiratory health both in the short and long term. Children who smoke are two to six times more susceptible to coughs and

¹⁵ Brown KF, Rumgay H, Dunlop C, et al. [The fraction of cancer attributable to known risk factors in England, Wales, Scotland, Northern Ireland, and the UK overall in 2015](#). British Journal of Cancer 2018.

¹⁶ NHS Information Centre (2011). Statistical Bulletin.

¹⁷ NHS Digital. Statistics on Smoking - England, 2018 [PAS]. <https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-smoking/statistics-on-smoking-england-2018>

¹⁸ Doll R, Peto, R, Boreham & Sutherland I. Mortality in relation to smoking: 50 years' observations on male British doctors. BMJ 2004; 328: 1519

¹⁹ Action on Smoking and Health (ASH). [Smoking Statistics](#). This fact sheet includes statistics on tobacco consumption and smoking related illness and death. November 2017.

²⁰ NHS Digital (2017). Statistics on Smoking: England: 2017. Available at: <http://content.digital.nhs.uk/catalogue/PUB24228/smokeng-2017-rep.pdf>

²¹ Local Tobacco Control Profiles. <https://fingertips.phe.org.uk/profile/tobacco-control/data#page/1/qid/1938132885/pat/6/par/E12000007/ati/102/are/E09000023/iid/92443/age/168/sex/4> (accessed 11 July 2018)

increased phlegm, wheeziness and shortness of breath than those who do not smoke.²² Smoking impairs lung growth and initiates premature lung function decline which may lead to an increased risk of chronic obstructive lung disease later in life. The earlier children become regular smokers and persist in the habit as adults, the greater the risk of developing lung cancer or heart disease.²³

Most long term smokers start smoking in their teens. Experimentation is an important predictor of future use. Children who experiment with cigarettes can quickly become addicted to the nicotine in tobacco. Children may show signs of addiction within four weeks of starting to smoke and before they commence daily smoking.²⁴

Children are also more susceptible to the effects of passive smoking. Parental smoking is the main determinant of exposure in non-smoking children. Although levels of exposure in the home have declined in the UK in recent years, children living in the poorest households have the highest levels of exposure as measured by cotinine, a marker for nicotine.²⁵

It is estimated that each year around 207,000 children aged 11-15 start smoking in the UK.²⁶ 77% of smokers aged 16 to 24 in 2014 began smoking before the age of 18, however, 32% of smokers (current and ex-smokers) aged 16-24 started when they are 16 or 17.²⁷ As a result many young people become addicted before they fully understand the health risks associated with smoking. Research shows that in 2014, 46% of pupils aged 11 to 15 who are current (regular and occasional) smokers were usually bought their cigarettes in shops, despite the law which prohibits the sale of cigarettes to those under the age of 18.²⁸

An estimated 7% of 15 year olds were classified as current smokers in Lewisham in 2014/15 and use of e-cigarettes is 9.5% and use of the other tobacco products are as high as 21.2% compared to England's 15.2%.²⁹

It is very important to reduce the number of young people who take up smoking, as it is an addiction largely taken up in childhood and adolescence. Most smokers start smoking before they are 18.

There is a strong association between smoking, other substance use, alcohol consumption and truanting or school exclusion.

The WAY Survey (Figure 1 below) indicates less 15 year olds in Lewisham (6.7%) smoke than in England (8.2%) but higher than London (6.1%), however the confidence intervals for this indicator are wide at borough level.

²² Royal College of Physicians. Smoking and the young. *Tobacco Control*. 1992;1:231-235.

²³ Seddon C. Breaking the cycle of children's exposure to tobacco smoke. *British Medical Association*. 2007.

²⁴ DiFranza J, Rigotti N, McNeill A, Ockene J, Savageau J, Cyr D, Coleman M. Initial symptoms of nicotine dependence in adolescents. *Tobacco Control*, 2000;(9)3.

²⁵ Royal College of Physicians. [Going smoke-free: The medical case for clean air in the home, at work and in public places](#). A report by the Tobacco Advisory Group. 2005.

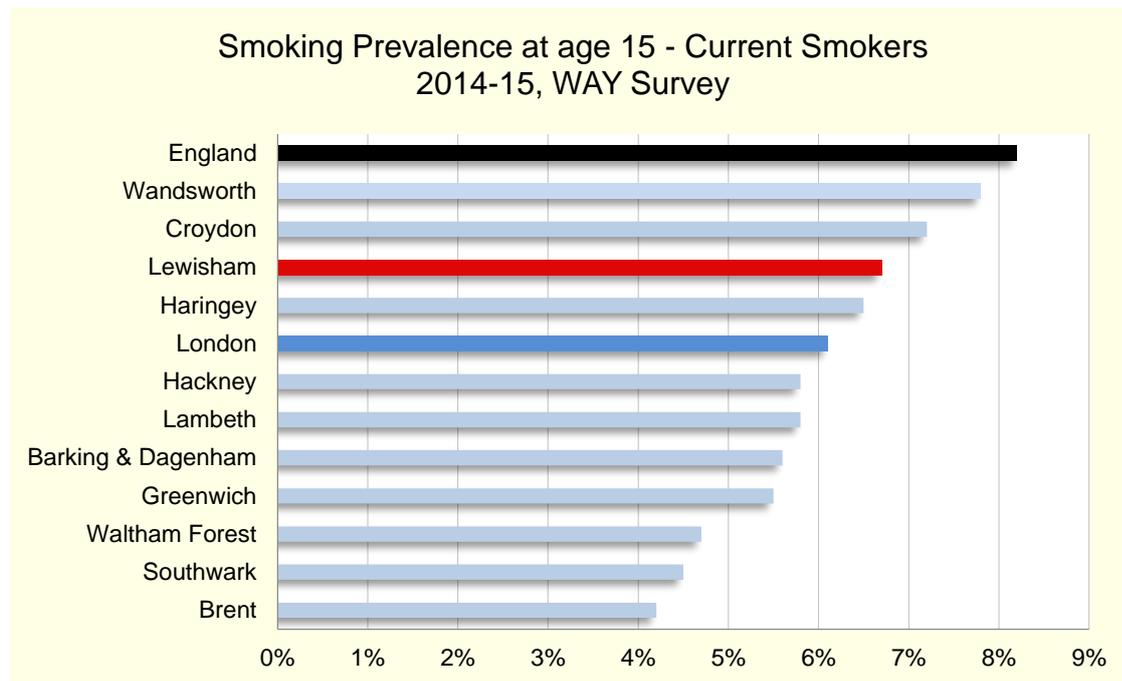
²⁶ Hopkinson N, Lester-George A, Ormiston-Smith N, Cox A, Arnott D. [Child uptake of smoking by area across the UK](#). *Thorax*. 2013;69(9):873-875.

²⁷ DH analysis on Health Survey for England 2014 data.

²⁸ NHS Digital. 'Smoking, Drinking and Drug Use Among Young People in England - 2014'. Table 3.1. 23 July 2015 (viewed June 2017)

²⁹ Local Tobacco Control Profile, Public Health England 2018

Figure 1: Smoking Prevalence of 15 year olds by London borough³⁰



1.4 Mental health and smoking

Smoking rates amongst people with a mental health condition are significantly higher than in the general population and there is a strong association between smoking and mental health conditions. This association becomes stronger relative to the severity of the mental condition, with the highest levels of smoking found in psychiatric in-patients. It is estimated that of the 10 million smokers in the UK about 3 million have a mental health condition.³¹

Those with severe mental illness die on average 25 years earlier than the general population and are 10 times more likely to die from respiratory disease. Most of this increased mortality can be attributed to higher rates and levels of smoking. Doses of many psychiatric medications can be reduced by up to 50% if a mental health service user stops smoking, with a reduction in side effects.

Smoking rates are much higher among people with mental illness. Over 70% of psychiatric inpatients smoke; 50% of them heavily, and 76% of people with first episode psychosis are smokers. More than 40% of total tobacco consumption is by those with mental illness. Over 50% of smokers with mental illness say they would like to stop, but are less likely to be offered help to do so.

1.5 Pregnancy and Smoking

Maternal smoking is a major risk factor for low birth weight. Babies born to women who smoke are on average 200-250 grams lighter than babies born to non-smoking mothers. Furthermore, the more cigarettes a woman smokes during pregnancy, the less well the

³⁰ <https://fingertips.phe.org.uk/profile/child-health-profiles/supporting-information/health-behaviours>

³¹ Royal College of Physicians, Royal College of Psychiatrists. [Smoking and mental health](#). London, RCP, 2013

foetus grows and develops. It is estimated that one third of all peri-natal deaths are caused by maternal smoking. More than one quarter of the risk of Sudden Infant Death Syndrome is attributable to smoking. Women who smoke in pregnancy are more likely to be younger, single, of lower educational achievement and in unskilled occupations.

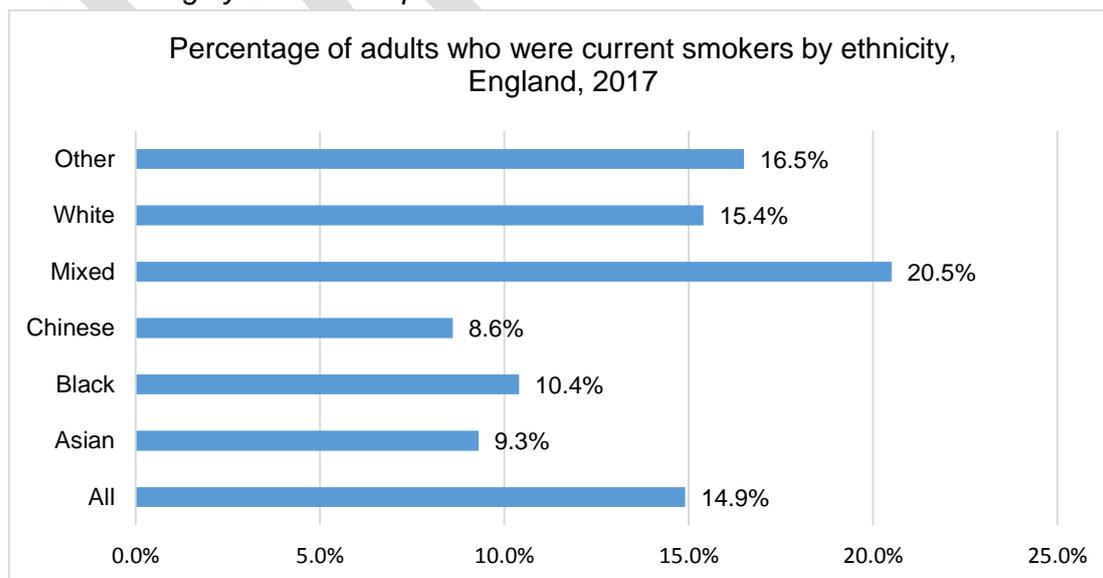
The 2005 Infant Feeding Survey found that almost half (49%) of women who smoked before pregnancy managed to stop once they became pregnant but 17% of mothers-to-be continued to smoke throughout their pregnancy. In 2010, the percentage of mothers reported to be smoking at delivery in England had dropped to 13.6% in 2010/11 (Quarter 1 figures) to 10.8% in 2017/18. However it is widely felt that these self-reported figures are likely to be inaccurate³². Following the attainment of the Government's 11% target, the Smoking in Pregnancy Challenge Group has proposed a new target to reduce the percentage of women smoking during pregnancy to 6% or less by 2020.

1.6 Ethnicity and Smoking

The data on smoking habits in the UK come from the Annual Population Survey (APS). The data on smoking is collected on the Labour Force Survey, which forms a component of the APS. In 2017, there were 158,889 survey respondents to the question on smoking habits. Interviews are carried out either on a face-to-face basis or on the telephone. The main facts and figures for adult smokers in England show³³ that:

- overall, in 2017, 14.9% of adults in England said they were current smokers
- rates of smoking were higher than the England average in the Mixed and White ethnic groups (at 20.5% and 15.4% respectively); although the rate for the Other ethnic group also appears to be higher than the England average, the difference and the size of the group were too small to draw firm conclusions
- rates of smoking were below the England average in the Chinese, Asian and Black ethnic groups (8.6%, 9.3% and 10.4% respectively)

Figure 2: Smoking by Ethnic Group - Prevalance



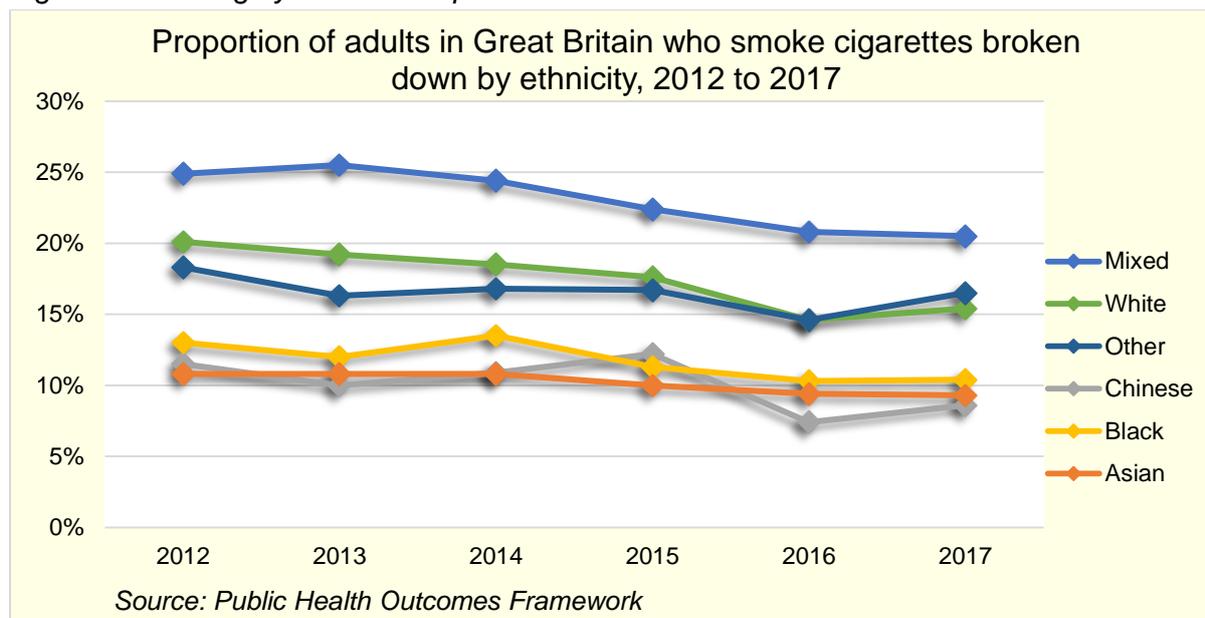
³² Action on Smoking and Health Fact Sheet 2011

³³ Adult Smokers in England by ethnicity. <https://www.ethnicity-facts-figures.service.gov.uk/health/preventing-illness/adult-smokers/latest#>

This data shows that:

- overall, from 2012 to 2017, the percentage of adults who were smokers went down by 4.4 percentage points, from 19.3% to 14.9%
- in the same period, the smoking rate decreased for adults in the White ethnic group (from 20.1% to 15.4%), the Black ethnic group (from 13.0% to 10.4%), and the Asian ethnic group (from 10.8% to 9.3%); it is not possible to draw firm conclusions about the change in smoking rates for the other ethnic groups because of the wide variation in responses and small number of responses for these groups.

Figure 3: Smoking by Ethnic Group - Trend Data



1.7 Deprivation and smoking

Smoking is responsible for more than half the difference in premature death rates between people on high incomes and those on low incomes.

Smoking rates are markedly higher among poorer people. The General Lifestyle Survey (conducted by ONS) has consistently shown striking differences in the prevalence of cigarette smoking in relation to socio-economic status, with smoking being much more prevalent among those in manual groups than among those in non-manual groups. Smoking prevalence is higher in lower socio economic groups and the number of cigarettes smoked per day is also high in this group. Cigarette smoking is higher among households classified as routine and manual (26%), than those classified as professional and managerial (15%)³⁴. Smoking prevalence among low income groups is declining at a slower rate than the general population of smokers. People in deprived circumstances are not only more likely to take up smoking but generally start younger, smoke more heavily and are less likely to quit smoking, each of which increases the risk of smoking-related disease.

In poorer families, parents' addiction to tobacco can sometimes divert scarce funds away from meeting basic needs. The UK government's independent inquiry on inequalities in health

³⁴ ONS Smoking and drinking among adults, 2009 General Lifestyle Survey 2009

reported that parents smoked in more than 70% of two-parent households on income support, spending about 15% of their disposable income on cigarettes. Children in these families were more likely to lack basic amenities such as food, shoes and coats. Interviews with smokers in low socioeconomic groups support the idea that the majority will find the money or use other strategies to obtain cigarettes, even when circumstances are difficult.

1.8 Second Hand smoking

Breathing in other people's cigarette smoke is called passive smoking, or secondhand smoking. The US Environmental Protection Agency classifies environmental or secondhand tobacco smoke as a Class A carcinogen. The British Medical Association says that there is no safe level of exposure to secondhand smoke. Exposure to other people's smoke increases the risk of lung cancer by 20-30% and coronary heart disease by 25-35%. In babies and children it can cause respiratory disease, cot death, middle ear infections and asthma attacks.

Table 1: Main health risks of Second Hand Smoking

Main health risks of Second Hand Smoking	There is conclusive evidence that exposure to SHS causes:	There is substantial evidence that exposure to SHS causes:
Adults	Lung cancer Coronary heart disease Asthma attacks in those already affected Onset of symptoms of heart disease Worsening of symptoms of bronchitis	Stroke Chronic obstructive pulmonary disease Reduced lung function Onset of asthma
Children and pregnancy	Cot death Middle-ear disease (ear infections) Respiratory infections Asthma attacks in those already affected Reduced lung function	Reduced fetal growth Premature birth Development of asthma in those previously unaffected

Promote Smokefree Homes:

Children exposed to tobacco smoke are at much greater risk of cot death, meningitis, lung infections and ear disease³⁵. Each year it results in over 300,000 GP visits, 9,500 hospital visits in the UK and costs the NHS more than £23.6 million³⁶.

Millions of children in the UK are exposed to secondhand smoke that puts them at increased risk of lung disease, meningitis and cot death. It results in over 300,000 GP visits, 9,500 hospital visits in the UK each year and costs the NHS more than a staggering £23.6 million

³⁵ Royal College of Physicians (2010) Passive Smoking in Children - <https://www.rcplondon.ac.uk/sites/default/files/documents/passive-smoking-and-children.pdf>

³⁶ NICE (2018) London: National Institute for Health and Clinical Excellence (NICE) Guideline 92. Stop smoking interventions and services. <https://www.nice.org.uk/guidance/ng92>

every year. A survey³⁷ undertaken of 1,000 young people aged 8-13, on behalf of the Department of Health in October 2011, demonstrated that children want smokefree lives.

This found:

- 98% of children wish their parents would stop smoking
- 82% of children wish their parents wouldn't smoke in front of them at home
- 78% of the children wished their parents wouldn't smoke in front of them in the car
- 41% of children said cigarette smoke made them feel ill
- 42% of children said cigarette smoke made them cough

Exposure to second-hand smoke in confined spaces such as a car is particularly hazardous, as there is no safe level of exposure to tobacco smoke.

1.9 Smoking in Lewisham

Tobacco use is the biggest single factor in the gap in healthy life expectancy between Lewisham and England.

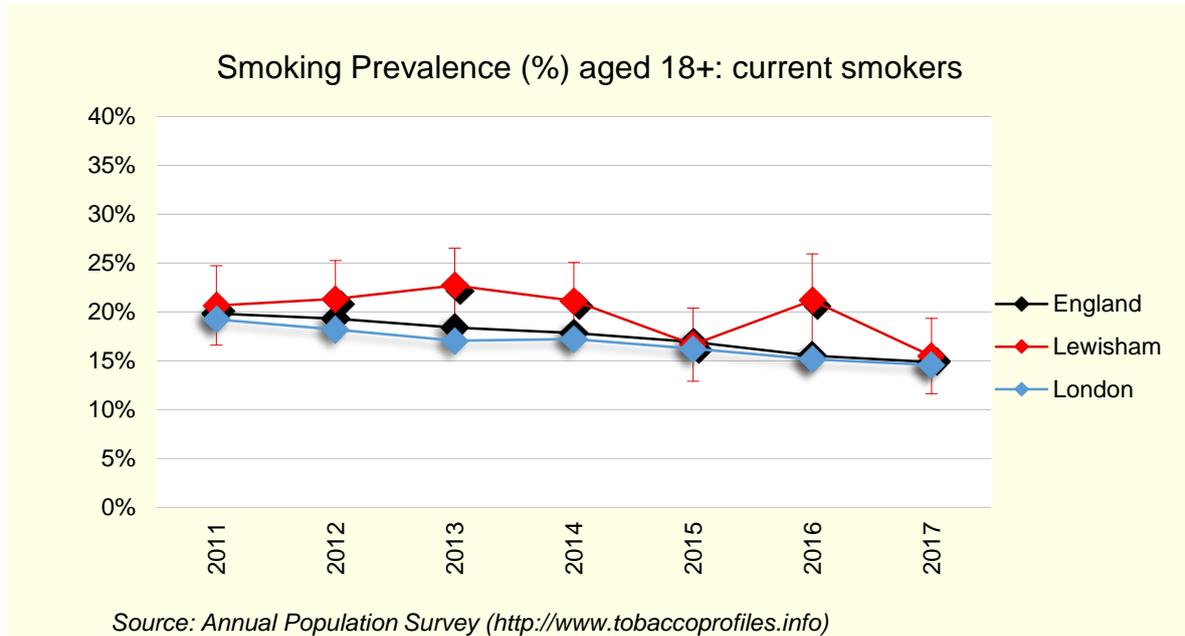
In Lewisham, the prevalence of smoking among adults (current smokers) is 15.5% (35,780) - higher than both London and England (14.6% and 14.9%, respectively).³⁸ Further, this prevalence is higher than that of our neighbouring boroughs of Lambeth and Southwark (14.6% and 12.2%, respectively) and 11th amongst all London Boroughs. Smoking prevalence has been declining in Lewisham since the initiation and redesign of our Stop Smoking services (e.g. prevalence was 22.7% in 2013), however we still have significant improvements to make if we are to achieve the target set out in the national tobacco control strategy (of 12%).

The burden of smoking-related ill health is particularly great in Lewisham, as indicated by many of the commonly cited measures of public health impact (such as hospital admissions and cause-specific mortality) which show a relatively greater impact of smoking in our borough as compared to the London and national averages.

³⁷ Children call for smokefree homes. Published by Department of Health and Social Care and The Rt Hon Andrew Lansley CBE. 31 March 2012. <https://www.gov.uk/government/news/children-call-for-smokefree-homes>

³⁸ Public Health England, Local Tobacco Control Profiles, <https://fingertips.phe.org.uk/profile/tobacco-control/data#page/1/gid/1938132885/pat/6/par/E1200007/ati/102/are/E09000023/iid/92443/age/168/sex/4>

Figure 4: Smoking Prevalence in Lewisham



In 2016/17, there were an estimated 1,954 per 100,000 hospital admissions attributable to smoking in Lewisham – a much higher proportion than in Lambeth, Southwark or London as a whole (e.g. 1,549 per 100,000 in the London region). The importance of targeting smoking cessation in Lewisham is also demonstrated by our high level of smoking-attributable mortality, which is statistically significantly higher than the national or London average at 327.1 per 100,000 (and the third highest in London). In Lewisham, smoking attributable deaths from stroke are the highest in London (at 13.6 deaths per 100,000). Smoking attributable deaths from heart disease are also the fourth highest in London at 30.8 deaths per 100,000. Furthermore, it is estimated that 1,669 per 100,000 potential years of life are lost due to smoking related illness.

Figure 5: Smoking Attributable Hospital Admissions

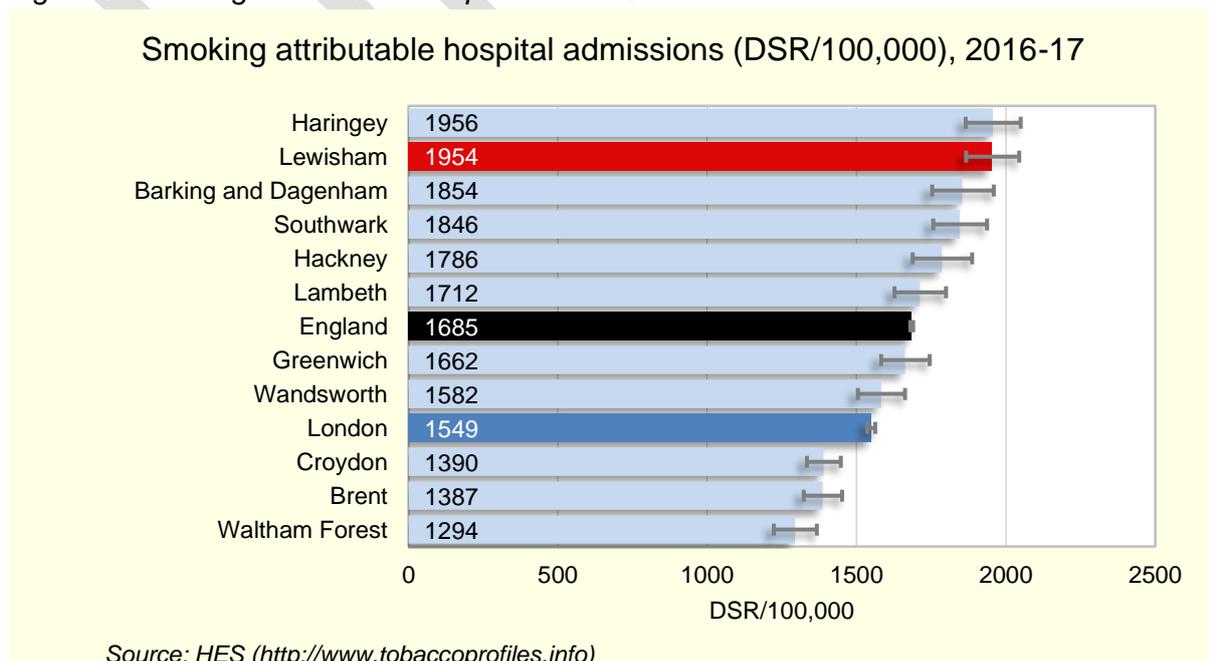
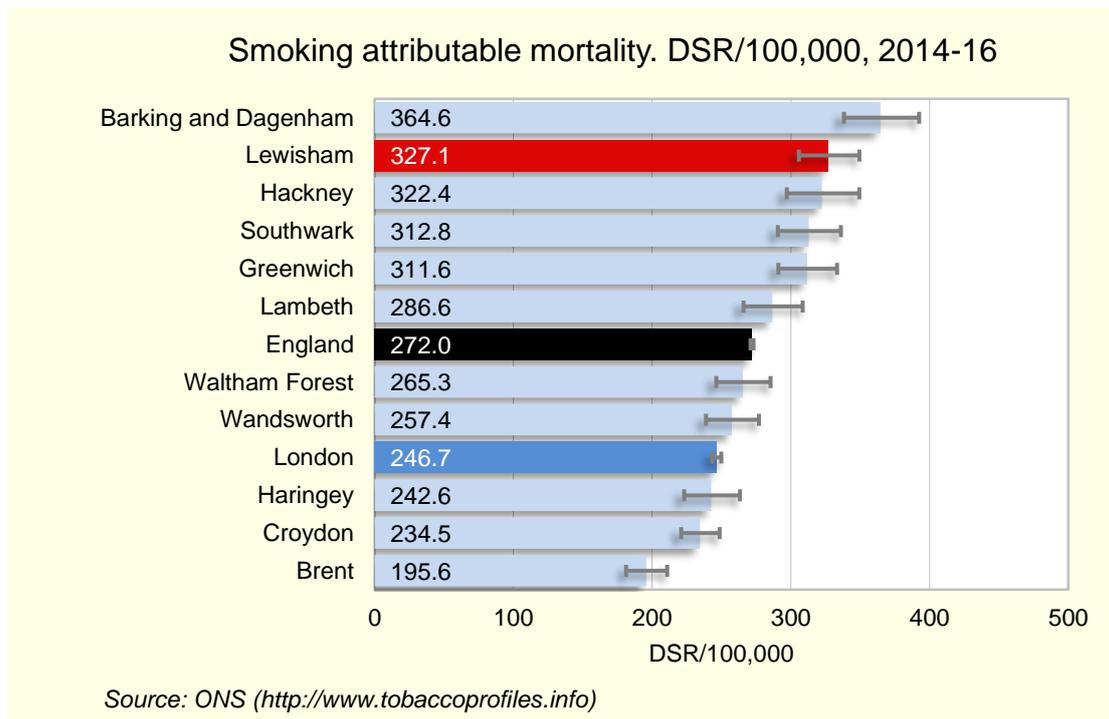
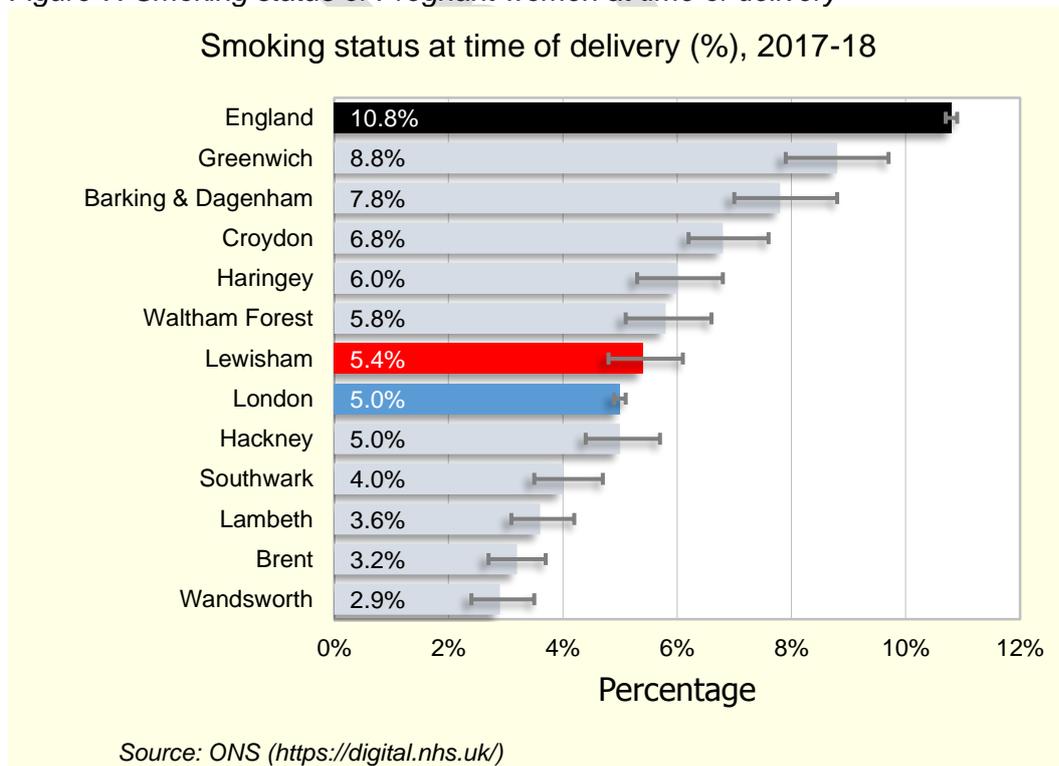


Figure 6: Smoking Attributable Mortality



Data is available on the numbers of pregnant women smoking at the time of delivery in Lewisham. The 2017/18 data shows that 5.4% of pregnant women were still smoking throughout pregnancy in Lewisham. This is taken from data collected by various hospitals in Lambeth, Southwark and Lewisham, however, this is much lower than England rate but higher than London rate.

Figure 7: Smoking status of Pregnant women at time of delivery



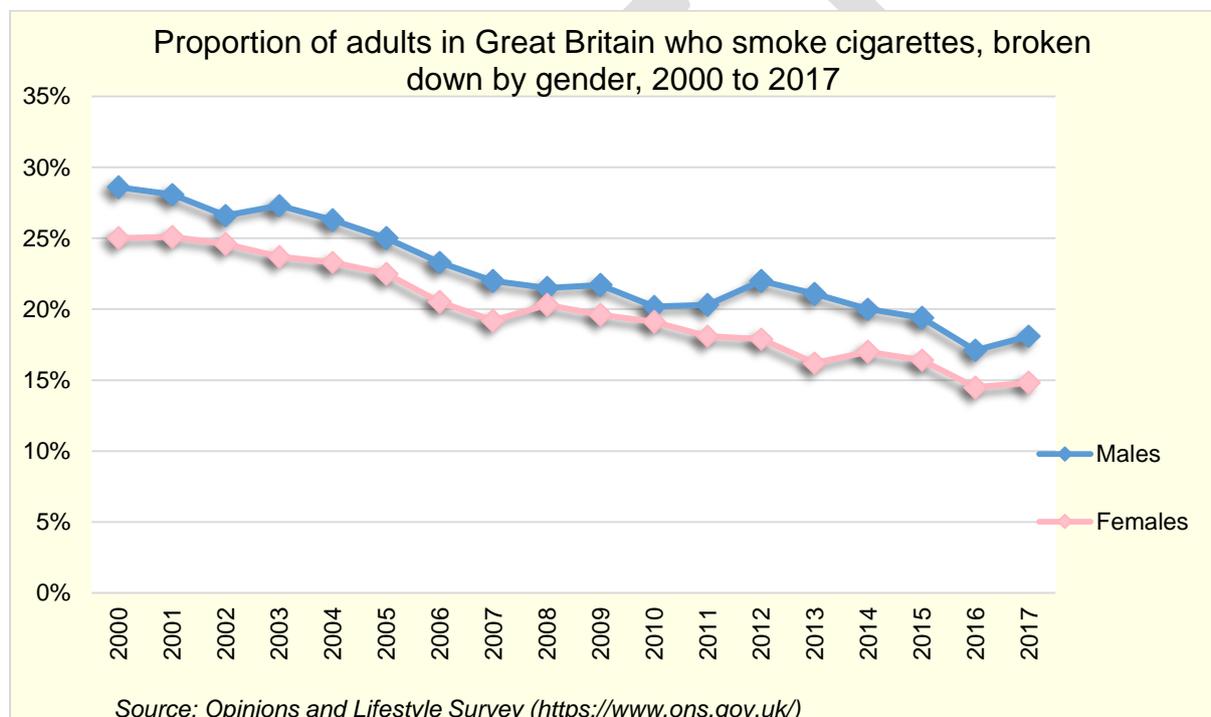
2. Trends

The overall prevalence of smoking in England has been around 21% since 2007. The prevalence of cigarette smoking fell substantially in the 1970s and the early 1980s, from 45% in 1974 to 35% in 1982. The rate of decline then slowed, with prevalence falling by only about one percentage point every two years until 1994, after which it levelled out at about 27% before resuming a slow decline in the 2000s⁶.

2.1 Gender

The smoking prevalence difference between men and women in England has substantially dropped to 18% in men and 15% in women in 2017, from the 2000 level of 29% in men and 25% in women.³⁹ In the UK, 17.0% of men smoked compared with 13.3% of women.

Figure 8: Smoking prevalence by gender



Throughout the period in which the Opinions and Lifestyle Survey (for ONS) has been monitoring cigarette smoking, prevalence has been higher among men than women and this continues to be the case, with 18% men and 15% women smoking in 2017. In 1974, 51% of men smoked cigarettes, compared with 41% of women. Since the early 1990s there has been an increase in the proportion of women taking up smoking before the age of 16. In 1992, 28% of women who had ever smoked started before the age of 16. In 2009 the corresponding figure was 37%. There has been little change since 1992 in the proportion of men who had started smoking regularly before the age of 16.

³⁹ Adult smoking habits in England, 2017, Office for National Statistics as part of the Opinions and Lifestyle Survey

2.2 Age

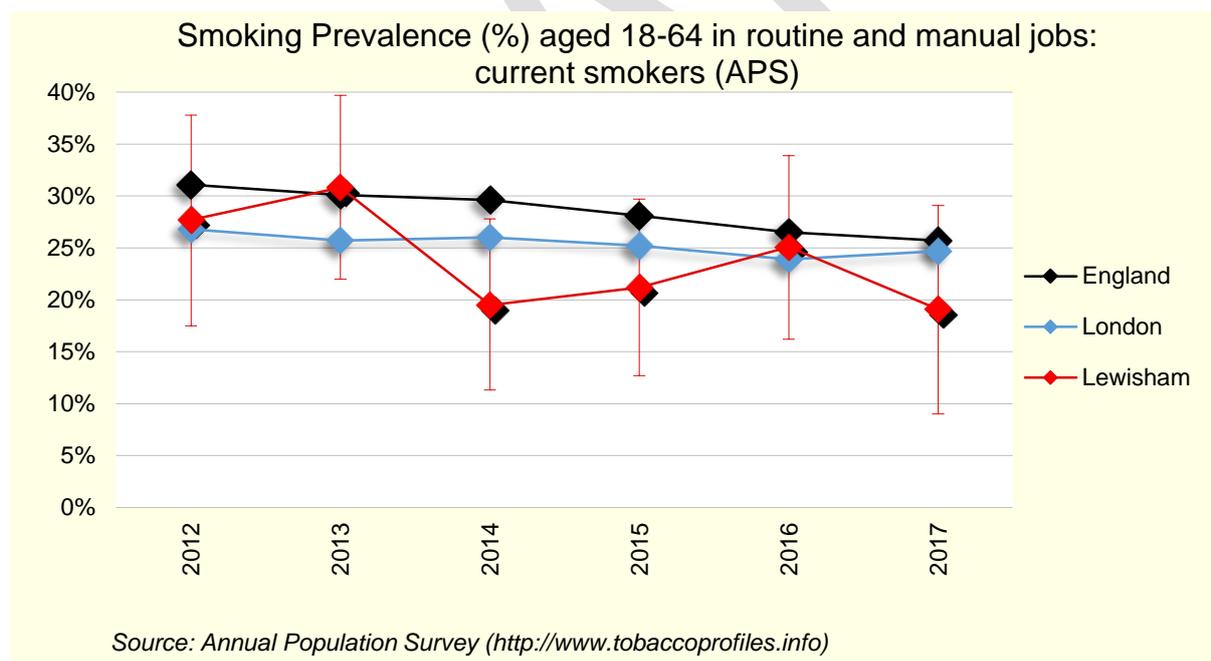
Since the early 1990s, the prevalence of cigarette smoking has been higher among those aged 20-34 than among those in other age groups. In 2009, 25% 16-24 year olds and 29% of 25-34 year olds were current smokers. Smoking prevalence continues to be lowest in those aged over 60 years at 14%. Since the survey began, it has shown considerable fluctuation in prevalence rates among those aged 16 to 19 years. However, this is mainly due to the small sample size in this age group and has occurred within a pattern of overall decline in smoking prevalence in this age group from 31% in 1998 to 25% in 2009.

In the UK, those aged 25 to 34 years had the highest proportion of current smokers (19.7%).⁴⁰

2.3 Socio-economic status

In the 1970s, 1980s and 1990s, the prevalence of cigarette smoking fell more sharply among those in non-manual than in manual groups, so that differences between the groups became proportionately greater.⁴¹ Smoking prevalence in adults in routine and manual jobs is lower in Lewisham than England and London and it has been low for the last few years.

Figure 9: Smoking Prevalence for those in routine and manual jobs



2.4 Ethnicity

The proportion of cigarette smokers in adults fell to 14.9% in 2017, from 19.3% in 2012. In the same period, the smoking rate decreased for adults in the White ethnic group (from

⁴⁰ Adult smoking habit in the UK, 2017

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2017>

⁴¹ Office for National Statistics (2010) Smoking and drinking among adults, 2008. ONS

20.1% to 15.4%), the Black ethnic group (from 13.0% to 10.4%), and the Asian ethnic group (from 10.8% to 9.3).

Use of chewing tobacco was most prevalent among the Bangladeshi group, with 9% of men and 16% of women reporting using chewing tobacco. Among Bangladeshi women, use of chewing tobacco was greatest among those aged 35 and over (26%). Among men, there was no difference in use of chewing tobacco by age.

2.5 Smoking in Lewisham

The trend in smoking prevalence in Lewisham is shown above in Figure 4, however it is definite that smoking prevalence has decreased in Lewisham as it has in England.

2.6 Stopping smoking

In the UK, 60.8% of people aged 16 years and above who currently smoked said they wanted to quit and 59.5% of those who have ever smoked said they had quit, based on the estimates from the Opinions and Lifestyle Survey.⁴²

3. Targets

There are two targets, one which is set out nationally for smoking prevalence and one which is set locally for stop smoking services.

Department of Health published a tobacco control plan 'Towards a Smoke free Generation – A Tobacco Control Plan for England 2017-2022' which aims to, by the end of 2022:⁴³

- reduce the number of 15-year-olds who regularly smoke from 8% to 3% or less;
- reduce smoking among adults in England from 15.5% to 12% or less;
- reduce the inequality gap in smoking prevalence, between those in routine and manual occupations and the general population;
- reduce the prevalence of smoking in pregnancy from 10.5% to 6% or less.

Local targets are set for achieving four week quits set by the Department of Health. A quit is defined as someone who has stopped smoking for four weeks from an agreed quit date, with not a single puff in weeks three and four of the quit attempt. This should be confirmed by carbon monoxide testing. The quit is supported by a stop smoking advisor trained to the standard set by the National Centre for Smoking Cessation and Training. The Client's data is entered onto a database, and the date they wish to stop is recorded. The outcome measure is the smoking status at four week follow up. Clients are followed up for longer than this, but data is not always recorded. The target for Lewisham Stop Smoking Service for 2018/19 is 1,000 quits.

⁴² Adult smoking habit in the UK, 2017

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2017>

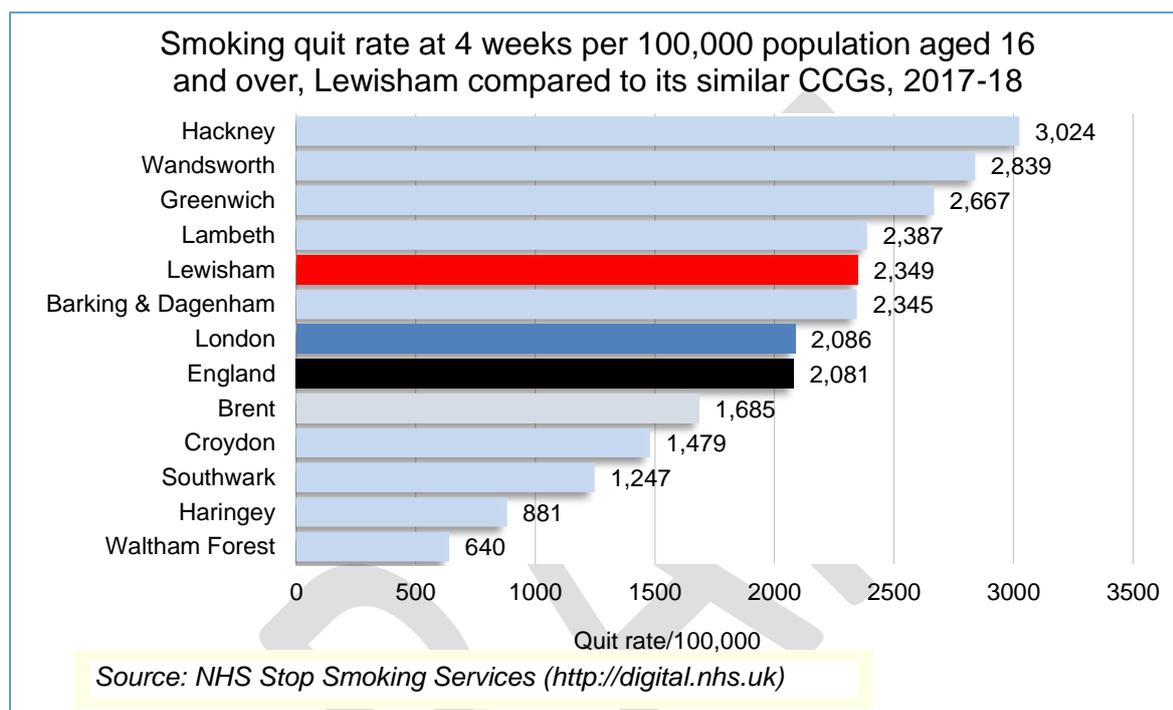
⁴³ Department of Health: Towards a Smoke free Generation – A Tobacco Control Plan for England 2017-2022. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/630217/Towards_a_Smoke_free_Generation_-_A_Tobacco_Control_Plan_for_England_2017-2022_2_.pdf

4. Performance

The main measurable method for tobacco control is the number of smoking quitters at 4 weeks (expressed as a percentage per 100,000 of the adult population) through the Lewisham Stop Smoking Service. The latest full year analysed data at the time of writing was that for 2017/18.

4.1 Overview

Figure 10: Smoking Quit Rate



In 2016/17:

- Lewisham recorded 1,120 quits; 12% over target.
- Lewisham's performance on quits was 2,203 per 100,000 population; 17th of 31 CCGs in London. Both Greenwich and Islington achieved 2,899.
- Only 1% of Lewisham's estimated smokers aged under 18 set a quit date with the service
- 52% of those setting a date to quit were successful at 4 weeks
- 48 pregnant women set a date to quit and 24 quit: 49% success rate.
- Lewisham's poorest wards recorded the highest number of smoking quits, a correlation which halved in 2017/18.
- 15% of those setting a date to quit were of black Caribbean or black African background; 67% were white.

In 2017/18:

- Lewisham recorded 863 quits; 14% under target
- 1,676 people set a date to quit. This is approximately 6-10% of Lewisham's smokers.
- 80 pregnant women set a date to quit and 39 quit: 49% success rate.

- 51% of all those who set a quit date had quit at 4 weeks
- 30% of those who quit were from ethnic minorities; 8.5% black Caribbean, 5.3% black African, 1.5% other black groups, 5.2% all Asian groups, 5.4% mixed parentage, 3.6% Chinese and other groups, 1% not stated.

Lewisham’s Stop Smoking Service level of performance was lower than other similar boroughs, (Figure 11 below).

4.2 Deprivation and quitting

There is a correlation between dates set to quit smoking and the Index of Multiple Deprivation (IMD), this correlation has become stronger in 2009/10 compared with 2008/09. It shows there has been an increase in the numbers of people setting a date to quit smoking in the most deprived wards of Lewisham (figure 5). Figure 6 shows the breakdown of those setting a date to quit by ward, in descending order of IMD.

Figure 11: Smoking Quits by Ward IMD Score (2015)

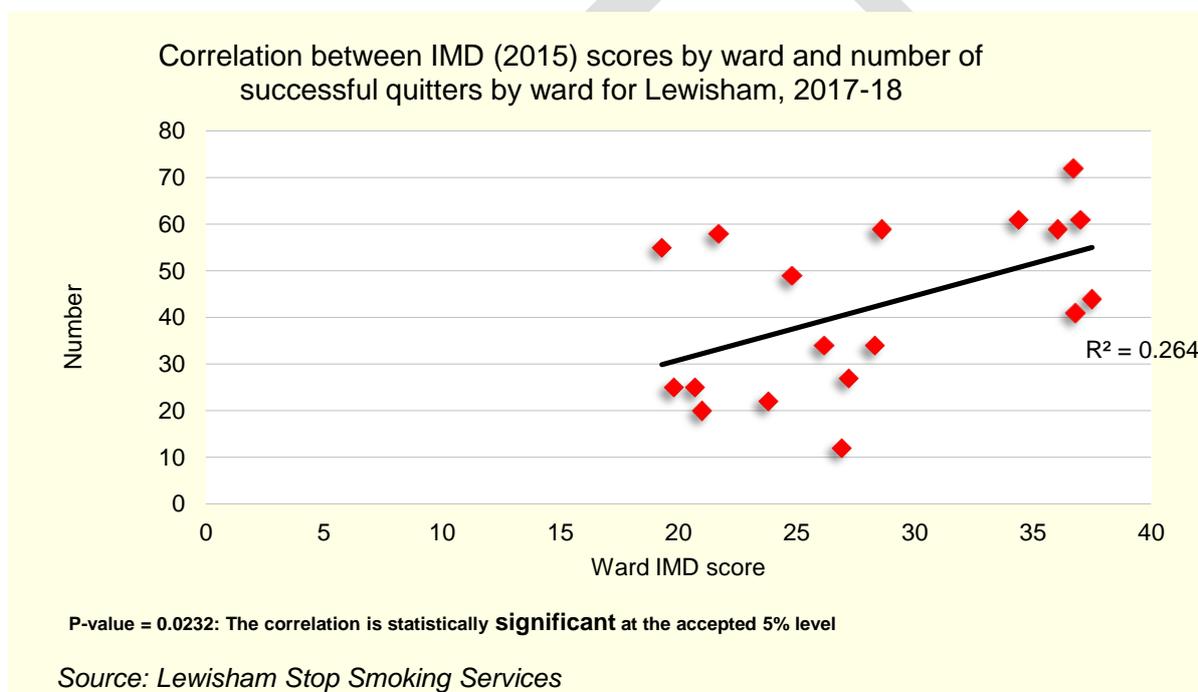
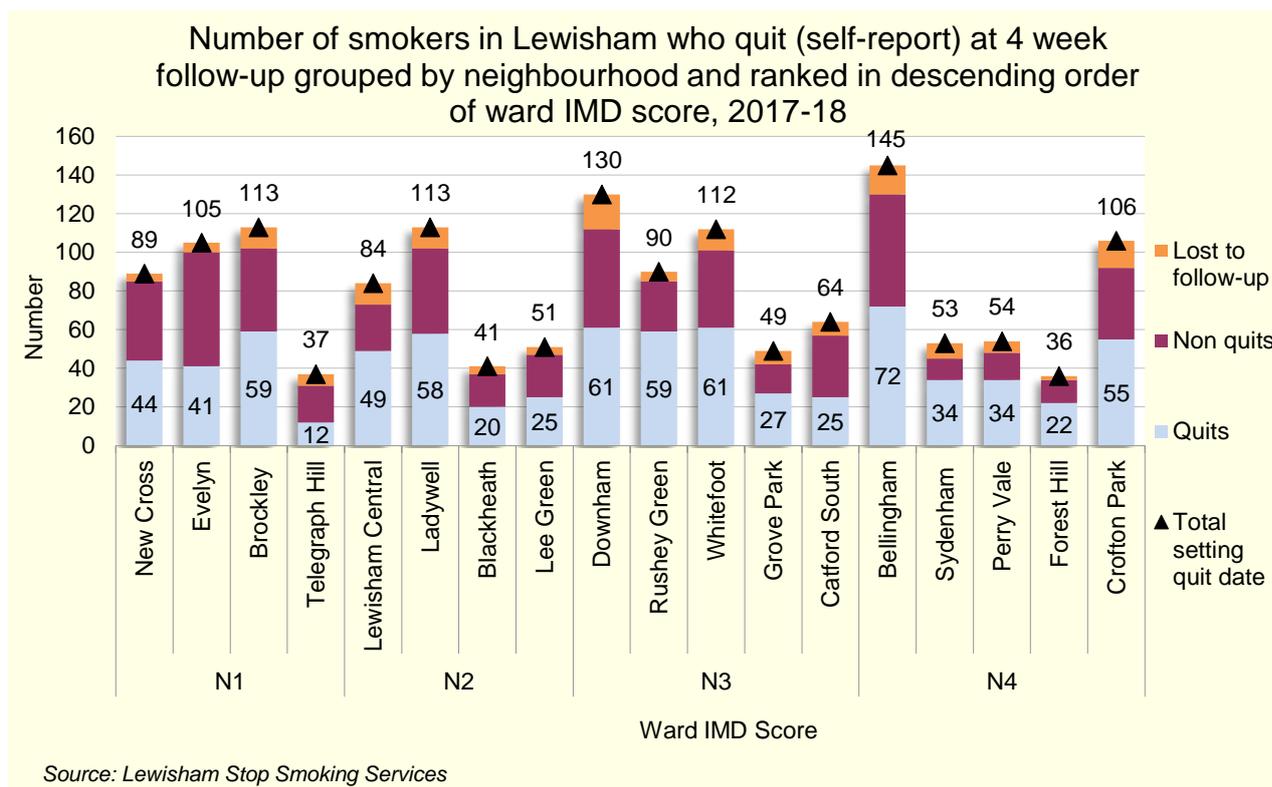


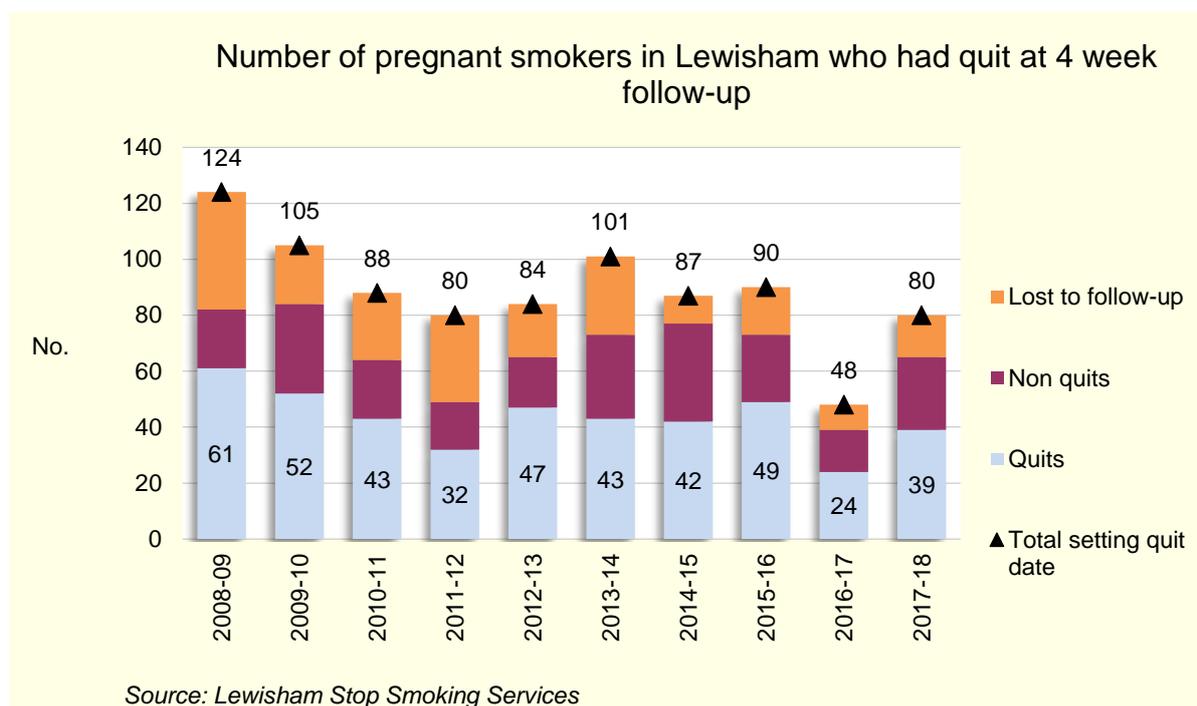
Figure 12: Smoking Quits by Ward



4.3 Pregnant Women quits

In 2017-18, more than 300 midwives and support workers were trained and were provided with CO monitor to better support pregnant women to quit smoking while pregnant. There is always a provision to refer pregnant women to Lewisham stop smoking service. Midwives and health visitors refer pregnant women, their partners or parents of a child aged 0-5yrs, who smoke. The systematic approach to referring pregnant women would increase the number of pregnant women and their partners who use the stop smoking service to quit smoking.

Figure 13: Number of Pregnant Women who Quit Smoking



4.4 Quits by age

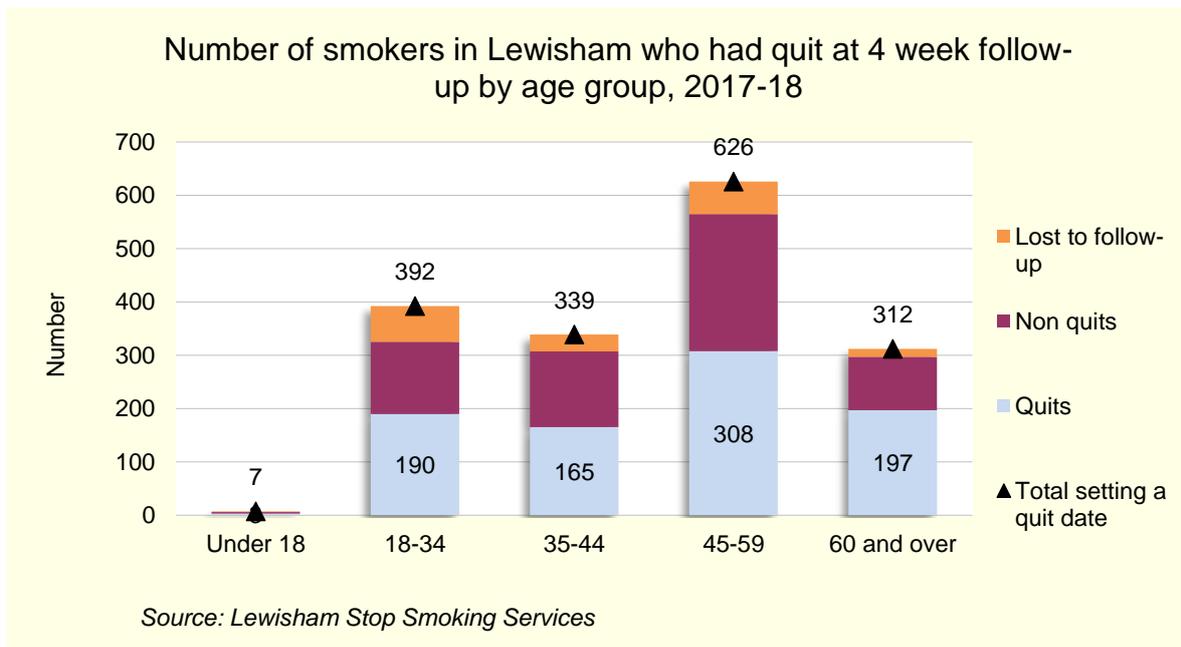
Table below shows the distribution of quitters by age for 2016/17 and 2017/18. It shows that there were very few people under the age of 18 who set a quit date. However, the number of young people accessing the service is increasing. The rate of successful quitting appears to increase with age. The number for under 18s is too small to draw conclusions, however over 60 appear to have the highest success rates. Table 2 shows those setting a date to quit and the proportions that are successful, by age group, in Lewisham 2016/17 - 2017/18.

Table 2: Lewisham Smoking Quits by Age

Age band	2016-17		2017-18	
	Quit date set	Successfully quit	Quit date set	Successfully quit
under 18	13	3 (23%)	7	3 (43%)
18-34	479	207 (43%)	352	166 (47%)
35-44	409	175 (43%)	310	143 (46%)
45-59	696	302 (43%)	582	282 (48%)
over 60	396	216 (54%)	291	182 (62%)

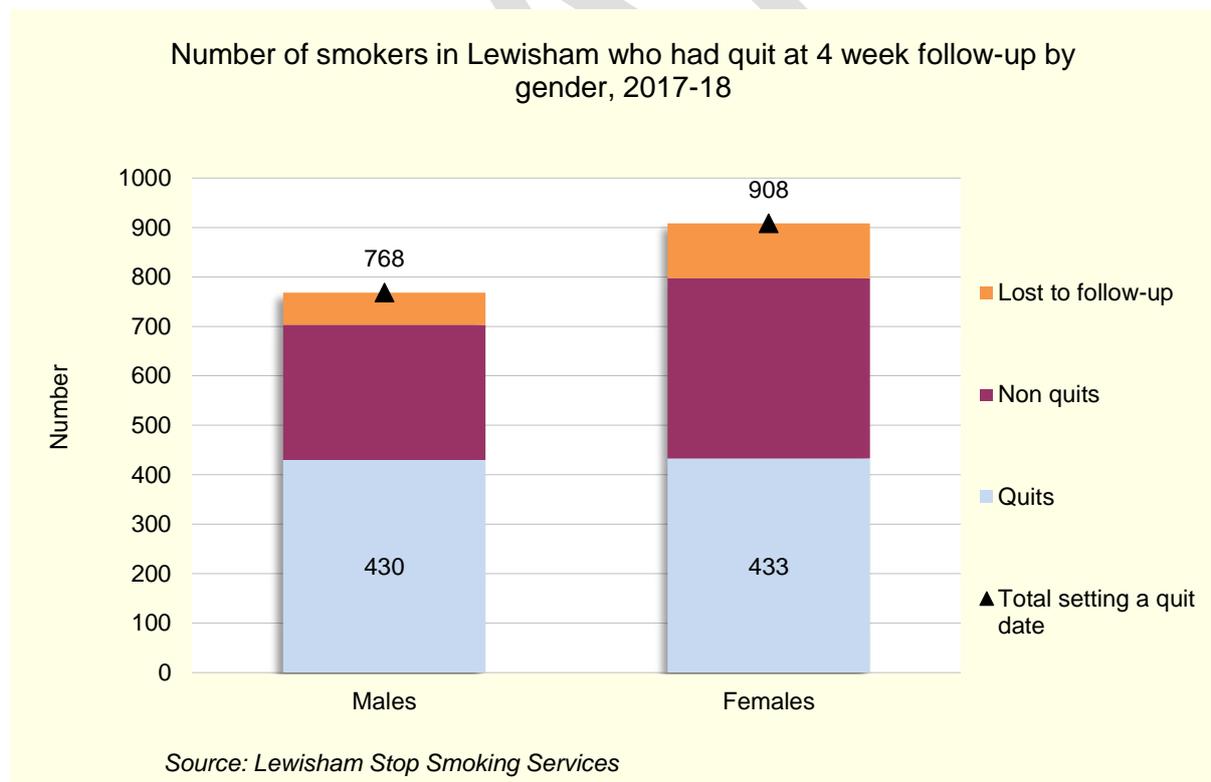
Source: Lewisham Stop Smoking Service

Figure 14: Lewisham Smoking Quits by Age



4.5 Ethnic Minorities who Quit Smoking

Figure 15: Lewisham Smoking Quits by Gender

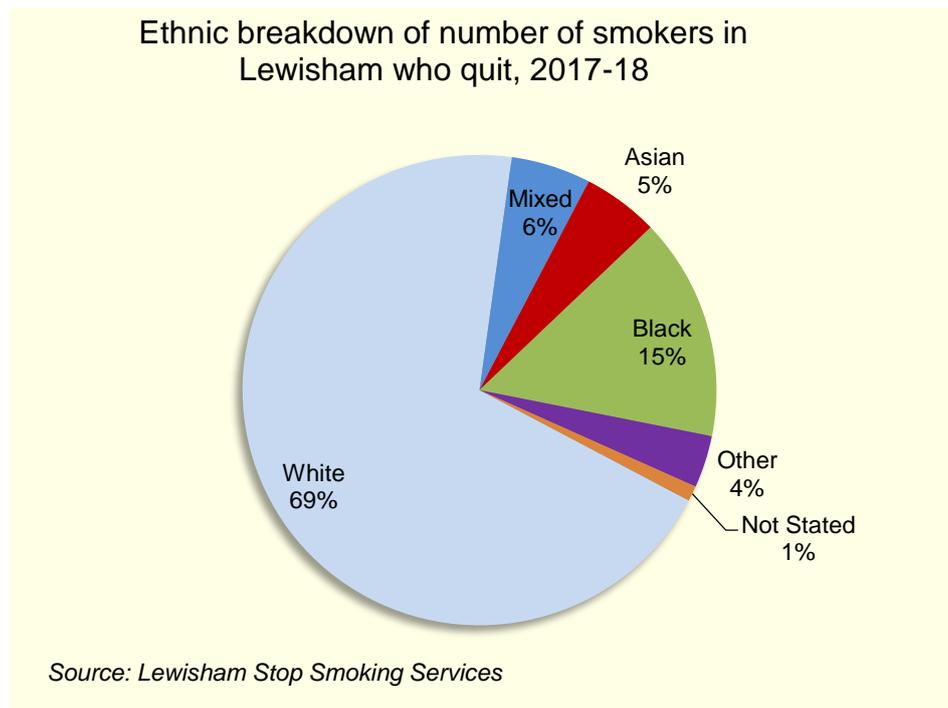


In Lewisham, 433 females quit compared to 430 males. However, the number of females setting a quit date was 908 compared to 768 males, of which 111 females and 65 males were lost to follow up and 364 females and 273 males did not quit smoking even after setting a quit date.

4.5 Ethnic Minorities who Quit Smoking

In Lewisham, 11.6% of the general population are black African and 9.9% are black Caribbean and around 15% of the total number of people who quit were black Caribbean or black African. Those from Asian backgrounds make up almost 10% of the population of Lewisham, 5% of those accessing the Lewisham stop smoking service were from an Asian background. However, just over 50% of Lewisham residents are white, yet 69% of residents who quit smoking through the service in 2017/18 are white.

Figure 16: Lewisham Smoking Quits by Ethnic Group



5. Local Views

Lewisham stop smoking service gathers view on the service from those who have used it. The service makes follow up calls to clients recorded in the database. There is a good level of satisfaction overall from people who use the service.

Overall the customer care survey report from December 2017 suggests that the service is achieving its aims of delivering a high quality, accessible service to the people of Lewisham. The report is limited to clients who have been able to access the service, and any information that the service receives regarding lack of accessibility are acted upon accordingly. 98% of clients were satisfied or very satisfied with the service. This is the highest rating that the service had in the last three years. The service users provided very positive feedback in terms of accessibility and time for appointments with positive reflections on the quality of interventions including the availability of medication support. Suggestions for improvement included organising group sessions for more peer support. How to cope with stress without smoking is cited by smokers as the main reason for smoking, relapsing and lack of confidence in being able to quit for good.

6. National and Local Strategies

The Government's 1998 White Paper 'Smoking Kills' was a landmark public health strategy. Since then progress has been made to reduce the harm from tobacco use, by implementing the following:

- Stop Smoking Services were set up in 1999 to help people to quit
- Most forms of advertising and sponsorship were banned in 2003/4
- In 2007 a landmark piece of legislation made all enclosed public spaces and workplaces smoke-free to protect people from exposure to secondhand smoke
- The legal age for buying tobacco was raised to 18 in 2007
- Pictorial health warnings on cigarette packets started in 2008

In July 2017, the government published its Tobacco Control Plan for England, to pave the way for a smokefree generation. The comprehensive plan sets out the following national ambitions for achievement by the end of 2022.⁴⁴

- To reduce smoking prevalence among adults in England from 15.5% to 12% or less.
- To reduce the prevalence of 15 year olds who regularly smoke from 8% to 3% or less.
- To reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less.
- To reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population.

Since publication of the last Tobacco Control Plan, smoking prevalence among adults in England has dropped from 20.2% to 14.9% - the lowest level since records began.

In January 2019 the Long Term NHS Plan was published. It states that the NHS will make a significant new contribution to making England a smoke-free society. Action to achieve this includes:

- by supporting people in contact with NHS services to quit based on a proven model implemented in [Canada and Manchester](#). By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.
- the model will also be adapted for expectant mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments.
- a new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services. On the advice of PHE, this will include the option to switch to e-cigarettes while in inpatient settings.

Lewisham's Smokefree Future Delivery Group is implementing this strategy in Lewisham. A work plan is developed to match the Tobacco Control Plan for England.

⁴⁴ Department of Health: Towards a Smoke free Generation – A Tobacco Control Plan for England 2017-2022. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/630217/Towards a Smoke free Generation - A Tobacco Control Plan for England 2017-2022_2_.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/630217/Towards_a_Smoke_free_Generation_-_A_Tobacco_Control_Plan_for_England_2017-2022_2_.pdf)

7. Current Activity and Services

7.1 Stopping the inflow of young people recruited as smokers

Lewisham Council's Trading Standards, with the assistance of young volunteers, periodically carries out supervised test purchase attempts at premises selling tobacco to ensure that the over 18yrs requirements are complied with. Premises are also monitored to ensure that the relevant tobacco warning signs are displayed. The service provides signs to retailers along with other informative material on age restricted goods, including tobacco.

There were three sessions of underage test purchases in 2009/10 resulting in 32 attempts with 1 sale made. A warning was issued to this trader. In 2010/11, 30 premises were visited over 3 operations and 3 sales were made; 2011/12, 1 operation visiting 8 premises and no sales was made; 2012/13, 3 operations 28 premises and 3 sales; 2013/14, 3 operations 31 premises and 2 sales; 2014/15, 2 operations 15 premises and 6 sales; 2015/16 1 operation 19 premises 0 sales; 2016/17 2 operations 21 premises 0 sales and in 2017/18 so far 1 operation 13 visits 0 sales were made.

Tobacco vending machines are now illegal and there is no known vending machine in the borough. The exception to this is wholesaler machines that are not for public use.

7.2 Motivating and assisting every smoker to quit

Lewisham's Stop Smoking Service is provided by Lewisham and Greenwich Trust (<https://www.lewishamandgreenwich.nhs.uk/>) and commissioned by Lewisham Public Health. It offers evidence based interventions: a combination of behavioural support and medication for up to 12 weeks, in line with NICE guidance, which states that all smokers who wish to stop smoking should be offered intensive support usually at an NHS Stop Smoking Service. The service is provided in a variety of ways, including:

- Specialist clinics in various locations throughout the borough including 11 GP surgeries
- 6 pharmacies provide Champix through Patient Group Directive (PGD), previously a prescription only medication, to increase access
- 300+ trained midwives, nurses, pharmacists, health care assistants and pharmacy staff provide a service in primary care
- A Clinic at University Hospital Lewisham runs four days a week
- Specialist advisors run clinics in the most deprived wards in health centres
- Specialist advisors contact everyone who smokes during pregnancy and mental health patients and parents of children under five
- An online quit tool has been launched that can be used from phone, tablet or PC which is simple to use, helps to work out the best treatment for the quitter, and provide moral support or a boost to help through text messages as needed.
- There is a dedicated Freephone, text, e-mail and website

Referrals come from all health staff: midwives, GPs, health visitors, acute trust staff and from individuals. People who want to quit are offered support and motivational counselling, together with medication. The outcome measure is smoking status at 4 week follow up, as defined by the Department of Health. However, an additional 12 week quit status check is

likely to be introduced in future. This should increase the quality of the service provided, and ensure more long term health gain.

Advice on smokefree homes is also given to people in pregnancy and to parents of under 5s.

The Lewisham Stop Smoking Service also launched an online platform in December 2017 (<https://www.smokefreelewisham.co.uk/services/iquit/>) which all Lewisham residents can access. This website provides two main functions. Firstly, it directs users to the relevant parts of the service (e.g. behavioural support, medications, and specialist services). Secondly, it provides Lewisham residents with an online personalised step-by-step tool to aid smoking cessation (iQUIT).

7.3 Protecting families and communities from harm

7.3.1 *Reducing the attraction of tobacco products.*

While most forms of tobacco advertising and promotion in the UK are banned, the tobacco industry has continued to promote its products through packaging and “below the line” marketing. Also, the UK has become the first country in Europe to require cigarettes to be sold in standardised packaging.

7.3.2 *Taking action on illicit tobacco*

The government’s pricing policy has had an impact on the number of young people taking up smoking. Easy access to cheap illicit cigarettes is a particular risk to people on lower incomes including most young people. Lewisham Council’s work combating illicit and counterfeit cigarettes is an important aspect of protecting children from tobacco harm.

Illegal tobacco undermines efforts to improve the health of our residents by making low cost illegal tobacco available to smokers including under-age children. In particular it entrenches inequalities in disadvantaged communities and lower income groups in which smoking rates remain high, despite overall drops in the prevalence of smoking across the population. The trade is a very lucrative one controlled by criminal gangs which also deals in drugs, people trafficking and prostitution further entrenching inequality and deprivation.

7.3.3 *Counterfeit Tobacco Seizures*

Lewisham Council advises residents to be wary about buying cheap hand rolling tobacco from unregulated sources. Officers from the council seized significant amounts of counterfeit hand rolling tobacco from itinerant sellers who target customers of pubs and betting shops, as well as approaching people on the street. The tobacco does not meet the standards set by the UK Government for levels of tar, nicotine and carbon monoxide and may contain harmful chemicals and other substances that are hazardous to peoples' health.

It is found that around 11% of all cigarettes and 49% of all hand rolling tobacco consumed in the UK are illicit, whether smuggled, counterfeit, stolen or bootlegged. Possibly as many as third of cigarettes sold across London are illegal. Four times as many people die from illegal tobacco than all illicit drugs combined. Organised criminal gangs play a key role in the supply of illicit tobacco, especially counterfeit and smuggled cigarettes. This illegal trade can support other criminal activity such as the supply of controlled drugs, stolen goods and illegal alcohol. Some counterfeit and smuggled tobacco contains asbestos, mould and human faeces.

Lewisham Council is working with other councils across south east London to curb the sale of illicit tobacco. The work also involves the police and fire services. The council is also working with the police and HM Customs to carry out targeted raids on premises considered to be selling illegal tobacco. Any proprietor found to stock or sell these are prosecuted.

Lewisham Public Health works closely with the Pan London Illegal Tobacco Group that collaborated with other London Councils, London Trading Standards and ADPH London to deliver the London Illegal Tobacco Campaign in 2016/17:

- Over 21,000 illegal tobacco products were seized in a series of raids carried out by local Trading Standards teams across London as the result of the local intelligence gathered during the campaign.
- A total of 572 surveys were completed which reveal prevalence and attitudes.

During 2018/19 the London Illegal Tobacco Campaign hosted an illegal tobacco unit roadshow which included sniffer dog demonstrations in July 2018 for three weeks. Lewisham participated in the communications for the campaign.

7.4 Shisha

Shisha has a negative health impact⁴⁵. Public Health in collaboration with the Trading Standards and Smokefree Lewisham intends to work together to raise awareness of the dangers of smoking shisha. It is hoped that shisha bar owners will cooperate with this intervention allowing shisha smokers greater information. Trading Standards have a key responsibility to ensure the labelling of the shisha product meet the legal requirements, that the premises are displaying correct price lists and that age restriction notices are displayed. Both the teams strive to make businesses compliant with respective legislations to make shisha smoking as 'safe as possible'.

7.5 Electronic Cigarettes

An 'electronic cigarette' is a product that can be used for consumption of nicotine-containing vapour via a mouth piece, or any component of that product, including a cartridge, a tank and the device without cartridge or tank. E-cigarettes can be disposable or refillable by means of a refill container and a tank, or rechargeable with single use cartridges.⁴⁶

Electronic cigarettes are marketed as a cheaper, safer alternative to conventional cigarettes. As they do not produce smoke, research suggests that electronic cigarettes are relatively harmless in comparison with smoking. The charity Action on Smoking and Health (ASH)⁴⁷ produced a briefing which reviews the safety of e-cigarettes and how effective they are as an aid to stopping smoking. It is estimated that there are currently 2.8 million adults in Great Britain using e-cigarettes (6% of the adult population). Of these, approximately 1.3 million (47%) are ex-smokers while 1.4 million (51%) continue to use tobacco alongside e-cigarettes. Current use of electronic cigarettes amongst self-reported non-smokers is negligible (0.1%) and only around 1% of non-smokers report ever trying electronic cigarettes. Awareness of electronic cigarettes is widespread among adults.

⁴⁵ <http://www.adph.org.uk/wp-content/uploads/2017/03/PHE-ADPH-Shisha-Report-February-2017-.pdf>

⁴⁶ <https://www.gov.uk/guidance/e-cigarettes-regulations-for-consumer-products#keyterms>

⁴⁷ <http://ash.org.uk/stopping-smoking/ash-briefing-on-electronic-cigarettes-2/>

In May 2016, the Tobacco Products Directive implemented legislation for e-liquids used in vapes to contain a maximum of 20 mg/ml and tank sizes must be 2ml. The legislation also extended to re-fill bottles with a capped quantity of 10ml.⁴⁴

In January 2016, the increasing use of e-cigarettes as a method of quitting or harm reduction led to the National Centre for Smoking Cessation and Training (NCSCT) creating a national document on the use of Nicotine Containing Products (NCPs) in combination with behavioural support to aid a quit attempt. Data from English smoking cessation services for the year 2014-15 show that 2,221 smokers used an unlicensed NCP alone and 1,932 used an unlicensed NCP in combination with a licensed stop smoking medicine to support their quit attempt. These are relatively small numbers of people, although there may be some underreporting, given that 450,582 quit attempts were made with the services during that 12 months. E-cigarettes can support people to quit smoking. Clients of stop smoking services who combined e-cigarettes with behavioural support had the highest quit-rates in 2014–15. Public Health England (PHE)⁴⁸ published an independent expert e-cigarettes evidence review in February 2018, which provides an update on PHE's 2015 review. The report covers e-cigarette use among young people and adults, public attitudes, the impact on quitting smoking, an update on risks to health and the role of nicotine. It also reviews heated tobacco products.

The main findings of PHE's evidence review are that:

- vaping poses only a small fraction of the risks of smoking and switching completely from smoking to vaping conveys substantial health benefits
- e-cigarettes could be contributing to at least 20,000 successful new quits per year and possibly many more
- e-cigarette use is associated with improved quit success rates over the last year and an accelerated drop in smoking rates across the country
- many thousands of smokers incorrectly believe that vaping is as harmful as smoking; around 40% of smokers have not even tried an e-cigarette
- there is much public misunderstanding about nicotine (less than 10% of adults understand that most of the harms to health from smoking are not caused by nicotine)
- the use of e-cigarettes in the UK has plateaued in recent years at just under 3 million
- the evidence does not support the concern that e-cigarettes are a route into smoking among young people (youth smoking rates in the UK continue to decline, regular use is rare and is almost entirely confined to those who have smoked)

Lewisham Stop Smoking Service welcome smokers who want to use an e-cigarette to help them quit. The South London and Maudsley NHS Foundation Trust ensures that all patients who are admitted to Ladywell Unit, Lewisham Hospital are screened for smoking status, provided with support and offered the opportunity to engage with specialist tobacco dependence interventions with easy access to nicotine replacement therapy and e-cigarettes are also essential components of the plan.

7.6 Cigarette related fire

Smoking is the most common cause of fire fatalities. The London Fire Brigade believes that the best way to stay safe is to stub out the cigarettes for good, for smokers who are not ready to quit yet, e-cigarettes (vapes) are a better option from a fire safety perspective. Dropping a vape on a carpet, duvet or armchair will not start a fire. So if quitting completely is not possible, it is a simple swap that can save lives.

⁴⁸ <https://www.gov.uk/government/news/phe-publishes-independent-expert-e-cigarettes-evidence-review>

Table 3 provides statistics on fire incidents related to smoking in the last four years but the smoking related fire incidents fluctuate every year.

Table 3: Fire incidents in Lewisham

	2014-15	2015-16	2016-17	2017-18
Accidental Dwelling Fires	646	697	350	201
Smoking related fires	30 (4.6%)	48 (6.9%)	21 (6.0%)	38 (18.9%)
Smoking related Accidental Dwelling Fires				13
Fatalities from smoking related fires	0 (0%)	1 (50%)	0 (0%)	
Serious injuries from smoking related fires	9 (20.5%)	7 (17.1%)	1 (4.0%)	3

WHAT IS THIS TELLING US?

8. What are the key inequalities?

Smoking in itself contributes to health inequalities; anyone who smokes is increasing their likelihood of numerous health and social problems. There are four broad population groups amongst whom smoking is likely to have a greater effect, and therefore a need to focus efforts on reducing smoking among these groups of people. The groups amongst whom there is the greatest need are pregnant women, young people, those with mental health problems and those from a low socio economic group.

Pregnant women are an important group to focus on due to the potential consequences for their unborn child. The risks of smoking during pregnancy are serious, from premature delivery to increased risk of miscarriage, stillbirth or sudden infant death. It is also known that children with parents who smoke are more likely to become smokers themselves, therefore parents need to be encouraged to stop smoking in order to break this cycle.

The emphasis for young people should be to stop them from coming into contact with smoking or accessing cigarettes in order to reduce the likelihood of them starting to smoke. Young people are in particular danger from the effects of smoking and therefore targeting this group before they start is essential.

Due to the fact that those with mental health issues are more likely to smoke, but are less likely to be offered help to stop; this group of people needs an increased input from services in order to reduce this inequality.

Those living in poorer communities are more likely to smoke, which in itself exacerbates the inequalities experienced by people in this group. If those who are in lower socio economic groups can be helped to reduce smoking, this will reduce both health and economic inequalities. The Lewisham Stop Smoking Service is successful in reaching those people living in areas of high deprivation and that the proportion of smokers who quit are higher in these areas and is increasing. This trend should be continued.

It is encouraging to see that smoking prevalence is decreasing nationally and more people are setting a date to quit smoking, through the stop smoking service. The overall numbers of those managing to give up for four weeks is increasing. The numbers using the service,

although increasing, are small and represent only around 6-10% of the smoking population of Lewisham.

9. What are the key gaps in knowledge or services?

Even though the local smoking prevalence has reduced with the implementation of the various strategies on tobacco control, there are gaps in local knowledge about how much people smoke and who is smoking.

In terms of assisting people to stop smoking, there are gaps in the Lewisham stop smoking service provision for those who are most heavily addicted, in specialist services for people with poor mental health, for minority ethnic groups with high tobacco use for example Polish, Vietnamese, and Somali people. The stop smoking service will need to work more closely with people who want to stop and have additional difficulties in achieving this. Referral systems will need to be improved across all care pathways with specific focus on pregnant women and people with mental illness.

Most importantly there is a gap in between the capacity of the stop smoking service and the number of smokers.

10. What is coming on the horizon?

A more strategic approach to implementing smoke free policies and raising awareness will be needed to help protect children and young people from tobacco harm through secondhand smoke and reduce the number of young people who take up smoking.

Reorganisation of the NHS and reductions in local authority funding will challenge partnership working, and investment in initiatives to prevent premature mortality. The Lewisham 'smoke free future delivery group' will continue to work towards their current goals and aim to adapt to the forthcoming challenges they will encounter.

11. What should we be doing next?

There is a need to scale up the provision of Stop Smoking Services so that they are able to reach more smokers. This is particularly important as those people who are still smoking are likely to be more heavily addicted than those who have already quit smoking. However, with the shrinking Public Health Grants and local authority savings plan, this is difficult to achieve, indeed some of the London and out of London councils have completely stopped funding stop smoking services.

One of the key priorities must be to prevent as many young people as possible taking up smoking in the first place through the de-normalising of tobacco.

Plans for future include delivering Lewisham's Smoke Free Future Action Plan, and adapting to changes from national plans. The Action plan focuses on 'de-normalising' smoking to reduce uptake by young people, on implementing policies to protect children from the harm of secondhand smoke, and increasing the contribution to prevalence reduction. The Stop Smoking Service aims to improve referral systems from GP practices and hospitals and develop expertise and effectiveness in supporting people to stop smoking. It will focus on helping parents and pregnant women, those most heavily addicted, those with mental health problems, as well as those in poorer communities and in some minority ethnic groups.

Public Health will continue to work with the wider tobacco control network to strengthen partnership working around: tackling the sale of illegal tobacco (which is typically sold at cheaper prices increasing accessibility of tobacco for children and young people); encouraging partners e.g. health, education and community services to recognise their role in prevention through providing very brief advice around smoking through initiatives such as 'Making Every Contact Count'; and supporting smokefree initiatives in public spaces, particularly those where children and young people may be affected by second hand smoke e.g. playgrounds and community spaces. We would also encourage Lewisham CCG to contribute to the cost of medications that would have been covered by the service.

DRAFT

Immunisations JSNA

REFRESHED DECEMBER 2018

Public Health
LONDON BOROUGH OF LEWISHAM



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Introduction

Immunisation is a proven tool for controlling and eliminating life-threatening infectious diseases and is estimated to avert between 2 and 3 million deaths each year globally. Furthermore it is one of the most cost-effective health investments, with proven strategies that make it accessible to even the most hard-to-reach and vulnerable populations. The 2018 theme of World Immunisation Week was “Protected Together, #VaccinesWork”, and encouraged people at every level – from donors to the general public – to go further in their efforts to increase immunisation coverage.

Currently the European Region of the World Health Organisation (WHO) recommends that on a national basis at least 95% of children are immunised against diseases preventable by immunisation and targeted for elimination or control (specifically, diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenza b, measles, mumps and rubella). The routine childhood immunisation programme for the UK includes these vaccinations recommended by WHO as well as a number of others as defined by Public Health England (**Figure 1**).

Since 2013, NHS England have been responsible for commissioning immunisation programmes in Lewisham. The local public health team is however responsible to ensure that these programmes are delivered to a high standard and that coverage is adequate amongst their local population. Increasing the uptake of immunisation is one of the priorities of the Be Healthy element of the Children and Young People’s Plan and has been identified as a priority within the Health and Wellbeing Strategy.

This Joint Strategic Needs Assessment (JSNA) - refreshed in December 2018 - outlines the trends in vaccination coverage for routine childhood and adult immunisation, identifies the unmet needs and provides recommendations for future actions to enhance delivery and uptake of immunization.

Herd immunity

When a vaccination programme against a disease begins, the number of people catching the disease goes down. As the threat decreases, it's important to keep vaccinating, otherwise the disease can start to spread again. If enough people in a community are vaccinated, it's harder for a disease to pass between people who have not been vaccinated. This is called herd immunity. Herd immunity is particularly important for protecting people who can't get vaccinated because they're too ill or because they're having treatment that damages their immune system.

Public Health England (PHE) records the vaccinations that adults and children receive. PHE also records the number of cases of each disease each year. This way, PHE can work out the impact that each vaccination has on a particular disease. This data helps the Joint Committee on Vaccination and Immunisation (JCVI) consider whether the routine vaccination programme needs to be changed.

Current services

Since the Health and Social Care Act 2012, NHS England is responsible for the routine commissioning of national immunisation programmes under the terms of the Section 7a

agreement. In London, commissioning of immunisation programmes is done by the NHS England (London) immunisation commissioning team. This team comprises of Public Health England and NHS England staff who work together to improve the uptake and quality of commissioned vaccination services in London. These services are provided through general practice, school aged vaccination teams, pharmacies, and maternity services.

Lewisham public health team have a responsibility to provide information and advice to relevant bodies within its area to protect the population's health. Director of Public Health will provide independent scrutiny and challenge of the arrangements of NHS England, PHE and providers. This is done in Lewisham through Lewisham Partnership Immunisation Strategy Group chaired by Director of Public Health and ensure that these programmes are delivered to a high standard and that coverage is adequate amongst their local population. Increasing the uptake of immunisation is one of the priorities of the Be Healthy element of the Children and Young People's Plan and has been identified as one of its priorities by the Lewisham Health and Wellbeing Board. Lewisham CCG have a duty of quality improvement for services delivered by GP practices.

The routine childhood immunisation programmes are delivered by GPs. The school aged and adolescent immunisation services are provided by Lewisham and Greenwich trust through School Nursing Services, jointly commissioned by Lewisham Council. Both NHS England and PHE ensures that all providers have access to training that meets nationally agreed standards. Most routine queries from the public about immunisations are addressed by providers within the scope of *Immunisation against infectious diseases* ('the Green Book'). Providers are encouraged to answer queries from the public within this remit.

Childhood Immunisations

What do we know?

Routine childhood immunisation schedule

The full childhood immunisations schedule is appended as Appendix A.

It is important to note that the routine childhood immunisation schedule has been expanded since the previous JSNA – some of the updates of note are:

- Seasonal influenza vaccines are recommended for children aged 2-7 years (via a nasal vaccine, one dose each year).
- Addition of Human Papilloma Virus (HPV) vaccine – two doses 6-12 months apart for girls aged 12-14 years.

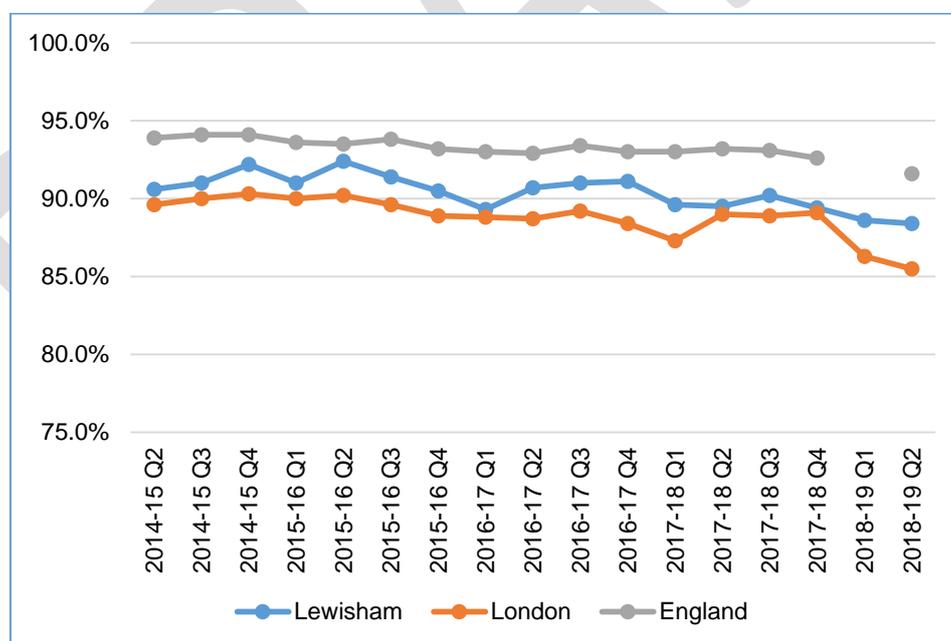
Facts, figures and trends

Figures 1-8 show the trends in uptake of key childhood vaccinations between 2014 and the first quarter of 2018.

D3 at 1 year

- Uptake of the third dose of Diphtheria vaccine (D3) is an indicator of completion of the primary course of immunisation of children under 12 months that aims to protect children against diphtheria, tetanus, whooping cough, polio, Haemophilus influenza b and Group C Meningococcus.

Figure 1: Percentage uptake of DTaP/IPV/HiB (D3) for Age 1 cohort



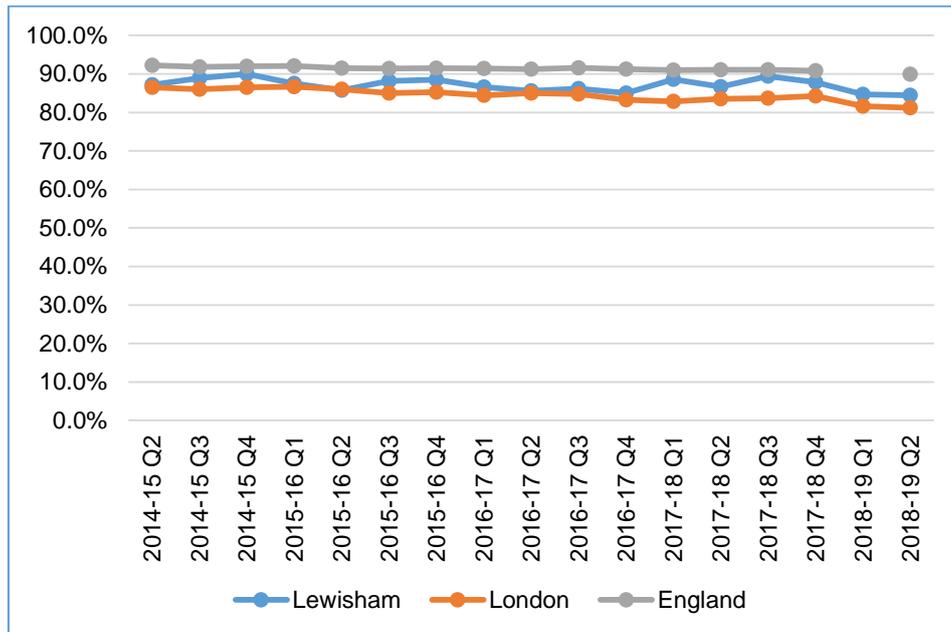
Source: Cover of vaccination evaluated rapidly (COVER) programme

- D3 Uptake has remained quite stable in the period 2014-18. Uptake in 2017-18 and 2018-19 (first two quarters) is above the London average but below the England average.

MMR

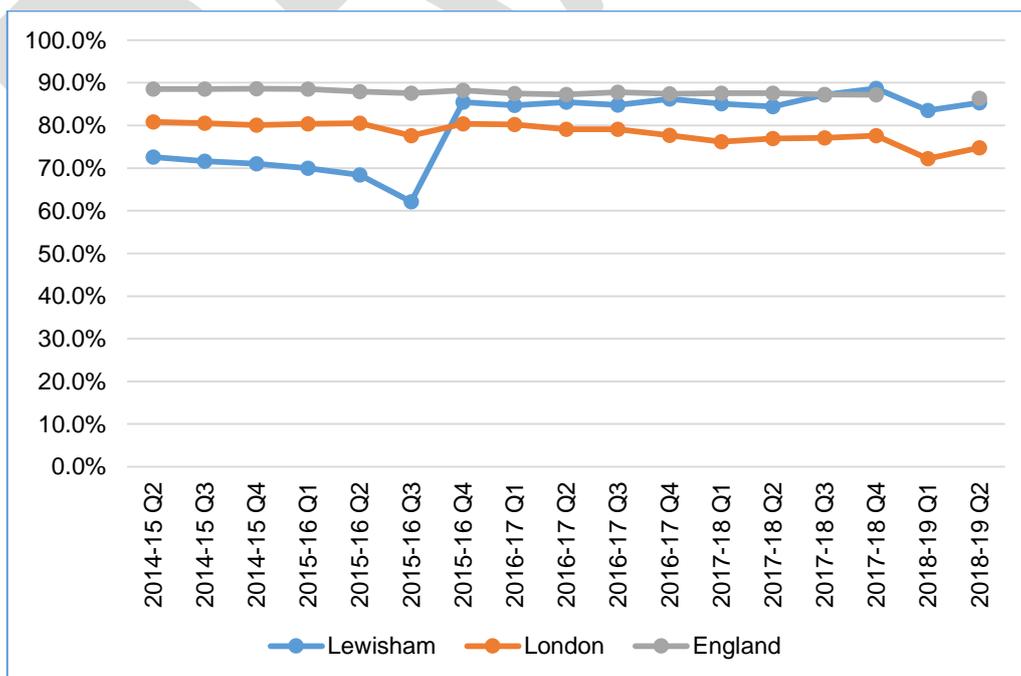
- MMR aims to protect children against measles, mumps and rubella. Two doses are required: MMR 1 at 12 months and MMR2 is given at 18 months in Lewisham like other South East London Boroughs (Southwark & Lambeth)
- Although a significant increase in uptake of MMR2 has been observed since 2015, uptake of both MMR1 and MMR2 are below the national average but has been above London average.

Figure 2: Percentage uptake of MMR1 for Age 2 cohort



Source: Cover of vaccination evaluated rapidly (COVER) programme

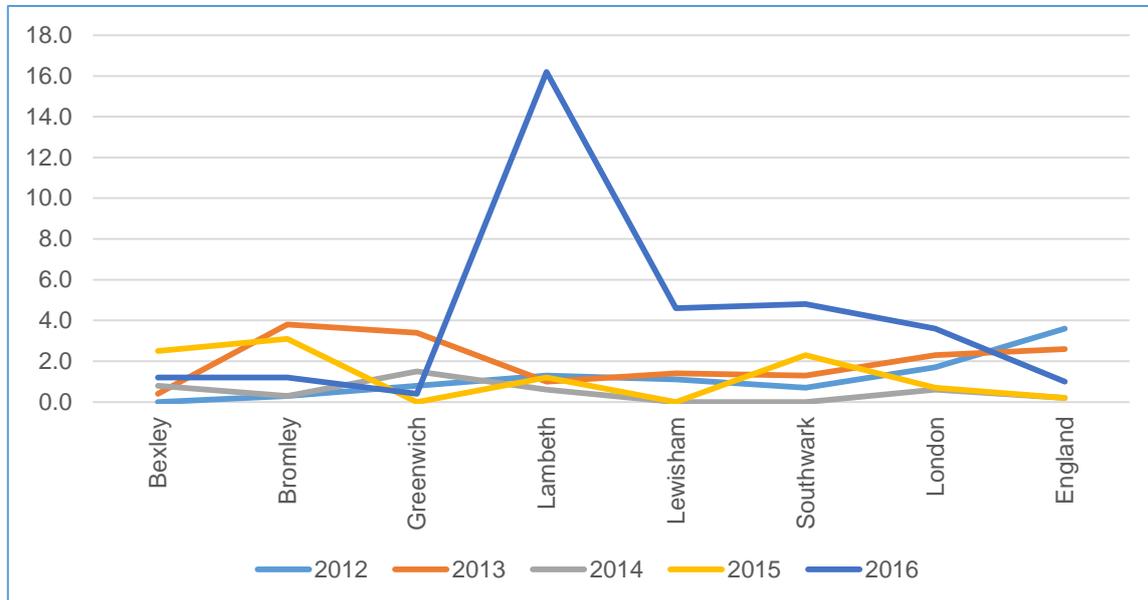
Figure 3: Percentage uptake of MMR2 for Age 5 cohort



Source: Cover of vaccination evaluated rapidly (COVER) programme

- MMR in context: Figure 4 illustrates the measles diagnosis rate per 100,000 from 2012 to 2016, even though South East London previously had large number of cases but with the higher vaccination rate with MMR, the numbers have fallen.

Figure 4: Measles New Diagnosis Rate per 100,000 in South East London

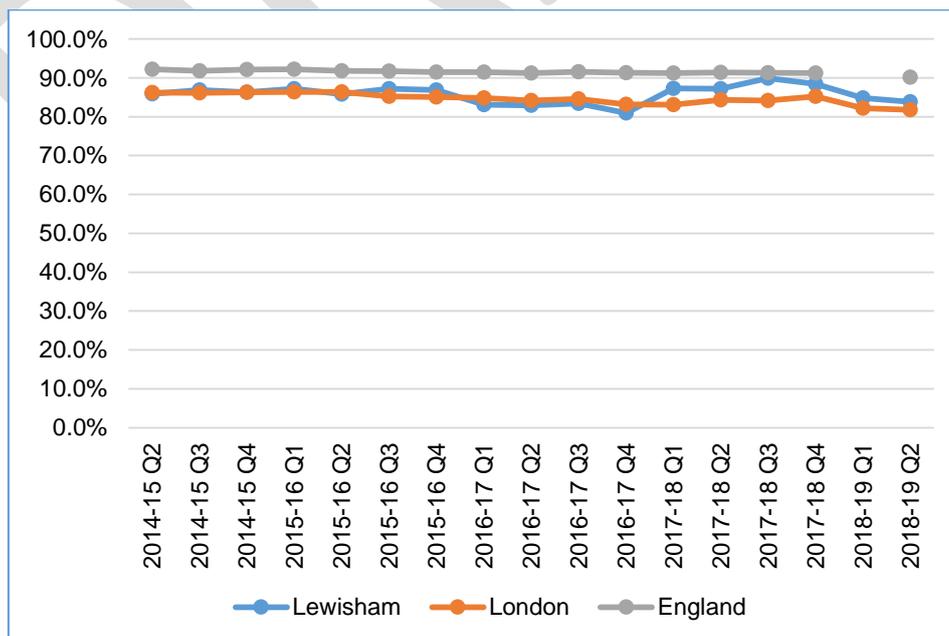


Source: <https://fingertips.phe.org.uk/profile/health-protection>

Hib/MenC and PCV boosters

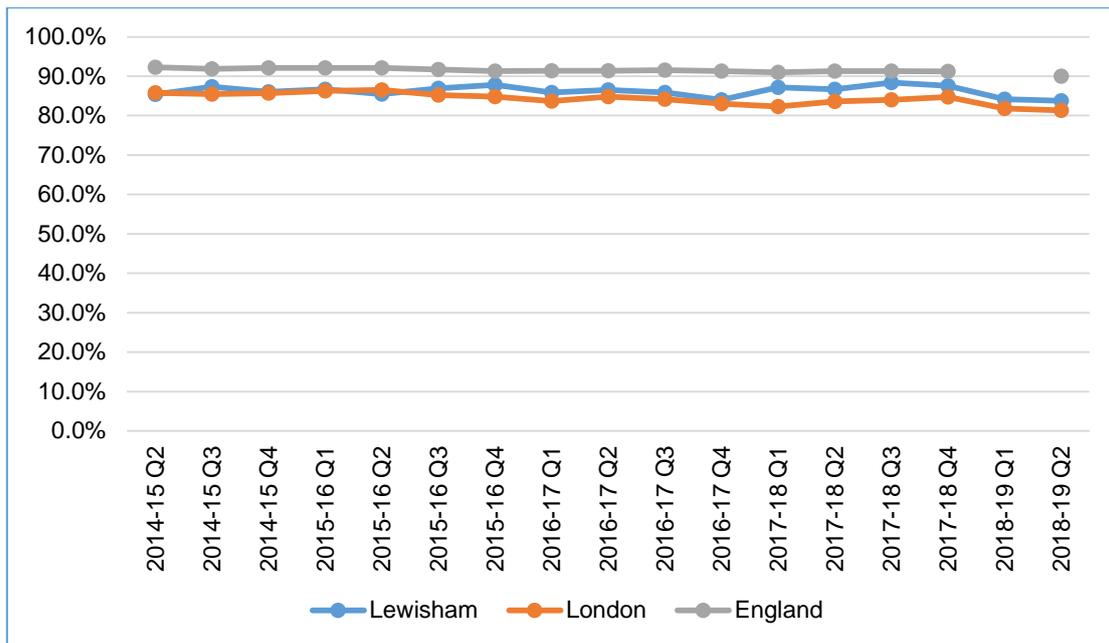
- Given at 12 months and aim to protect children against Haemophilus influenza B, Group C Meningococcus and pneumococcus.
- Uptake has remained relatively stable, similar to the London average but below the national average.

Figure 5: Percentage uptake of Hib/MenC Bstr for Age 2 cohort



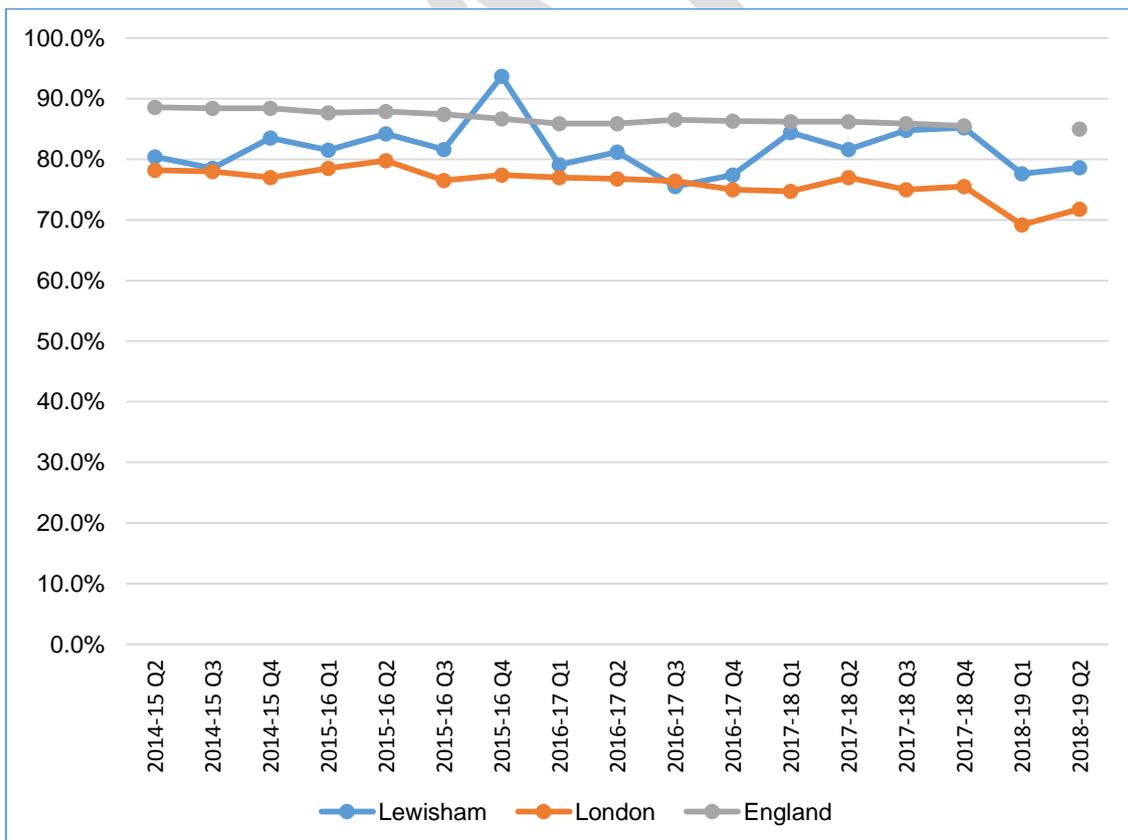
Source: Cover of vaccination evaluated rapidly (COVER) programme

Figure 6: Percentage uptake of PCV Bstr for Age 2 cohort



Source: Cover of vaccination evaluated rapidly (COVER) programme

Figure 7: Percentage uptake of DTaP/IPV Bstr for Age 5 cohort (D4)



Source: Cover of vaccination evaluated rapidly (COVER) programme

- D4 is the fourth dose of diphtheria vaccine. It is a key component of the preschool booster, which should be given at any time from the age of 3 years and 4 months but before the child starts school.

- The preschool booster completes the protection of children against diphtheria, tetanus, whooping cough and polio.

Neonatal BCG

- The Maternity Service is responsible for delivering neonatal BCG vaccinations. This includes a universal offer for all babies to the age of 28 days, and a targeted offer for babies up to 12 months who are at risk of TB due to one or more parent or grandparent being born in a country where the annual incidence of TB is 40/100,000 or greater.

Influenza (Children)

Children from the age of two upwards are now offered the flu vaccine in the form of a nasal spray to help protect them from catching and spreading flu. The vaccine is offered in schools to children in reception and in years 1, 2, 3, 4 and 5 and to two and three year olds through general practice. The programme will eventually roll out to all primary school children. Due to having typically poorer hand and respiratory hygiene than adults, children tend to spread flu more easily, so protecting them is also important for protecting the rest of the population.

Table 1: Flu Monthly Child (Primary School Age Delivery) 2017-18

Reception	4-5 Year Olds Birth Cohort: 1 September 2012 - 31 August 2013	Total no. of eligible children in Lewisham	3,805
		Total no. of children vaccinated	1,995
		% Uptake	52.4
Year 1	5 -6 Year Olds Birth Cohort: 1 September 2011 - 31 August 2012	Total no. of eligible children in Lewisham	3,763
		Total no. of children vaccinated	1,908
		% Uptake	50.7
Year 2	6 -7 Year Olds Birth Cohort: 1 September 2010 - 31 August 2011	Total no. of eligible children in Lewisham	3,891
		Total no. of children vaccinated	1,947
		% Uptake	50.0
Year 3	7-8 Year Olds Birth Cohort: 1 September 2009 - 31 August 2010	Total no. of eligible children in Lewisham	3,774
		Total no. of children vaccinated	1,844
		% Uptake	48.9
Year 4	8-9 Year Olds Birth Cohort: 1 September 2008 - 31 August 2009	Total no. of eligible children in Lewisham	3,643
		Total no. of children vaccinated	1,574
		% Uptake	43.2

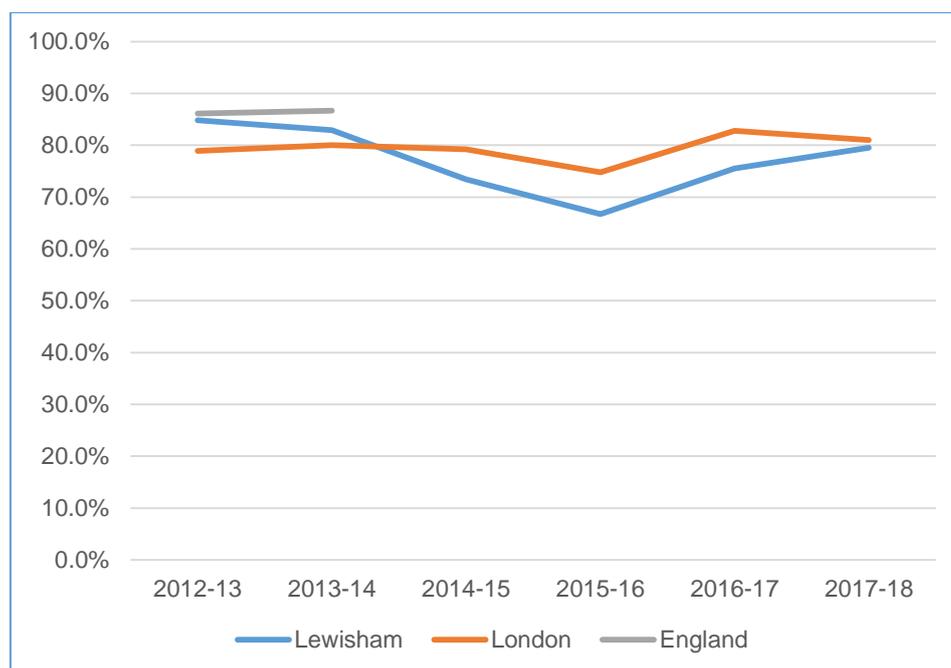
Source: Immform, January 2018

These figures are improvements on previous years.

HPV

The latest available data for HPV vaccine uptake shows a marked improvement from the previous reporting period. Public Health and school nursing are working closely with the joint commissioning team and NHS England to address the fall in HPV vaccine coverage in the previous reporting periods which was related to increasing numbers of parents withholding consent for their daughters to be vaccinated, as well as changes to the dosage schedule and delivery in schools.

Figure 8: Percentage of females aged 12-13 who have received all* doses of the HPV vaccine, 2012-18



Source: Immform, January 2018

* In 2014, the HPV vaccine changed from 3 doses to 2 doses. England-level data not available for 2014-16 onwards.

The MenACWY and Td/IPV

The MenACWY vaccine was introduced in 2015 to respond to a rapid and accelerating increase in cases of invasive meningococcal group W (MenW) disease. MenACWY was added to the routine adolescent schools programme (school year 9 and 10) from Autumn 2015. The 2015/16 survey collected coverage data for both the catch-up campaign, school year 11 (Cohort 1), and the first year of MenACWY inclusion in the routine adolescent schools programme, school year 10 (Cohort 2) or school year 9 (Cohort 3) depending on local arrangements.

Td/IPV vaccine has been included in the adolescent schedule for many years but delivery has varied locally; school based, GP and combined programmes have all been adopted and coverage data collection has been challenging. Data can be provided for year 9 and/or 10 depending on local arrangements.

Table 2 :MenACWY and Td/IPV Booster Uptake 2017-18 (01/09/2017 - 31/08/2018)

Cohort 5 - 13-14 Year Olds (Year 9) born between 1 September 2003 - 31 August 2004	Number of students	2,493
	No. vaccinated with MenACWY by 31/08/2018	2,201
	% Uptake	88
	No. vaccinated with Td/IPV booster by 31/08/2018	2,143
	% Uptake	86
Cohort 4 - 14-15 Year Olds (Year 10) born between 1 September 2002 - 31 August 2003	Number of students	2,390
	No. vaccinated with MenACWY by 31/08/2018	1,819
	% Uptake	76.1
	No. vaccinated with Td/IPV booster by 31/08/2018	1,749
	% Uptake	73.2

Source: ImmForm

What are the key inequalities?

There is evidence to suggest that the following groups of children and young people are at risk of not being fully immunised:

- children and young people who have missed previous vaccinations;
- looked after children;
- children with physical or learning difficulties;
- children of teenage or lone parents;
- children not registered with a general practitioner;
- younger children from large families;
- children who are hospitalised;
- minority ethnic groups;
- vulnerable children, such as those whose families are travellers, asylum seekers or homeless.

There are evidences that there are differences in MMR uptake between GP Practices. Data indicates that in 2016-17 there were significant differences in MMR uptake between GP practices, however Public Health are awaiting approval to access more recent data.

Adult immunisations

Routine adult immunisation schedule

The routine immunisation schedule for adults comprises three vaccinations:

- Pneumococcal - offered at 65 years old
- Influenza - offered to those aged 65 and over and other at risk groups (annually from September)
- Shingles - offered at 70 years old

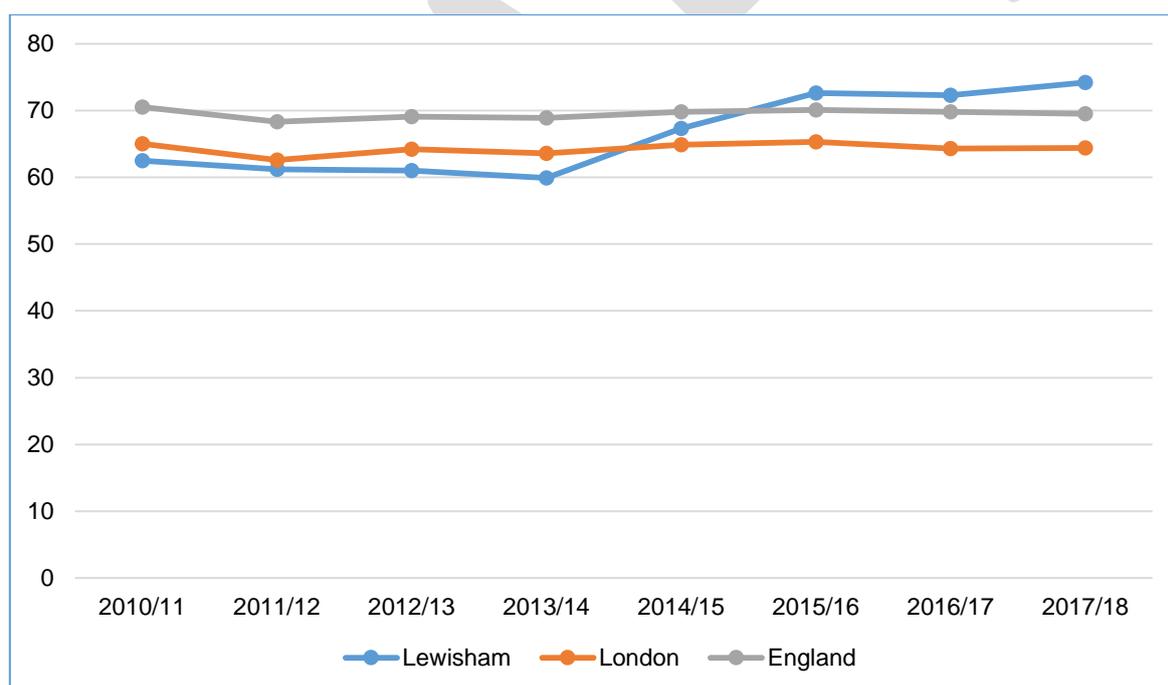
Facts, figures and trends

During the seasonal flu vaccination period (1st Oct - 31st Jan each year) data is collected on a monthly basis from GPs at a national level to monitor the uptake of this vaccination campaign. The GPs also provide other adult vaccination including pneumococcal, shingles alongside seasonal flu vaccination as well pre-natal pertussis and neonatal BCG.

Pneumococcal

Public Health England reported a 74.2% population coverage of the PPV vaccine for Lewisham adults aged 65 years and over in 2017/18.

Figure 9: Pneumococcal Polysaccharide Vaccine (PPV) Uptake



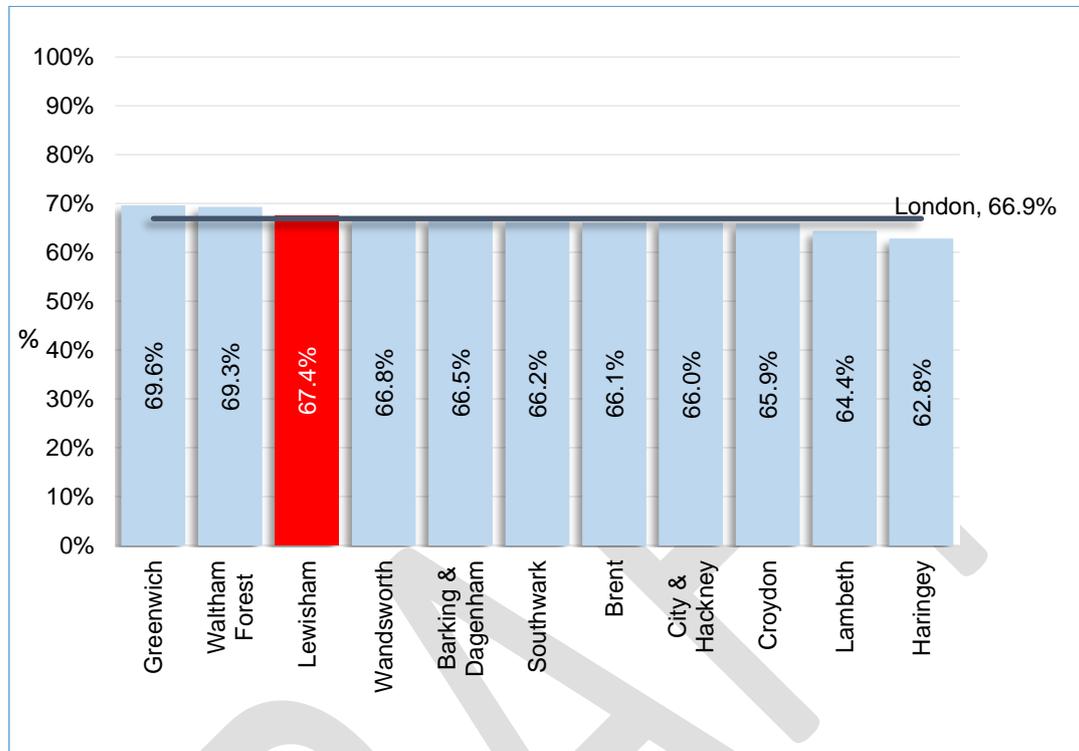
Source: <https://fingertips.phe.org.uk/profile/health-protection>

Influenza

There are certain groups who are at higher risk from flu; these include pregnant women, those over the age of 65, healthcare workers and those with serious health conditions. Seasonal flu vaccine is offered to people in all of these groups, to help protect them from catching and spreading flu. Eligible people can have their flu vaccine at their GP surgery or a local pharmacy offering the service. Some midwifery services can offer the vaccine to pregnant women each winter.

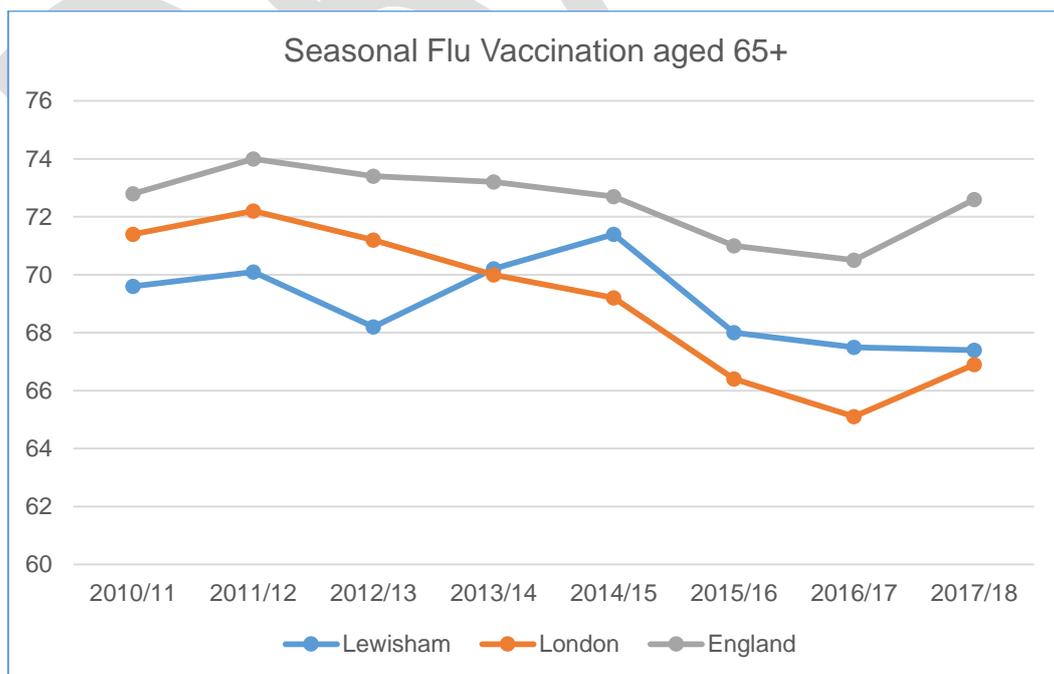
Lewisham uptake in patients 65 years and over was 67.4% in 2017-18 (and 67.5% in 2016-17).

Figure 10: Flu vaccine monthly uptake in patients 65 and over. Lewisham compared to its similar CCGs, 2017-18



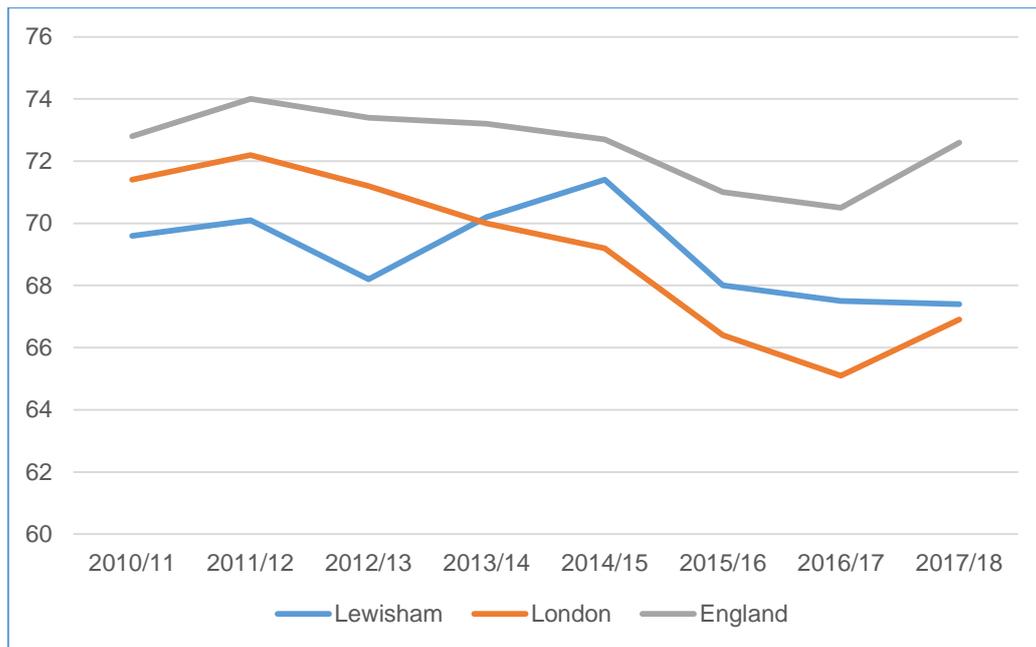
Source: ImmForm (<https://www.gov.uk>)

Figure 11: Seasonal Flu Vaccination aged 65+



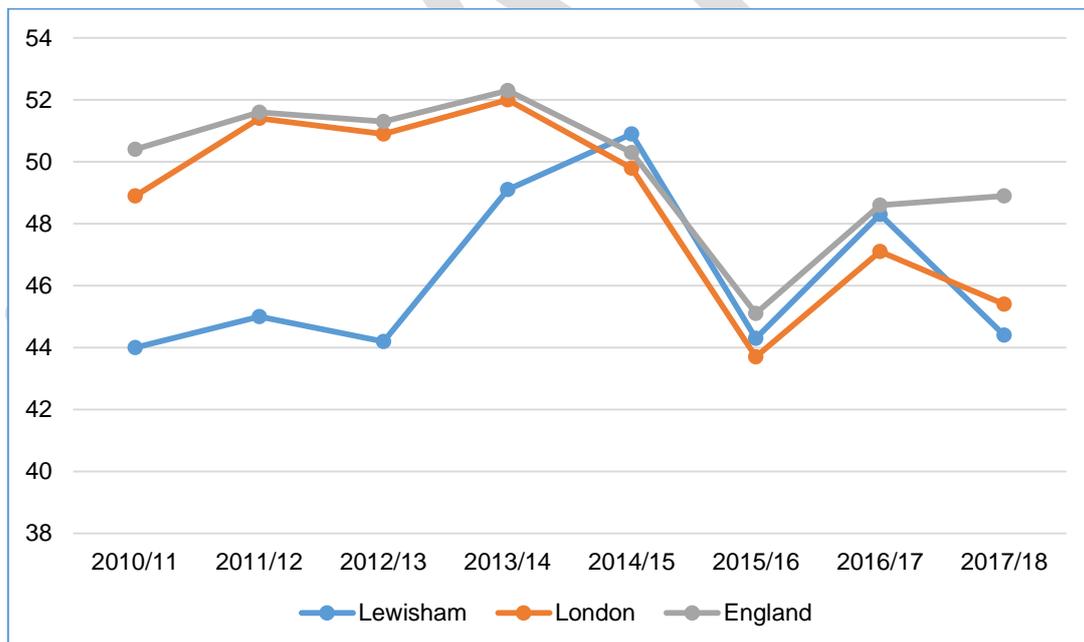
Source: <https://fingertips.phe.org.uk/profile/health-protection>

Figure 12: Population Vaccination Coverage - Flu, aged 65+ (%)



Source: <https://www.gov.uk/government/collections/vaccine-uptake#seasonal-flu-vaccine-uptake:-figures>

Figure 13: Population vaccination coverage - Flu, at risk individuals (%)

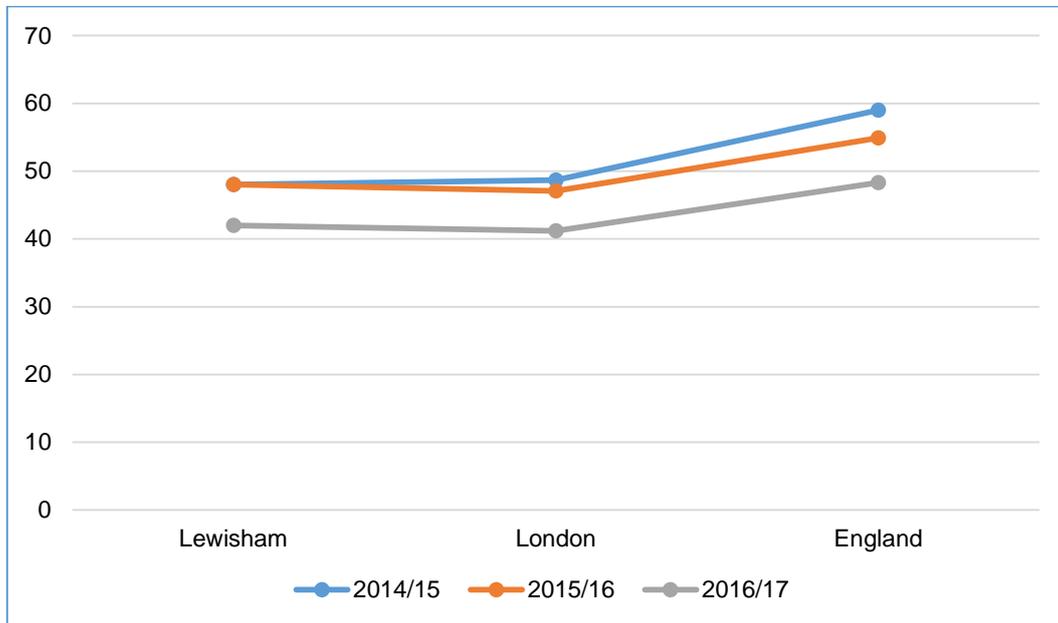


Source: <https://www.gov.uk/government/collections/vaccine-uptake#seasonal-flu-vaccine-uptake:-figures>

Shingles

Public Health England report a 42% population coverage of the shingles vaccination for adults at 70 years old in Lewisham. (2016-17 figure)

Figure 14: Shingles Vaccination Coverage (70 years old)



Source: <https://fingertips.phe.org.uk/profile/health-protection>

Pre-natal pertussis

Pertussis immunisation would be offered to pregnant women from 1 October 2012 to protect infants from birth. This programme aims to passively protect infants from birth, through intrauterine transfer of maternal antibodies, until they can be actively protected by the routine infant programme with the first dose of pertussis vaccine scheduled at eight weeks of age.

During 2017-18 (01/04/2017 to 31/03/2018), 35 out of 40 GPs reported about the uptake of pre-natal pertussis vaccination. Of the 2,902 women who delivered in the survey month (regardless of gestational age at birth), 1,857 women received pertussis vaccination between week 16 of pregnancy and delivery, which makes the uptake of 64.0%, and this needs to improve. 20 women declined taking pertussis vaccination in the 26 weeks prior to delivery who have not been vaccinated.

National and local strategies

Nationally

Since the changes to the NHS in April 2013, nationally NHS England is the organisation responsible for the commissioning of the immunisation programme across the country and for providing assurance to the Director of Public Health in Lewisham that the standards for this programme are being met. The immunisation programmes delivered to the Lewisham residents are recommended by the Joint Committee on Vaccination and Immunisation (JCVI) - the national body for scheduling the national vaccinations programmes and introducing new vaccines into the schedules as and when required.

GPs deliver both the childhood vaccination schedules to the local GP registered population. The cover of vaccination evaluated rapidly programme (COVER) evaluates childhood immunisation in England, collating data for children aged 1, 2 and 5. COVER collects the quarterly coverage figures for all the childhood vaccinations given across Lewisham similar to other parts of England and Wales. This provides comparative data for this vaccination schedule at a London and national level. The data tables are provisional and give an indication of current coverage. Data is collected by financial year.

During the seasonal flu vaccination period (1st Oct - 31st Jan each year) data is collected on a monthly basis from GPs at a national level to monitor the uptake of this vaccination campaign.

School nursing services provide vaccinations to school aged children. The school aged vaccination team provides HPV, MenACWY, and school leaver booster (Td/IPV) to adolescents (between the ages 12 to 18 years). The school team also provide seasonal flu vaccination to year 1, 2, 3, 4, and 5 through nasal spray.

The NHS Long-term Plan was published in January 2019. The document states improving childhood immunisations is a priority. The programme will also work closely with other areas of government and key programmes such as the Healthy Child Programme. The expectation is that CCGs should ensure that all screening and vaccination programmes are designed to support a narrowing of health inequalities. The plan also states:

- In 2019, a fundamental review of GP vaccinations and immunisation standards, funding, and procurement will be undertaken to support the goal of improving immunisation coverage, using local coordinators to target variation and improve groups and areas with low vaccines uptake.
- From September 2019, all boys aged 12 and 13 will be offered vaccination against HPV-related diseases, such as oral, throat and anal cancer.
- A digital version of the 'red book' will help parents record and use information about their child, including immunisation records and growth.

Locally

Lewisham Immunisation Partnership Strategy Group comprising of the various stakeholders including the providers, NHS England, Public Health England, and Lewisham CCG provides strategic directions locally. This group is chaired by Director of Public Health. A Lewisham Immunisation Partnership Action Group is also in existence for the providers only and is led by the Public Health Immunisation lead. Both groups work closely to ensure immunisation

uptakes are improving to achieve herd immunity. An action plan provides direction in the effort to improve the uptake of the childhood, adolescent and adult immunisation.

In addition to elements on training and communication with the public, key elements of the action plan include:

- An Information Action Plan –improving information systems is where much of the efforts have been, and improvements are being made. The challenge is that these improvements have to be maintained, in addition with new changes made by NHS England to collect and analyse COVER data has proven to be challenging as well. Further improvement is necessary to influence uptake to have a positive influence on the behaviour of GPs locally.
- Working closely with various providers and stakeholders to improve uptake of various immunisation is another important component of action plan.

Support for GPs in aiming for best practice and to ensure good flow of data, including feedback of information to practices.

What is this telling us?

What are the key gaps in knowledge and/or services

- Lewisham is not achieving the majority of immunisation targets, particularly MMR vaccinations.
- There is a continued need to enhance information systems to allow live feedback.
- With the new ways of collecting childhood immunisation data from GP Practices, it has become challenging to look at practice specific data to identify variation in childhood immunisations uptake by GP practice. Work is in progress to access these from new Child Health Information Service (CHIS) providers, however current difficulty accessing this level of data hinders understanding and reactivity.

What is coming on the horizon?

- Expansion of routine HPV vaccination coverage to boys from September 2019, however, there is currently no guidance or direction from either a national or London level.

What should we do next?

- Working with relevant stakeholders to ensure implementation of appropriate immunisation pathway following national guidance and Green Book.
- Engaging with primary and secondary school vaccination providers to improve uptake of the school immunisations.
- Continue work on MMR pathway, improved information systems and with GPs. To improve uptake of MMR vaccination amongst residents by highlighting this situation with NHSE to find ways of promoting the MMR vaccination to all Lewisham residents.
- To continue to distribute targeted resources to key stakeholders to GPs/practice nurses/health visitors and children's centres to promote this issue.

- Opportunistic immunisation of children whenever they present within the health service. To improve coverage of childhood vaccination programme by encouraging GP practices to make necessary improvements to their programmes.
- To improve uptake of season flu vaccination in all eligible groups by learning from other GPs with higher levels of vaccination uptake amongst these groups.
- To continue to support improvement of uptake of Whooping Cough (Pertussis) vaccination in pregnant women by improving the access to through the new maternity service and to gather information on reasons why local women will not have this vaccination.
- To improve vaccination uptakes of vulnerable children and adults to ensure these groups are not being disadvantaged and are receiving all the vaccinations as required on the immunisation schedule.

DRAFT

Age for Immunisation	Protects against...	Which Vaccines to be Given	Number of Injections
Birth to 28 days	Tuberculosis	BCG	One injection
Two months 	Diphtheria, tetanus, whooping cough, polio, <i>haemophilus influenzae b</i> , hepatitis B and pneumococcal infection, rotavirus and meningitis B	DTaP/IPV/Hib/HepB PCV (Prevenar13) Rotavirus (Rotarix) MenB (Bexsero)	Three injections + Oral
Three months 	Diphtheria, tetanus, whooping cough, polio, <i>haemophilus influenzae b</i> , hepatitis B and rotavirus	DTaP/IPV/Hib/HepB + Rotavirus (Rotarix)	One injection + Oral
Four months 	Diphtheria, tetanus, whooping cough, polio, <i>haemophilus influenzae b</i> , hepatitis B and pneumococcal infection and meningitis B	DTaP/IPV/Hib/HepB + PCV (Prevenar13) + MenB (Bexsero)	Three injections
12 months 	Measles, mumps, rubella, Hib, meningitis C, pneumococcal infection and meningitis B 	MMR (MMRvaxPro, Priorix) Hib/MenC (Menitorix) PCV (Prevenar13) MenB Bexsero	Four injections
15 Months (or 3 months after MMR1)	Measles, mumps, rubella There needs to be a three month gap between the two doses of MMR for children in this age group.	MMR (MMRvaxPro, Priorix) 	One injection
2,3,4,5,6,7 year olds	Seasonal flu	Fluenz - nasal vaccine	One dose Each year
Three years and 4 months and over 	Diphtheria, tetanus, whooping cough and polio	dTaP/IPV (Infanrix/IPV) (NB Boostrix - DTaP/IPV for pregnant women 20-32 weeks. Can be given later if missed.)	One injection
Girls aged 12 to 14 years 	Cervical cancer and genital warts Girls in school year 8 and above are immunised against Human Papilloma Virus by school nurses.	 HPV (Gardasil) TWO doses 6-12 months apart 	Two injections

13 to 18 years 	Diphtheria, tetanus, polio and meningitis types ACW and Y 	Td/IPV (Revaxis) + MenACWY	Two injections
--	--	--	---------------------------

It's NEVER too late to catch up on vaccinations!!

If you have a question or concern, speak to your practice nurse, GP, health visitor or school nurse. You can also go to NHS Choices at www.nhs.uk/vaccinations
MC public/prof Lewisham and Greenwich NHS Trust 20170626

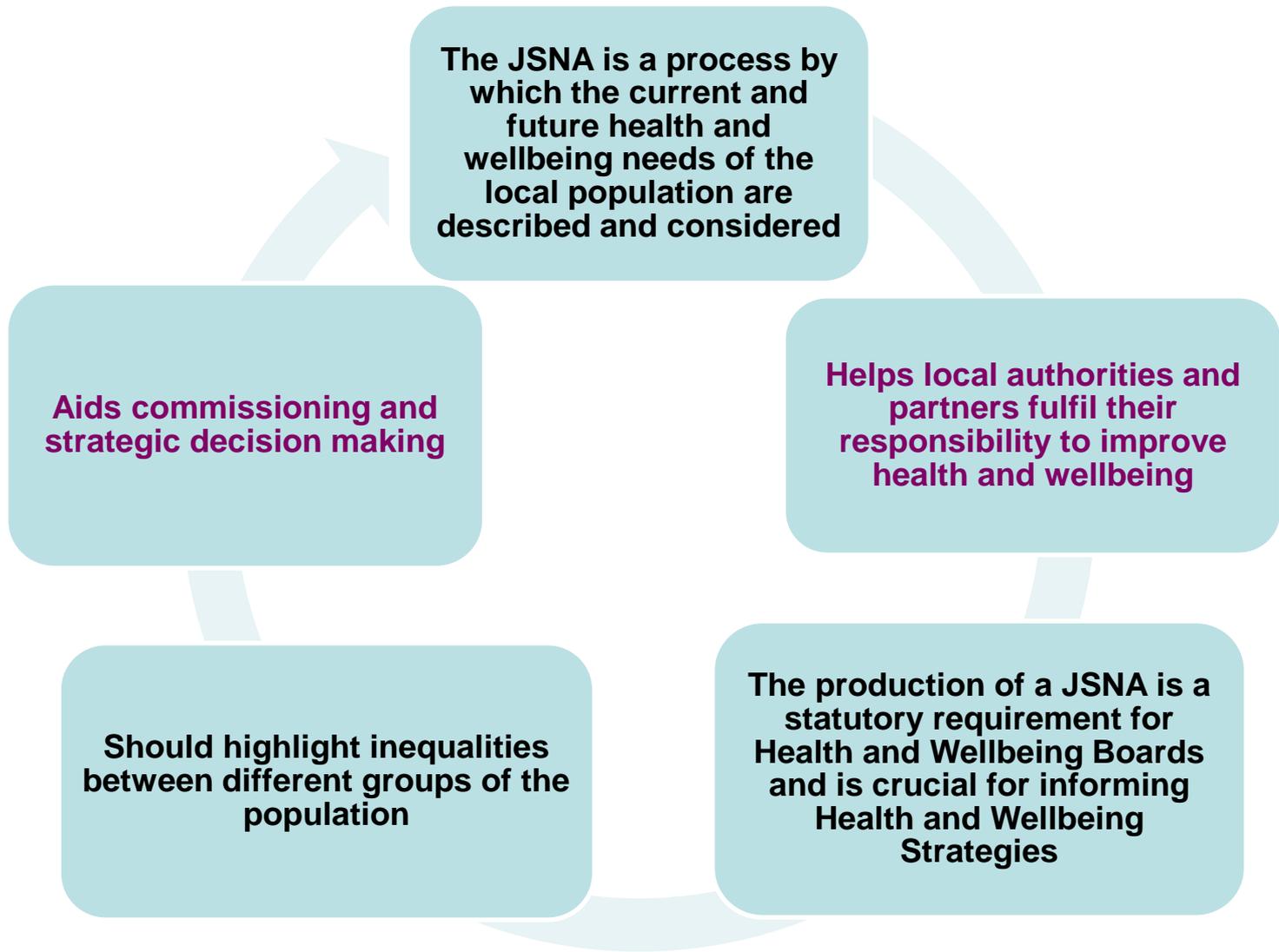
Lewisham and Greenwich 
NHS Trust

DRAFT

Joint Strategic Needs Assessment (JSNA)

Picture of Lewisham 2019

- What is a JSNA?
- The JSNA Process in Lewisham
- The Borough
- Mortality
- Overarching Health Indicators
- Health & Wellbeing Strategy Priorities
- Other Determinants of Health
- Services



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What is a JSNA?



- A revised JSNA process was agreed by the Health and Wellbeing Board in [July 2017](#)

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- This document describes the population of Lewisham in terms of the key health and socio-demographic characteristics, including mortality, morbidity, ethnicity and inequalities.
- The JSNA is updated with new information, evidence and intelligence as it becomes available and as new issues and gaps are identified.

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Demographics

Inequalities



A Picture of Lewisham

Achieving a healthy weight

Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years

Improving immunisation uptake

Reducing alcohol harm

Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking

Improving mental health and wellbeing

Improving sexual health

Delaying and reducing the need for long term care and support

Reducing the number of emergency admissions for people with long-term conditions

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Health and Wellbeing Strategy Priorities -

The health and wellbeing strategy explains what priorities the Health and Wellbeing Board has set in order to tackle health need





The Borough

With a population of 301,300 Lewisham is the 14th largest borough in London by population size and the 6th largest Inner London



Lewisham

	Males	Females	Total
0-17	35,019	33,253	68,272
18-64	101,138	103,809	204,947
65+	12,426	15,662	28,088
Total	148,583	152,724	301,307

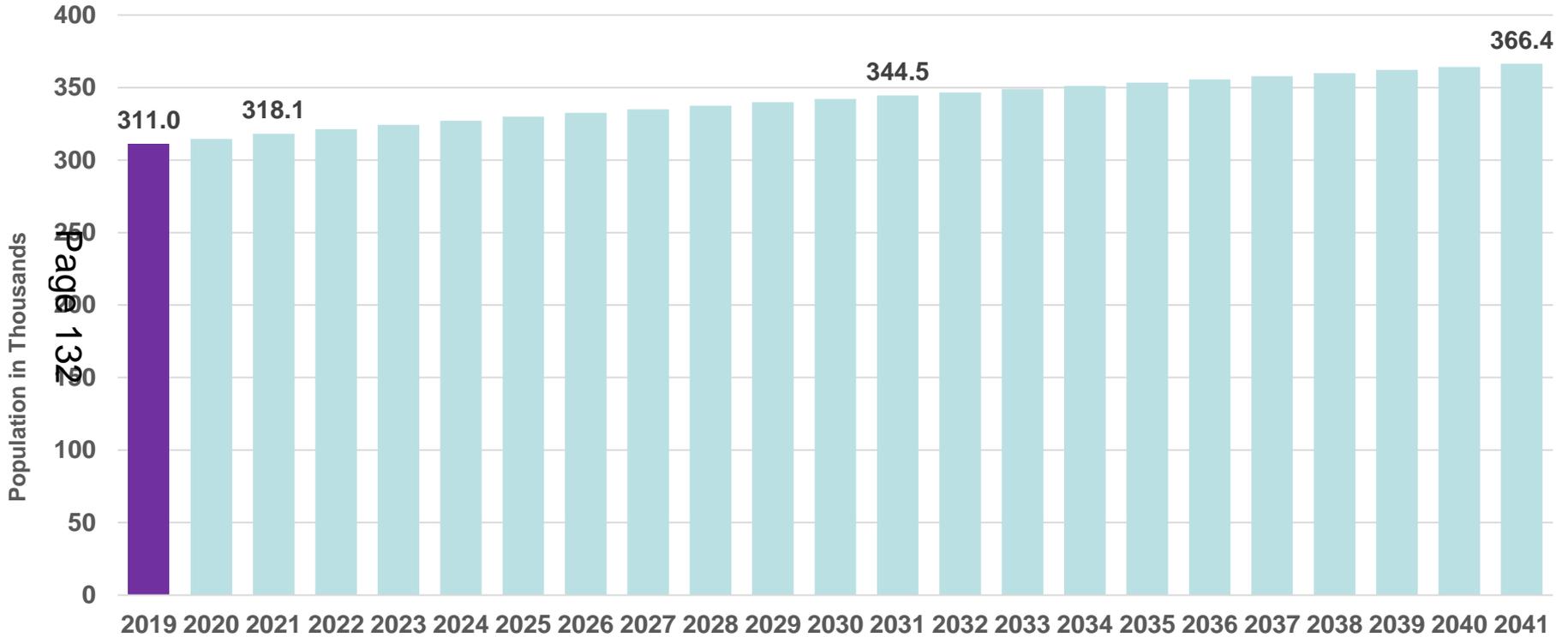
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Source: ONS 2017 Mid Year Population Estimates

Population by Age and Sex -
Lewisham has a young population bias



The population is set to continue to grow, by the time of the 2021 Census it is expected to reach 318,100 and climb to 344,500 by the time of the 2031 Census.

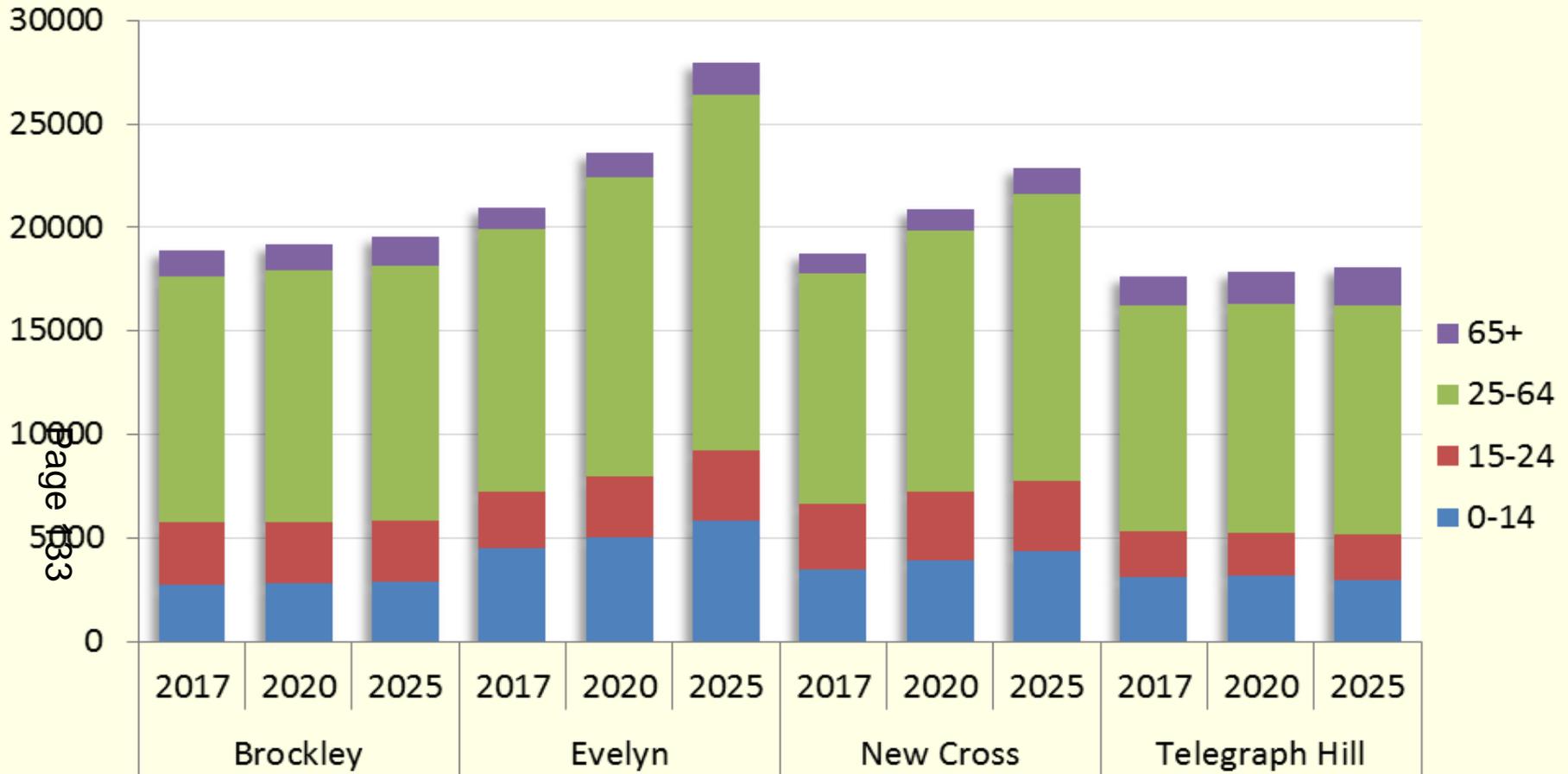


Source: ONS 2016

Population Growth - this growth is through a combination of the number of births exceeding the number of deaths and international migration, people moving to the borough from overseas



Projected changes in Lewisham's population by ward and age band for Neighbourhood 1



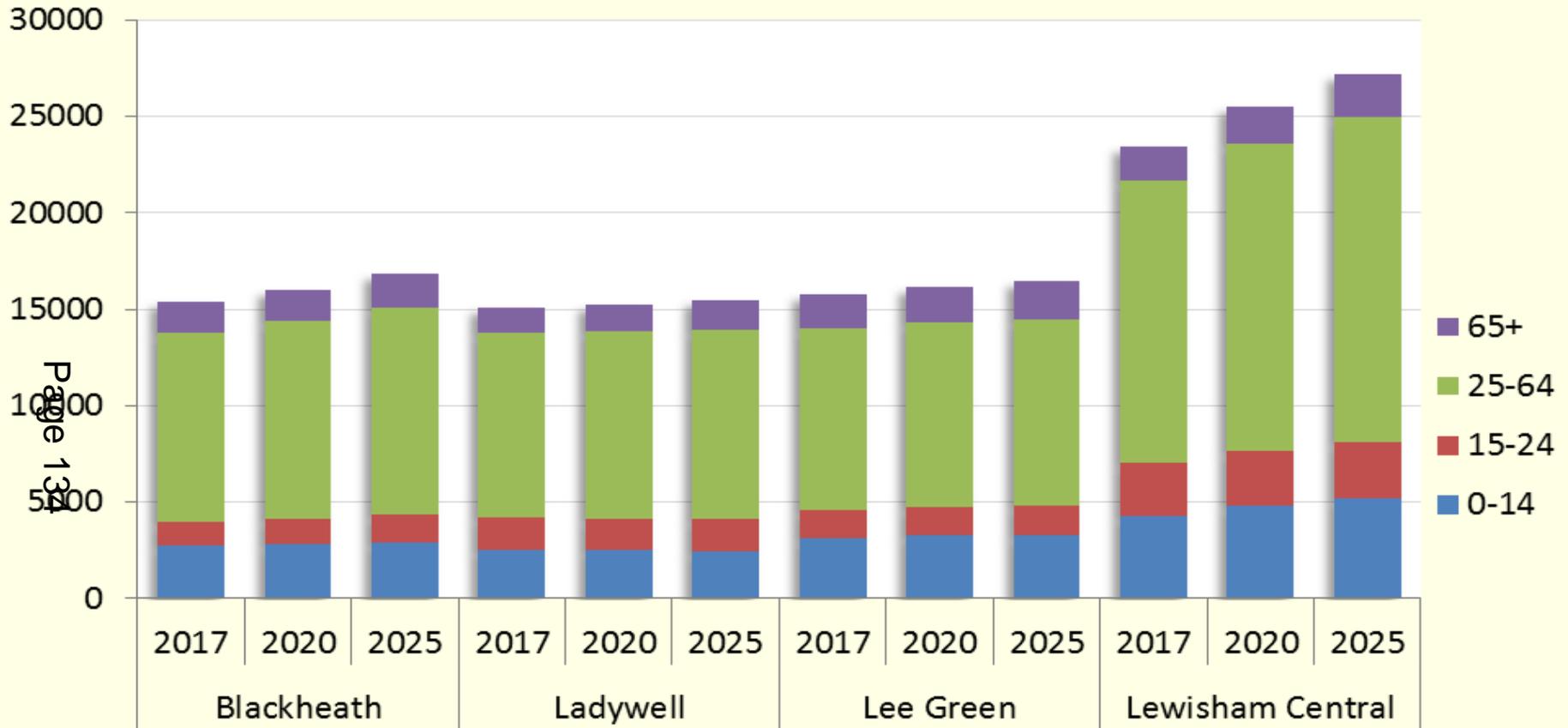
Source: GLA, 2015

Population growth - Neighbourhood 1

The growth will continue to follow the pattern of a younger population bias at the north of the borough



Projected changes in Lewisham's population by ward and age band for Neighbourhood 2



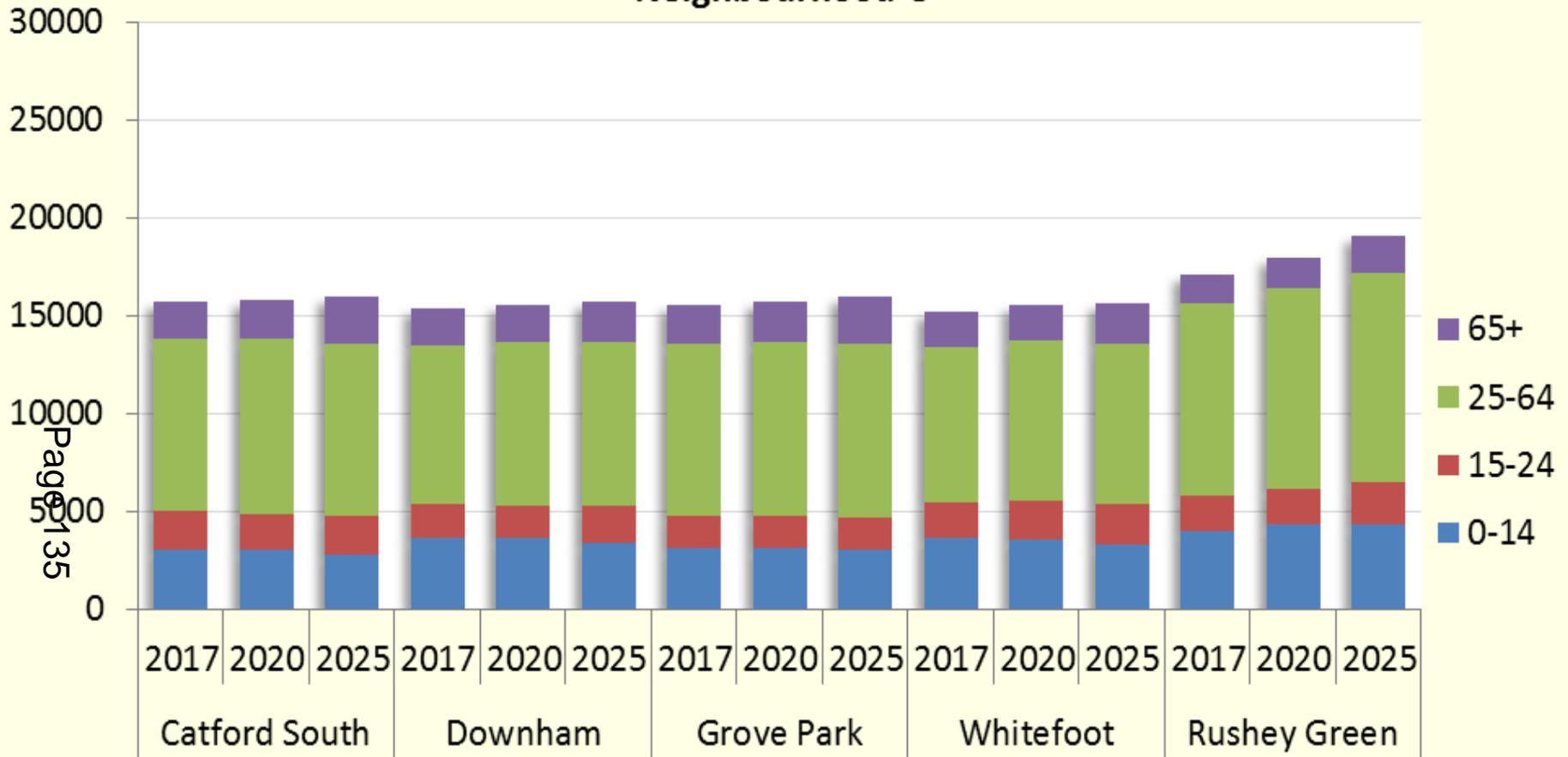
Source: GLA, 2015

Population growth - Neighbourhood 2

Growth will not be evenly distributed across the borough. Lewisham Central Ward is predicted to see notable increases due to planned developments in the area.



Projected changes in Lewisham's population by ward and age band for Neighbourhood 3



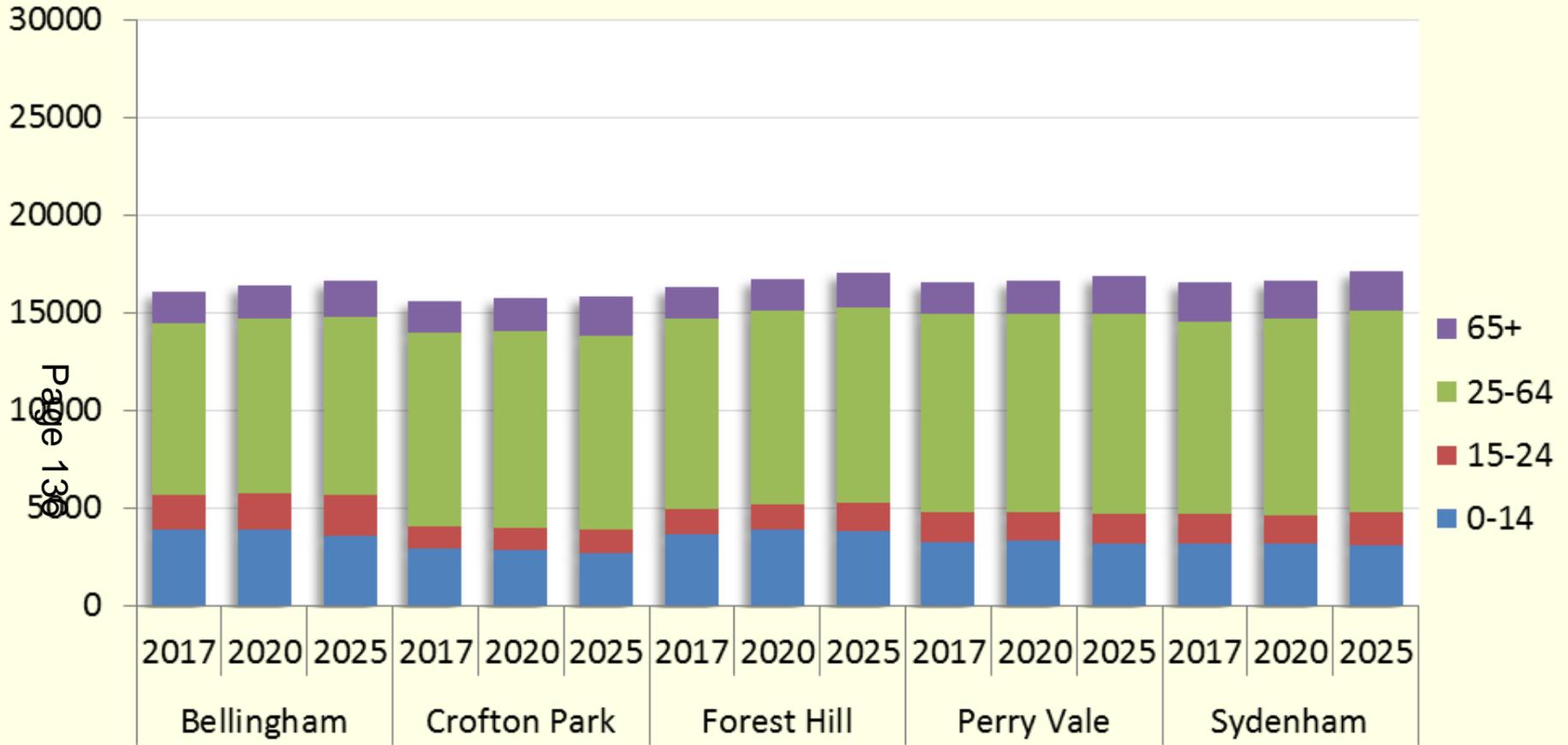
Source: GLA, 2015

Population Growth - Neighbourhood 3

Growth at the south of the borough will be at a slower pace



Projected changes in Lewisham's population by age ward and band for Neighbourhood 4



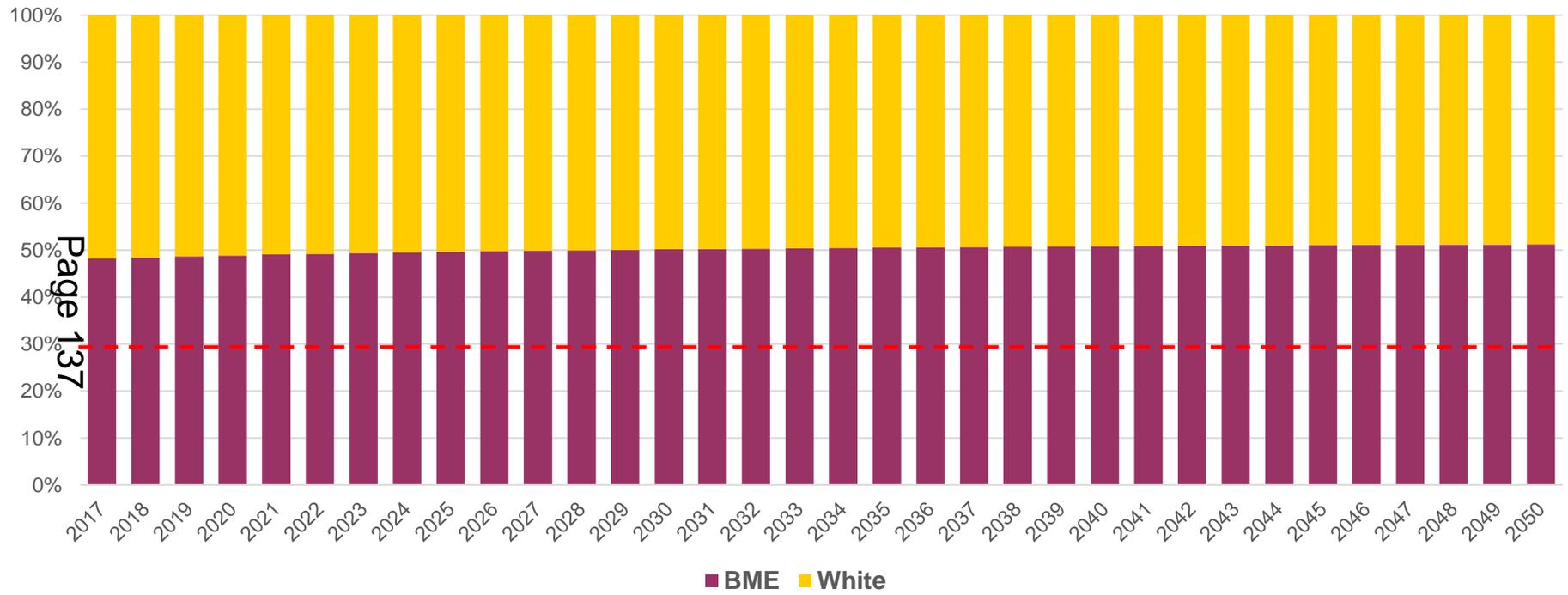
Source: GLA, 2015

Population Growth - Neighbourhood 4



- The ethnic profile of Lewisham residents is forecast to change up to 2050
- By 2028 it is forecast that the White and BME population will be 50/50
- Subsequently the BME population is predicted to exceed the White population

Lewisham population projections 2018-2050



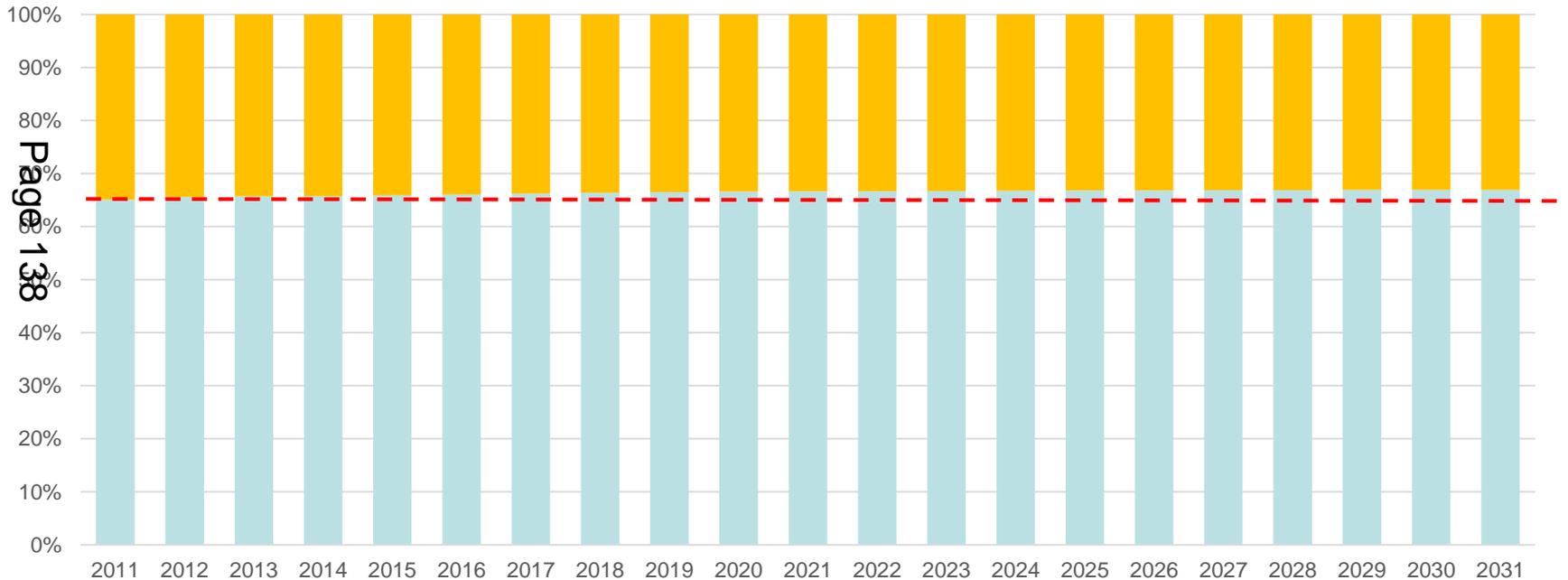
Source: 2015 Round Ethnic Group Population Projections, GLA

Ethnicity - understanding the current and future ethnic composition of the borough is important as some health conditions impact disproportionately on certain ethnic groups, e.g. diabetes. There is also disparity by ethnicity in use of and access to some services



However for young people the ethnic proportions are and will continue to be quite different. The percentage of 0-19s of BME heritage has remained at or marginally above 65% since 2011. By 2031 the proportion of BME residents aged 0-19 is projected to reach 67%.

Ethnic Population Trends and Projections of Children and Young People 0-19 as a Proportion of the Population



Source: 2015 Round Ethnic Group Population Projections, GLA

■ BME ■ White

Ethnicity of Young People - between 2011 and 2031 the size of the population of BME children & young people 0-19 will grow at more than three times the rate of their White counterparts



Home to residents of more than 75 nationalities

Fastest Growing Non-British Nationalities

Italian

Romanian

Spanish

Irish

Portuguese

Nearly half of the 23,000 EU nationals resident in Lewisham are from

Ireland

Italy

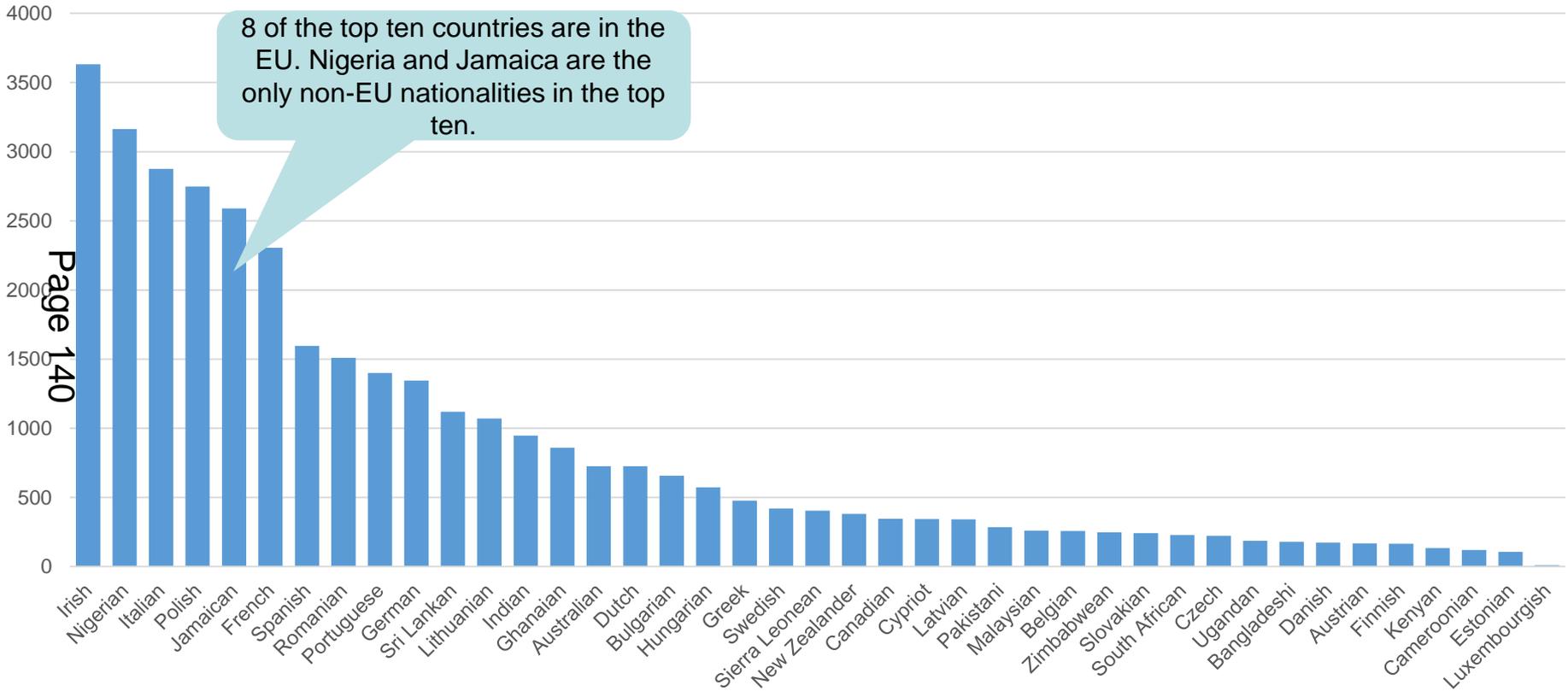
Poland

France

Other White residents are growing at a faster rate than White British or White Irish

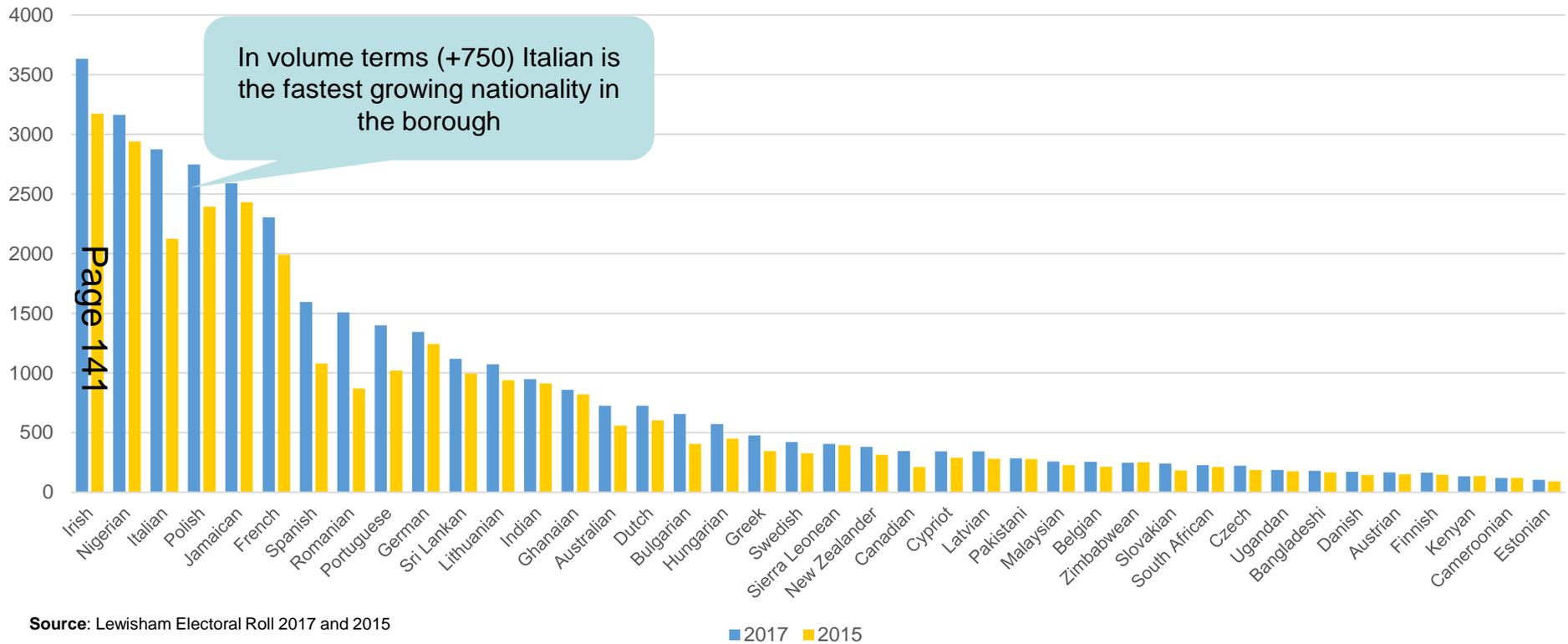
Diversity - The Lewisham population is predicted to continue to diversify as it grows over the coming decades

The chart below shows nationalities on Lewisham’s Electoral Roll that are at or above triple digits. Aside from those who identify as British, the top ten most numerous nationalities are Irish, Nigerian, Italian, Polish, Jamaican, French, Spanish, Romanian, Portuguese and German.



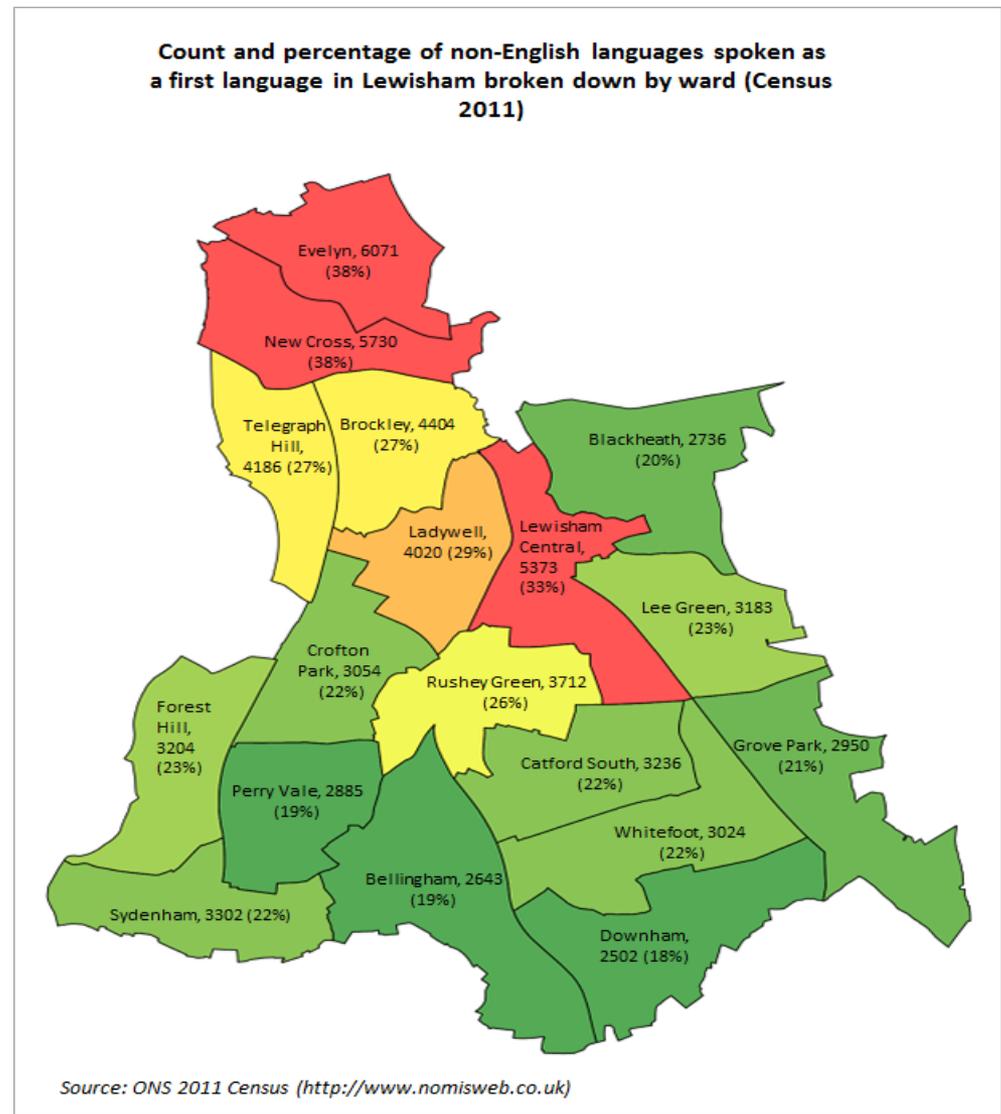
Source: Lewisham Electoral Roll 2017

Between 2015 and 2017 the fastest growing nationality on Lewisham's Electoral Roll (by volume) was Italian (up 750 over the period), followed by Romanian (up 640), Irish (up 458) and Portuguese (up 378). Over the same period, Italian replaced Jamaican as the third most numerous non-British nationality, Polish is the fourth most numerous and Jamaican is now the fifth most numerous. Romanian has replaced Portuguese as the eighth most numerous non-British nationality and Portuguese has replaced German as the ninth most numerous non-British nationality in the borough.



Source: Lewisham Electoral Roll 2017 and 2015

- Residents whose first language is not English are concentrated in the north of the borough as well as Lewisham Central ward.
- The School Language Census taken in Autumn 2018, showed over 170 languages are spoken by Lewisham pupils



In relative terms, Lewisham remains amongst the most deprived local authority areas in England

In the overall **Index of Multiple Deprivation** or IMD (the combined score from all the indices), Lewisham's average score was 28.59

This puts Lewisham as the **48th most deprived** of all 326 English Local Authorities (one being the most deprived), compared to a ranking of 31st for 2010 and 39th for 2007

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Therefore Lewisham is within the 20% most deprived Local Authorities in England

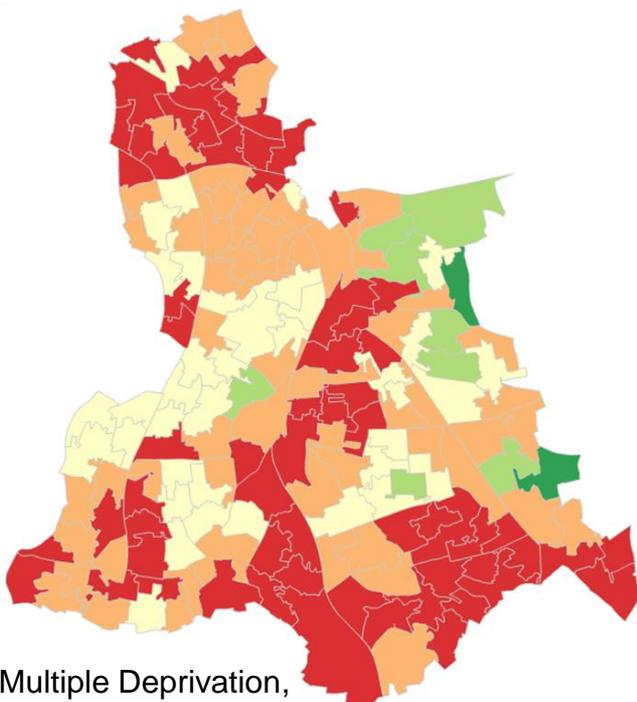
Within London Lewisham is ranked the 10th most deprived borough (DCLG, 2015)

Deprivation

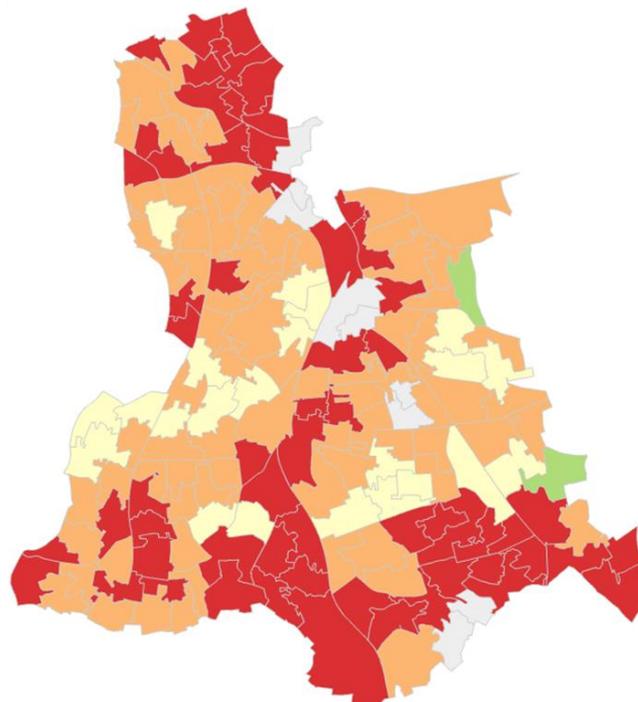
The maps breaks down urban deprivation into smaller geographies. It shows that whilst Lewisham was less deprived in 2015 compared to 2010, concentrations of deprivation in the north and south of the borough remain comparatively high.



2015

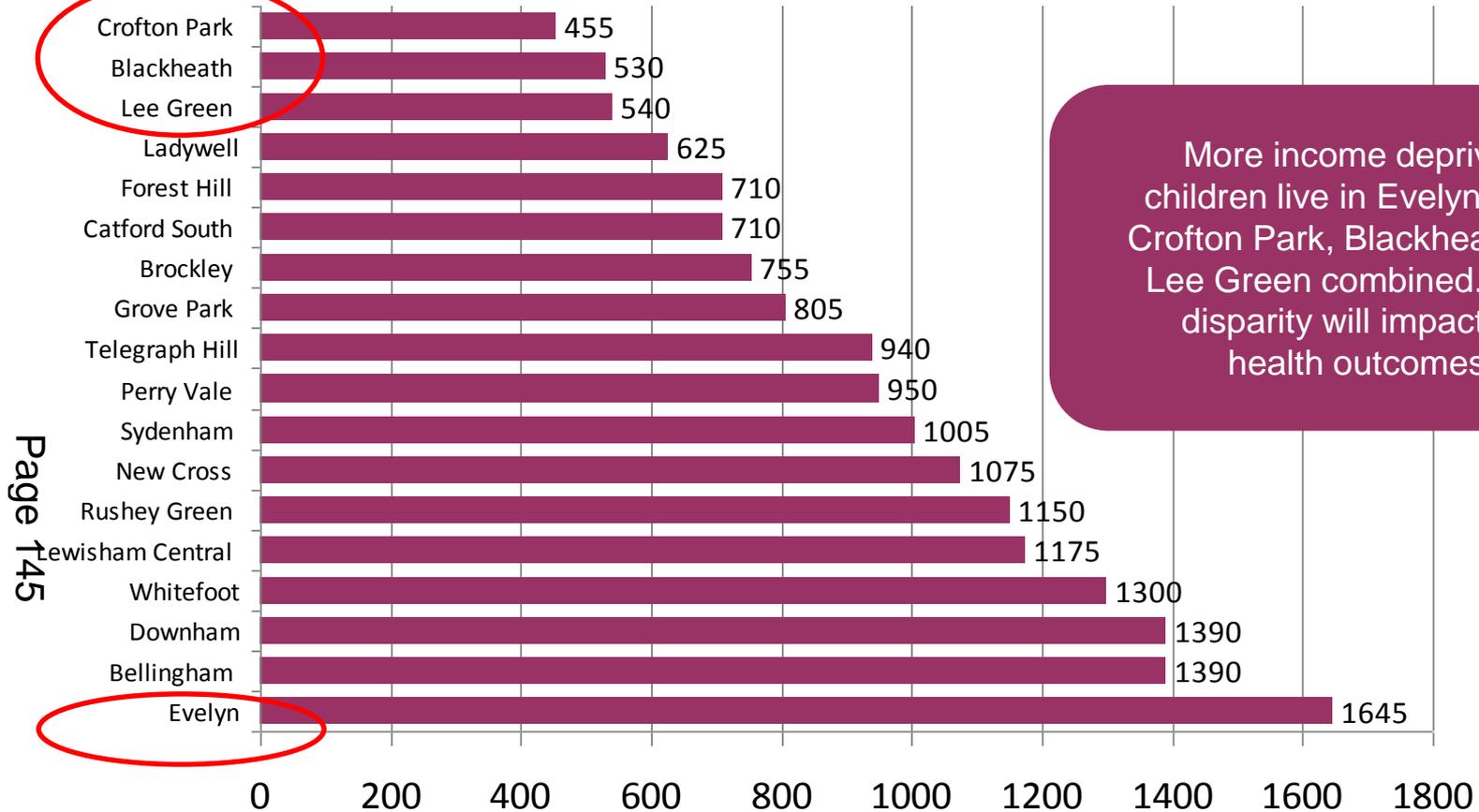


2010



Source: Indices for Multiple Deprivation, 2015, DCLG

Number of income deprived children by Lewisham ward



Source: Indices for Multiple Deprivation, 2015

Deprivation affecting children by ward

14.5% of residents are living with a long term condition which limits their daily activities*

This is slightly below the England average of 17.6%, however this is likely to be due to the younger population bias

For those of working age this reduces to 11.5%

* Proxy question for disability 2011 Census

People with a learning disability have shorter life expectancy

Disproportionately affected by certain health conditions including coronary heart disease, respiratory disease and epilepsy

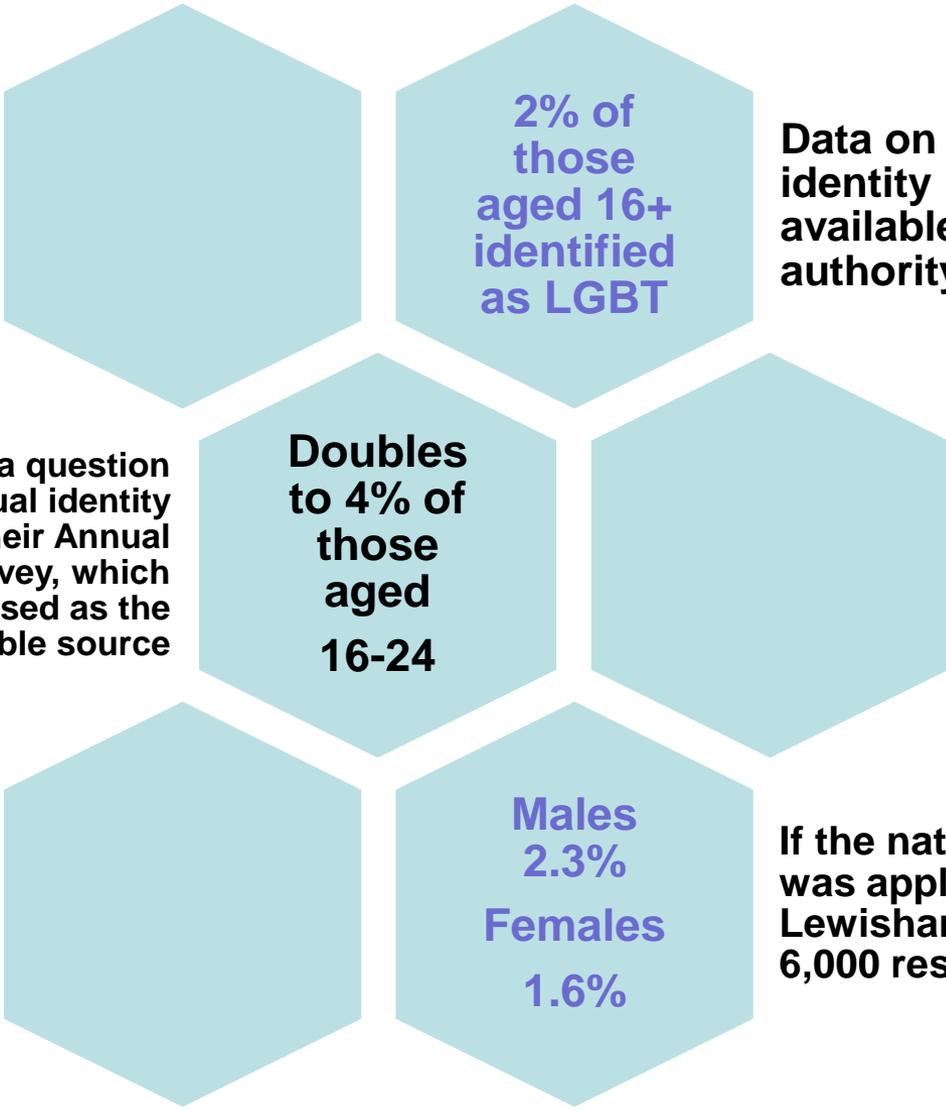
Lewisham QOF
Prevalence* is 0.4%

Equates to 1,296 patients

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*2017/18

ONS now ask a question regarding sexual identity in their Annual Population Survey, which is widely used as the most reliable source



2% of those aged 16+ identified as LGBT

Data on sexual identity is not readily available at local authority level

Doubles to 4% of those aged 16-24

Males 2.3%
Females 1.6%

If the national figure was applied to Lewisham, equates to 6,000 residents

Sexual Identity

- People providing high levels of care are twice as likely to have poor health compared with those without caring responsibilities ([Carers UK](#))
- 8.1% of Lewisham residents provide at least some unpaid care each week (around 22,500)

Day to Day Activities are Limited to Some Extent (2011 Census)

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<i>Carers</i>	<i>Non Carers</i>
23.7%	13.2%

- Only 36.6% of [adult carers](#) have as much social contact as they would like



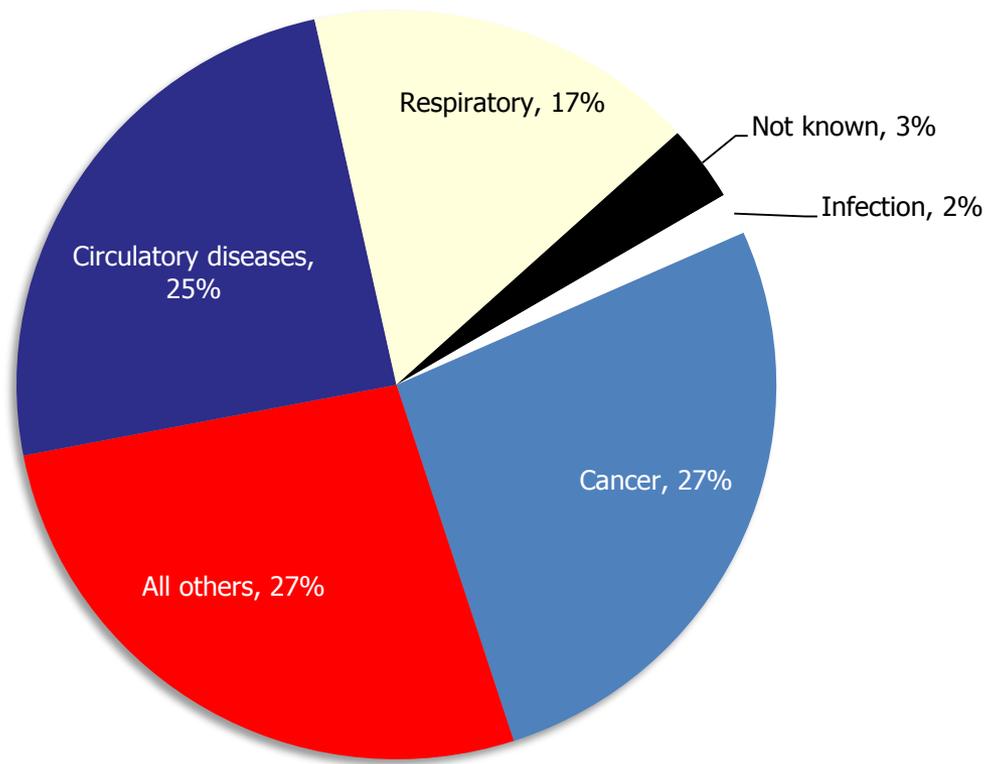
- The borough's growing population means extra demand for services, ranging from GP Practices, Pharmacies and Sexual Health Clinics
- It is crucial to understand where the bulk of this growth will be to plan effectively
- The continuing diversity must also be considered when planning and commissioning services
- Need to be aware of languages to keep service accessible
- To make services increasingly equitable it is crucial to be aware of the inequalities that currently exist

Mortality

Lewisham faces a number of challenges associated with identified health priority areas but health inequalities also exist within the borough

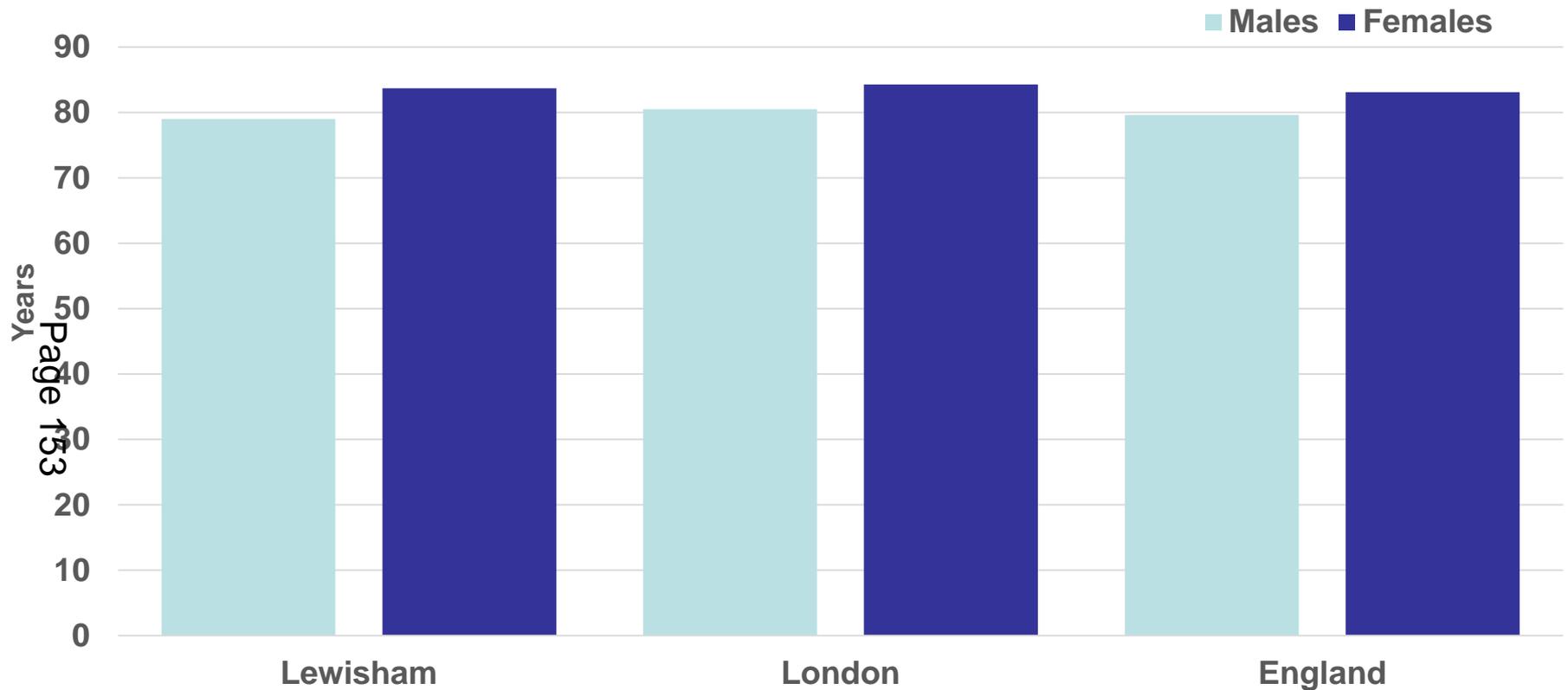
The main cause of death in Lewisham is cancer, followed by circulatory disease and respiratory

Lewisham's Black and Minority Ethnic communities are also at greater risk from health conditions such as diabetes, hypertension and stroke. Identifying those with disease early and treating them optimally is essential



Source: Primary Care Mortality Database, ONS (2017/18)

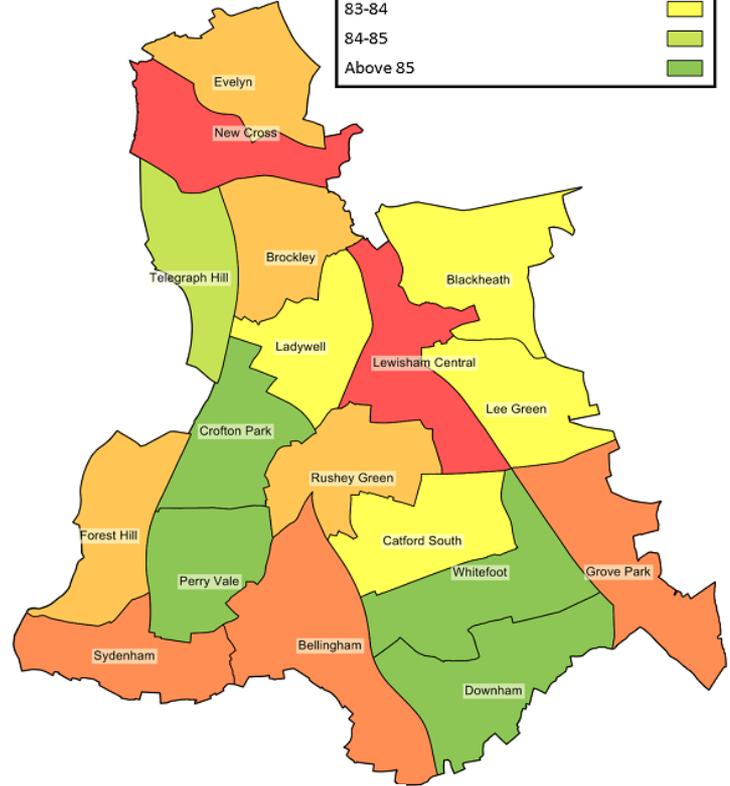
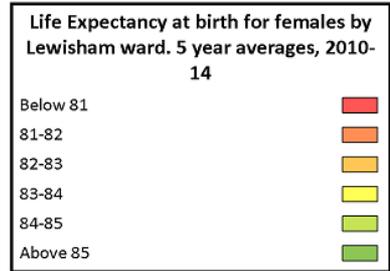
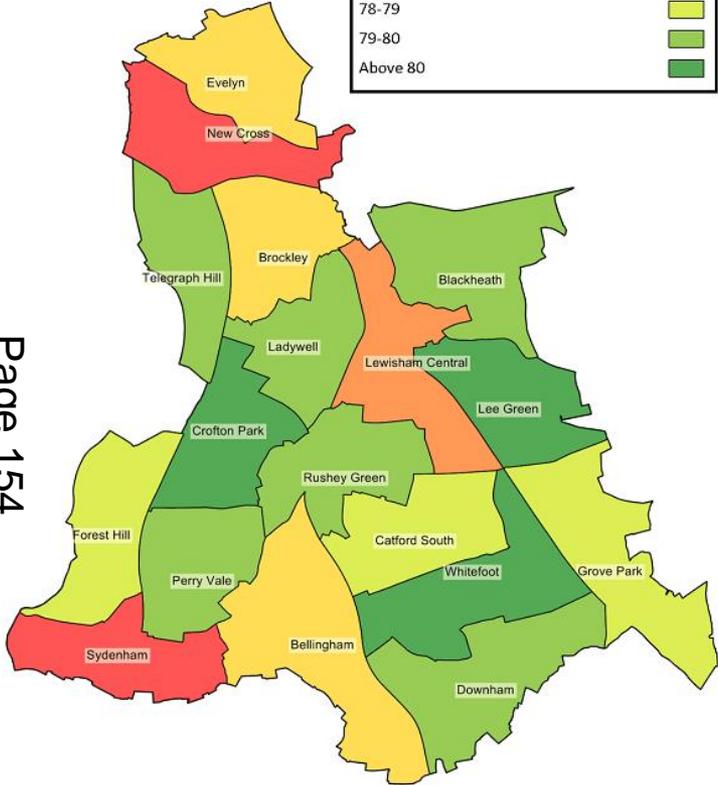
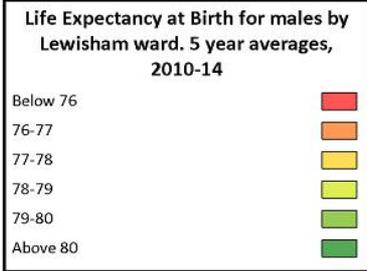
- Life expectancy has historically been lower in Lewisham than England
- However for females, Lewisham life expectancy now exceeds the national average
- For male residents life expectancy is significantly lower than the national average



Source: ONS, 2015-17

Life Expectancy



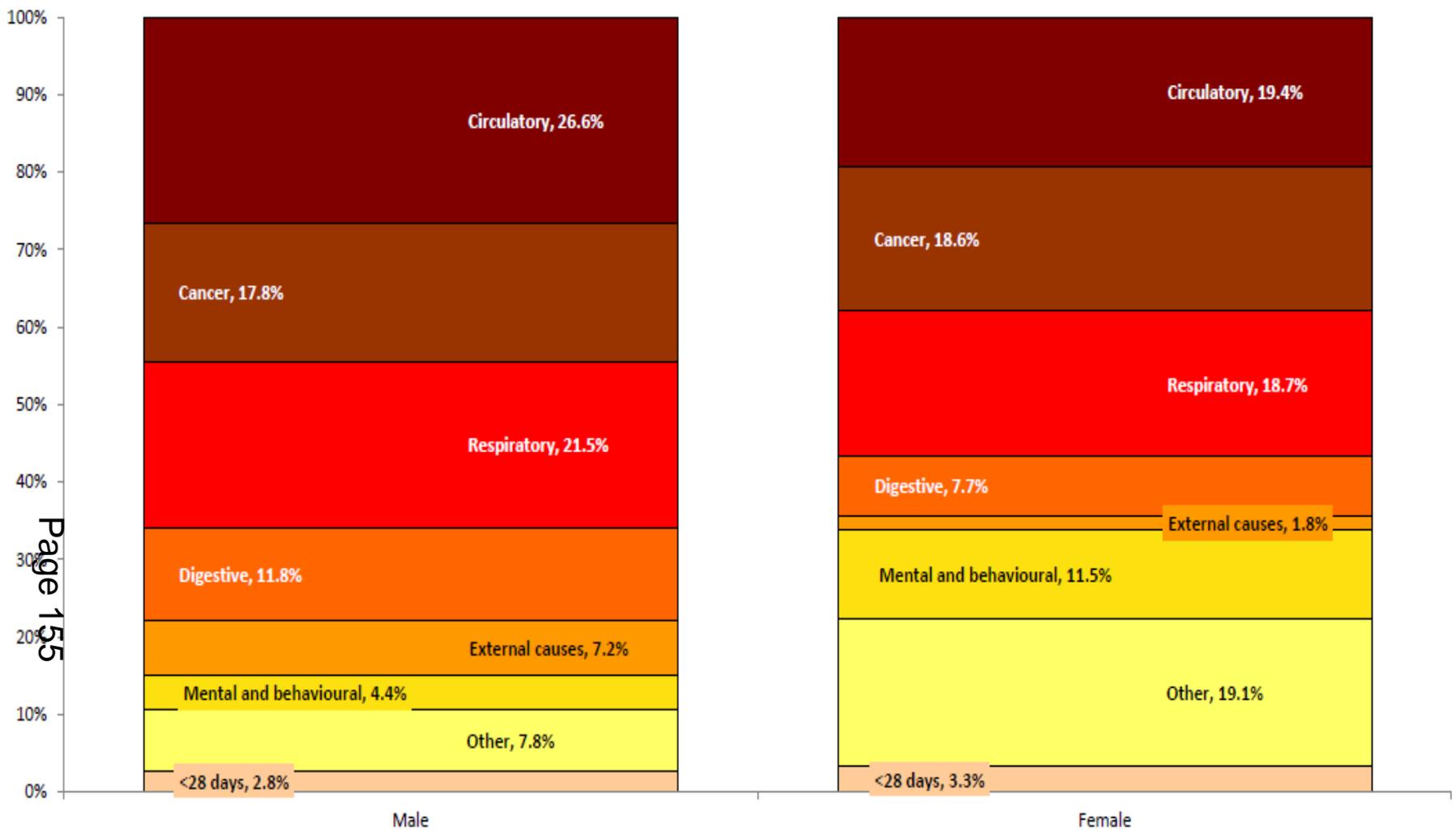


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Source: ONS, 2010-14

Map of Life Expectancy by Ward - variation is seen across the borough





Despite cancer being the major cause of death in the borough, in terms of reducing inequalities circulatory disease is a greater contributor for both men and women

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

Analysis by Public Health England Epidemiology and Surveillance team based on ONS death registration data, and mid year population estimates



SII shows how much healthy life expectancy varies with deprivation, within a borough, giving a score in years

The SII values are interpreted alongside the overall values for healthy life expectancy to gain a true picture of a local area

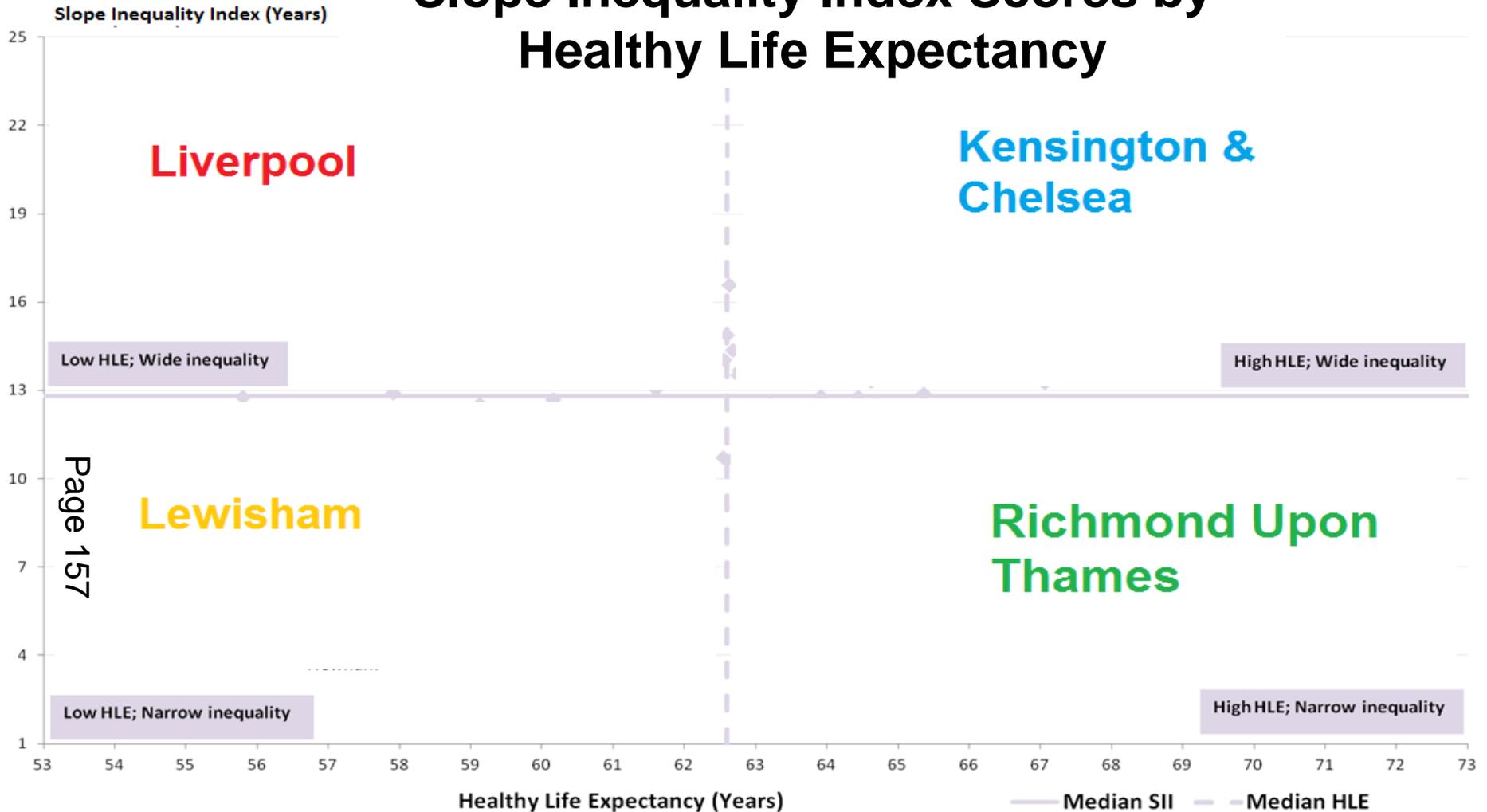
The higher the SII score, the greater the inequality. Boroughs are also ranked, with 1 seeing the highest inequality

Data is based on Middle Super Output Area* values for life expectancy, healthy life expectancy and disability-free life expectancy

* Lewisham has 36 MSOAs, (each electoral ward is split in two)

Slope Index of Inequality (SII)

Slope Inequality Index Scores by Healthy Life Expectancy



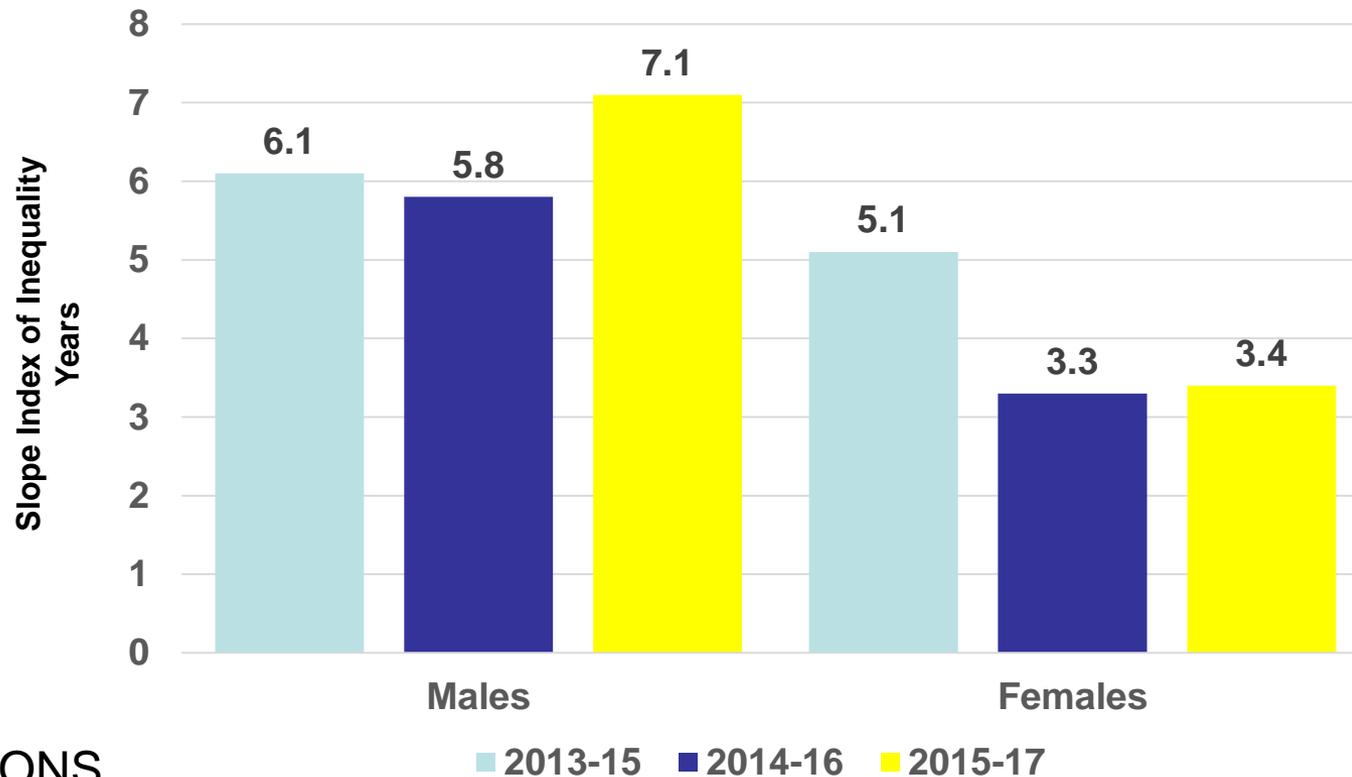
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Boroughs can be classified as one of the above four categories, determined by the years of Healthy Life Expectancy (HLE) and how wide the inequality is. Lewisham has relatively low Healthy Life Expectancy but inequality for this indicator is narrow



- For both men and women in Lewisham this inequality is reducing
- Lewisham is ranked 27th out of 32 London boroughs for women and 28th for men (1st sees the greatest inequality)
- Females have seen greater improvement that males

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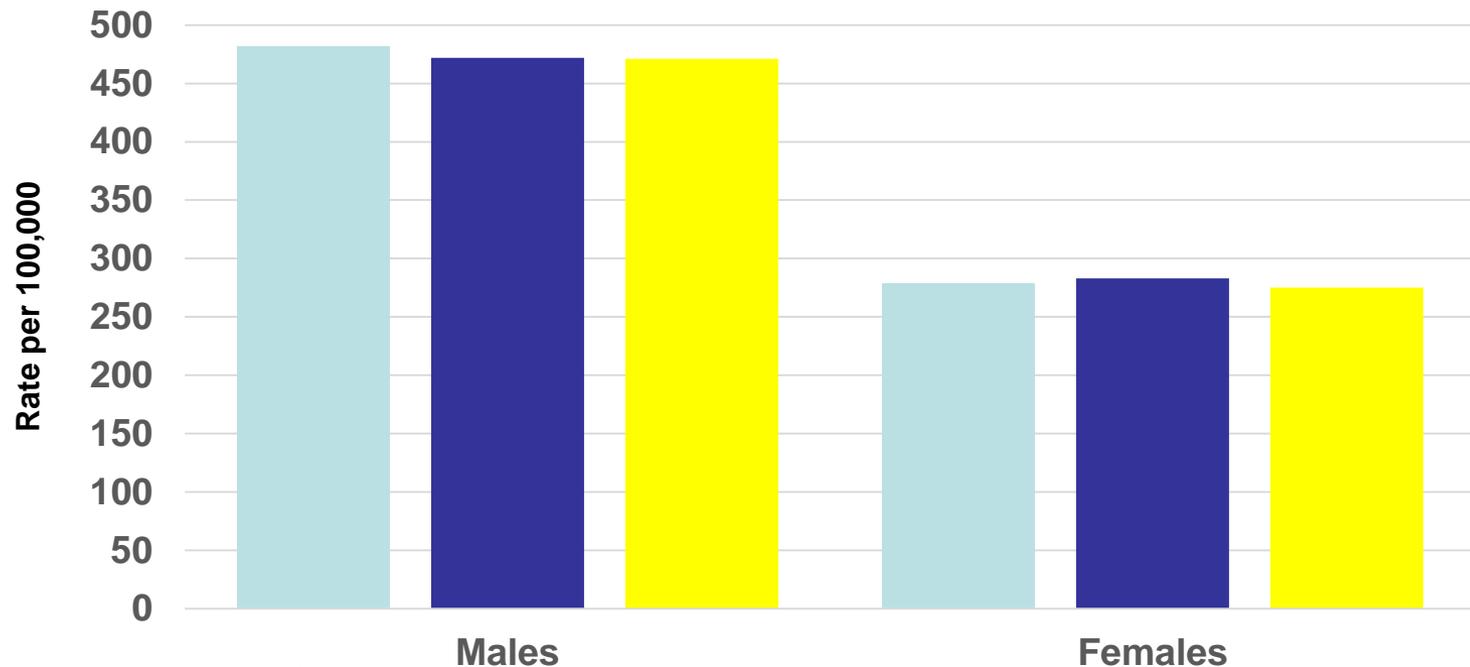


Source: ONS

Slope Index of Inequality (SII)

- Lewisham is faring less well for [premature deaths](#)
- Has 7th highest rate of all London boroughs for both [men](#) and [women](#)
- However the male rate is significantly worse than England

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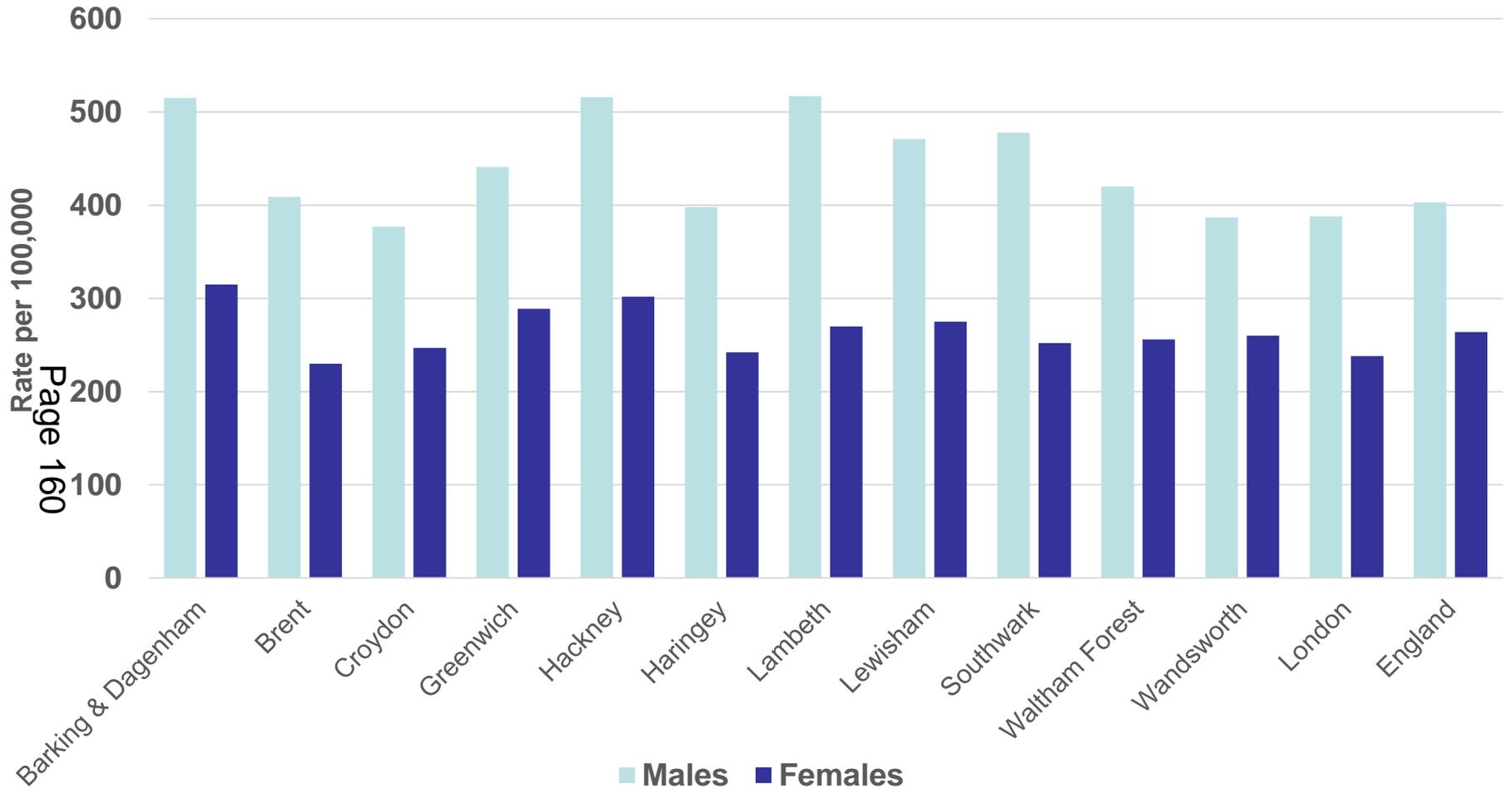


Source: Public Health England (based on ONS source data)

■ 2013-15 ■ 2014-16 ■ 2015-17

Premature Deaths

Premature Deaths per 100,000 population (2015-17)



Premature Deaths - Benchmarking



- Improvements have been made in life expectancy in Lewisham
- However there are concentrated areas where deprivation and poorer outcomes persist
- Planning of services should consider how to address these inequalities and aim to spread the improvements borough wide

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Health - Overarching Indicators

Under 75 Mortality from cardiovascular disease has declined and is now in line with the national average (PHE)

Stroke Admissions are also decreasing but above the national average (HES)

The Lewisham NHS Health Check programme is now in its second cycle. 16 pharmacies provide this service in Lewisham



The proportion of babies born at a low birth rate has decreased notably since 2012 and is now comparable to the England average

In 2016 (most recent data available) 7.3% of babies were born at a low birth weight (under 2500g)

This decreases to 2.7% for babies born at term (at least 37 weeks gestation)

**GP
Recorded
Levels**

Diabetes

Lewisham 6.4%
London 6.5%
England 6.8%

Hypertension

Lewisham 11.6%
London 11.0%
England 13.9%

COPD

Lewisham 1.3%
London 1.1%
England 1.9%

Stroke

Lewisham 1.1%
London 1.1%
England 1.8%

CHD

Lewisham 1.7%
London 2.0%
England 3.1%

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Source: Quality Outcomes Framework, NHS Digital, 2017-18

Long Term Conditions — Lewisham has a lower rate of many LTCs than England, however the younger age structure of the local population is a notable contributing factor

- More than one in five Lewisham children under 20 live in poverty (HMRC, 2015)
- Pupil absence is in line with London & England (The School Census, 2016/17)

Over 68,200 people aged 0-17
(ONS, 2017)



- School Readiness: Almost 8 in 10 children are achieving a good level of development at the end of reception, significantly better than the London and England averages (DfE, 2017/18)
- The latest data for the rate of first time entrants to the Youth Justice System has increased and remains significantly worse than the London and England average (Police National Computer, 2017)
- 6.0% of 16-17 year olds are Not in Education, Employment or Training (NEET) (in line with England) (DfE, 2017)

Children and Young People

Excess winter deaths (85+) are better than England (PHE, Aug 2016- Jul 2017)



Falls - Hips Fractures in people aged 65+, in line with the national average (HES, 2017/18)

The NHS Health Check, is a health check-up for adults in England aged 40-74. It's designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. In Lewisham the 2017/18 uptake of health checks was 38%

Page 167

The residential admissions rate per 100,000 aged 65+ is lower than England (2017/18, Better Care Fund)

Average health status score for adults aged 65+ is lower than London and England (GP Patient Survey, 2016/17)

Dementia, 4.49% of GP patients aged 65+ are recorded as having dementia (Sept 2017, NHS Digital)

Older People

NHS HEALTH CHECK

Helping you prevent

- diabetes
- heart disease
- kidney disease
- stroke & dementia

Lewisham

- Lewisham has seen improvements in certain health indicators, yet remains above the national average
- The proportion of children living in poverty is a key area for improvement, which will have a positive impact on a variety of outcomes in later life

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Health and Wellbeing Strategy Priorities

18% of children in Reception are overweight or obese

This rises to 38% in Year 6

Lewisham has high levels of childhood and adult obesity

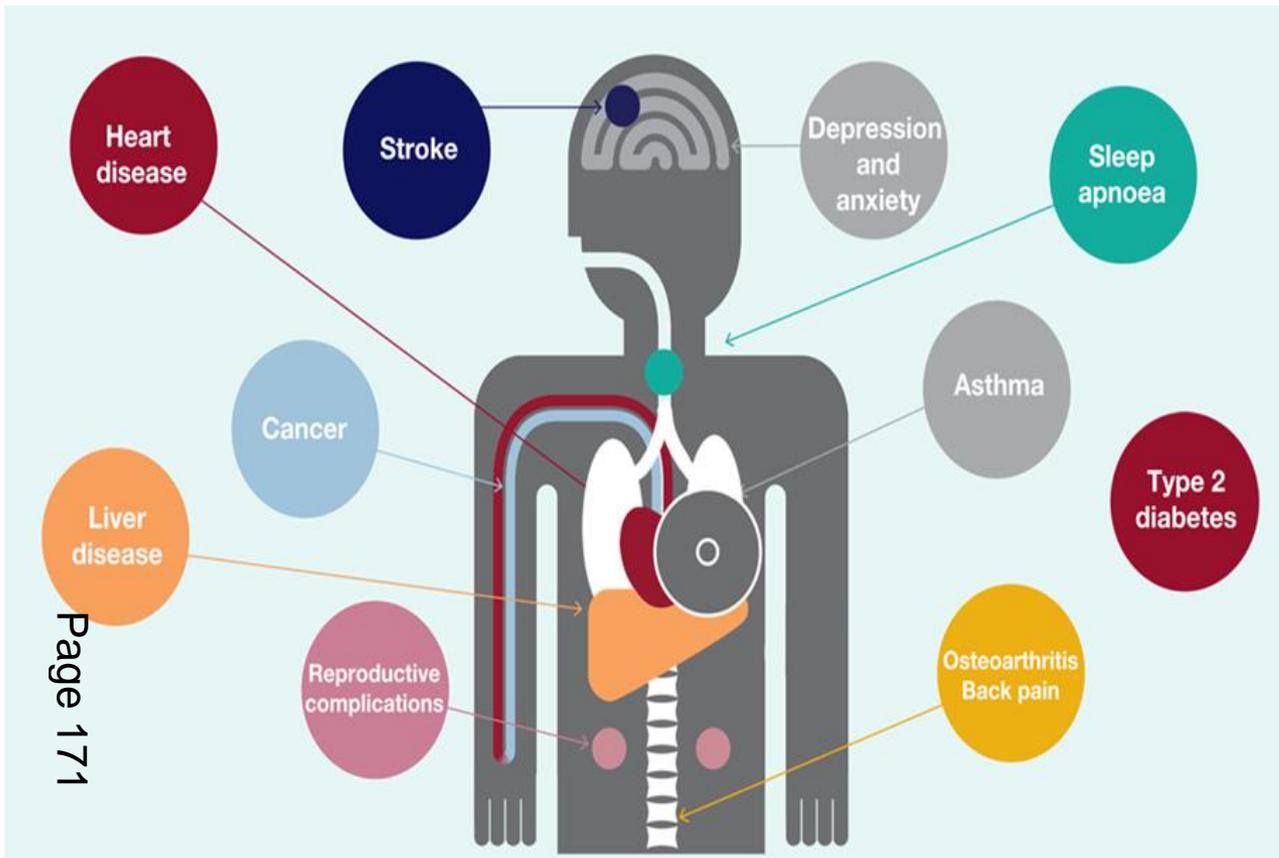
For adults the figure is 58%

Physical activity is similar to the national average

Page 170

Source: NCMP, 2017/18 & Active Lives Survey, 2016/17

Excess Weight



Page 171

Obesity is linked to many serious health risks in both children and adults

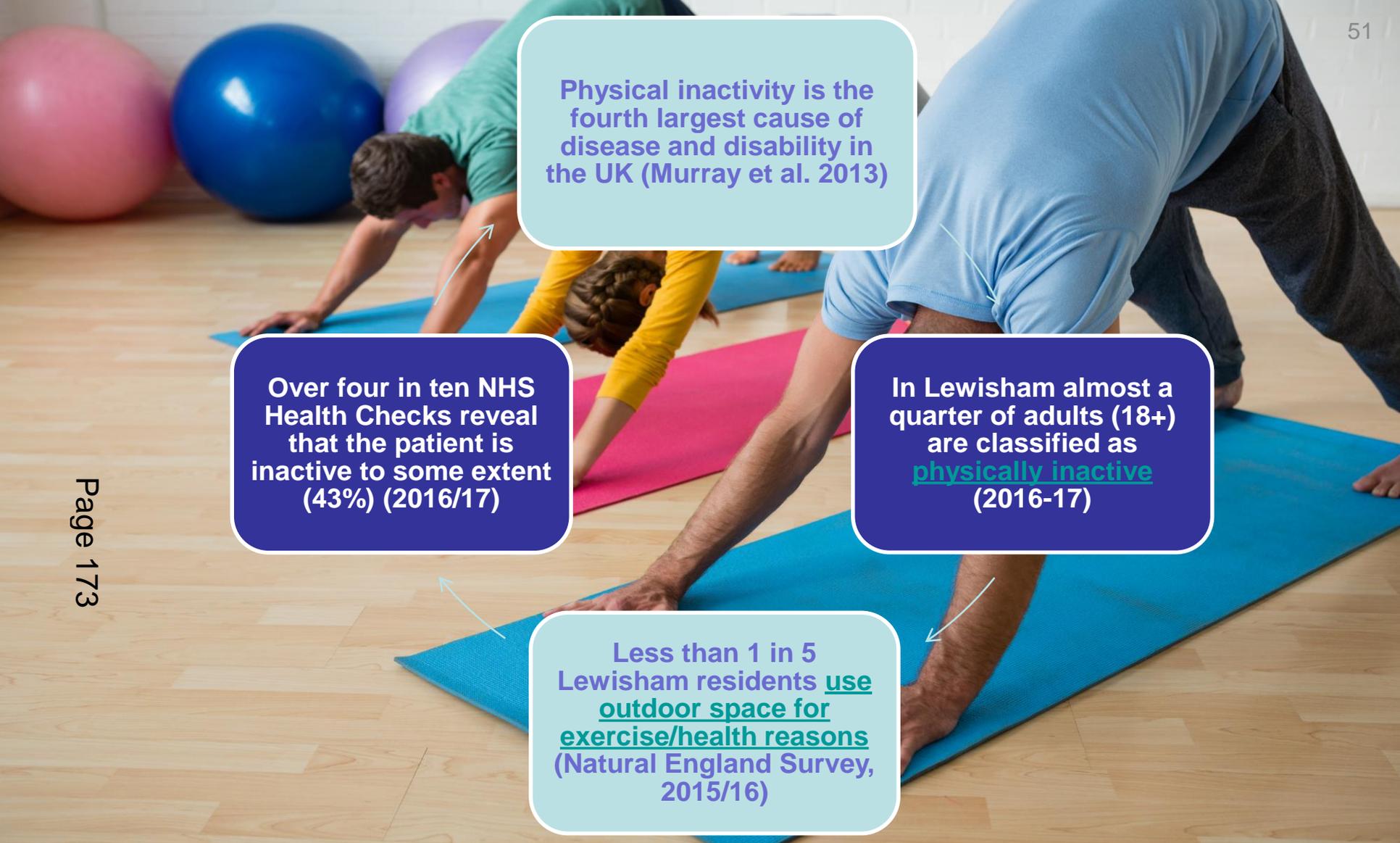
Obese adults are seven times more likely to become type 2 diabetic than adults of a healthy weight

Obesity also doubles the risk of dying prematurely

Impact of Obesity

- Lewisham continues to have high rates of breastfeeding, out-performing both London & England
- Almost 9 in 10 mothers initiate breastfeeding
- 3 out of 4 mothers are breastfeeding at 6-8 weeks
- The borough has achieved UNICEF Baby Friendly accreditation and continues work towards increasing rates





Physical inactivity is the fourth largest cause of disease and disability in the UK (Murray et al. 2013)

Over four in ten NHS Health Checks reveal that the patient is inactive to some extent (43%) (2016/17)

In Lewisham almost a quarter of adults (18+) are classified as physically inactive (2016-17)

Less than 1 in 5 Lewisham residents use outdoor space for exercise/health reasons (Natural England Survey, 2015/16)

Cancer is the
main cause of
death in
Lewisham



27% of deaths in
2016



Yet cancer
screening rates
remain low

Page 174

Breast cancer
screening: 67%
(2017)



Cervical cancer
screening: 69%
(2017)



Bowel cancer
screening: 47%
(2017)

Priority 2 - Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years

Immunisation remains one of the most cost effective healthcare interventions

Despite improvements, uptake for certain childhood immunisations falls below herd immunity

Key Vaccine

Uptake rate (2017/18)

Hib/Men C at 2

89.4%

D3 at 1

90.4%

D4 at 5

85.8%



Notable increase in uptake of **MMR vaccine**

Children in Reception, Y1 & Y2 now receive the flu vaccine

65+ Flu vaccine uptake is also low

HPV uptake has improved to be in-line with England

Key Vaccine

Uptake rate (2017/18)

MMR1 at 2

89.6%

MMR2 at 5

87.7%

Alcohol plays an important role in society, being consumed by the majority of adults and making an important contribution to the economy

However, the consumption of alcohol has both health and social consequences, including related health problems and loss of economic activity

Alcohol misuse also affects wider society through crime and adverse effects on inter-personal relationships

Page 176
It is of concern that under 75 liver disease mortality continues to rise in Lewisham for males and is statistically higher than England (PHE, 2014-16)

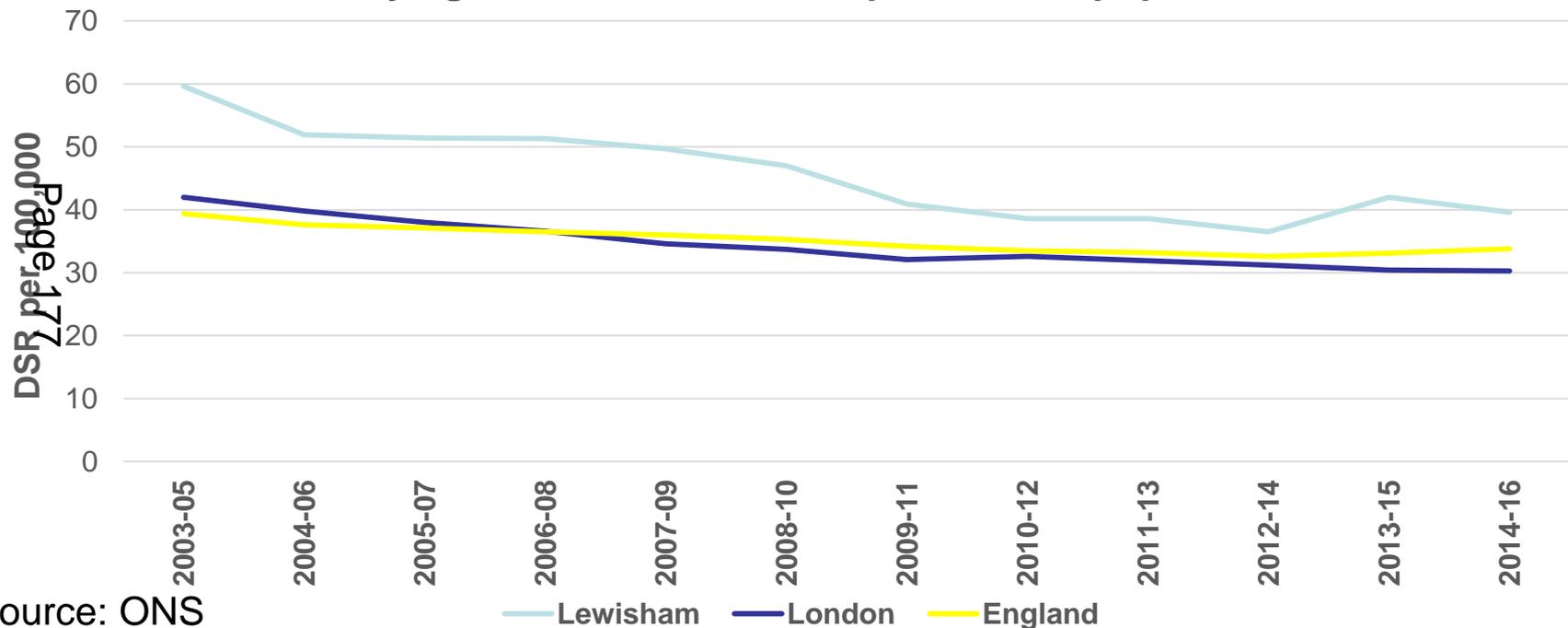
Alcohol related admissions remain significantly lower than England (PHE, 2017/18)

Lewisham Practitioners continue to be trained in Brief Interventions and Making Every Contact Count

Priority 4 - Reducing Alcohol Harm

- At 15.5% of the population, more people [smoke in Lewisham](#), compared to London and England (ONS, 2017)
- People who work in [routine & manual occupations](#) are more likely to smoke
- Smoking attributable [hospital admissions](#) and [mortality](#) are statistically higher than in England and London (HES, 2016/17 & ONS 2014-16)

Under 75 mortality from respiratory disease
Directly aged-standardised rate per 100,000 population



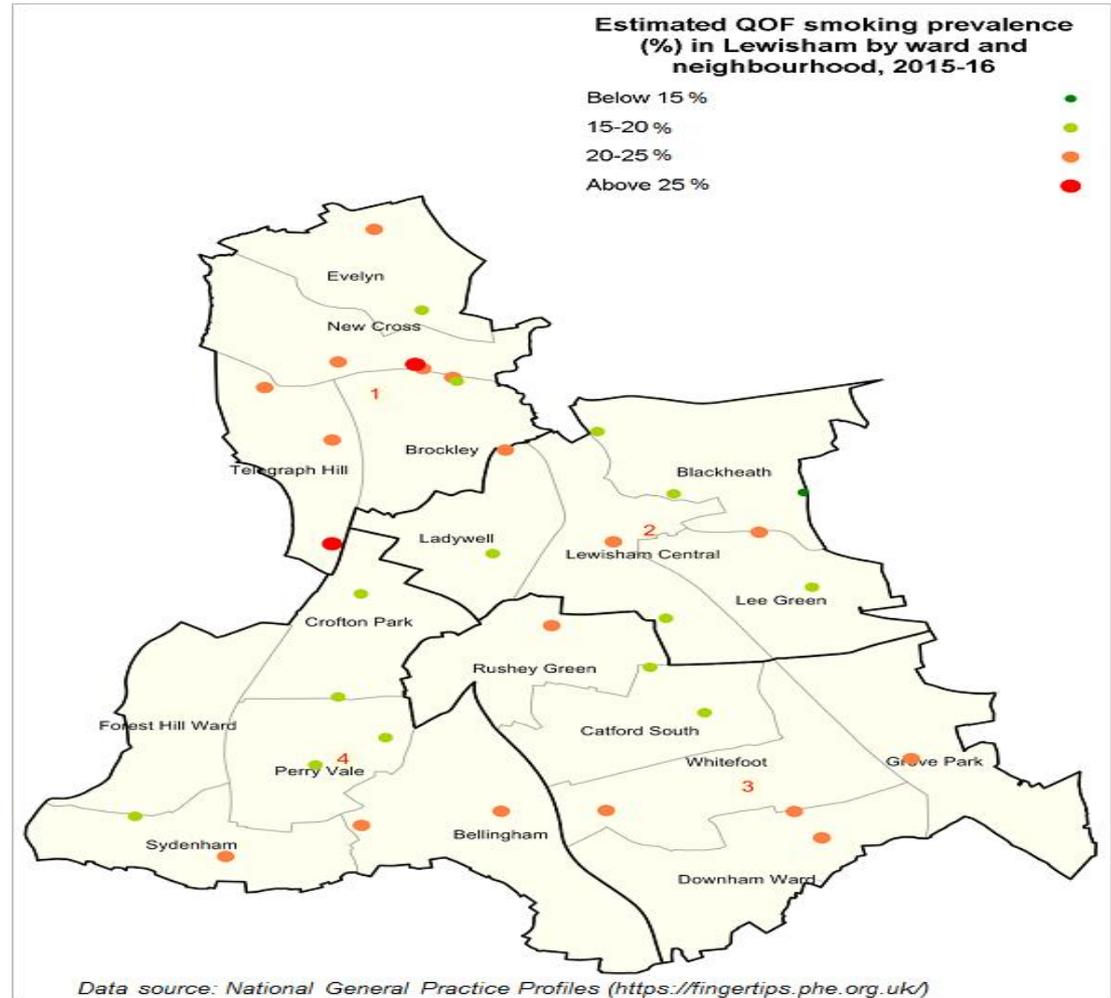
Source: ONS

Priority 5 - Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking



The map plots prevalence of smoking as known to GP Practices.

There appears to be a correlation between more deprived areas of the borough having higher smoking rates.



Smoking Prevalence by GP Practice

GP recorded prevalence of depression (8.2%) is lower than England (9.9%) (2017/18)

Number of accepted referrals to the Lewisham Memory Service has remained steady since the launch in 2011

2017 Annual Public Health Report

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Number of patients on the Lewisham GP Practice Dementia Register has increased year on year since 2007

Significantly higher rates of serious mental illness in Lewisham (1.3%) compared to England (0.9%) (2017/18)

Priority 6 - Improving Mental Health and Wellbeing



The teenage conception rate has reduced notably and is now in line with the national average (ONS, 2016)

Chlamydia positivity rates remain higher than London and England (PHE, 2017)

The rate of new STI diagnoses (excluding Chlamydia) are significantly higher than London and England
PHE (2017)

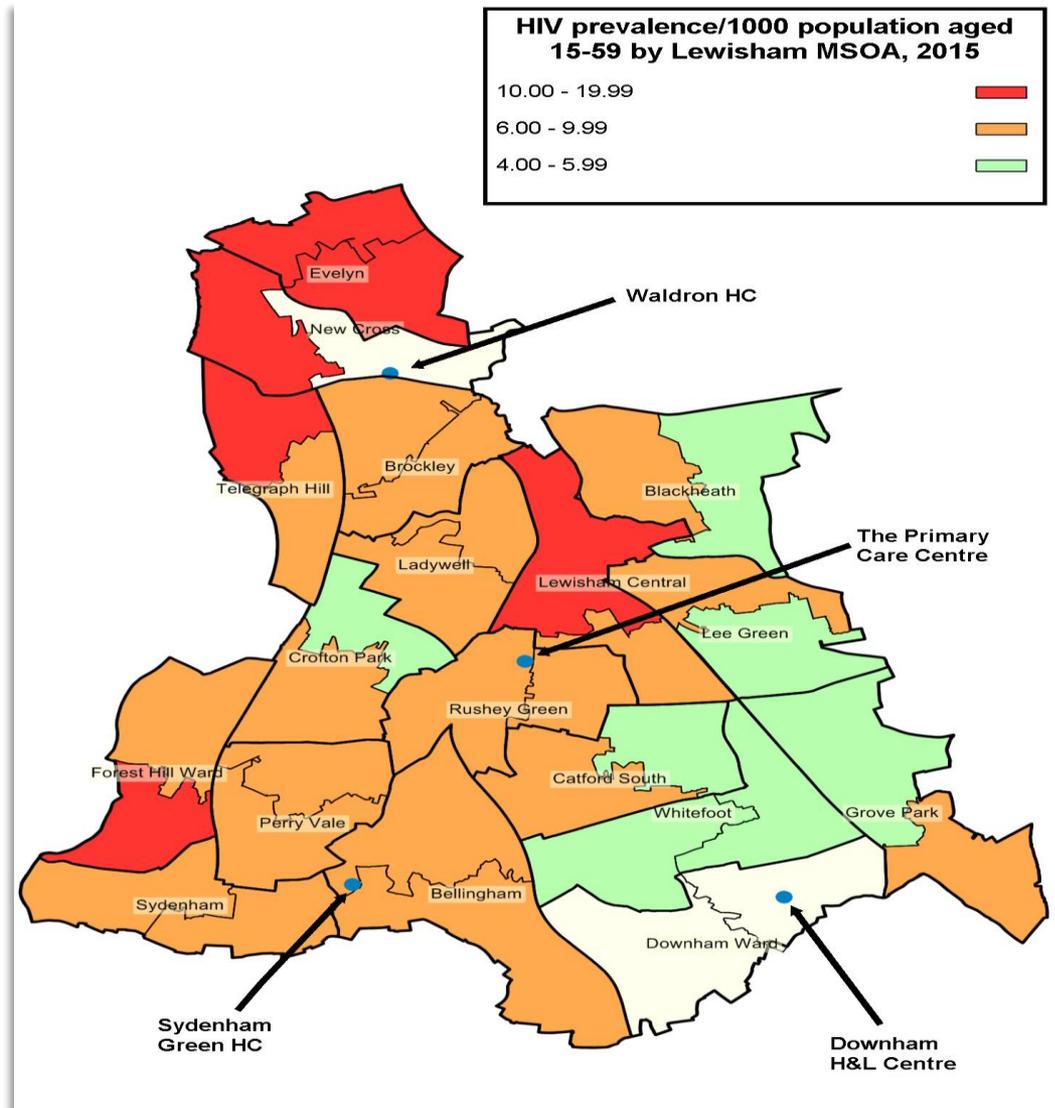
At 23.1 per 1000 women aged 15-44 the abortion rate in Lewisham is significantly higher than England and the 6th highest in London

Black Caribbean and Black African women are over represented in the number having abortions
(Department of Health/local analysis 2017)

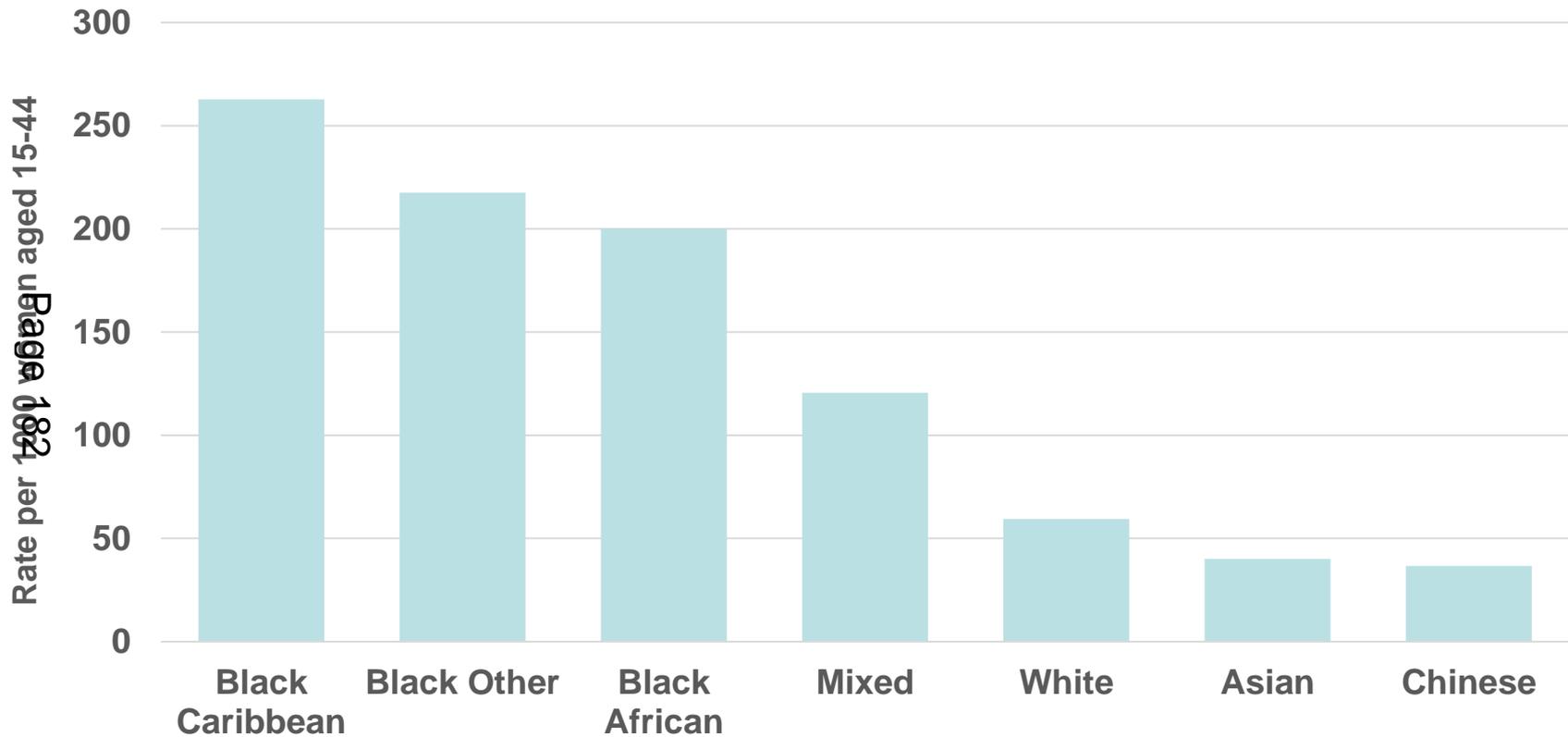
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Priority 7 - Improving Sexual Health

- HIV diagnosis is high compared to similar local authorities, as is the level of new diagnoses (PHE, 2016)
- The proportion of people presenting at a late stage of HIV infection has improved for the last five years



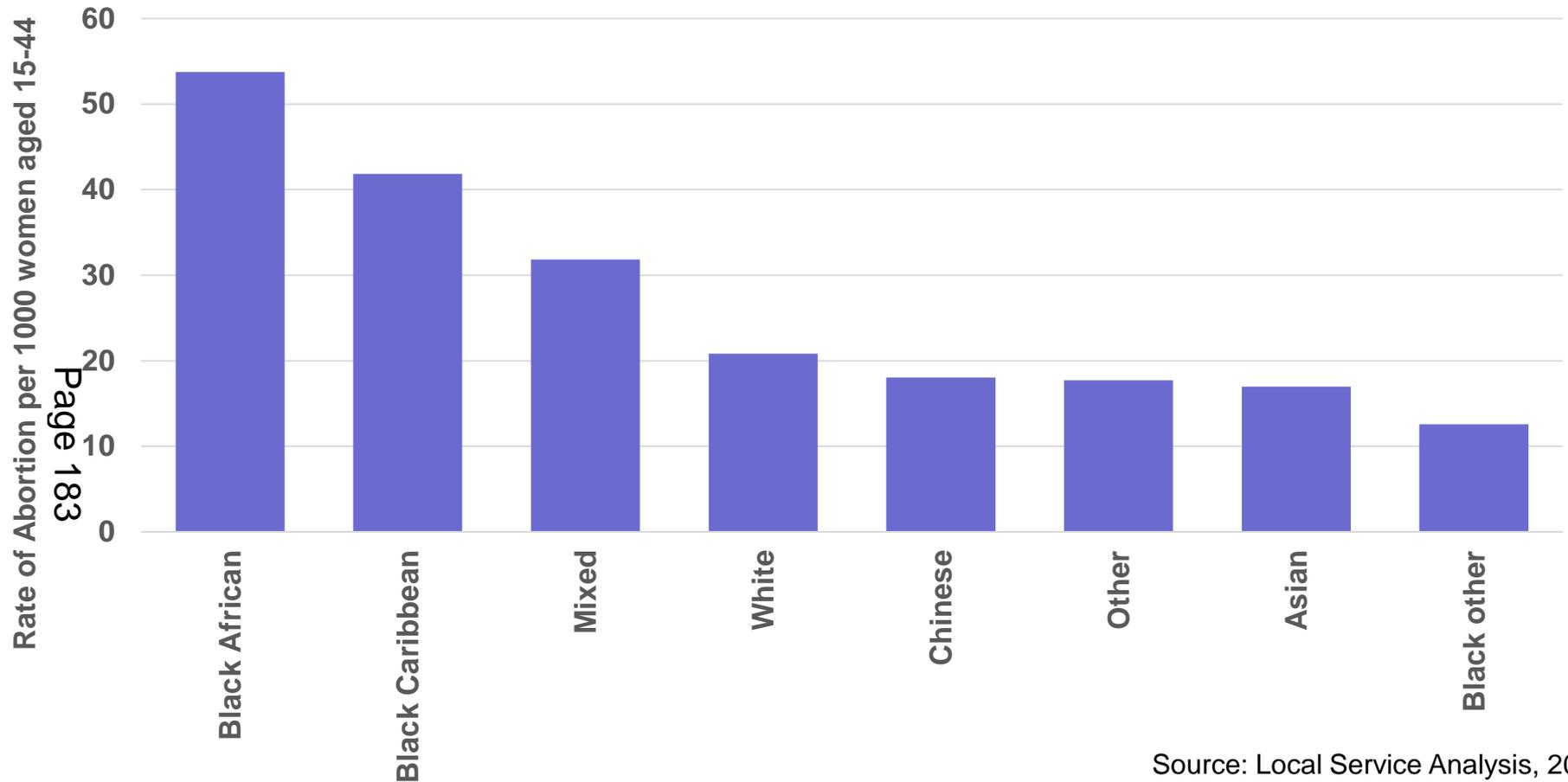
Use of EHC varies notably by ethnic group, with women from Black ethnic groups, seeing much higher usage rates. Data refers to pharmacy prescribed EHC.



Source: Local Pharmacy Database, 2016/17

Emergency Hormonal Contraception

The Abortion rate also varies notably by ethnic group. Women from Black African and Black Caribbean ethnic groups are more than twice as likely to have an abortion than White or Asian women.



Source: Local Service Analysis, 2016

Abortions by Ethnic Group

Lewisham Health and Care Partners (LHCP) share a collective vision for a sustainable and accessible health and care system in Lewisham by 2020 that better supports people to maintain and improve their physical and mental wellbeing, to live independently and to have access to high quality care when they need it

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Lewisham and Greenwich NHS Trust (LGT)

One Health Lewisham (Pan-Lewisham GP Federation);

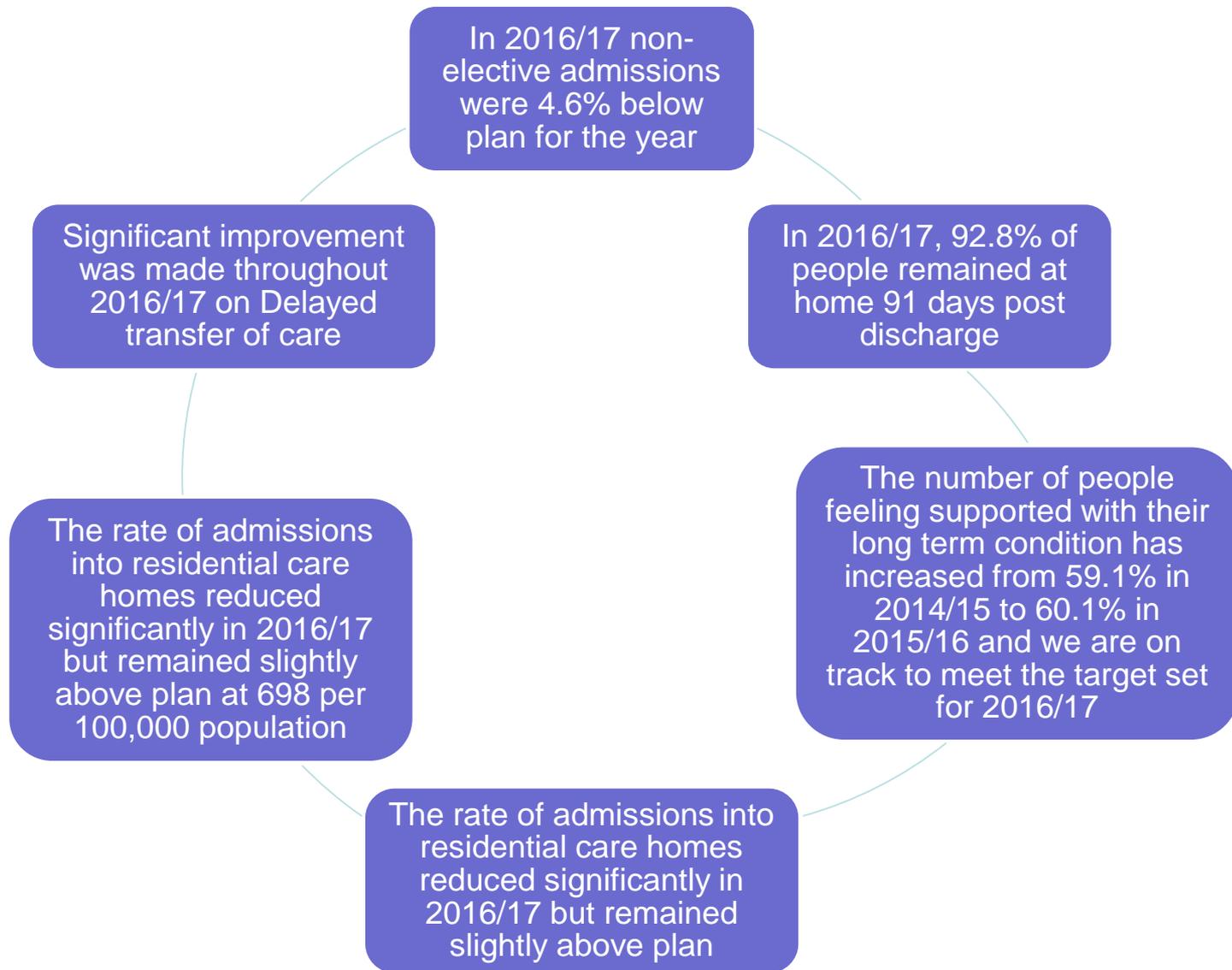
NHS Lewisham Clinical Commissioning Group (LCCG);

Lewisham and Greenwich NHS Trust (LGT);

South London and the Maudsley NHS Foundation Trust (SLaM);

Priority 8 - Delaying and reducing the need for long term care and support & Priority 9 - Reducing the number of emergency admissions for people with long-term conditions





Other Determinants of Health

- Crime can have a number of impacts on health, including fear of crime and the direct impact of detrimental effect on the physical and mental health of victims
- Lewisham has the 17th highest crime rate in London (MPS, 2016/17)
- Hospital admissions for violence are significantly higher than the London and England average (HES, 2014/15-2016/17)
- 26.6% of offenders are recorded as re-offending, in-line with London and England (2014, MoJ)
- In Lewisham the police are involved in a number of initiatives and groups alongside the council and health partners such as the Alcohol Delivery Group

There are several different gases which can occur in ambient air and which have been identified as having health impacts. These include nitrogen dioxide (NO₂), sulphur dioxide (SO₂) and ground-level ozone (O₃). 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), asthma cardiovascular disease and neurological impairments

The quality of the air in the local environment has an impact on the health of the public and ecosystems.

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Air pollution is estimated to reduce life expectancy of every person in the UK by an average of 7-8 months (Air Quality Information for Public Health Professionals – City of London)

In Lewisham the Proportion of all-cause adult mortality attributable to air pollution is 5.6%, this is in line with London, but higher than England PHE, 2015)

Condition	Indicator	Lewisham	London	England
Chronic Obstructive Pulmonary Diseases (COPD)	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	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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Prevalence of key air quality-related conditions in Lewisham

- Lewisham is the 13th most densely populated local authority in England
- Along with many inner London boroughs the availability and affordability of secure and quality housing is an issue
- The impacts on both physical and mental wellbeing are well documented

Key Figures	Lewisham	London	England
Households in temporary accommodation (rate per 1,000)	14.4	15.1	3.3
Statutory homelessness (rate per 1,000)	6.1	5.5	2.5





Services

GP Practices in Lewisham

● Neighbourhood 1

1. Amersham Vale
2. Clifton Rise
3. Deptford M.C.
4. Deptford Surgery
5. Grove M.C.
6. Kingfisher M.C.
7. Lewisham GP Led
8. Mornington Surgery
9. New Cross H.C.
10. QRP Surgery
11. Vesta Road
12. Waldron H.C.

● Neighbourhood 2

13. Belmont Hill
14. Burnt Ash
15. Hillyfields M.C.
16. Honor Oak
17. Lewisham M.C.
18. Lee Road Surgery
19. Morden Hill
20. Nightingale
21. Rushey Green
22. St John's M.C.
23. The Brockley
24. Triangle Group
25. Woodlands H.C.

● Neighbourhood 3

26. Baring Road M.C.
27. Downham Clinic
28. ICO Health Group
29. Oakview
30. Parkview
31. South Lewisham
32. Torridon Road

● Neighbourhood 4

33. Bellingham Green
34. Sydenham Green
35. Sydenham Surgery
36. The Jenner
37. Vale M.C.
38. Wells Park
39. Woolstone M.C.



GP Practices in Lewisham - Forest Hill Ward is the only ward which does not have a GP Practice

Pharmacies in Lewisham



Neighbourhood 1

1. Cheltenham Chemist
2. Krisons Chemist
3. Lloyds Pharmacy (Sainsburys)
4. Lloyds Pharmacy (Queen's Rd)
5. Lockyers Pharmacy
6. New Cross
7. Nightingale
8. Osbon
9. Pepys
10. Queens Rd
11. Station



Neighbourhood 2

2. ABC
3. Amin
14. Baum
5. Beechcroft
6. Boots (Lewisham High St)
7. Ladywell
18. Lee
19. Lewis Grove
20. Lewisham (Leegate)
21. Lloyds (Sainsburys)
22. Lords Pharmacy
23. Rains Chemist
24. Sheel Pharmacy Ladywell
25. Sheel Pharmacy Lewisham
26. Widdicombe
27. Woodlands



56. Integrated Pharmacy Services (DAC)



Neighbourhood 3

28. Boots (Rushey Green)
29. Brook Pharmacy
30. Brownes
31. BAA Trading Ltd
32. Day Lewis (Downham Way)
33. Day Lewis (Bromley Road)
34. Duncans
35. Gokul
36. Grove Park
37. Harris
38. Lloyds (Torrison Rd)
39. Rushey Green
40. Superdrug
41. Vantage



Neighbourhood 4

42. Bentley
43. Boots (Dartmouth Rd)
44. Boots (Sydenham Rd)
45. Crofton Park
46. Lloyds (Randlesdown Rd)
47. Lloyds (Southend Lane)
48. Perfucare
49. Perry Vale
50. Rickman Chemists
51. Superdrug
52. Touchwood
53. Touchwood
54. Touchwood
55. Touchwood



Map of Pharmacies - the 55 pharmacies are distributed across the four neighbourhoods

Acknowledgments

- Brian Coutinho, Lewisham Council
- Mike Hellier, Lewisham CCG
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- Sarah Wainer - Lewisham CCG

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Acknowledgements



Agenda Item 6

HEALTH AND WELLBEING BOARD			
Title	Lambeth, Southwark & Lewisham Sexual and Reproductive Health Strategy 2019-2024		
Key Decision	Yes	Item No.	6
Ward	Borough Wide		
Contributors	Director of Public Health		
Class	{Part 1or Part 2}	Date: 7 th March 2019	

1. Purpose

- 1.1 The purpose of this report is to provide members of the Health and Wellbeing Board with the Lambeth, Southwark & Lewisham Sexual and Reproductive Health Strategy 2019-2024.
- 1.2 The strategy outlines the key sexual health challenges facing our boroughs and identifies four key priority areas for action: healthy and fulfilling relationships; good reproductive health across the life course; high quality and innovative STI testing and treatment; and living well with HIV.
- 1.3 It is proposed that the three Cabinet Members and Directors of Public Health for Lambeth, Southwark and Lewisham publicly launch the strategy at Coin Street Conference Centre on Tuesday 12th March, 2019.

2. Recommendations

Members of the Health and Wellbeing Board are recommended to:

- 2.1 Note the content of the report and approve the publication and joint launch of the strategy on 12th March by all three boroughs.

3. Policy Context

Since the publication of LSL's most recent strategy (2014-17), there have been some significant changes in the sexual health landscape:

- 3.1 The financial climate for public services (and public health services in particular) is extremely challenging, and not predicted to improve in the near future.
- 3.2 New, sustainable ways of funding sexual health services have been adopted across London and other parts of England, which despite now meeting the

exact costs of sexual health service provision, have represented a considerable reduction in income for many NHS trusts.

- 3.3 Demand for sexual health services remains high and is not expected to decline, and people across the country often struggle to access sexual and reproductive health services exactly when they want them.
- 3.4 Commissioners and services have had to innovate, and LSL provided proof of concept of STI self sampling via an online service, which has now been adopted across many parts of London to alleviate pressure on sexual health clinics.
- 3.5 The use of pre-exposure prophylaxis (PrEP) has transformed HIV prevention and has likely contributed in part to a reduction in new diagnoses, particularly amongst MSM, and work is ongoing to establish how PrEP will form part of the publically-funded HIV prevention agenda nationally.

4. Background

- 4.1 Lambeth, Southwark and Lewisham (LSL) together face some of the greatest sexual health challenges in England. We have similarly young, mobile and diverse populations, and our local sexual health services are modern and popular. Our rates of HIV and STIs are the highest in England, and there are persistent inequalities in sexual and reproductive health, with young people, men who have sex with men (MSM), and Black and minority ethnic (BME) communities suffering the greatest burden.
- 4.2 Sexual health inequalities cannot be addressed in isolation; it must be done in partnership. Due to the similarities in the challenges we face, LSL collaborate on sexual health commissioning and strategy in order to maximise our efforts to meet the significant and ongoing needs of our populations. This strategy assesses the most up to date intelligence and sets out LSL's shared ambitions and priority areas in sexual and reproductive health over the next five years.
- 4.3 There have been considerable improvements in key outcomes since our last strategy was published in 2014, most notably a reduction in new diagnoses of HIV for the first time in the history of the disease in England, and a continued downward trajectory in rates of teenage conceptions. However, gains have not been made equally across our population. BME communities (and black communities in particular) remain at greater risk of poor sexual and reproductive health.
- 4.4 There is an extremely high rate of diagnosed HIV across LSL – it is the highest in England, and over 8,700 of our residents have been diagnosed with HIV. Just over three quarters of people living with a HIV in LSL are men, the majority of whom are white. Sex between men is the most common HIV exposure category in Lambeth (66%) and Southwark (58%), but in Lewisham,

heterosexual contact is the most common exposure type (54%) of those diagnosed.

- 4.5 New HIV diagnosis rates are falling across in LSL, but too many people still receive a late diagnosis, and there are still people living with HIV that are unaware of their status. There remain significant inequalities in those diagnosed late in LSL; people aged 50-64 years, of black African ethnicity, those exposed through heterosexual contact, and women have the highest rates of late diagnosis. Furthermore, a disproportionate number of HIV cases locally are diagnosed in people living in the 40% most deprived areas.
- 4.6 Across LSL, 22,000 new STIs were diagnosed in 2017, with rates highest amongst men and those aged 20-24. While men have higher rates of STIs across most of the life course, women have higher rates of STIs than men at age 15-19. It is unclear what is driving this pattern, but it may be that young people lack the skills and confidence to negotiate safer sex. There is a general downward trend in new diagnoses of STIs in LSL, with the exception of gonorrhoea and syphilis (which most affect MSM). The increases in these STIs is concerning due to antimicrobial resistance and the severity of syphilis. Given the general burden of STIs in our populations, untreated STIs remain a concern in protecting the reproductive health of residents.
- 4.7 In terms of reproductive health, user-dependent contraceptive methods (e.g. condoms, or the pill) are the most common form of contraception used in LSL. This combined with challenging access to services translates to a high use of emergency contraception and abortion, indicating that reproductive health needs continue to be unmet, particularly amongst young, black women.
- 4.8 We know that a large part of improving sexual and reproductive health is supporting people to develop the skills to negotiate the sex (and sexual relationships) that they want to have. Abusive and coercive relationships affect people of all ages, genders, and sexualities, but some groups are at higher risk of unhealthy sexual relationships than others, including young women, people with learning disabilities, and people identifying as LGBTQI+. MSM in particular may be at risk through chemsex, as maintaining control of behaviour and choices while under the influence of drugs may be difficult. However, few local data are available on indicators for safe and healthy sexual relationships.

5. Summary of the Lambeth, Southwark & Lewisham Sexual and Reproductive Health Strategy 2019-2024

- 5.1 Our vision for maximising sexual and reproductive health for all people in our boroughs focuses on four key priorities:

Healthy and fulfilling sexual relationships

- **VISION:** People have healthy, safe and fulfilling sexual relationships

Good reproductive health across the life course

- **VISION:** People effectively manage their fertility and reproductive health, understand what impacts on it, and have knowledge of and access to contraceptives

High quality and innovative STI testing and treatment

- **VISION:** The local burden of STIs is reduced, in particular among those who are disproportionately affected

Living well with HIV

- **VISION:** We move towards achievement of 0-0-0: zero HIV-related stigma, zero HIV transmissions, and zero HIV-related deaths

5.2 LSL will work collaboratively to deliver our vision, guided by a common set of principles:

We will work in partnership, at a local, London and national level	We will commission high quality, effective and financially sustainable services, and capitalise on technological innovations	We will listen to service users' views and experiences and use these to improve what we do	We will focus on reducing inequalities in sexual and reproductive health	We will support the development of a resilient sexual health system
Prevention focused				
Evidence based				

5.3 The strategy and supporting evidence review (see Appendix) describes the aims and objectives that will achieve the vision for each of the four priorities, how we will

work together to achieve them, and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, each borough will have an annual delivery plan which will set out the borough-specific actions needed to achieve these objectives in a given year.

6. Financial Implications

6.1. The strategy does not contain any specific commissioning intentions and therefore there are no financial implications. Any specific commissioning decisions arising from the development of the local response to the strategy will be presented to the Committee and consulted on separately. Detailed financial implications will be considered at that stage. Any expenditure will need to be contained within the agreed budget for sexual health services. Currently this is entirely funded from the ring-fenced Public Health Grant.

7. Legal Implications

7.1. Legal implications arising are set out in the draft Strategy, in particular Section 5: 'Commissioning responsibilities and local services'.

8. Crime and Disorder Implications

8.1 There are no specific crime and disorder implications arising from this report.

9. Equalities Implications

9.1 The Equality Act 2010 protects us all from discrimination or harassment as a result of a personal characteristic. Good sexual and reproductive health is not equally distributed in the population. Some groups are more at risk of poorer sexual and/or reproductive health based on a common characteristic, most notably young people, Black communities, and MSM.

9.2 While we will continue to commission welcoming, accessible and non-discriminatory services, to reduce inequalities in sexual and reproductive health we also need to commission services aligned with the concept of proportionate universalism. This means that whilst we will maintain open access sexual and reproductive health services for all, we also need to also target resources to those most at risk in order to reduce the burden of poor sexual health in our communities. This theme is threaded throughout this strategy.

10.Environmental Implications

10.1 There are no specific environmental implications arising from this report.

11.Conclusion

11.1 This strategy sets out the actions we will take in each of the above priority areas to continue improving sexual and reproductive health in our boroughs over the next five years. Each borough will have an annual action plan which will include specific steps to deliver this strategy. This approach allows us to collaborate to deliver an overarching strategy and to take local action as needed. Progress against this strategy will be overseen by the LSL Sexual Health Commissioning Board in addition to each borough's Health and Wellbeing Board.



Lambeth, Southwark and Lewisham
Sexual and Reproductive Health Strategy 2019–24

Lambeth, Southwark and Lewisham Public Health Departments

Glossary

The following list provides a glossary of common terms used throughout this strategy.

ART	Anti-retroviral therapy	NHS	National Health Service
BAME/BME	Black and minority ethnicities	OC	Oral contraception
BASHH	British Association for Sexual Health and HIV	PID	Pelvic inflammatory disease
CCG	Clinical Commissioning Group	PEP(SE)	Post-exposure prophylaxis (for HIV) (after sexual exposure)
Chemsex	Sex that occurs under the influence of drugs	PHE	Public Health England
CSE	Child sexual exploitation	PLHIV	People living with HIV
EHC/EC	Emergency hormonal contraception	PrEP	Pre-exposure prophylaxis (for HIV)
EJAF	Elton John AIDS Foundation	PSHE	Personal, social, health and economic education
EMA	Early medical abortion	RSE	Relationships and sex education
FTC	HIV Fast-Track Cities initiative	Sexual health	Sexual health is used interchangeably with sexual and reproductive health
GHB/GBL	Gammahydroxybutyrate / gammabutyrolactone	SHL	London's sexual health e-service, 'Sexual Health London'
GP	General practice	SRH	Sexual and reproductive health
HARS	HIV and AIDS reporting system	STI	Sexually transmitted infection
HIV	Human immunodeficiency virus	TasP	Treatment as prevention (for HIV)
HPV	Human papillomavirus	TOP	Termination of pregnancy; abortion
HSV	Herpes simplex virus	UDM	User-dependent method (of contraception)
LARC	Long-acting reversible contraception	UK	United Kingdom
LGA	Local Government Association	UNAIDS	Joint United Nations Programme on HIV and AIDS
LGBTQI+	Lesbian, gay, bisexual, transgender, queer/questioning, intersex and others	U=U	Undetectable = untransmittable
LGV	Lymphogranuloma venereum	Women	In this strategy, the term 'women' (in the context of the reproductive health of those that have sex with men) encompasses both cis women and other people with uteri (e.g. trans men) that have sex with men.
LSL	Lambeth, Southwark and Lewisham		
MC	Molluscum contagiosum		
MSM	Men who have sex with men		



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Key facts and figures

Indicators of HIV, sexual health and reproductive health in our boroughs



Our population: BME, YP and MSM remain at greater risk of poor sexual and reproductive health



Our local services are at the forefront of creating and delivering modern and innovative sexual health provision



Healthy and fulfilling sexual relationships



Good reproductive health across the life course



High quality and innovative STI testing and treatment



Living well with HIV

2017

Lambeth, Southwark and Lewisham councils each launch new integrated services for young people, taking a holistic approach



User-dependent contraceptive methods are the most common form of contraception used in LSL



22,000 new STIs were diagnosed in 2017

8,700

residents have been diagnosed with HIV



Introduction of statutory of RSE offers an opportunity to improve and extend universal RSE



LSL is working to increase access to contraception, including online



We pioneered online STI testing for asymptomatic patients

95-98-97

London became the first city in the world to diagnose, treat and virally suppress 95% of people living with HIV

1.0 Executive summary

Lambeth, Southwark and Lewisham (LSL) together face some of the greatest sexual health challenges in England.

We have similarly young, mobile and diverse populations, and our local sexual health services are modern and popular. Our rates of HIV and STIs are the highest in England, and there are persistent inequalities in sexual and reproductive health, with young people, men who have sex with men (MSM), and black and minority ethnic (BME) communities suffering the greatest burden. Sexual health inequalities cannot be addressed in isolation; it must be done in partnership. Due to the similarities in the challenges we face, LSL collaborate on sexual health commissioning and strategy in order to maximise our efforts to meet the significant and ongoing needs of our populations. This strategy assesses the most up to date intelligence and sets out LSL's shared ambitions and priority areas in sexual and reproductive health over the next five years.

Since the publication of LSL's most recent strategy (2014–17), there have been some significant changes in the sexual health landscape. The financial climate for public services (and public health services in particular) is extremely challenging, and not predicted to end in the near future. New, sustainable ways of funding sexual health services have been adopted across London and other parts of England, which despite now meeting the exact costs of sexual health service provision, have represented a considerable reduction in income for many NHS trusts. Demand for sexual health services remains high and is not expected to decline, and people across the country often struggle to access sexual and reproductive health services exactly when they want them. Commissioners and services

have had to innovate, and LSL provided proof of concept of STI self sampling via an online service, which has now been adopted across many parts of London to alleviate pressure on sexual health clinics. Finally, the use of pre-exposure prophylaxis (PrEP) has transformed HIV prevention and has likely contributed in part to a reduction in new diagnoses, particularly amongst MSM, and work is ongoing to establish how PrEP will form part of the publicly-funded HIV prevention agenda nationally.

There have been considerable improvements in key outcomes since our last strategy was published in 2014, most notably a reduction in new diagnoses of HIV for the first time in the history of the disease in England, and a continued downward trajectory in rates of teenage conceptions. However, gains have not been made equally across our population. BME communities (and black communities in particular) remain at greater risk of poor sexual and reproductive health.

There is an extremely high rate of diagnosed HIV across LSL – it is the highest in England, and over 8,700 of our residents have been diagnosed with HIV. Just over three quarters of people living with HIV in LSL are men, the majority of whom are white. Sex between men is the most common HIV exposure category in Lambeth (66%) and Southwark (58%), but in Lewisham, heterosexual contact is the most common exposure type (54%) of those diagnosed.

New HIV diagnosis rates are falling across LSL, but too many people still receive a late diagnosis, and there are still people living with HIV that are unaware of their status. There remain significant inequalities in those diagnosed late in LSL; people aged 50–64 years, of black African ethnicity, those exposed through heterosexual contact, and women have the highest



rates of late diagnosis. Furthermore, a disproportionate number of HIV cases locally are diagnosed in people living in the 40% most deprived areas.

Across LSL, 22,000 new STIs were diagnosed in 2017, with rates highest amongst men and those aged 20–24. While men have higher rates of STIs across most of the life course, women have higher rates of STIs than men at age 15–19. It is unclear what is driving this pattern, but it may be that young people lack the skills and confidence to negotiate safer sex. There is a general downward trend in new diagnoses of STIs in LSL, with the exception of gonorrhoea and syphilis (which most affect MSM). The increases in these STIs is concerning due to antimicrobial resistance and the severity of syphilis. Given the general burden of STIs in our populations, untreated STIs remain a concern in protecting the reproductive health of residents.

In terms of reproductive health, user-dependent contraceptive methods (e.g. condoms or the pill) are the most common form of contraception used in LSL. This combined with challenging access to services translates to a high use of emergency contraception and abortion, indicating that reproductive health needs continue to be unmet, particularly amongst young, black women.

We know that a large part of improving sexual and reproductive health is supporting people to develop the skills to negotiate the sex (and sexual relationships) that they want to have. Abusive and coercive relationships affect people of all ages, genders and sexualities, but some groups are at higher risk of unhealthy sexual relationships than others, including young women, people with learning disabilities, and people identifying as LGBTQI+. MSM in particular may be at risk through chemsex, as maintaining control of behaviour and choices while under the influence of drugs may be difficult. However, few local data are available on indicators for safe and healthy sexual relationships.



To build on the progress we have made and meet the most salient challenges facing our boroughs over the next five years, we will work together on four key priority areas:

Priority	Vision and key outcomes
Healthy and fulfilling sexual relationships	<p>People are empowered to make their sexual relationships healthy and fulfilling:</p> <ul style="list-style-type: none"> • People make informed choices about their sexual and reproductive health • People in unhealthy or risky sexual relationships are supported appropriately
Good reproductive health across the life course	<p>People effectively manage their fertility and reproductive health, understand what impacts on it and have knowledge of and access to contraceptives:</p> <ul style="list-style-type: none"> • Reproductive health inequalities are reduced • Unwanted pregnancies are reduced • Knowledge and understanding of reproductive health and fertility are increased
High quality and innovative STI testing and treatment	<p>The local burden of STIs is reduced, in particular among those who are disproportionately affected:</p> <ul style="list-style-type: none"> • There is equitable, accessible, high-quality testing and treatment that is appropriate to need • Transmission of STIs and repeat infections are reduced
Living well with HIV	<p>We move towards achievement of 0–0–0: zero HIV-related stigma, zero HIV transmissions and zero HIV-related deaths:</p> <ul style="list-style-type: none"> • People living with HIV know their status and are undetectable (=untransmittable) • People living with HIV are enabled to live and age well

This strategy sets out the actions we will take in each of the priority areas to continue improving sexual and reproductive health in our boroughs over the next five years. We know that this is an ambitious strategy, and we cannot deliver it in isolation. We recognise that within LSL, some areas have further to progress than others and there will be local factors which may be unique to individual boroughs. Therefore, the boroughs will have an annual action plan which will include specific steps to deliver this strategy. This approach allows us to collaborate to deliver an overarching strategy and to take local action as needed. Progress against this strategy will be overseen by the LSL Sexual Health Commissioning Partnership Board in addition to each borough's Health and Wellbeing Board.

2.0 Context

2.1 What is this document?

This report sets out Lambeth, Southwark and Lewisham's (LSL) shared ambitions for sexual and reproductive health (SRH) in our boroughs for the next five years. Our strategy is built on the most up to date intelligence and information we have on SRH, sets out a number of priority areas for action between 2019 and 2024 and what actions we will take to address these priorities.

Appended to this document are two additional resources for readers: a *statistical appendix* which summarises the latest sexual and reproductive health data and intelligence in LSL, and a pack of *evidence summaries* which provides a short summary of the most up to date evidence and guidance in relation to each of our priority areas. The evidence summary pack also includes a full list of references (references are not included in the strategy itself for presentation purposes).



Our strategy is built on the most up to date intelligence and information on SRH and HIV in our communities

2.2 Why do we need a joint strategy?

Separately, LSL face some of the greatest sexual health challenges in England, including high rates of HIV, STIs, emergency contraception use and abortions.

We have young, mobile and diverse populations, and our local sexual health services are modern and popular. Proportionately and in real terms, we spend a significant sum on sexual and reproductive health services, spending between a quarter and a third of the Public Health Grant, to meet both the needs and demands of our populations.

As the challenges we face are similar, LSL are in a stronger position to meet the needs of our populations through collaborating on sexual health commissioning and strategy. Through this approach, we are able to effectively pool both financial and human resources to maximise our impact in many areas. However, there remain areas where we commission separately to meet the differing requirements of our boroughs.

To underpin our collaboration, we need a clear strategic direction for action. This strategy provides that direction.

When our last strategy was published in 2014, we set out to improve sexual health in LSL by building effective, responsive and high quality sexual health services, which effectively meet the needs of our local communities. This focus on service delivery was appropriate for the time, a year after commissioning responsibility transferred to local government. In the period of the last strategy, we:

- Integrated sexual and reproductive health services across our local system, maintaining a high quality of delivery;
- Invested in and developed a new model of online STI testing and provided proof of concept for this type of service (leading to it being adopted across London);



Young people, black communities and MSM are most at risk of poor sexual health



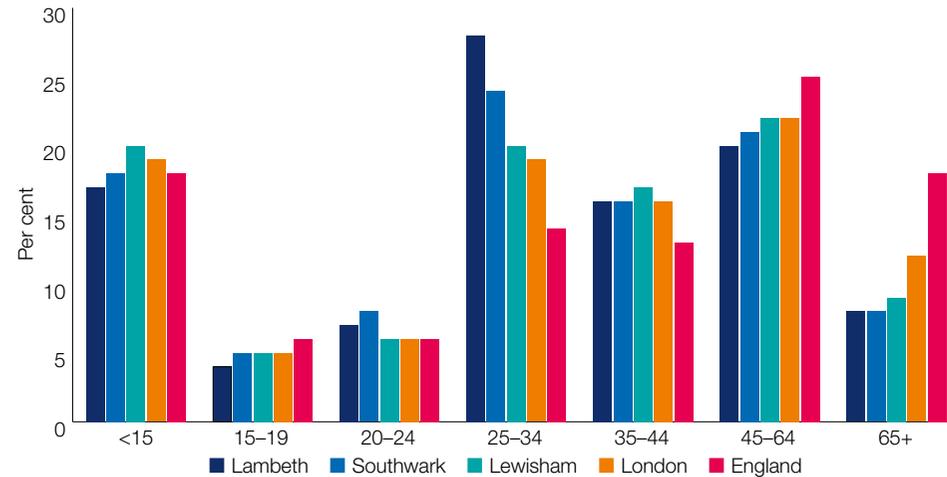
- Commissioned community-focused HIV prevention programmes and rolled out condom distribution schemes; and
- Commissioned innovative and collaborative young people’s services with a greater focus on overall wellbeing.

Four years on from our last strategy, some challenges remain, and there have been substantial changes in sexual health and in the system as a whole. There have been improvements in many outcomes, but not experienced by all; a focus on reducing inequalities is more salient than ever. Despite the creation of new ways of accessing sexual health services, demand continues to rise, and access to other settings such as general practice is reported by sexual health service users as being increasingly difficult. The availability of pre-exposure prophylaxis (PrEP) has transformed HIV prevention, especially for men that have sex with men (MSM), but condomless sex is now an increasing challenge, and some STIs are on the rise. The financial climate is ever more challenging, but despite this, we remain committed to investing in prevention and exploring new ways of delivering services.

We’re proud of the innovative way we approach sexual and reproductive health service provision in LSL, and we strive to continue to be system leaders over the next five years (and beyond).

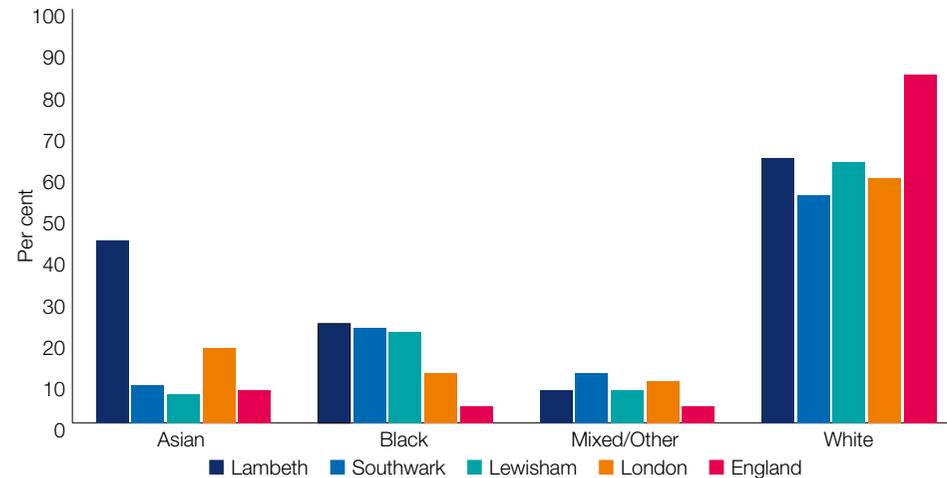
However, we can’t make improvements in isolation. We recognise that good sexual and reproductive health is intertwined with many other areas of health and wellbeing, as well as our wider communities. This joint strategy has therefore been developed to complement and tessellate with a range of other local strategies in each borough, and other strategies at a regional level (e.g. *Mayor’s Health Inequalities Strategy*).

Age profile in Lambeth, Southwark and Lewisham, 2016



ONS (2018) Revised population estimates: mid-2016

Population of LSL by broad ethnic group, 2016



London Datastore (2018) Ethnic groups by borough

The graphs above show that the populations of LSL are much younger and more diverse, on average, than those of London and particularly England. Young people and BME communities are more likely to suffer from poor SRH, which partly explains the significant SRH needs in LSL.



2.3 Inequalities in sexual and reproductive health

The Equality Act 2010 protects us all from discrimination or harassment as a result of a personal characteristic. Good sexual and reproductive health is not equally distributed in the population.

Some groups are more at risk of poorer sexual and/or reproductive health based on a common characteristic, most notably young people, black communities and MSM.

The following characteristics are protected under the Act:

- Age
- Race
- Gender
- Disability
- Marital status
- Pregnancy and maternity
- Religion or belief
- Sexual orientation
- Gender reassignment

While we will continue to commission welcoming, accessible and non-discriminatory services, to reduce inequalities in sexual and reproductive health we also need to commission services aligned with the concept of proportionate universalism. This means that whilst we will maintain open access sexual and reproductive health services for all, we also need to tailor services to those with greater need in order to reduce the impact of poor sexual health in our communities. This theme is threaded throughout this strategy.



53%
of lesbian, gay, and bisexual young people are never taught about homosexual sex and relationships issues at school

3.0 Vision

Our vision for sexual and reproductive health in LSL

Our vision for maximising sexual and reproductive health for all people in our boroughs focuses on four key priorities:



VISION: People are empowered to make their sexual relationships healthy and fulfilling



VISION: People effectively manage their fertility and reproductive health, understand what impacts on it and have knowledge of and access to contraceptives



VISION: The local burden of STIs is reduced, in particular among those who are disproportionately affected



VISION: We move towards achievement of 0–0–0: zero HIV-related stigma, zero HIV transmissions and zero HIV-related deaths

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Principles underpinning our strategy

LSL will work collaboratively to deliver our vision, guided by a common set of principles:

We will:

<p>WORK IN PARTNERSHIP, at a local, London and national level</p>	<p>commission HIGH QUALITY, EFFECTIVE and FINANCIALLY SUSTAINABLE services, and capitalise on TECHNOLOGICAL INNOVATIONS</p>	<p>LISTEN to service users' views and experiences and use these to improve what we do</p>	<p>focus on REDUCING INEQUALITIES in sexual and reproductive health</p>	<p>support the development of a RESILIENT SEXUAL HEALTH SYSTEM</p>
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4.0 Commissioning responsibilities and local services

We recognise that the commissioning landscape for sexual and reproductive health can be complex.

Various bodies have commissioning responsibilities in this area, which could make delivery of a strategy challenging. This is why the first principle of our strategy is to ‘work in partnership’ to deliver our shared vision.

While local authorities are responsible for most sexual and reproductive health care, this is not exclusively the case. Since April 2013, local authorities, Clinical Commissioning Groups (CCGs) and NHS England have had commissioning responsibility for the following services:

Local authorities	<ul style="list-style-type: none"> • Contraception, including any enhanced services commissioned in general practice or pharmacy settings including all prescribing costs – but excluding contraception provided as a service under the GP contract • STI testing and treatment, including chlamydia testing and HIV testing • Sexual health aspects of psychosexual counselling • Any sexual health specialist services, including young people’s sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion work, services in schools, colleges and pharmacies
CCGs	<ul style="list-style-type: none"> • Abortion services • Vasectomy • Non sexual-health elements of psychosexual health services • Gynaecology, including the use of any contraception for non-contraceptive purposes.
NHS England	<ul style="list-style-type: none"> • Contraception provided as an additional service under the GP contract* • HIV treatment and care, including post-exposure prophylaxis after sexual exposure (PEP(SE)) • Promotion of opportunistic testing and treatment for STIs, and patient requested testing by GPs* • Sexual health elements of prison health services • Sexual Assault Referral Centres • Cervical screening

*Delegated responsibility to CCGs locally

Public Health England (PHE) supports effective local commissioning by providing data and intelligence, guidance and also commissioning central prevention programmes (e.g. HIV Prevention England).

The commissioning responsibilities outlined above translate into the services and programmes on the following page, mapped against the key priorities of this strategy.



Commissioning responsibilities

Priority	Healthy and fulfilling sexual relationships	Good reproductive health across the life course	High quality and innovative STI testing and treatment	Living well with HIV	
What does good look like?	<ul style="list-style-type: none"> Knowledge, confidence and skills for safe, healthy and fulfilling relationships 	<ul style="list-style-type: none"> In control of their body and fertility Understand what factors impact on fertility Choice and access to a range of contraceptive methods 	<ul style="list-style-type: none"> Self-sampling of STIs Access to appropriate testing High quality clinical services 	<ul style="list-style-type: none"> Increased HIV testing Earlier diagnosis Retention in care Holistic health management 	
Commissioner	Council	<ul style="list-style-type: none"> High quality RSE in schools Targeted work to young people Tackling homophobia, transphobia and misogyny in communities Community outreach / targeted health promotion work Targeted chemsex work 	<ul style="list-style-type: none"> High quality RSE in schools Young people friendly services Knowledge of and access to full range of contraceptive offers Come Correct condom scheme for under-25s Integrated reproductive and sexual health services 	<ul style="list-style-type: none"> High quality RSE in schools Young people friendly services Come Correct condom scheme for under-25s Online STI self-sampling or testing Integrated reproductive and sexual health services Specialist clinical services 	<ul style="list-style-type: none"> Reducing stigma and promoting good sexual health Community outreach / targeted health promotion work Online STI self-sampling or testing Integrated reproductive and sexual health services
	Council & CCG	<ul style="list-style-type: none"> Psycho-sexual health services 	<ul style="list-style-type: none"> Online offer of oral contraception Pharmacy and primary care FGM prevention 	<ul style="list-style-type: none"> Pharmacy and primary care testing 	<ul style="list-style-type: none"> Pharmacy and primary care testing
	CCG		<ul style="list-style-type: none"> High quality abortion services Vasectomy and sterilisation services 		<ul style="list-style-type: none"> HIV-related care and support
	NHSE		<ul style="list-style-type: none"> HPV vaccination Cervical screening Contraception under GP contract 	<ul style="list-style-type: none"> PrEP 	<ul style="list-style-type: none"> HIV treatment services

5.0 Our priorities

5.1 Healthy and fulfilling sexual relationships

What do we mean by ‘healthy and fulfilling sexual relationships’?

Our ambition is for all people in our boroughs to be empowered to make their sexual relationships healthy and fulfilling.

We know that a large part of improving sexual and reproductive health outcomes is supporting people to develop the skills to negotiate the sex (and sexual relationships) that they want to have. Much of the work relevant to this topic falls within the remit of safeguarding teams and complementary strategies are available to support this work, addressing domestic abuse, violence against women and girls, and child sexual exploitation, among others.

However, public health has a role supporting relationships and sex education (RSE) in schools. Through effective collaborations, Public Health can promote and encourage partners, agencies, and providers to champion healthy relationships with the aim of supporting people of all ages to understand and identify risky sexual behaviour and prevent abuse.

This chapter therefore serves as the preventative strand of our strategy.

Introduction

Background and policy context

Social relationships are an important determinant of health and wellbeing across the life course.

A positive familial environment provides children with secure attachment and a healthy blueprint for future relationships. Negative, harmful relationships have consequences to physical and emotional health and, in some cases, may drive a cycle of unhealthy behaviour. For this reason, developing an understanding of healthy relationships early in life is critical to equip young people with the knowledge, confidence and control to engage in healthy sexual relationships.

Comprehensive relationships and sex education (RSE) contributes to a young person’s safety by supporting them to navigate through their own developmental changes and helping to raise awareness of exploitation or abuse. Despite this, schools currently (as of 2019) have had no statutory responsibility to provide comprehensive RSE. There is strong evidence of the impact of high quality RSE in reducing early sexual activity, teenage conceptions and STIs, and in increasing reporting of sexual exploitation and abuse. Moreover, young people have increasingly reported that lessons from school are their preferred source of information about sex when growing up, further highlighting the importance of appropriate RSE. However, recent national surveys, qualitative studies and local surveys across LSL on RSE have revealed significant inadequacies in the breadth of topics covered and the quality of teaching.

Amendments to the Children and Social Work Act by the Department for Education have legislated statutory RSE across the UK as of September 2020, a delay on the anticipated 2019 start-date. This affords schools (maintained, academy and independent) the opportunity to



‘Relationships and sex’ is the issue most concerning to young people



Some groups are at higher risk of unhealthy sexual relationships than others, including young women, people with learning disabilities and people identifying as LGBTIQ+



develop – alongside health professionals – comprehensive, relevant lessons that address these reported inadequacies and capitalise on our knowledge of vulnerable groups, in particular the lack of RSE sufficiently inclusive of vulnerable women, young LGBTIQ+ people and others. Effective collaboration between partners and providers is critical to achieving this. Topical issues of consent – what it looks like, giving it, understanding it can be withdrawn – will also be included. In primary schools, the subject will be taught as ‘relationships education,’ extending to ‘relationships and sex education’ in secondary schools. Schools will have flexibility in how these subjects are taught and parents retain the right to withdraw a child from RSE, as they do currently.

The strategic direction for sexual assault and abuse services over the next five years has been set out by NHS England (April 2018) and echoes this emphasis on prevention. It recognises the increasing role of the internet in sexual assault and abuse, and the difficulties faced by vulnerable groups (e.g. LGBTIQ+, BAME, those with learning difficulties) in reporting an incident. Knowledge and guidance about healthy relationships is an important resource to enable people to navigate their own sexual experiences and can help people of all ages to identify unhealthy relationship behaviours and give them the confidence to address it. Healthy and fulfilling sexual relationships are important for good reproductive health, and for reducing the risk of acquiring STIs and HIV. Empowering people to make their sexual relationships healthy and fulfilling is an integral part of a holistic sexual and reproductive health strategy.

Current picture

Epidemiology / local needs

We know that sexual health is more than the absence of disease, however, few data are available on the broader aspects, including safe and healthy sexual relationships. Proxy measures can instead be used to indicate general trends and suggest areas of improvement or good practice.

Comprehensive, contemporary RSE can empower people to engage in healthy sexual relationships and may act as a protective factor against future risky behaviour. Local research with young people in Lewisham and Southwark during 2016 and 2017 revealed views that ‘relationships and sex’ was the issue most concerning to young people and their peers. However, these studies also exposed sparse and inconsistent education about healthy relationships across different schools. Details about what constitutes a healthy or unhealthy relationship and how to spot the signs of abuse (beyond physical) were reported as lacking. When asked about how they would prefer RSE to be provided, young people vocalised a desire for an open, interactive discussion with professionals, more information on the emotional and social aspects of sex, and a general inclusion of healthy relationships. A key part of this is reducing stigma around sex and sexual relationships, and developing professionals’ confidence and skills in having these conversations. Additional gaps in knowledge were identified in the legal consequences of sexting (sending sexually explicit photographs or messages via mobile phone) that, despite its prevalence in this age group, remained largely undiscussed in RSE.

2020

By September 2020, all schools will need to deliver RSE



Knowledge and guidance about healthy relationships is an important resource to enable people to navigate their own sexual experiences



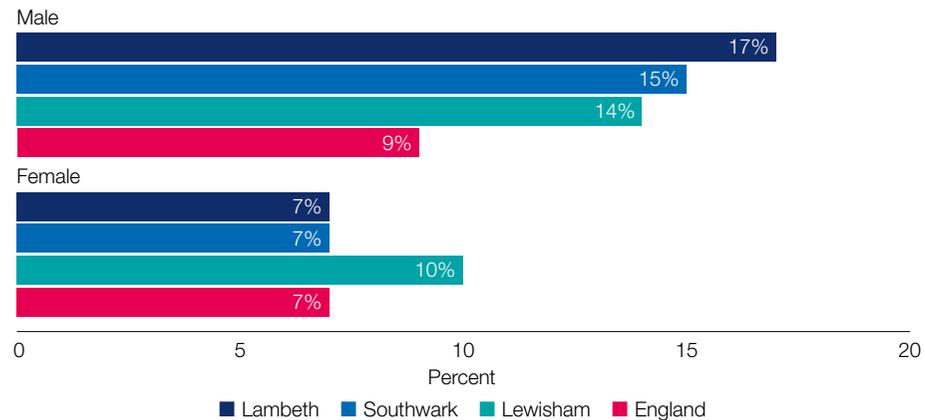
Empowering people to define the terms of their sexual relationships and use contraception when desired is an important part of protecting sexual and reproductive health (SRH). Ensuring the equality and accessibility of our contraception services has been a local priority. For young people under 25, condoms and sexual health information are available free of charge through the pan-London distribution scheme *Come Correct*, delivered by Brook across LSL. Condom distribution schemes were recently evaluated nationally and found to be successful nationally. This is reflected in the high number of repeat users (compared to new registrations) locally.

Abusive and coercive relationships affect people of all ages, genders, and sexualities but some groups are at higher risk of unhealthy sexual relationships than others.

People identifying as LGBTQI+ may be at greater risk of experiencing abuse in a relationship. The prevalence of domestic abuse in MSM is high: from the age of 16, 49% report experiencing at least one episode of abuse. Given our significant local population of MSM, these figures are cause for concern. The prevalence of abuse in transgender people is even higher; an estimated 80% report experiencing emotional, physical or sexual abuse from a partner or ex-partner. Despite the risk of domestic abuse in these populations, over half (53%) of lesbian, gay and bisexual young people are never taught about homosexual sex and relationships issues at school and therefore may not be sufficiently equipped with the knowledge and skills to engage in the sexual relationships that they want.

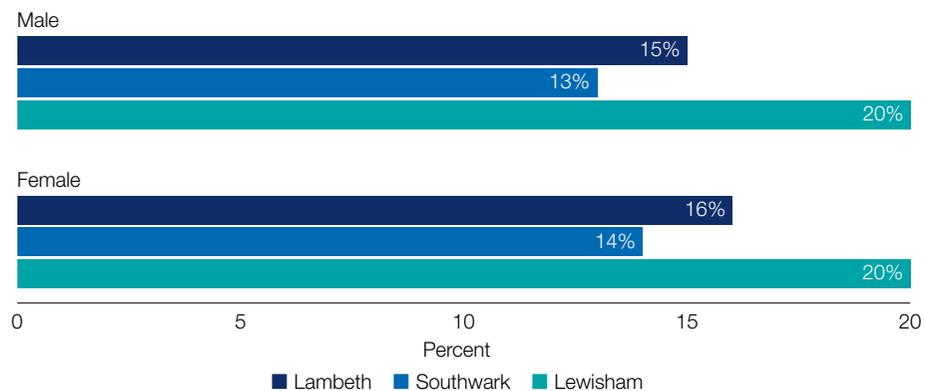
In 2016/17 across London, the rate of domestic abuse-related incidents and crimes recorded by the police was 23 per 1,000; women are nearly twice as likely to have experienced domestic abuse as men. The number of accounts of violence against women and girls in London has increased since 2012 but it remains an under-reported

Re-infection within 12 months all STIs all age groups, 2012–16



PHE (2017) Local authority HIV, sexual and reproductive health epidemiology report (LASER): 2016

Re-infection within 12 months all STIs 15–19 year olds, 2012–16



PHE (2017) Local authority HIV, sexual and reproductive health epidemiology report (LASER): 2016

Re-infection with an STI is a marker of persistent risky behaviour. Across LSL, men are more likely to have a reinfection within 12 months of diagnosis. The proportion of people with a re-infection in LSL is much higher than the rest of England. Teenagers are considered to be at increased risk of re-infection because they are more likely to lack the skills and confidence to negotiate safer sex, and this is particularly the case in Lewisham.



crime. While we lack quantitative data locally, qualitative research has highlighted the prevalence of emotionally abusive behaviour among LSL's population of young people. The 2017 Lewisham Healthwatch report 'Let's Talk About Sex' revealed young people were rarely identifying controlling behaviour or emotional abuse as evidence of an unhealthy relationship. The 2016 SHEU survey of secondary students in LSL found that 12–17% of students surveyed reported a jealous partner when seeking to spend time with friends and 10–14% said their partner looked through their phone.

Engaging in risky sexual behaviour, e.g. condomless sex, may be one of many indicators of an unhealthy sexual relationship. The rate of new STI diagnoses in LSL has been consistently higher than the London and England average since 2012. Re-infection with an STI indicates ongoing risky behaviour and across LSL men are more likely than women to become re-infected within 12 months of diagnosis. Young people are considered to be at increased risk of re-infection because they tend to lack the skills and confidence to negotiate safer sex. In 2016, twice the proportion of 15–19 year old women were re-infected compared to women of all ages. Lewisham had the highest rate of STI re-infection among LSL from 2012–16, particularly in young people.

'Chemsex' – sex that occurs under the influence of drugs, most commonly crystal methamphetamine, GHB/GBL and mephedrone – has become prominent in some parts of the MSM community. Through local surveys, we know that our population of MSM are more likely to use drugs associated with chemsex than MSM elsewhere in London or England. These substances pose significant health risks and risk of overdose. Qualitative research in Southwark indicated an increased mental health risk (including low self-esteem) for those who partake in chemsex. Research participants also

identified vulnerability and risky sexual activity as common concerns since maintaining control of behaviour and choices while under the influence of chemsex drugs may be difficult. As sexual health commissioners, we need to ensure that people who are more likely to engage in risky sexual relationships are also appropriately supported and empowered to make safe, healthy decisions.

Achievements since the last strategy and ongoing challenges

Achievements since the last strategy

The focus on healthy sexual relationships in this strategy is a new development, in line with local needs and a changing policy context.

The introduction of statutory RSE from September 2020 is a significant achievement for public health and RSE advocates across the UK, and has created opportunities for the development of meaningful, relevant discussions of healthy sexual relationships.

In 2017, Lambeth, Southwark and Lewisham councils each launched new integrated services for young people, taking a holistic approach to the wellbeing of young people. The services focus (to varying degrees) on the provision of services and information on sexual health, substance misuse and mental and emotional wellbeing. Underpinning these services is an acknowledgement that young people take risks, and a shared ambition to support young people with risk-taking behaviours to build resilience, coping strategies and decision-making skills. These services have been in place for a short time, but early outputs and service user engagement is encouraging.



2017

Lambeth, Southwark and Lewisham councils each launched new integrated services for young people, taking a holistic approach to the wellbeing of young people



Ongoing challenges

Data

Insufficient data are available to describe and quantify potential inequalities in achieving healthy relationships. We are working with our partners to explore methods of capturing childhood risk factors (such as adverse childhood experiences), which impact on a child's risk seeking and taking behaviour later in life. We also don't fully understand the needs of sex workers in our boroughs, which may have changed since the previous strategy, and their access to and use of services to support their sexual health.

Detailed needs assessments are on-going and planned to better understand local needs where routinely collected data are not available.

RSE provision

Until RSE is made statutory in 2020, provision will remain inconsistent across schools. As such, there are likely inequalities in children's experiences and understanding of relationships and sex. Individual programmes and workshops have been developed for schools, e.g. the Esteem programme in Southwark that delivers lessons on critical thinking around peer pressure and understanding healthy relationships. However, programmes such as this must be purchased by schools and there is therefore significant variation in provision across the boroughs.

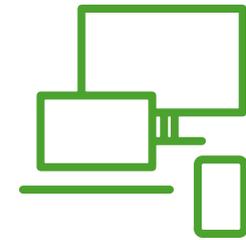
Emerging issues

Youth violence

Serious youth violence (SYV) is a growing issue across London and LSL. Serious youth violence and poor sexual health have a number of shared risk factors. Young people involved in gangs are at risk of significant physical and mental health impacts; however, young women in particular are increasingly recognised as the invisible victims. UK research has exposed widespread sexual abuse of women and girls involved in gangs and in county line drug trade, who are frequently exploited as part of initiations or to pay off debts. Challenging the impact of gang violence and protecting young women and men is a regional and local priority. Among our local efforts is a Southwark school-based, peer-led workshop by The Participation People on understanding healthy relationships. Lambeth is developing its response to serious youth violence which will be informed by a public health approach. Helping young people to recognise and avert risky sexual behaviour and relationships is a critical outcome for this strategy.

Online relationships and safety

In the current landscape, young people face a plethora of emerging challenges that are becoming increasingly difficult to navigate. Relationships are now conducted with a growing online element, exposing children to new risks such as revenge porn and increasing opportunities for online grooming and exploitation. It is therefore critical that young people have the knowledge and the skills to operate safely online.

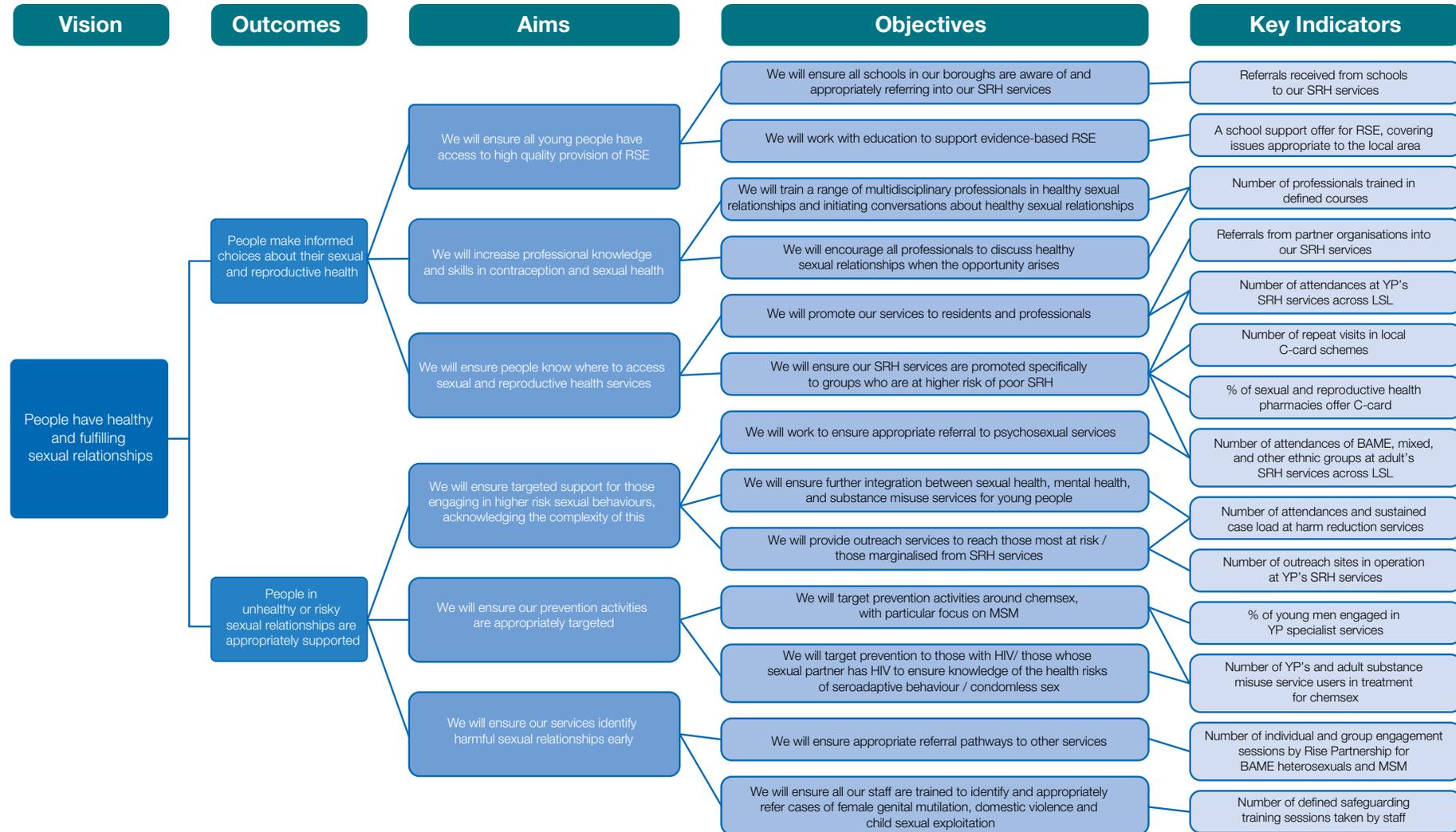


Relationships are now conducted with a growing online element, exposing children and young people to new risks such as revenge porn and increasing opportunities for online grooming and exploitation



Healthy and fulfilling sexual relationships: what we want to achieve by 2024

The figure below sets out our vision for healthy sexual relationships in LSL, how we will work together to achieve this vision, and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, our boroughs will have an annual delivery plan which will set out shared and borough-specific actions needed to achieve these objectives in a given year.





5.2 Good reproductive health across the life course

What do we mean by ‘good reproductive health across the life course’?

Our ambition is for all people – but especially women and people with uteri – in our boroughs to have the skills, knowledge and access to services that allow them to effectively manage their fertility and reproductive health.

The reproductive life course – starting at menarche and continuing through to menopause and beyond – is important for all, although the relative importance of reproductive issues varies between individuals and at different stages of life. Reproductive experiences and choices are embedded in and influenced by societal constructs, with societal and cultural expectations of what is ‘normal’ affecting how people, and especially women, make their reproductive decisions. There is a need for conversations about reproductive health to be normalised, allowing frank and open discussion, and enabling those who need additional support to reach it.

We recognise the importance of reproductive health on overall wellbeing, and that for many people, this includes the capability to have children and the freedom to decide if and when to do so. The birth rate is declining, as people delay their first pregnancy. This strategy does not focus on conception

support, but on the wider factors affecting reproductive health. These include: knowledge and understanding of fertility, reproductive health and contraceptive options; access to high quality contraception and termination services that meet the needs of all and the uptake of screening, vaccination and testing programmes, which affect reproductive health in the long term, including if, when and how women choose to become pregnant. Professionals’ knowledge, beliefs and attitudes are as important as those of individuals in improving reproductive health.

This chapter has clear links with our other ambitions in this strategy. Being in a healthy and fulfilling relationship and having access to high quality STI testing and treatment impacts on reproductive wellbeing. Thus, our ambitions in these other chapters will also contribute to delivering good reproductive health across the life course.

Introduction

Background and policy context

Nationally, the integration of sexual and reproductive health services under the umbrella of ‘sexual health services’ has been a positive development in terms of improving access to a wider range of services and reducing stigma.

However, it has meant that the big issue of STIs has often dominated the national conversation around sexual health, as well as local and regional strategies. We want to redress this balance and focus on improving reproductive wellbeing in LSL.

Reproductive health is an important component of overall health across the life course, and can impact wellbeing at any stage, as well as the wellbeing of children. Consequences of poor reproductive health exacerbate inequalities in health, education and socio-economic status (and conversely, these factors also impact on reproductive health). In the UK, more than three-quarters of women of reproductive age want to either avoid or achieve pregnancy at any given time. Overall, women spend approximately 30 years of life avoiding unwanted pregnancy and therefore require effective contraceptive methods. In Britain, nearly half of pregnancies (45%) are unplanned and one in 60 women (1.5%) experiences an unplanned pregnancy in a year. Unplanned pregnancies are also a missed opportunity to optimise pre-pregnancy health for both woman and child.

Unplanned pregnancies leading to maternity may have long-term costs not only in health terms, but also to local authority housing, education, and social care, and may have additional unintended consequences for the family itself. For example, teenage pregnancies may, in some cases, be costly to both mother and child in regards to the



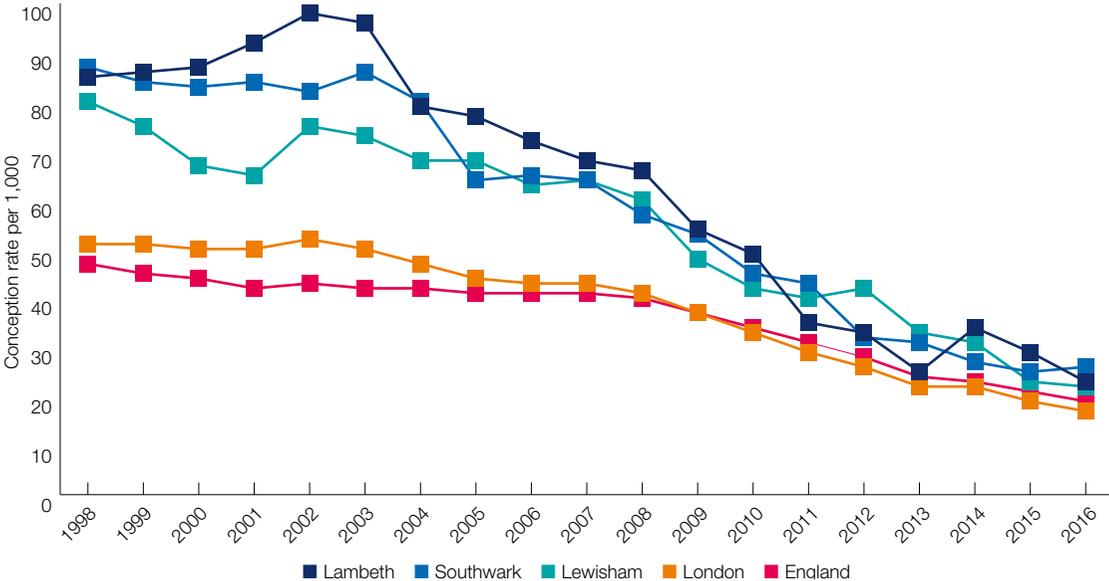
opportunity to complete education, earning potential and future employment. In the whole population, risk factors for unplanned pregnancy include lower educational attainment, younger age, substance misuse and smoking. Some BME groups have higher rates of abortion (an indicator for unwanted pregnancy), and this is the case for black African and Caribbean women in LSL.

Some unplanned pregnancies, regardless of the age of the mother, will become wanted. However, a proportion will result in termination. Access to safe, legal abortion, free from harassment, has a critical role in protecting the reproductive health of women who choose to end a pregnancy.

Terminating a pregnancy has direct costs to the health economy: in 2010, approximately £143m was spent on abortions in England (the number and rate of abortion has stayed approximately stable since). In contrast, publicly-funded contraception to prevent unintended pregnancy is extremely cost-effective and is one of the highest value public health interventions. While NHS and local authority spending on contraception totalled £246.1m in 2016, new analyses in England suggest that every £1 invested in contraception saves these public services £4.64 over a four year period, and £9.00 over 10 years. Benefits include savings that result from avoiding unwanted pregnancies, including healthcare costs (for example birth costs, abortion costs, miscarriage costs and ongoing child health care costs) and non-healthcare costs (such as education costs, welfare costs, children in care costs). Good reproductive health therefore not only an essential contributor to good overall health and wellbeing, but also yields savings for public services.

In 2013, the Government published a national 'Framework for Sexual Health Improvement in England', which recognised the need to ensure that people have access to the full range of contraception, that women with unwanted

Under 18 conception rate per 1,000 in LSL, 1998–2016



PHE (2018) Sexual and Reproductive Health Profiles

The graph above illustrates a 70% decline in the number of teenage conceptions in LSL since 1998. Numbers remain small, but rates are higher than London and England averages.



pregnancies are supported to make timely, informed decisions, and that local areas develop innovative, value for money interventions and services to respond to needs. The 2018 PHE guidance ‘*Sexual and reproductive health and HIV: Applying All Our Health*’ also emphasised the importance of facilitating easy access to the full range of contraceptive methods in a range of accessible settings. These ambitions remain central to local areas’ reproductive health improvement strategies.

The LGA / PHE Teenage Pregnancy Prevention Framework (2018) was published to help local areas address and reduce teenage pregnancy, and suggested key factors for a successful, whole-systems strategy. This approach was first outlined in the 2016 report ‘*Good progress but more to do: teenage pregnancy and young parents*’, by the same authors. This report highlighted the health inequalities experienced by young parents and their children and included best practice case studies. It remains a valuable resource to date.

In June 2018, PHE published the beginnings of a new 5-year framework for reproductive health improvement. This included a survey of women’s views on reproductive health (the key findings of which are captured in sections below) and a professional consensus statement on six key pillars of reproductive health, as follows:

1. Positive approach: The opportunity for reproductive health and access to reproductive healthcare, to be free from stigma and embarrassment.
2. Knowledge and Resilience: The ability to make informed choices and exercise freedom of expression in all aspects of reproductive health.
3. Free from violence and coercion: The ability to form enjoyable relationships whilst not fearing or experiencing any form of power imbalance or intimidation.

4. Proportionate universalism: The ability to optimise reproductive health, and social and psychological well-being through support and care that is proportionate to need.
5. User-centred: The ability to participate effectively and at every level in decisions that affect reproductive lives.
6. Wider determinants: The opportunity to experience good reproductive health and ability to access reproductive healthcare when needed free from the wider factors that directly and indirectly impact on reproductive well-being.

Good reproductive health in LSL is thus reflective of a comprehensive, prevention-centred, whole-system approach to reproductive wellbeing that offers support from adolescence through to older age, targeting those most at risk in order to reduce inequalities. At any reproductive stage, individuals should have the ability and freedom to make choices about the aspects of their reproductive lives, and be able to access a range of contraceptive methods and other reproductive support services. Likewise, services need to be arranged to facilitate easy access to the full range of reproductive health services to ensure people continue to enjoy safe and healthy sexual lives.

Despite the availability of guidance, improvement frameworks and quality local services, challenges remain in preventing unwanted pregnancy and in ensuring knowledge, uptake and access to contraceptive options across LSL.

Current picture

A declining birth rate and older age of first maternity

There were a total of 13,433 births to women living in LSL in 2016. The general fertility rate (measured as the birth rate) in LSL has been declining since at least 2012. The birth rate is lower in Lambeth and Southwark than it is in Lewisham: in 2016 the birth rate in Lambeth was 47.4 births

£4.64

The amount saved by public services for every £1 invested in contraception



Women are choosing to have children increasingly later in life



per 1,000 women aged 15 to 44 years, compared to a rate of 54.3 per 1,000 in Southwark. Lewisham (63.7 per 1,000) had a similar rate to London (63.6) and England (62.5). This is linked to women choosing to delay their first pregnancy.

The mean age of mothers having their first live child has increased over time nationally. In 2016, the mean age of first time mothers in England was 28.8 years and has been increasing by 0.2 years annually for the previous ten years. A similar pattern can be seen in LSL; hospital admission records show that in 2016/17, the proportion of deliveries to women aged 35 years or above was 33%, 31% and 32% respectively. Between 2014/15 and 2016/17, there has been an increase in the proportion of deliveries to women aged 35 years or above by 2.2% in Lambeth, 1.9% in Southwark and 2.3% in Lewisham suggesting that more women are having children at a later age.

Prevention of HPV

The national human papillomavirus (HPV) immunisation programme was introduced to protect women against the main causes of cervical cancer, which in turn impacts on reproductive health. The national target in England is for 95% of all Year 8 girls to have received at least one dose of the vaccine. LSL did not meet this target in 2016/17, with 90% coverage in Lambeth, 86% in Southwark and 82% in Lewisham. The London coverage rate was 83.8%. There has been a slight improvement in LSL in recent years, although Lewisham remains consistently behind Lambeth and Southwark.

As of July 2018, the Joint Committee on Vaccination and Immunisation recommended HPV vaccination be extended to boys aged 12–13. However, the specifics of this programme remain unknown. Trans men and women, and MSM are eligible for the HPV vaccine up to and including age 45 through sexual health clinics.

Knowledge and attitudes toward contraception

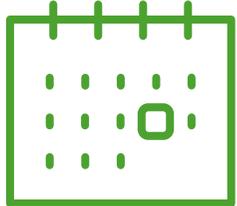
Contraception is important for all women of reproductive age who have sex with men as it enables them to effectively control if and when they choose to become pregnant. If women do want to become pregnant at some stage, contraception also provides a longer opportunity to address health issues in advance of the pregnancy, leading to better health outcomes for both mother and child. Contraception is not purely a woman’s responsibility, but women need to be empowered to make conscious decisions about their reproductive life, and have the knowledge, skills and access to services to allow them to do so.

Relationships and sex education (RSE) in schools provides an opportunity to educate children and young people about safer sex, types of contraception and local support services in order to prevent unintended pregnancy and the transmission of STIs. However, school-based surveys in LSL have revealed poor knowledge amongst young people about where to obtain free condoms, and this is reflected in rates showing that LSL young people experience STIs more than the London and England average. This suggests a missed opportunity to embed discussions of effective methods of contraception (and where to obtain them) when educating children and young people as part of RSE to promote good overall sexual and reproductive health.

Poor knowledge of contraceptive options continues through to adulthood, and is perhaps reflected in high rates of user-dependent methods (UDM) such as the contraceptive pill and condoms. Recent focus groups with women across LSL demonstrated poor knowledge of LARC methods in older women of reproductive age (range: 25–45 years), and while younger women (18–24 years) knew about a wider range of contraceptive methods including LARC, there were misconceptions about their use and safety. We acknowledged that our population is fluid; young people that



Women in LSL are having fewer children since at least 2012



30
The number of years women spend avoiding unwanted pregnancy and therefore requiring effective contraceptive methods



go to school in our area may not stay in our area as adults, and vice versa. However, there is a clear need for improved education as part of RSE in schools, in addition to public awareness campaigns. RSE was anticipated to be made statutory as of September 2019 but this has been delayed until September 2020.

Access to and choice of contraception

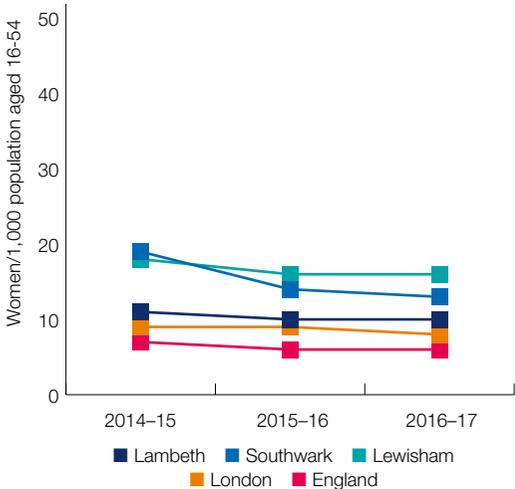
LARC methods are the most effective contraceptives available. Despite this, their use is much lower than UDM. Of women attending SRH services, LSL women are more likely than the national average to choose UDM such as the contraceptive pill or condoms, and this is highest in Lewisham.

Rates of LARC prescription in general practice across LSL are lower compared to prescriptions at sexual and reproductive (SRH) services, with the exception of Lambeth. This is the opposite to England and likely reflects the accessibility of SRH services in our boroughs (and in London in general). Lambeth has better-developed sexual health provision in general practice, and this is reflected in these rates. However, LARC prescribing rates in SRH across LSL are now lower than London. Compared to Lambeth and Lewisham, Southwark rates of GP-prescribed LARC have declined substantially, compared to stable rates of prescription from SRH.

Common issues in general practice preventing the provision of a LARC service include training and difficulty maintaining competency, general practice capacity (longer appointment time, availability of trained staff and chaperones, suitable rooms), and financial incentives (the opportunity cost of providing a different service in the same time).

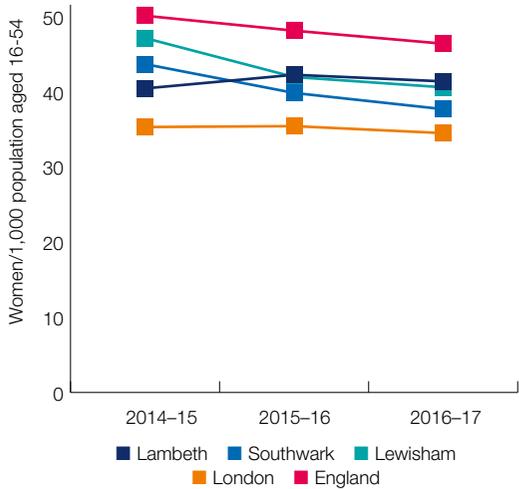
Rates of emergency contraception usage are higher in LSL than England and London, and only in Lewisham have rates of EHC fallen in the past three years. Repeat use of EHC is a significant issue in LSL. 80% of women using EHC

Women provided emergency contraceptives by SRH services per 1,000 population aged 16–54, 2014–15 to 2016–17



NHS Digital (2017) Sexual and Reproductive Health Services, England – 2016-17

Total prescribed LARC per 1,000 in LSL, 2014–16



NHS Digital (2017) Sexual and Reproductive Health Services, England – 2016-17

While rates of prescribed LARC (in SRH settings and in general practice) in LSL are higher than the London average, they are lower than the national average (and rates of prescribing in primary care are particularly low). Rates of EC use in LSL are higher than the London and national averages.



LARC methods are the most effective contraceptives available. Despite this, their use is much lower than UDM



in Lambeth and Southwark pharmacies in 2016/17 self-declared previous use; half of these had used EHC in the last six months (Southwark). This is a strong indicator of unmet reproductive health needs and a major missed opportunity for intervention.

Women who are not using existing contraceptive services should receive opportunistic contraceptive advice when they are in contact with health services for other issues or conditions, for example, after taking emergency contraception, after having an abortion or after having a baby.

Teenage conceptions

Since 1998, LSL has achieved dramatic decreases in teenage conceptions, however, the under-18 conception rate remains higher than in London and England. Teenage pregnancy is more likely to end in abortion than other age groups, and approximately two-thirds of under-18 conceptions in LSL are terminated. The rate of under-18 conception is consistently higher across LSL compared to London and England, which reflects Lambeth's higher starting point and prevalence of risk factors, and which may suggest an unmet need in contraception care. Moreover, this suggests a lack of awareness of, or confidence in accessing other more effective methods of contraception. LARC methods do not depend on daily concordance and have been proven more effective than oral contraception at only one year of use. Despite these benefits, uptake remains low in the UK and in LSL. This suggests that barriers remain in communicating the benefits of LARC or in ensuring that women of reproductive age have easy access to the full range of contraception, including LARC.

Listening to local women

Focus groups on contraception and reproductive health undertaken with a diverse sample of women across LSL in 2018 supplemented what data have told us about the needs of local women, with the following key findings.

Views on contraception

- Women are anxious about unwanted pregnancies and want to be confident in their contraception choices so that they can fully enjoy sex. They also want to know that the contraceptive they use will not have a detrimental impact on their physical and emotional wellbeing now and in the future.
- While they know that contraception is there for them, they have difficulty accessing services when they need it.
- Fairly low level of knowledge and low confidence, combined with false beliefs are reducing their perceived choices.
- Many women feel they aren't always getting the full picture from professionals, and feel the way professional advice is delivered to them can be 'cold' and/or judgemental, failing to take in to account feelings and past experiences.
- Social taboos, stigma and fear of shame and embarrassment are major barriers to accessing contraception services.

The services women want

- Women who don't currently have their contraceptive needs met can be broadly characterised into two main groups:
 - Transactional: Women who know what contraception they want, but are having trouble accessing this;
 - Unsure: Women who don't know which contraception they want or aren't actively seeking contraception, who may need help to decide.
- Services need to be more tailored to meet the needs of all of these women.
- Women described a need for 'whole woman' focused services that consider their wider needs around sex and reproductive health, that helps women feel positive and empowered though a discrete, non-judgemental and comfortable service.
- Women were in agreement about needing more choice in accessing contraception, e.g. whether she has to attend in person, or can access the service remotely through online/phone access and home or local pharmacy deliveries of contraception.



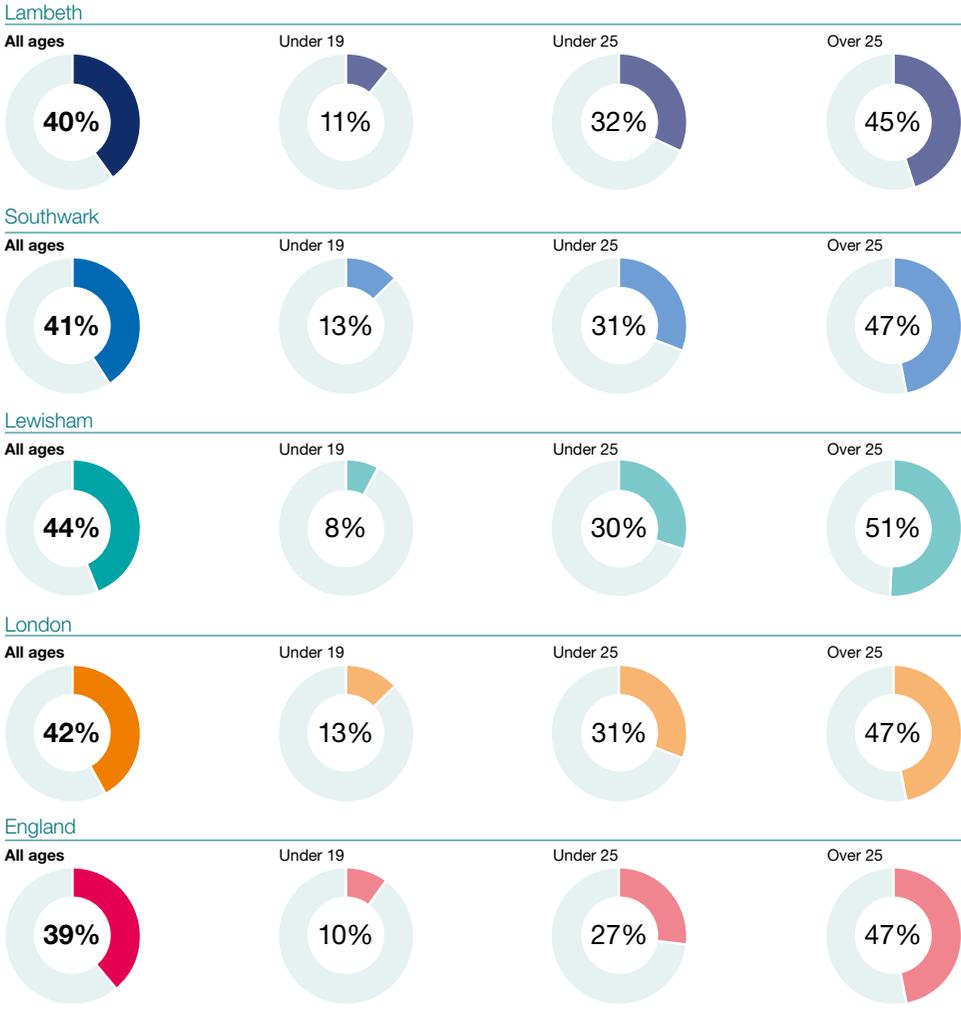
Abortion

Across the life course, the rate of abortion can be viewed as an indicator of a lack of access to contraception services and advice, as well as problems with individual use of contraceptive methods. Analysis suggests there are inequalities in the abortion rates in women aged 15–44 in LSL, with the highest rates among women identifying as black African or Caribbean.

Across LSL, over 40% of abortions in 2017 were among women who had previously had at least one abortion ('subsequent abortions'). This is higher than the England average, and highest in Lewisham (44%). Subsequent abortions are also not distributed equally in the population, with black African and Caribbean women again disproportionately represented. This indicates a lack of access to and/or use of appropriate contraception. New data on subsequent abortions in women aged under 19 years show that the rate of subsequent abortion in this age group declined slightly between 2016 and 2017 (in LSL, London and England), but rates are still too high given their younger age and missed opportunities for intervention. In 2017, 8% of Lewisham women, 11% of Lambeth women and 13% of Southwark women aged under 19 who had an abortion had also had a previous abortion in that year. Rates of subsequent abortion specifically in those over-19 are not available.

The time immediately following abortion is an important period for contraceptive intervention, particularly LARC methods. However, LARC uptake in abortion services in LSL has remained below 45% since 2014/15, and has now declined to around 20%. This may be due to the increase in women choosing early medical abortions (EMAs, under 10 weeks), as opposed to surgical abortion or a later medical abortion. EMAs do not require clinical follow-up and therefore these women may miss out on the opportunity to discuss LARC methods post-abortion. In 2017–18, local clinic data

Proportion of women terminating pregnancy who have had one or more previous abortions, by age, 2017



DHSC (2018) Abortion statistics for England and Wales: 2017

The chance that a woman has had a previous abortion increases with age. Rates of previous abortion in LSL are similar to London, but higher than England. Younger women (under 19) in Southwark are more likely to have had a previous abortion than those in Lambeth or Lewisham, but in older women (over 25), the rate of previous abortion is highest in Lewisham.



for LSL women indicate that 61% of abortions at BPAS and 64% of abortions at MSI were EMAs, slightly higher than the national rate (60%), and trends indicate that EMA uptake rates are expected to increase. Exploring other methods of on-going contraception (e.g. OC) while undergoing termination may serve as a bridging method until LARC is appropriate.

Admissions related to poor reproductive health

Pelvic inflammatory disease (PID) refers to infection and inflammation of the upper female genital tract which may lead to serious complications such as ectopic pregnancy and tubal factor infertility. About one-quarter of cases are caused by untreated STIs. Admissions for PID have been consistently higher in Lewisham than the other LSL boroughs and remains above the national average, but have declined since 2012/13 – by contrast, rates in Southwark and Lambeth have increased (but remain below the national average).

Ectopic pregnancy is a serious condition that usually results in hospital admission. Rates of admission have fluctuated over time. In 2015/16, Southwark had the third-highest rate (140 per 100,000) of ectopic pregnancy in England. All three boroughs’ admission rate for ectopic pregnancy is above the national average, and Lewisham is also above the London rate.

High rates of both PID and ectopic pregnancy are a consequence of high rates of STIs locally.

Achievements since the last strategy and ongoing challenges

Achievements since the last strategy

The following have been the most notable achievements in reproductive health in LSL since the publication of our last sexual health strategy:

- A reduction in the number of teenage mothers and teenage pregnancies leading to birth. This has been underpinned by:
 - An ongoing and sustained reduction in teenage pregnancy, both in young women aged under 18 and under 16
 - Of teenage conceptions that have occurred, an increasing majority have not led to maternity
 - Improved access to emergency contraception and termination services
 - The roll-out of the C-Card scheme across the boroughs (though we cannot say that this has had a linear impact on teenage conception rates)
- A slight decline in the rate of abortion in women of all ages
- A slight increase in the proportion of women choosing LARC at sexual health centres
- An increase in the coverage rates for the HPV vaccine for teenage girls, protecting them from future HPV infection.
- The HPV vaccine has now been extended to MSM opportunistically (during 2018), to prevent infection leading to HPV-associated cancers, including anal, throat and penile cancer. However, heterosexual males are currently unable to access HPV vaccination on the NHS.



Women have told us they want to be confident in and understand the impact of their contraception choices, so that they can fully enjoy sex



However, despite these achievements, significant challenges remain. There are still a number of poorer outcomes in reproductive health in LSL, which are driven by ongoing and emerging issues described in this section.

Ongoing challenges

General access to contraception

Since our 2014–17 strategy, services have regularly been at full capacity. Wider system pressures on general practice have meant that it has been reportedly increasingly difficult for many people to access their practice, which has had an impact on GPs being able to meet residents’ urgent or ongoing reproductive health needs (e.g. repeat prescriptions, LARC or emergency contraception). More recently, there have been similar pressures on sexual health services, with demand outstripping the number of appointments and walk-in spaces available.

Within LSL, rates of EHC usage are highest in Southwark and local surveys have shown that there is already considerable demand for sexual health services, with patients being turned away from busy clinics, and online services also regularly at capacity. As may be expected, demand for emergency contraception is high and the rate of abortion in LSL (despite a declining trend) remains high and is above the national average. Furthermore, the rate of women taking up LARC following their attendance at an abortion clinic has declined in the last 5 years in LSL, which may lead to ongoing unmet reproductive health needs.

We are operating within the constraints of reducing public health budgets, but we continue to innovate to meet increasing demand. To improve access to reproductive health services, we have moved to provide support in new and innovative ways. New models of practice include leveraging the accessibility, ease and anonymity of pharmacies, and increasingly incorporating an online

aspect to our services (for low risk individuals). The condom distribution scheme Come Correct has been popular locally and has capitalised on non-traditional settings (e.g. leisure centres and libraries) to distribute condoms to young people. Our ambitions and ongoing innovations are outlined in more detail in the accompanying action plans.

Inequalities

Like overall health and sexual health, good reproductive health is not equally distributed in the population. If the need for abortion is used as a proxy measure for not having reproductive needs met (abortion being the last intervention to prevent an unwanted maternity), black women in LSL have the poorest reproductive health. The rate of abortion is higher in LSL amongst women describing themselves as of black Caribbean and black African ethnicities. Nationally, women that have sought abortion on more than one occasion are more likely (than those who have had one abortion) to be black, have left school at an earlier age, be living in rented accommodation, report an earlier age at first sexual experience, be less likely to have used a reliable method of contraception at sexual debut and report a greater number of sexual partners.

Not all services work for all people, so a range of responsive universal and targeted services are needed. In developing new and improving reproductive health services, and following on from recent focus groups with local women, we need to understand the issues and barriers around use of contraception, and will be working alongside young, black women in LSL in particular to understand their specific needs and co-design services and programmes.

We also know that there is a growing Latin American population in our boroughs, and we will be working to better understand their sexual and reproductive health needs and tailor our services appropriately.



The use of e-services in sexual health is growing in popularity



The rate of abortion is higher in LSL amongst women of black Caribbean and black African ethnicities



Emerging issues and trends

E-services for contraception

The use of e-services in sexual health is growing in popularity. E-services to this point have primarily been for STI testing and treatment, and complement traditional sexual health clinics by enabling appropriate low risk (asymptomatic and non-vulnerable) individuals to self-sample through the usage of kits ordered online and posted to an address of choice. In LSL, women accounted for just under half of the patients attending sexual health clinics that were offered and took up the offer of online instead of clinic testing. While it is clinically appropriate for low risk women to use e-services, this has removed opportunistic contraception consultations in these patients. Service-level data from sexual health clinics indicate a reduction in contraception provision since the channel shift to the e-service was implemented, and we intend to explore this further. It is essential that women using online STI services receive appropriate messaging around contraception, and that there are a range of services in place to meet the contraceptive needs of women in LSL. Furthermore, we will endeavour to ensure that vulnerable people will always be seen face-to-face, as appropriate to their needs.

A pilot of online oral contraception in Lambeth and Southwark proved popular, and there are online contraception options in the commercial market. These developments will feed into how we will meet the vision of this strategy, allowing us to better respond to local needs in a cost effective and modern way.

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Fertility awareness apps

A number of app-based methods supporting ‘natural family planning’ (fertility awareness) have emerged in recent years. These support women in monitoring and recording different fertility signals during their menstrual cycle to estimate when they are likely to get pregnant, and take appropriate action to avoid this if relevant (e.g. abstaining from sex, or using contraception such as condoms). Some of these apps have been promoted as being as effective as the oral contraceptive pill with perfect use (but remain untested in independent clinical trials), and like many user dependent methods, perfect use is uncommon – 7 in 100 women had an unintended pregnancy in a year of typical use of one of the most popular fertility awareness apps. For comparison, condoms are 82% effective when used typically (98% when used perfectly) and the combined pill is 91% effective when used typically (99% when used perfectly). Fertility awareness methods are also affected by factors such as illness, stress, alcohol and travel. Non-user dependent methods remain the most effective form of contraception, and condoms protect against STIs.

Anti-choice protests at abortion clinics

People have a right to access safe and legal abortion, free from harassment. This has a critical role in protecting the reproductive health of women who choose to end a pregnancy. Anti-choice protests at abortion clinics in our boroughs and across London are unwelcome and actively harmful to local people. LSL will uphold the rights of local people to access abortion-related care free from harassment as a key tenet of promoting reproductive health.

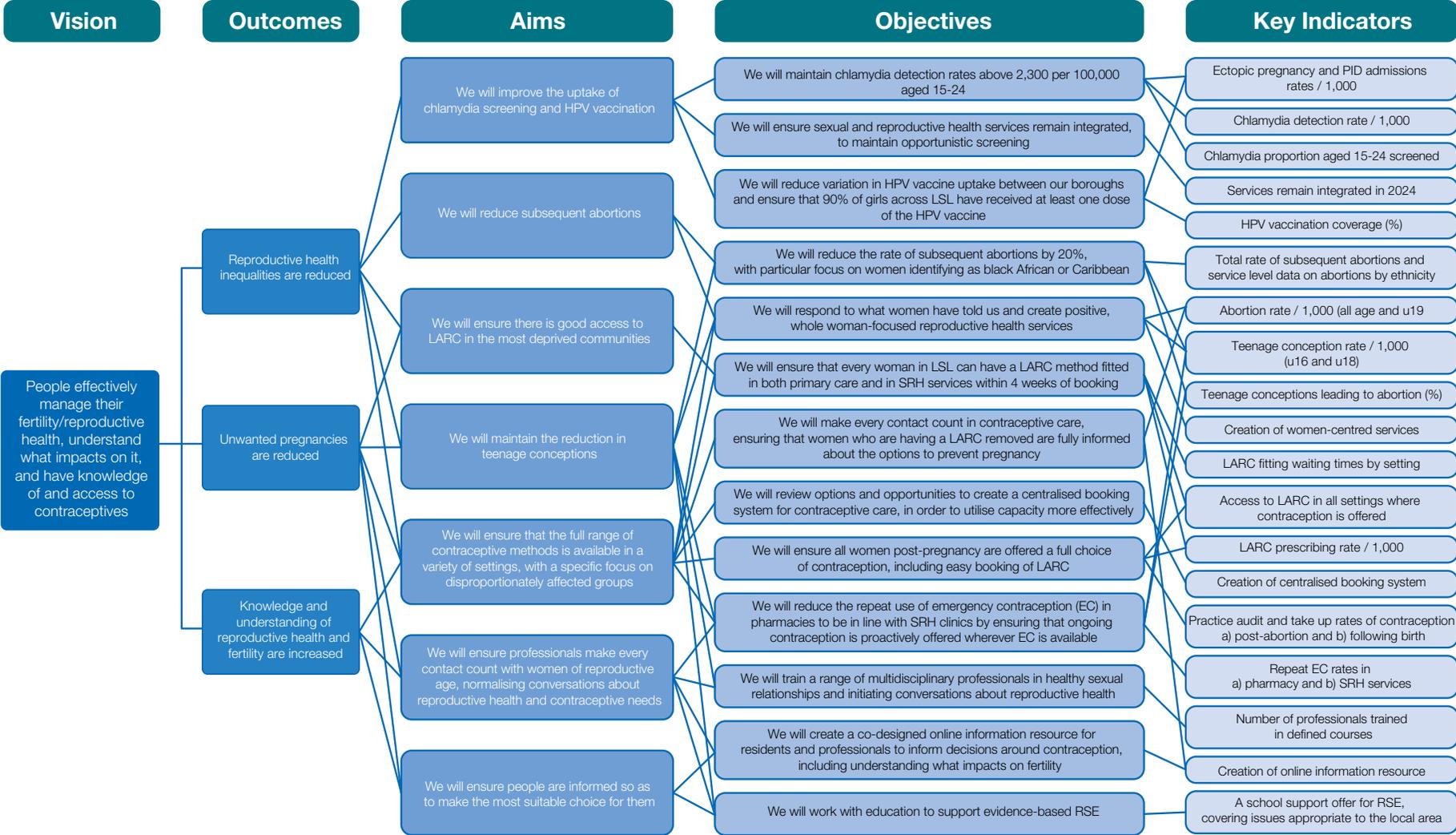


New models of practice include leveraging the accessibility, ease and anonymity of pharmacies, and increasingly incorporating an online aspect to our services (for low risk individuals)



Good reproductive health across the life course: what we want to achieve by 2024

The figure below sets out our vision for reproductive health in LSL, how we will work together to achieve this vision, and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, our boroughs will have an annual delivery plan which will set out the shared and borough-specific actions needed to achieve these objectives in a given year.



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5.3 High quality and innovative STI testing and treatment

What do we mean by ‘high quality and innovative STI testing and treatment’?

Early access to comprehensive high quality STI testing and treatment services helps to reduce transmission, trace and treat sexual partners, prevent repeat infections and reduce inequalities in sexual and reproductive health.

We are fortunate in LSL to have a number of world-class sexual health centres. Building upon this, we will focus on ensuring quality across the totality of our system, from prevention to testing, treatment and partner management. We believe that this will ensure the best use of capacity within the local sexual health system and support the reduction of the burden of STIs, particularly in young people, MSM and black and other minority ethnic communities unequally affected. We see an opportunity to strengthen the links between sexual health services and education, prevention and promotion activities.

Our sexual health services have a history of innovation: from the integration of sexual and reproductive health provision, to the development of online services. We want to continue to support and foster further cross-sector innovation to meet our dual challenge of ensuring a financially sustainable system and changing the trajectory of STIs in our population.

Introduction

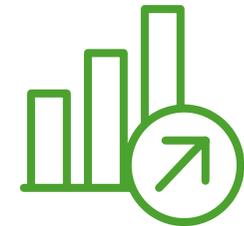
Background and policy context

LSL has some of the highest rates of STIs in England. In 2017, Lambeth had the highest rate of new STI diagnoses nationally, followed by Southwark in third, with Lewisham 11th. This partly reflects our young, ethnically diverse and mobile populations, but also our local provision of modern and accessible STI testing and treatment.

STIs are a significant contributor to and result of health inequalities. We cannot reduce these inequalities without improving the overall sexual and reproductive health (SRH) of key groups, including young people, MSM and black and minority ethnic groups. LSL residents are predominantly young, with a larger proportion of the population aged 25–34 years. We are also more ethnically diverse than England, with approximately one quarter of LSL residents identifying as Black. Furthermore, Lambeth and Southwark have the second and third largest lesbian, gay and bisexual communities in England.

In the five years since the responsibility for commissioning sexual health services transferred to local government, demand for sexual health services and STI testing has increased against a backdrop of reducing Public Health Grants to fund services. This has driven a need for innovation to ensure our services remain fiscally sustainable.

LSL have historically been leaders in innovative SRH services in London. We pioneered online STI testing for asymptomatic patients, and provided proof of concept for e-services as a core part of a cost-effective sexual health system. This approach has since been adopted across London (‘Sexual Health London’). Although e-services primarily aim to create capacity at SRH clinics by targeting asymptomatic patients, they may be attractive to people who feel uncomfortable accessing SRH services, thereby improving testing accessibility.



In the five years since the responsibility for commissioning sexual health services transferred to local government, demand for sexual health services and STI testing has increased



We pioneered online STI testing for asymptomatic patients and provided proof of concept for e-services; this approach has now been adopted across London



Condom use remains a primary method of preventing STI acquisition and transmission. The pan-London condom distribution scheme, Come Correct, is delivered by Brook across LSL and provides free condoms and sexual health information to young people under 25 who hold a 'c-card'. C-card schemes for condom distribution were evaluated nationally and found to be successful in engaging young people. Increasing numbers of repeat users compared to new registrations suggest the scheme is popular and acceptable. These schemes are particularly important in reaching young men, who are less likely to visit their GP or specialist sexual health clinics for contraceptives and may otherwise miss out on SRH advice.

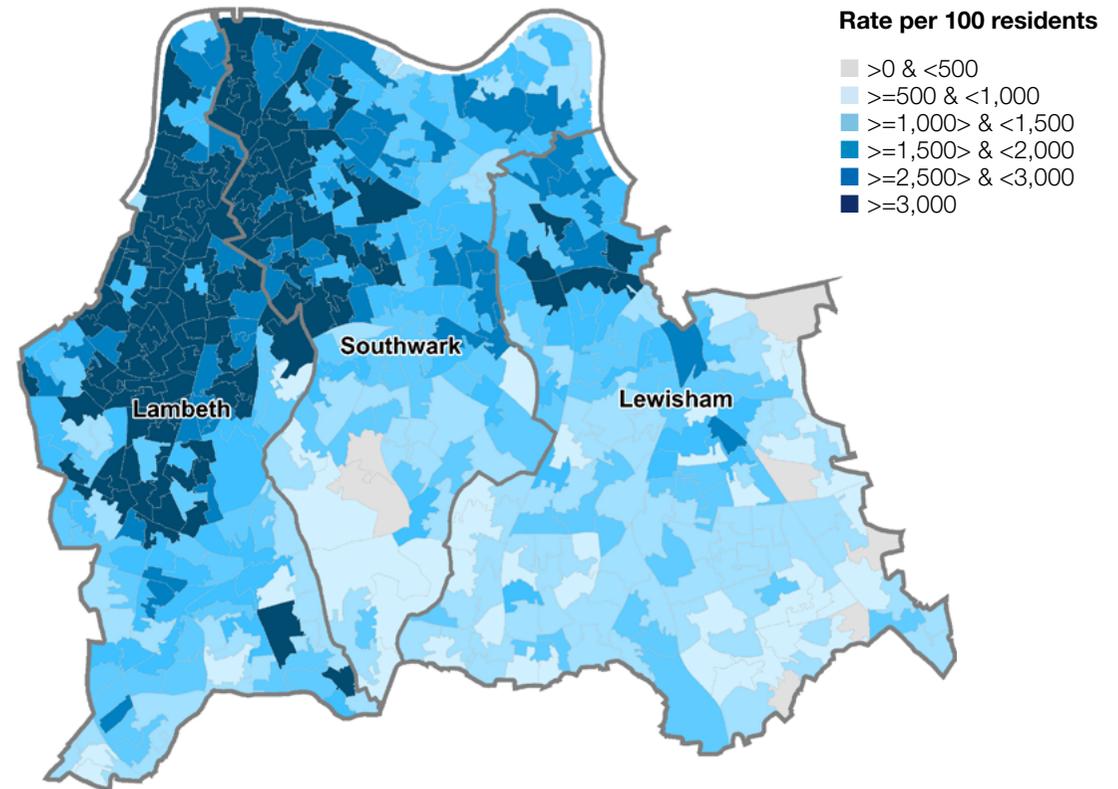
Free condoms are also a core component of the London HIV Prevention Programme, Do It London, of which LSL are major contributors. This element of the programme provides condoms to MSM, primarily in gay venues. Condom outreach to MSM will remain central to a health promotion strategy to reduce STIs alongside PrEP for HIV prevention in the coming years.

The open access nature of services means we have to collaborate across London and enable innovation to meet the diverse needs of our local populations, building on the work of the London Sexual Health Transformation Programme.

Current picture

In 2017, just over 22,000 new STIs were diagnosed across LSL. STIs are unequally distributed within the population and disproportionately affect young people, MSM and some black and minority ethnic populations. Across LSL, there is a strong correlation between areas of deprivation and rates of STIs, highlighting transmission within geographically connected sexual networks and how this contributes to overall health inequalities.

Diagnosis rate of new sexually transmitted infections across LSL, 2017



PHE (2018) HIV and STI web portal (GUMCADv2)

This map illustrates that new diagnoses of STIs are not evenly distributed across LSL, with rates particularly high in northern and central Lambeth, north-west Southwark and north Lewisham. However, lower diagnosis rates in some communities may reflect lower levels of access rather than lower levels of need.



Trends in STI diagnoses are multifactorial and reflect a combination of sexual behaviours, service accessibility and use, diagnostic techniques and surveillance systems. Lambeth, Southwark and Lewisham have historically had some of the highest rates of STIs and HIV nationally. This partly reflects local provision of modern and accessible STI testing and treatment services but also our young, ethnically diverse and mobile populations.

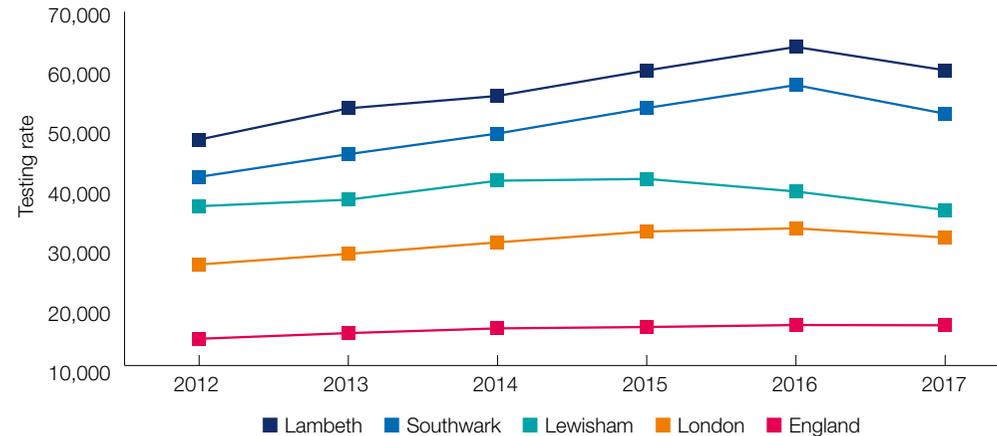
Relationships and sex education (RSE) in schools provides an opportunity to educate children and young people early in life about safer sex, types of contraception and local services, in order to prevent the transmission of STIs. However, school-based surveys in LSL have revealed poor knowledge amongst young people about where to obtain free condoms. LSL young people also experience STIs more than the London and England average. This suggests a missed opportunity to embed discussions of where to obtain condoms, and their use in preventing STIs when educating children and young people as part of RSE to promote good overall sexual and reproductive health.

Many STIs such as trichomoniasis, shigella and hepatitis remain a burden and the cause of considerable activity in sexual health clinics. However, this strategy will largely focus on the five most commonly diagnosed STIs in LSL: chlamydia, gonorrhoea, syphilis, genital warts and herpes.

Chlamydia

Prevalence of chlamydia in the general population is low and it is likely that many infections are undiagnosed and untreated. About 10% of untreated infections will result in reproductive health complications. Of all chlamydia diagnoses made across LSL in 2016, 61% of these cases were in men and, while chlamydia is more prevalent among men across the life course, the rate among young women (aged 15–19 years) is approximately double that for men. While the chlamydia detection rate across all three boroughs

STI testing rate (excluding chlamydia in under 25 year olds) per 100,000, 2012–17



PHE (2018) Sexual and Reproductive Health Profiles

Rates of new STIs per 100,000 population, 2012–17



PHE (2018) Sexual and Reproductive Health Profiles

Testing rates across LSL are consistently above levels in London and England, substantially so in the case of Lambeth and Southwark (though declined slightly in 2017). The rise in testing rates in Lambeth and Southwark after 2014 may be attributable to the widespread introduction of online STI self-testing. The rates of diagnosed STIs have been declining in recent years across LSL, despite stable rates in London and England.



exceeds the recommended rate of 2,300 diagnosis per 100,000 people aged 15–24 years, it has fallen since 2014 and continues on a downward trend. The reasons for this reduction need to be understood. Increasing the screening rate overall and in young men is a priority.

Gonorrhoea and syphilis

Gonorrhoea is the second most commonly diagnosed bacterial STI, however, its prevalence within the general population is low. Moreover, due to its relatively short period of infectiousness, gonorrhoea is concentrated within groups with higher rates of partner change and partner concurrency. Gonorrhoea infection is a global concern as it has developed resistance to an increasing range of antibiotics and it is estimated that a third of all infections are now resistant to one antibiotic. Gonorrhoea primarily affects men: nine in ten cases in LSL are diagnosed among men, with over three-quarters of those being MSM.

The rate of syphilis diagnosis in Lambeth and Southwark has increased by 103% and 116% respectively since 2008; these are now the highest rates of syphilis nationally. However, this is still considerably lower than the number of Gonorrhoea cases: there were just under 1,000 cases of syphilis in LSL in 2017 compared to over 4,500 cases of Gonorrhoea in the same time period. While rates of syphilis fell from 2015 to 2016, they increased again in 2017 with approximately 850 cases diagnosed. The rate of syphilis diagnosis in Lewisham is similar to London (41 per 100,000) and, while Lewisham has experienced a larger proportional increase since 2008, rates remain at half that of Lambeth and Southwark. Syphilis tends to be associated with high-risk sexual networks.

In Lambeth and Southwark, 90% of syphilis cases in 2017 were in people who identified as gay. This was lower in Lewisham: 78%. Rates by age reveal the greatest burden of syphilis is in the 34–44 years age group. This is significantly

older compared to other STIs but reflects the London age distribution. Small outbreaks of syphilis have occurred in male heterosexual groups. In heterosexual women, cases are disproportionately concentrated among black and minority ethnic women. In London, rates of congenital syphilis remain extremely low due to a comprehensive antenatal screening programme.

Across LSL, a third of all diagnoses occur in the primary stage of infection, a third in the secondary phase, and a third early latent. This is particularly worrying as we know that if left untreated, syphilis can spread to the brain or other parts of the body and cause serious, long-term health problems. Genital sores caused by syphilis also make it easier to transmit and acquire HIV infection sexually. Across London, half of MSM cases of syphilis also have HIV. This is concerning as co-infection with HIV increases the risk of central nervous system complications.

Our proportion of early latent cases of syphilis is higher than the London average and suggests a lack of testing uptake in high-risk groups. There is evidence that people with recurrent syphilis infections play an important role in transmission and may be at higher risk of subsequent infections. SRH services should therefore focus on reaching this high risk population. Increasing testing in high risk MSM groups is another priority as is reducing late syphilis diagnosis and improving partner testing and treatment.

Genital warts

Genital warts are caused by infection with specific subtypes of human papilloma virus (HPV), commonly passed on through condomless sex. Genital warts are the third most commonly diagnosed STI in LSL, with just under 2,000 cases diagnosed in 2017. The majority of these are in heterosexuals. Rates of diagnosis were highest among those aged 20–24 across all three boroughs. There are inequalities in the rate of genital wart acquisition, in particular among



mixed ethnic groups in Lewisham and other ethnic groups in Lambeth. The national HPV immunisation programme was introduced to protect women against HPV, the main cause of cervical cancer. This programme was extended to MSM in April 2018 and is expected to help reduce the incidence of genital warts and other HPV-related illnesses, including anal and other cancers though there may be a lag before benefits are observed in full.

Genital herpes

Rates of genital herpes have been broadly stable since 2012. Among these five most common STIs, genital herpes is the only one in which more women are diagnosed than men. As with genital warts, rates of diagnoses are considerably higher in those aged 20–24 years. In young people aged 15–19 years, the difference in diagnoses rates between the sexes is particularly pronounced.

The majority of genital herpes (83%) cases are diagnosed in people who identify as heterosexual, and most in heterosexual women. Rates of diagnosis across the three boroughs vary by ethnicity, with the highest rates in Lambeth ‘other’ and Lewisham mixed ethnic groups. Asian ethnic groups have the lowest rates of genital herpes across LSL.

Other STIs

While this strategy focuses on chlamydia, gonorrhoea, syphilis, genital warts and genital herpes, the collective burden of other STIs on individual wellbeing and service capacity is important and we must remain agile to emerging diseases. Of particular importance are high risk STIs such as shigella and viral hepatitis, which can be diagnosed and treated in other settings besides sexual health services and for which our services play a vital role in prevention. Shigellosis clusters predominantly associated with sexual transmission in MSM have increased significantly since 2014.

During 2017, there was a Europe-wide outbreak of sexually transmitted hepatitis A virus, with 942 cases in England and Wales alone, primarily affecting MSM in the 25–34 age group. Of these, 414 were from London. Control of the outbreak was confounded by a global hepatitis A virus vaccine shortage and the fragmentation of commissioning responsibilities between NHS England, Public Health England and Local Authorities. As of January 2018, the incident had been de-escalated from enhanced to standard response, however London has been the worst affected region and there will likely be a significant lag-time before diagnoses return to pre-outbreak levels. It remains critical to raise awareness amongst MSM and ensure opportunistic vaccination continues.

Lymphogranuloma venereum (LGV) is a type of chlamydia that infects the lymph node for which surveillance was established in 2004. Diagnoses in LSL peaked in 2014 and have been declining steadily since then, in parallel with chlamydia as a whole. There were 109 diagnoses in LSL in 2017, all of which were in men of predominantly 24–34 years. Despite the decline, it is still vital to maintain a high index of suspicion for LGV and offer asymptomatic testing for HIV-positive MSM as this group is most affected (67.5% of new diagnoses).

Shigella clusters in MSM have increased significantly since 2014, with 1,056 excess male cases reported in London between 2012 and 2016. This population is disproportionately affected by the *S. flexneri* species which causes severe disease. People living with HIV are particularly vulnerable to a severe, invasive form of shigellosis. Despite the risk, PHE has reported extremely low awareness of shigella among MSM.

There was also a significant London-wide excess of male cases of hepatitis B in 2016, explained at least partly by sexual transmission amongst MSM. LSL has consistently

One-third

The proportion of early latent cases of syphilis is higher than the London average and suggests a lack of testing uptake in high-risk groups



While the chlamydia detection rate across all three boroughs exceeds the recommended rate of 2,300 diagnosis per 100,000 people aged 15–24 years, it has fallen since 2014 and continues on a downward trend



had a significantly higher incidence of hepatitis B than the London average: a mean incidence of 2.54 per 100,000 compared to 1.7 per 100,000 in London.

For shigella and hepatitis A and B, SRH services play a crucial role in raising awareness amongst the most at risk populations as well as key preventative activities such as condom distribution and opportunistic vaccination.

With regards to hepatitis C, admissions and mortality in LSL remain higher than regional and national levels, with local data suggesting that MSM may again be disproportionately affected. This indicates a need for SRH services to work closely with substance misuse services to protect the most vulnerable populations.

Although not clinically severe infections, trichomoniasis and molluscum contagiosum together accounted for over 1,000 new diagnoses in LSL in 2016, affecting mainly heterosexual women. Trichomoniasis has been linked to poor outcomes in pregnancy and to increased HIV transmission, therefore warranting prompt treatment in all patients. Molluscum contagiosum is closely linked with the incidence of other STIs and therefore affected patients should undergo full STI testing.

Risk groups

Sexually transmitted infections contribute to health inequalities and some groups are disproportionately affected by STIs.

Young people

Young people have higher rates of STIs, reflecting their higher rates of sexual activity and partner change, and relatively poorer skills in negotiating safer sex. In LSL in 2016, double the proportion of 15–19 year old women were re-infected with an STI compared to women in all age groups.

Men who have sex with men

MSM report higher rates of partner change and partner concurrency and are more likely to belong to sexual networks which facilitate rapid STI transmission. In LSL, 77% of cases of gonorrhoea and approximately 86% of cases of syphilis were in MSM. Seroadaptive behaviours (modification of sexual behavior based on the person's (perceived) HIV status, the (perceived) status of the partner and/or HIV transmission risk by type of sexual interaction) increase exposure to STIs and may account for this group being disproportionately affected. Moreover, recent literature on HIV PrEP has suggested that use is associated with reduced use of condoms. This may further contribute to the increased risk this cohort faces of STI acquisition. The national HPV vaccination programme was extended to MSM in April 2018 and is expected to help reduce the incidence of genital warts and other HPV-related illnesses including cancers, though there may be a lag before benefits are observed in full.

Black and minority ethnic groups

White and black heterosexual women and black and mixed heterosexual men experience a large burden of STI diagnoses. In Lewisham, chlamydia rates are highest in mixed and black ethnicities. Across LSL, there are complex patterns of STI prevalence by ethnic group and gender. The higher rates of STIs in some black and minority ethnic groups are partly explained by the relationship between socio-economic deprivation and ethnicity, but not fully. There is a complex interplay between cultural and behavioural factors, and access to and use of healthcare services.

Progress to date

Achievements since the last strategy

Since our last sexual health strategy, LSL successfully launched a proof of concept model of online testing of



STIs. SH:24 was an innovative method of encouraging asymptomatic individuals seeking STI testing to self-test at home, thus reducing the burden on sexual health clinics and freeing up capacity within the service to treat symptomatic patients. This pilot spurred the now London-wide sexual health e-service, ‘Sexual Health London’ (SHL) to provide online STI testing, which was rolled out in LSL in July 2018.

We have achieved fundamental changes to the way in which we finance sexual health services, to ensure value-for-money and effective commissioning. The previous ‘tariff’ was a flat-rate payment, regardless of intervention type. The integrated sexual health tariff (ISHT) matches payment to the specific costs of an intervention. We acknowledge that despite now meeting the exact costs of an appointment, these new contracts have delivered a significant drop in income for our local trusts, which has contributed to the financial pressures they face. We continue to work closely with our partners to ensure that any service changes will continue to meet the sexual health needs of the population.

Ongoing challenges

LSL have proportionately large groups at higher risk of poor sexual health. Given the prevalence of STIs in our population we need to balance accessible, open-access services with targeted and proactive testing aimed at the most at risk groups (some of whom also access traditional services the least). Recent outbreaks have highlighted that under-testing of certain infections, particularly in MSM, continues to be a challenge.

Sexual and reproductive health services in LSL are at capacity. Fiscal challenges including the reduction of the public health grant have contributed to changes in the way that sexual health services are delivered and commissioners are continuing to innovate to improve the reach and accessibility of our services.

Partner notification of STIs helps to prevent the onward transmission of infections. Our local SRH services actively encourage patients receiving an STI diagnosis to disclose their result to previous partners but this is highly user-dependent. SXT is a local innovation that allows for anonymous online notification of partners. Effective partner notification needs to be built into all parts of the local system.

Emerging issues and trends

PrEP

Pre-exposure prophylaxis has dramatically changed the landscape of HIV prevention. However, PrEP may be associated with a reduction in the use of condoms and an increase in STI acquisition. While these emerging results should not diminish the success of PrEP in preventing HIV transmission, sexual health commissioners and practitioners should be aware of and mitigate against this potential outcome.

Antibiotic resistance

Chlamydia, gonorrhoea and syphilis are three common STIs typically curable by antibiotics. However, over recent years, these STIs have developed a resistance to antibiotic treatment; this is particularly the case with gonorrhoea. In March 2018, the first case of multi-drug resistant gonorrhoea in the UK was identified and the World Health Organisation has warned this infection may soon become untreatable. Local authorities and SRH services must continue to work with PHE and national partners to survey and report any resistant strains, and ensure timely and effective treatment of new cases of STIs in our local population. In the future, the issue of antibiotic resistance may require changes to the practices and working cultures of sexual health professionals.



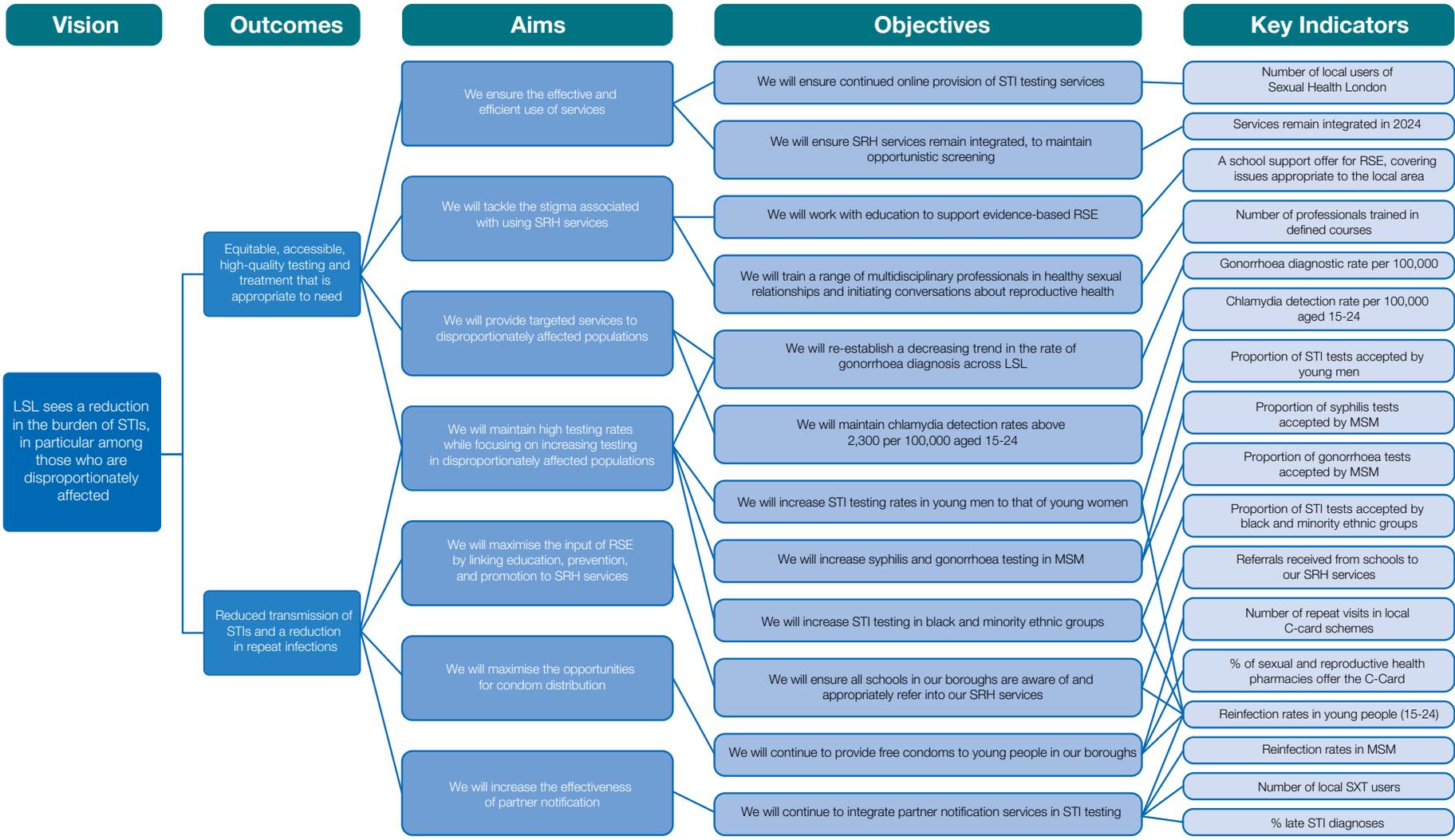
There is a complex interplay between cultural and behavioural factors, as well as access to and use of healthcare services



High quality and innovative STI testing and treatment: what we want to achieve by 2024

The figure below sets out our vision for STI testing and treatment in LSL, how we will work together to achieve this vision and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, our boroughs will have an annual delivery plan which will set out the shared and borough-specific actions needed to achieve these objectives in a given year.

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With advances in treatment, the proportion of people living with HIV who are aged 50 years and over will continue to rise

5.4 Living well with HIV

What do we mean by ‘living well with HIV’?

Our ambition is to prevent the transmission of infection, ensure diagnosis as early as possible and ensure that PLHIV in LSL have the services and support to enable them to live a healthy and fulfilling life.

This means moving towards zero new diagnoses, zero HIV-related stigma and zero deaths related to HIV, in alignment with the Fast Track Cities’ aims. We will provide our populations with services and support that will enable them to live and age well with HIV, and prevent new infections and onward transmission.

Thirty years on from the beginning of the HIV / AIDS crisis in the UK, knowledge and understanding of HIV has increased dramatically, bringing real advances in HIV treatment and prevention. An HIV diagnosis today means living with a long-term condition and HIV is no longer the fatal infection that it was 20 years ago. This strategy reflects these changes, reframing HIV as a long-term condition. However, HIV infection is still frequently regarded as stigmatising and has a prolonged ‘silent’ period during which it often remains undiagnosed. In addition, recruitment and retention in care and treatment is still a critical focus for some of our most at-risk groups.

Encouraging all people to be aware of their HIV status will require a commitment to

ensuring accessible testing opportunities are available through a variety of channels and that people at all risk levels are encouraged to know their status. This will continue to drive the number of new diagnoses and late diagnoses down and contribute towards the goal of zero new transmissions.

With advances in treatment, the proportion of people living with HIV who are aged 50 years and over will continue to rise. To ensure that people are able to both live and age well with HIV, it is recognised that specialist HIV services and primary care will need to work together to provide a holistic care approach, managing HIV together with other chronic health conditions.

Our focus in this chapter is therefore to reinforce our commitment to ensuring access to the medical aspects of tackling HIV including strengthening combined prevention efforts and early treatment. We also commit to better understanding the social aspects of HIV, to eradicating the ongoing stigmatisation of those living with HIV and to tackling the new challenges of an aging population.



Introduction

Background and policy context

HIV remains a priority nationally, in London and especially in LSL where diagnosed HIV prevalence rates are the highest in the England. Excluding the City of London, Lambeth and Southwark respectively have the highest rates of prevalence in England.

New HIV diagnosis rates have decreased nationally and in London and 2016 saw three firsts in the 30-year history of the UK HIV epidemic: the number of new HIV diagnoses in MSM fell, the death rate among people with HIV who are diagnosed promptly and on treatment became comparable to the rest of the population, and in London the UNAIDS 90–90–90 targets were met. In 2017, London became the first city in the world to exceed 95–95–95 – that is, 95% of Londoners living with HIV infection were diagnosed, 98% of those diagnosed were receiving treatment and 97% of those on treatment were virally suppressed and unable to transmit the virus.

Widespread use of combination prevention approaches has contributed towards the decline in HIV rates. Combination prevention refers to a set of behavioural, biomedical and structural approaches tailored to local levels of infrastructure and culture as well as to populations most affected by HIV. In the UK, the combination of approaches has included encouraging condom use, promoting the use of PrEP, promoting expanded HIV testing and diagnosis, advocating for self-sampling kits and ensuring prompt treatment when people are diagnosed with HIV and other STIs. Antiretroviral therapy (ART) is now so effective that those on treatment who maintain an undetectable viral load (<200 copies) have effectively no risk of sexually transmitting the virus (undetectable = untransmittable ('U=U')). The London HIV Prevention Programme campaign, Do It London, promotes four key ways to prevent the spread of HIV: regular testing;

use of condoms; PrEP and for people living with HIV to receive treatment and have an undetectable viral load (U=U). LSL echoes this strategy locally.

With knowledge of their status and access to effective treatment, people living with HIV (PLHIV) are able to live as long as the rest of the population. As a result, HIV is transitioning away from the life-threatening illness it once was and into a long-term condition that must be managed alongside other age-related conditions and care needs.

In January 2018, London signed up as a Fast-Track City, committing partners across the capital to work together to exceed the UN's 90–90–90 targets and end new infections in the capital by 2030, reduce the negative impact of stigma and discrimination to zero, stop preventable deaths from HIV related causes and to work to improve the health, quality of life and wellbeing of people living with HIV.

Current picture

Epidemiology and local needs

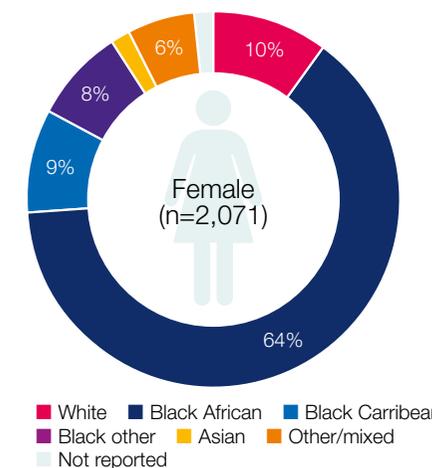
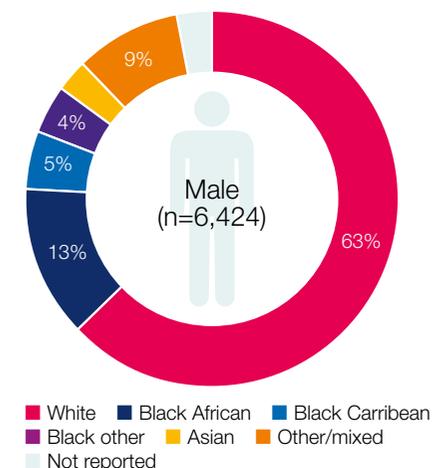
Prevalence

Each borough in LSL exceeds the threshold for 'extremely high prevalence' (as defined by NICE and PHE) of HIV, and the region has the highest rates of HIV in England.

Prevalence in Southwark and Lewisham has fluctuated little in the past five years and is approximately 12.2 per 1,000 people aged 15–59 in Southwark and 8 per 1,000 in Lewisham. In Lambeth, HIV diagnosed prevalence increased up to 2015 but declined in 2017, and is currently 14.6 per 1,000 people - the highest prevalence rate in the country.

There is considerable variation in diagnosed prevalence rates across LSL as illustrated below, and a disproportionate number of new diagnoses are in the most deprived areas (particularly in Lambeth).

Proportion of all diagnosed HIV cases seen for care by sex and ethnicity in LSL, 2017



PHE (2018) Sexual and Reproductive Health Profiles

Across LSL, the majority (76%) of HIV diagnoses are in men. Of all men living with HIV in LSL, nearly two-thirds are white, and of women, nearly two-thirds are black African.



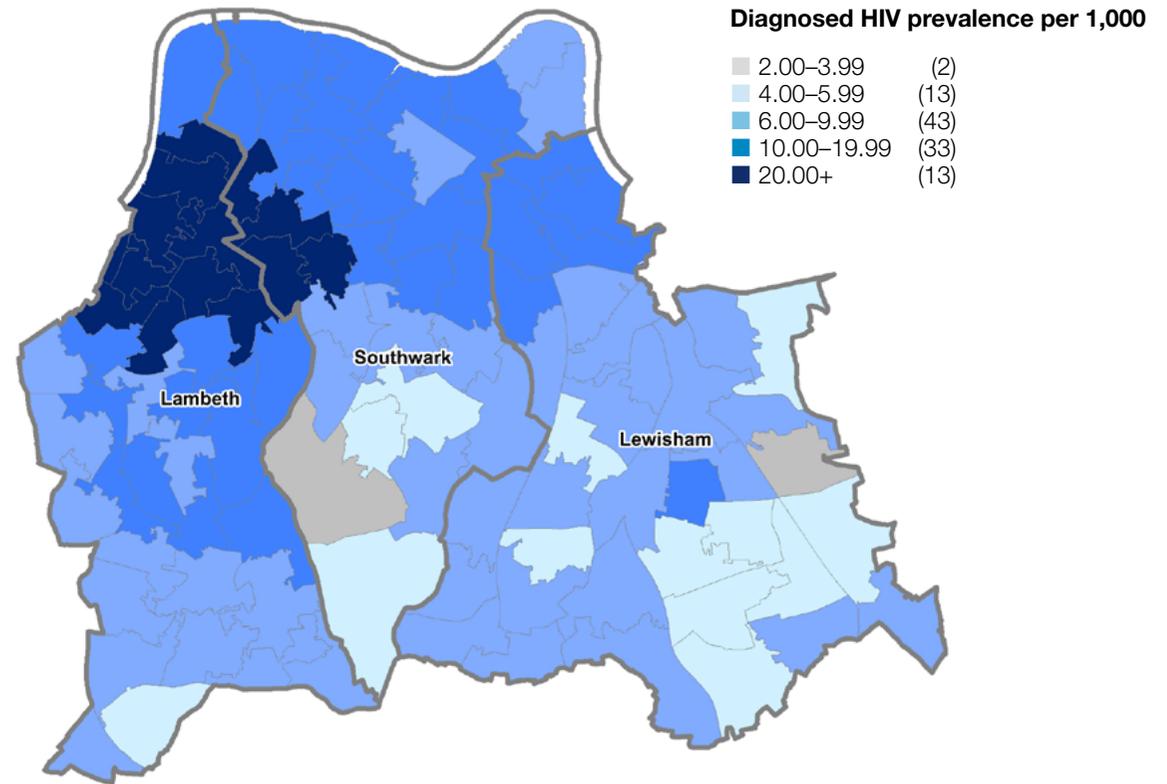
Certain population groups are more likely to be affected by HIV, namely MSM and people identifying as black African. The high prevalence of diagnosed HIV in LSL is driven by a range of factors. All three boroughs have high population turnover, including high rates of external migration. LSL also have a high population of LGBTQI+ people and very diverse populations in terms of ethnicity. Lambeth and Southwark are estimated to have the first and second highest gay and lesbian populations in the country respectively and while there are no estimates available for Lewisham, we can make an assumption of at least 2.7% which is the estimate for London. Additionally, with high rates of HIV among the black African population, our boroughs' ethnic make-up is a significant driver; across LSL, people identifying as black African account for 11% of the population aged 15 years and over.

Testing

HIV testing, including frequent testing among those most at risk of HIV, continues to be one of the most important interventions to identify infection and prevent onward transmission, and is one of the four Do It London strategies to prevent HIV. Providing access to and encouraging testing in our resident population will reduce the number of undiagnosed residents, reduce the time period over which infected individuals are not receiving treatment and prevent onward transmission.

HIV testing coverage is used to monitor progress towards national recommendations on increasing testing and is defined as the proportion of 'eligible new attendees' to specialist sexual health services in whom an HIV test was accepted. Performance against this indicator is poor in LSL where coverage in all boroughs has consistently trended below the overall London rate. There is a decreasing trend in testing coverage in Lambeth and Southwark, though coverage has increased in Lewisham. Given the high prevalence of HIV in LSL, poor performance against this

Prevalence of diagnosed HIV per 1,000 by MSOA, in LSL 2017



PHE (2018) Local authority HIV surveillance data tables

The map above shows that the prevalence of diagnosed HIV is not evenly distributed across LSL. The highest prevalence of diagnosed HIV is an area across north Lambeth and north west Southwark, with a prevalence of over 20 per 1,000 population.



indicator is concerning and we will seek to better understand and address this. We will also encourage increased testing in primary care and A&E settings.

The coverage indicator measures only those tests offered and accepted within specialist sexual health services and therefore does not capture those accessing testing privately, via online channels or in alternative settings (e.g. general practice, hospital settings). Access to testing through specialist services will also show a systematic bias towards certain high-risk groups, such as MSM, who are more likely to access these services regularly.

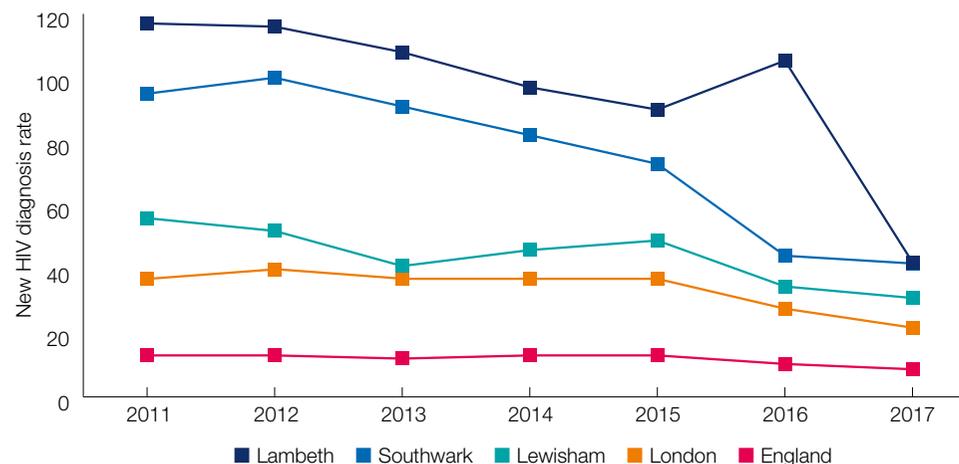
New diagnoses

Total new diagnosis rates have continued to decline nationally year on year. Since 2015, LSL have seen a decline in key risk groups where rates have previously remained stable: MSM and the black African population. The 2017 PHE report *Towards elimination of HIV transmission, AIDS and HIV related deaths in the UK* suggests that the decline among the black African heterosexual population is likely due to changes in migration patterns, with fewer people arriving from high HIV prevalence countries, though this is being reviewed.

However, the decreasing trend in new diagnoses has not been seen across all populations and there has been no significant change in Lambeth and Lewisham, though rates have decreased in Southwark. New diagnoses in heterosexual women and black African men also remain disproportionately high. Sustained effort therefore continues to be required to reduce new infections and onward transmission.

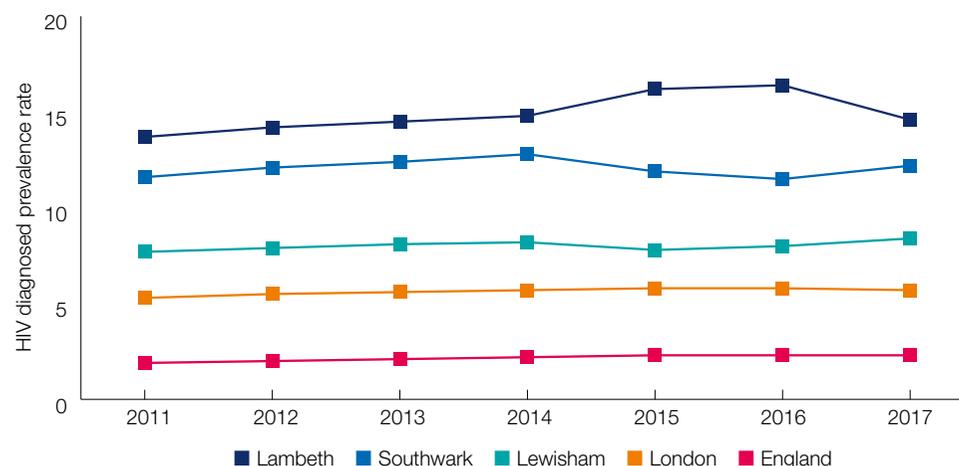
Rates of new diagnoses among residents of LSL continue to trend above both national and London rates, though there are differences between the three boroughs as seen in the accompanying figures.

New HIV diagnosis rate per 100,000 aged 15+ LSL, 2012–2017



PHE (2018) Local authority HIV surveillance data tables

HIV diagnosed prevalence rate per 1,000 aged 15–59 LSL, 2012–17



PHE (2018) Local authority HIV surveillance data tables

An HIV prevalence of more than 5 per 1,000 is considered extremely high – all boroughs in LSL are above this, with Lambeth and Southwark first and second in England, respectively. However, new diagnosis rates have declined across LSL in recent years, with a significant decline in Lambeth due to a large number of cases diagnosed in 2016 being erroneously mapped to St Thomas’ hospital (in Lambeth) rather than the patient’s area of residence.



Our epidemiological review revealed that in LSL in 2017:

- Rates of HIV diagnosis are highest among those aged 35–64 years.
- The majority (76%) of HIV diagnoses are in men.
- Of all men diagnosed with HIV, 64% were white, and of all women diagnosed with HIV, 64% were black African.
- Sex between men accounts for the majority (53%) of new HIV cases, followed by heterosexual female (14%) and heterosexual male (13%) exposure (as per figure at right).

By understanding the profile of those diagnosed, we can target ongoing efforts to tackle HIV through combination prevention approaches – for example through commissioning community-focused services targeted to black African and Caribbean communities and MSM across LSL.

Late diagnoses

Late diagnosis of HIV infection is associated with increased morbidity and mortality, increased costs to healthcare services, reduced response to antiretroviral treatment and increased risk of onward transmission of HIV. People diagnosed late have a ten-fold risk of death compared to those diagnosed promptly. Reducing late diagnosis is therefore a critical target in our strategy.

Over time, fewer people in LSL are receiving a late HIV diagnosis and efforts to increase testing through a variety of routes (including online and a range of community and healthcare settings) appear to have contributed to this downward trend from 2009–11 to 2015–17.

However, across LSL in 2015–17 more than 25% of people diagnosed with HIV were diagnosed at a late stage of the disease. Late diagnosis was highest in Lewisham where almost 40% of people received a late HIV diagnosis in 2015–17.

In 2016, certain groups had a higher proportion of people with late diagnosis, including those aged 50–64 (53%), those identifying as black African (49%), those identifying as ‘other’ ethnicity (46%), those whose route of transmission was through heterosexual contact (59%) and women (55%).

These data afford us insight into groups who would benefit from outreach programmes and targeted prevention and testing. We know that women and BAME groups are less likely to accept HIV testing and this is reflected in higher rates of late diagnosis. Regular testing is a good way to identify HIV early and routine or opportunistic offers of HIV tests by healthcare professionals (outside of sexual health services) have been shown to be acceptable and facilitate greater uptake of testing, especially in at-risk African communities.

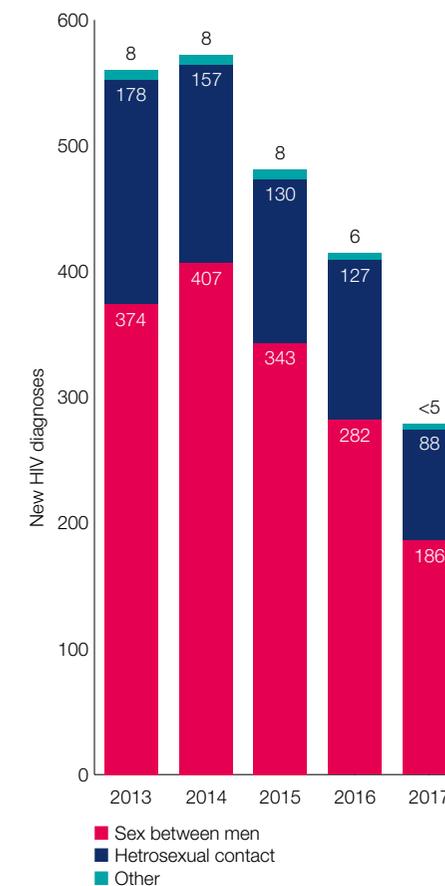
A multi-faceted approach is needed to tackle late diagnosis across LSL, including measures to encourage those at risk to come forward to be tested, and education and support for clinicians, particularly those working in primary care and A&E to improve their knowledge of HIV and testing, including raising the issue.

Engagement in care

Widespread use of effective ART has led to a significant reduction in morbidity and mortality among people living with HIV and is an effective means of reducing HIV transmission. The ‘U=U’ (undetectable = untransmittable) message is growing in recognition. However, individual and public health treatment benefits can only be achieved if PLHIV know their status, access care and have sustained engagement with care on an ongoing basis. Poorer health outcomes are experienced among people living with HIV who engage poorly with care.

The UK has made significant progress in ART coverage in recent decades. 96% of those diagnosed are now accessing

Proportion of new HIV diagnoses by exposure type in LSL, 2013–17



PHE (2018) Local authority HIV surveillance data tables

Sex between men is the leading exposure type in people newly diagnosed with HIV.



treatment and 94% are virally suppressed. In London in 2016, 97.2% of residents with diagnosed HIV were receiving ART. Of these, 96.6% were virally suppressed and were very unlikely to pass on HIV, even if having sex without condoms or use of other preventative interventions in partners such as PrEP.

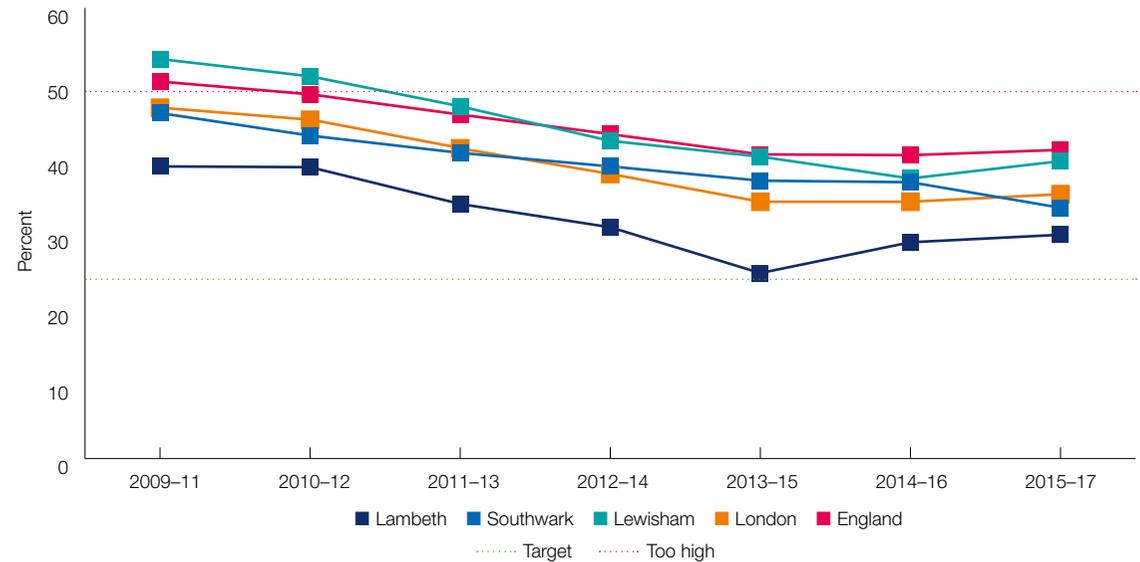
More than 8,700 LSL residents accessed HIV care in 2016. This number has increased steadily in line with new diagnoses and an increased life expectancy. 98% of those accessing care in 2016 were on treatment. However, 2015 data indicates that there remain challenges in retaining a proportion of those diagnosed in care – with just 85% of those diagnosed retained within care at 1 year after diagnosis.

Substance misuse and mental health co-morbidities are risk factors for poor treatment adherence and level of engagement in HIV care is associated with multiple underlying causes and demographic, socio-economic and HIV-related factors. It's therefore key that the services provided in LSL, both in specialist and mainstream community services, cater to the differing needs of PLHIV. A range of approaches are required to improve engagement with care, and we will continue to work to maximise engagement and support adherence to treatment across the boroughs.

PLHIV also have the primary role in managing their condition. Individuals, families and communities are assets that support self-management including:

- Providing information and perspectives about HIV and treatment
- Peer support, including understanding of and assistance with self-management skills
- Reduction in HIV-related stigma

Percentage adults (15+) with late HIV diagnosis among all newly diagnosed adults in LSL, 2009–11 to 2015–17



PHE (2018) Sexual and Reproductive Health Profiles

Late diagnosis rates are pooled over three-year periods. Over time, fewer people in LSL are receiving a late HIV diagnosis. However, in all boroughs in 2015-17, more than 25% (target) of people diagnosed with HIV received a late diagnosis. Late diagnosis was highest in Lewisham where almost 40% of people received a late HIV diagnosis in 2015-17.



Families of people living with HIV, including children, may also have particular health or social needs, as may younger people transitioning from children and young people's specialist HIV services to adult services. The needs of these and other specific groups will be considered when planning services.

One of the greatest successes of HIV care, research and activism is that PLHIV can now lead healthy lives and have similar life expectancies to those of the general population. In 2016, more than one-third of people accessing HIV care in LSL (35%) were aged 50 years and over, compared with 24% in 2012.

There is however evidence that PLHIV are more likely to develop diseases such as diabetes, kidney disease, liver disease and other long term medical conditions associated with age. In addition, a proportion of people experience side effects when taking ART long-term.

Some older people living with HIV can feel stigmatised by both their age and HIV status, and may suffer isolation and loneliness as a result.

Both specialist HIV and mainstream services in LSL and across London will need to adapt to this changing demographic of PLHIV. Co-coordinating care more closely with other health and care services that older people need and focusing on overall quality of life as well as clinical treatment will be essential. Exploring shared care models with primary care and planning for how HIV care will be coordinated with social care, for example in care homes, is essential.

Achievements since the last strategy and ongoing challenges

Achievements since the last strategy

LSL's 2014–17 sexual health strategy set ambitious targets to support PLHIV in leading healthy and fulfilling lives. These included increasing testing rates to ensure residents know their status and are on ART as quickly as possible. We implemented the following projects and system changes:

- Introduction of HIV testing in acute and primary care settings.
- Development and implementation of online STI and HIV self-sampling service, SH:24. This innovation inspired London to procure an online STI and HIV self-sampling service on behalf of most London boroughs, Sexual Health London (SHL), which LSL has now adopted. In addition, LSL bought into the national online HIV self-sampling service, Test.HIV.
- Lambeth host and commission on behalf of London boroughs the London HIV Prevention Programme which runs an award-winning campaign, 'Do It London', to increase testing and safer sex behaviours, and also has an outreach programme that works with MSM to encourage testing, give advice and increase knowledge around prevention methods.
- Implemented recommendations of the 2010 HIV care and support review, making changes to our local service offer towards an integrated care model in line with the HIV now being a manageable long-term condition. This work has included piloting HIV clinics in GP surgeries and improving the competence and capacity of mainstream advice, welfare and other agencies to respond to the needs of people living with HIV in line with support for those with other long term conditions.



Lambeth host and commission on behalf of London boroughs the London HIV Prevention Programme which runs an award-winning campaign, 'Do It London', to increase testing and safer sex behaviour

1,000

There are estimated to be around 1,000 people living in LSL who are unaware they are living with HIV



- At King's College Hospital NHS Foundation Trust, work has been undertaken to review the needs of patients aged over 50, review IT solutions to support integration of primary and specialist care, improve communication between clinicians and potentially develop training for GPs to support integrated care.

These achievements were enabled by workforce developments that saw the introduction of more appropriate staff skill mixes to better serve the needs of patients and service users and improve training standards in sexual health.

Ongoing challenges

Tackling stigma and discrimination

HIV-related stigma and discrimination refers to prejudice, negative attitudes and abuse directed at PLHIV. Though it is 30 years from the start of the HIV crisis, stigma and misconceptions around HIV remain and are a barrier to HIV prevention, testing, treatment, care and support. In 35% of countries with available data, over 50% of people report having discriminatory attitudes towards PLHIV.

PLHIV can face stigma, prejudice and discrimination in various spheres of life from services, in the workplace and from their family and friends. They may also experience that some non-specialist services are unable to meet their needs fully because of lack of specialist knowledge or training. These social aspects of the disease are less well understood, but can significantly impact on the ongoing health and wellbeing of PLHIV and their family and friends. Stigma and discrimination can undermine HIV prevention efforts by making people fearful to seek information on HIV information, access services and adhere to treatment.

Providing the right combination of services for the health care of all people living with HIV

PLHIV in LSL are a diverse group of people whose health needs will change as they age. It is critical that HIV specialists and other services continue to evolve to meet the needs of PLHIV, including the management of co-morbidities and other complex health conditions and that they reflect all members of the community that they serve.

Whilst early diagnosis and effective treatment means that people living with HIV can age well, the inevitable effects of ageing cannot be avoided and growing older with HIV can increase the chance of experiencing age-related illnesses earlier. PLHIV also have higher rates of mental health-related co-morbidities than the general population and substance use and addiction disproportionately affect people with HIV.

With increasing numbers of people living and ageing with HIV there will be increasing pressures on a range of services including specialist, primary, mental health and social care services. Complex and fragmented commissioning arrangements, and ongoing budgetary constraints across health and social care, could contribute to a lack of joined up care for PLHIV.

Given HIV is increasingly managed as a chronic disease, and along with other changes in health policy, there is a shifting in the emphasis of care towards partnership between specialist centres and primary care. LSL HIV services must learn from other existing models for co-ordinating long-term care (such as those for cancer) that have similarly evolved from providing specialised treatment to including long-term care, and adapt them as appropriate.

Work at KCH and with other partners towards understanding and designing the elements of a truly integrated care model for PLHIV in LSL has been ongoing for a number of years and actions stemming from this strategy will seek to support and further these efforts.



Undiagnosed and those not on treatment

There are estimated to be around 1,000 people living in LSL who are unaware they are living with HIV. Reviewing and increasing our testing activity (particularly in primary care and A&E), ensuring we are testing the right people and targeting those identified through profiling people who are diagnosed late will be critical to reduce the numbers of undiagnosed. This will include raising awareness among clinicians in general practice and secondary care settings of some indicator conditions that may suggest someone living with an undiagnosed HIV infection.

With the increasing incorporation of e-services in the sexual health system across London, service users must receive appropriate behaviour change messaging to ensure HIV tests are selected whenever possible.

Some residents who receive a diagnosis of HIV decline treatment or are lost to care, putting their health at risk and increasing the risk of onward transmission. Clinical and community outreach services will continue to target most at risk populations.

Data monitoring

Monitoring and the ability to assess the impact of the interventions are dependent on good quality data. HIV and AIDS reporting system (HARS) provides some of the best surveillance data internationally, but this system relies upon complete data being freely given by individuals who trust in the confidentiality of the system, and also being collected, recorded and returned in a timely and accurate manner.

Emerging issues and trends

PrEP

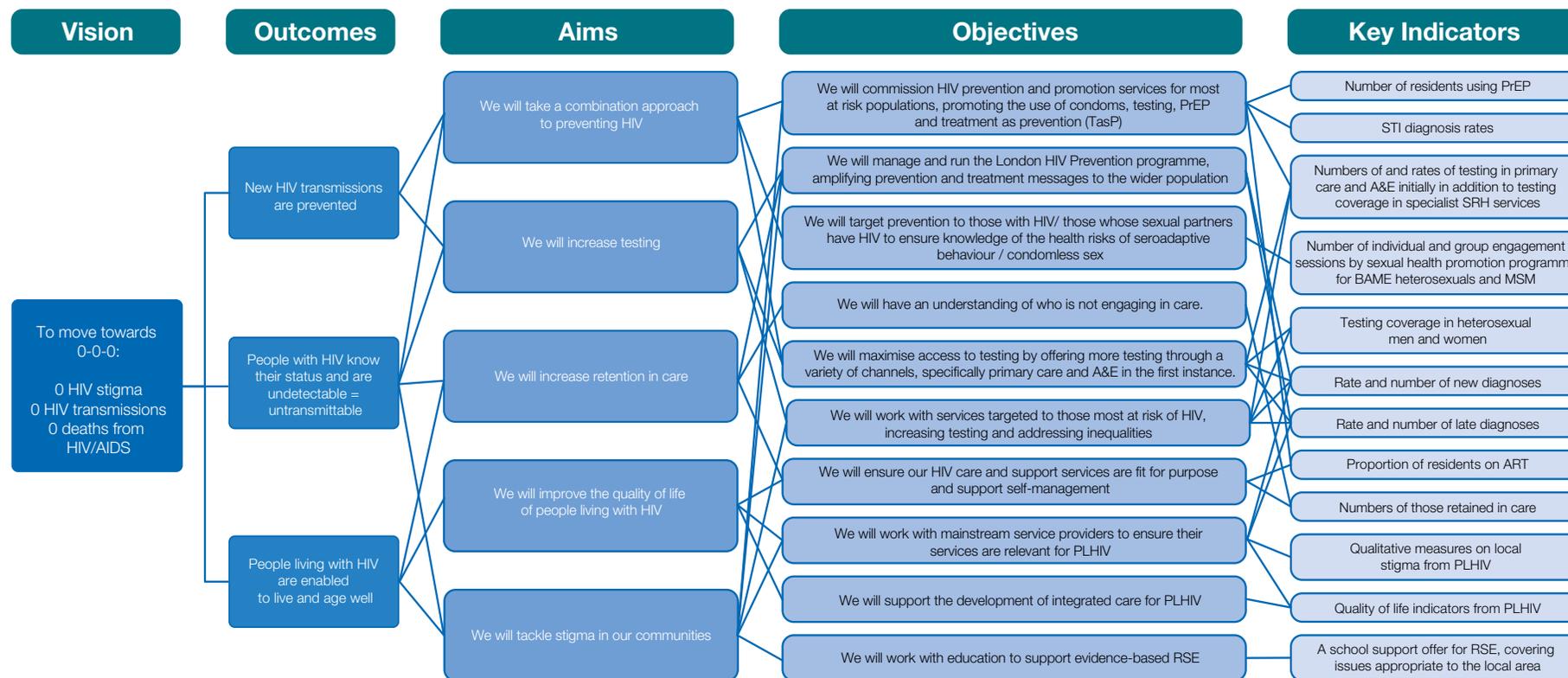
Pre-exposure prophylaxis (PrEP) is highly effective in reducing the risk of acquiring HIV. PrEP is not currently available on the NHS (aside from the Impact trial) but the private purchase of PrEP has been increasingly popular in recent years, particularly amongst MSM, and is supported by testing at sexual health clinics. The PrEP Impact trial is currently recruiting 13,000 participants (and proposed in January 2019 to be doubled) who are at a high risk of HIV, across England, to assess the need and demand for PrEP in those accessing sexual health clinics, and the likely benefit of its use in England. By late October 2018, 9,226 participants had been recruited across 140 sexual health clinics.

Although PrEP is highly effective for preventing HIV infection, research is beginning to highlight an associated decrease in consistent condom use and increase in STIs among MSM using PrEP. A reduction in condom use could also undermine PrEP's population level effectiveness if people stop using condoms and do not use PrEP consistently.



Living well with HIV: what we want to achieve by 2024

The figure below sets out our vision for improving the lives of PLHIV in LSL, how we will work together to achieve this vision and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, each borough will have an annual delivery plan which will set out the borough-specific actions needed to achieve these objectives in a given year. London has signed up to the Fast-Track Cities target of 0–0–0 (0 HIV stigma, 0 HIV transmissions, 0 deaths from HIV/AIDS). The vision for Lambeth, Southwark and Lewisham is also to move towards achieving this. Therefore, in addition to the specific indicators listed below, we will look to measure overall progress towards this vision, using any future indicators agreed at a London level.



6.0 How we will deliver our vision

The figures on the previous pages provide the map for how we will achieve our shared vision for sexual and reproductive health in LSL by 2024, and the indicators through which we will measure our progress.

However, we recognise that within LSL, some areas have further to progress than others and there will be local factors that are not applicable to other boroughs. Therefore, our boroughs will have an annual action plan which will include specific steps to deliver this strategy, which will form part of the Public Health business plans. This approach to a joint strategy allows us to collaborate on many areas, but take local action as needed.

Progress against the strategy will be reviewed annually by the LSL Sexual Health Commissioning Partnership Board, which comprises commissioning, Public Health and CCG representatives from each of the three boroughs. Shared actions to deliver this strategy will also be overseen by this board.

This strategy also forms a key part of each borough's Health and Wellbeing Strategy, and so progress will be reported to each of the Health and Wellbeing Boards as locally appropriate.



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Lambeth, Southwark and Lewisham Sexual and Reproductive Health Strategy 2019-24

Summary of the evidence

Lambeth, Southwark, and Lewisham
Public Health Departments

August 2018

What is this document?

This document summarises the evidence and good practice underpinning the LSL Sexual and Reproductive Health Strategy 2019-24. The four chapters of our strategy draw on these evidence reviews and the accompanying intelligence pack to set out our plans for the coming years. References for all evidence and statements within our strategy are provided within this document, and not within chapters themselves.

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HEALTHY AND FULFILLING SEXUAL RELATIONSHIPS

Social relationships are an important determinant of health and wellbeing across the life course. A positive familial environment provides children with secure attachment and a healthy blueprint for future relationships.¹ Exposure to domestic abuse and unhealthy relationships, as a victim or witness, is associated with poorer emotional wellbeing and physical health.² The mental and physical consequences of abuse may increase a victim's risk of further exploitation and may be associated with related risk factors for poor health, such as substance misuse and risky sexual behaviour.^{3,4} In some cases, domestic abuse is cyclical and those who were themselves victims may go on to perpetrate abuse or continue to enter into unhealthy interactions.⁵ For this reason, developing an understanding of healthy relationships early in life is critical to equip young people with the knowledge, confidence and control to engage in healthy interpersonal relationships.⁶

Comprehensive relationships and sex education (RSE) contributes to a young person's safety by supporting them to navigate through their own developmental changes and helping to prevent exploitation or abuse. Despite this, schools have had no statutory responsibility to provide comprehensive RSE and the most recent government guidance is now 17 years old.⁷ In Lambeth, Southwark and Lewisham (LSL), RSE is largely taught through science and through personal, social, health and economic (PSHE) education programmes at school. PSHE sits alongside the national curriculum and covers three broad themes: health and wellbeing, relationships, and living in the wider world. There is strong evidence of the impact of high quality RSE in reducing early sexual activity, teenage conceptions, sexually transmitted infections (STIs) and in increasing reporting of sexual exploitation and abuse.⁷⁻⁹ Moreover, young people have increasingly reported that lessons from school are their preferred source of information about sex when growing up,¹⁰⁻¹² highlighting the importance of appropriate RSE. However, important issues such as coercion, navigating the practicalities of consent, social media, online safety and same-sex relationships are topics poorly covered by current curricula.⁷ The majority of young men and women surveyed in the recent Natsal-3 report felt they should have known more when they first felt ready to have some sexual experience;¹² 62% of these cited lessons at school as their primary source of sex education. Among the additional topics they wanted to learn more about were sexual feelings, emotions and relationships. Alongside a focus on risk and unhealthy relationships, high quality RSE should emphasise the positive aspects of healthy sexual relationships, including negotiating the sex that you want. A recent national survey revealed that 60% of students hadn't learned about sexual pleasure.¹³ Young people should not be dissuaded from sexual relationships for fear of coercion or abuse. Instead, they should be properly equipped with the necessary information to negotiate safe and pleasurable sex when and how they want it. In order to deliver frank discussions around sex, however, teachers must be open and comfortable discussing the topic. Unfortunately, qualitative studies from the UK and abroad have highlighted that many teachers feel uncomfortable or embarrassed having these conversations.¹¹

As of September 2020, RSE will become statutory across the UK, a delay on the anticipated 2019 start-date.¹⁴ This affords schools (maintained, academy, and independent) the opportunity to develop – alongside health professionals – comprehensive, relevant lessons that address these reported inadequacies and capitalise on our knowledge of vulnerable groups, in particular the lack of RSE sufficiently inclusive of our vulnerable women, young LGBTQI+ people and others. Topical issues of consent – what it looks like, giving it, understanding it can be withdrawn – will also be included. In primary schools, the subject will be taught as 'relationships education,' extending to 'relationships and sex education' in

secondary schools. Schools have flexibility in how these subjects are taught and parents retain the right to withdraw a child from RSE, as they do currently.

The strategic direction for sexual assault and abuse services over the next five years (2019-2024) has been set out by NHS England¹⁵ and echoes this emphasis on prevention. It recognises the increasing role of the internet in sexual assault and abuse and the difficulties faced by vulnerable groups (e.g. LGBTQI+, BAME, and those with learning difficulties) in reporting an incident. Knowledge and guidance about healthy relationships is an important resource in navigating sexual experiences and can help people of all ages to develop an awareness of unhealthy behaviour and the confidence to address it. Facilitating healthy and fulfilling relationships is therefore important in preventing future unhealthy relationships and poor reproductive health, and reducing the risk of acquiring STIs and HIV. It is an integral part of a holistic sexual and reproductive health strategy.

Knowledge of healthy relationships is an important tool for all children and young people. However, some are more likely to suffer from unhealthy sexual experiences and relationships and thus may have additional need for information about risk factors and warning signs. Women are disproportionately affected by domestic violence across the life course and are nearly twice as likely to have experienced domestic abuse than men.¹⁶ The number of accounts of violence against women and girls in London has increased since 2012 but it remains an under-reported crime.^{17, 18} Coercive or controlling behaviour was introduced as a new offence in December 2015¹⁹ and research has suggested that these behaviours are highly gendered, with women being the predominant victims.²⁰ The Crime Survey for England and Wales was updated in 2017 to include related questions to better capture the nuanced aspects of unhealthy relationships and abuse.¹⁶

From the age of 16, 49% of gay and/or bisexual men report experiencing at least one episode of domestic abuse. This is compared to only 17% of men overall.⁵ The prevalence of abuse among transgender people is even higher: 80% reported experiencing emotional, physical or sexual abuse from a partner or ex-partner in 2010.²¹ Despite the prevalence of domestic abuse in these populations, over half (53%) of lesbian, gay, and bisexual young people are never taught about homosexual sex and relationships issues at school.²² The lack of information available in traditional settings such as schools may drive some young people to seek advice and support from adult-oriented groups, for example online forums where they may be vulnerable to exploitation.²³ Rates of intimate partner violence are higher among those with a physical or mental disability; they are between two to three-fold higher odds of being a victim.²⁴ In addition, any child living in a household in which there is intimate partner violence or a regime of intimidation or control is at increased risk of experiencing, and also perpetrating, violence as an adult.⁵ While many of these children may be reached by school-based interventions, special attention should be paid when they come into contact with health or social services. RSE lessons must therefore be inclusive of all levels of disability, sexual orientation, and life circumstances to ensure equal access to information.

The term 'chemsex' has become prominent in some parts of the MSM community and describes sex that occurs under the influence of drugs, most commonly crystal methamphetamine, GHB/GBL and mephedrone. Locally, we know that our population of MSM are more likely to take drugs associated with chemsex than MSM elsewhere in London or England.²⁵ These substances pose a significant health risk and risk of overdose. Anecdotal evidence from qualitative research in Southwark revealed an increasing mental health risk (including low self-esteem) for those who partake in chemsex.²⁶ Vulnerability and risky sexual activity were also a common concern as maintaining control of behaviour and choices while under the influence of chemsex drugs may be difficult. As sexual health commissioners, we

need to ensure that people in risky sexual relationships are also appropriately supported to make safe and healthy decisions.

Child sexual exploitation (CSE) is a significant concern in LSL as it is elsewhere, and we know through internal analyses that exploitation is linked with gang-related activity and with drug running across county lines. The responsibility of safeguarding children and identifying exploitation should be embedded within all professional practices. Children and young people at risk for, or currently being sexually exploited may present with physical injury, addiction, poor mental health and repeat use of emergency hormonal contraception, among others, and may interact with a range of professionals.²⁷ Training on identifying and referring cases of CSE should therefore be available across all services. Sexual health professionals are uniquely placed to discuss sexual activity and relationships with a young person and should be mindful of deteriorating health, disclosure of multiple partners or repeat visits for STI treatment.²⁷ Schools reach the majority of children and therefore have an important role to play in both preventative education and identifying CSE and abuse.²⁸ They tend to see the same group of children over time and can identify changes in behaviour or health. Evidence suggests that education programmes may increase the likelihood of a child disclosing abuse²⁹ and that a whole-school approach of zero tolerance for abuse, alongside longer-term lessons through RSE that teach young people about healthy relationships may be effective in preventing CSE.^{28, 30, 31}

In the current landscape, young people face a plethora of emerging challenges that are becoming increasingly difficult to navigate. Relationships are now conducted with a growing online element. Sexting may be construed as modern-day flirting, however, sending explicit photographs among under 18-year-olds is a criminal offence.³² Similarly, new forms of online abuse such as revenge porn (the non-consensual sharing of sexual content) are becoming increasingly recognised offences.³³ It is therefore critical that young people be informed of how to operate safely online. Notre Dame RC School in Plymouth was recently highlighted by Ofsted for their modernised PSHE programme.³⁴ At the suggestion of sixth form and year 10 students, they implemented peer-led workshops focusing on social media, coercion, and how to end a relationship safely. Students particularly liked being taught by older students and reported feeling more comfortable engaging with them on these topics.³⁴ Highlighting the grey areas before abuse begins may empower students to identify and prevent an abusive relationship from developing.

Findings from the 2016 Healthwatch Southwark report, 'Young Voices on Sexual Health,' revealed that education about healthy relationships was sparse and inconsistent across different schools.³⁵ Details about what constitutes a healthy or unhealthy relationship and how to spot the signs of abuse (beyond physical) were reported as lacking. When asked about how they would prefer RSE to be provided, young people vocalised a desire for an open, interactive discussion with professionals, more information on the emotional and social aspects of sex and a general inclusion of healthy relationships. Healthwatch Lewisham ran a series of workshops with young people aged 11-19 years in 2017 and found that 'relationships and sex' was the issue most concerning to young people and their peers.¹⁷ Additional gaps in knowledge were identified in the legal consequences of sexting that, despite its prevalence in this age group, remained largely undiscussed in RSE.¹⁷ Qualitative research identifying best practice in RSE has suggested that young people prefer to be taught by someone other than a teacher or tutor, as it might be uncomfortable or blur boundaries between them.³⁶ Peer educators were well respected, however, their credibility was in some cases undermined by youth. External sexual health professionals were preferred as they were perceived as providing greater confidentiality.³⁶

Empowering people to define the terms of their sexual relationships and use contraception when desired is an important part of protecting sexual and reproductive health (SRH). Ensuring the equality and accessibility of our contraception services remains a local priority. For young people under 25, condoms and sexual health information are available free of charge through the pan-London distribution scheme Come Correct, delivered by Brook across LSL. Condom distribution schemes were recently evaluated nationally and found to be successful in engaging young people. This is reflected in the high number of repeat users (compared to new registrations) locally.

For LSL's young and diverse population, knowledge and guidance about healthy relationships is an important resource in navigating their own sexual experiences; this is largely provided by school-led RSE. These lessons could benefit from integrating input from young people, such as employing external educators and widening the breadth of discussion to increase engagement in both the messages being delivered, and in local services. While information should be made available universally, vulnerable groups such as children exposed to domestic abuse, LGBTQI+, and children and young people with disabilities may benefit from targeted support.

GOOD REPRODUCTIVE HEALTH ACROSS THE LIFE COURSE

Reproductive health is important across the life course and can impact overall health at any stage. Consequences of poor reproductive health exacerbate inequalities in health, education and socio-economic status.

In Britain, nearly half of pregnancies (45%) are unplanned and one in 60 women (1.5%) experiences an unplanned pregnancy in a year.³⁷ Some unintended pregnancies do not lead to live-births; 52% and 12% of unplanned pregnancies are estimated to end in abortion and miscarriage respectively.³⁸ Having a child can put enormous financial and emotional pressure on couples and children born to mothers under the age of 20 have a 63% higher risk of living in poverty.³⁹ Moreover, teenage mothers themselves are 22% more likely to be living in poverty by age 30, compared to first time mothers over 24 years.³⁹ One in five 16-18 year-olds not in education, employment or training is a teenage mother.³⁹ Both physical and emotional health may also be affected. Sexually transmitted infections (STIs) such as chlamydia and gonorrhoea can cause pelvic inflammatory disease, which may increase a woman's risk of ectopic pregnancy or infertility.⁴⁰ Human papilloma virus (HPV) can cause genital cancers in men and women that, in some cases, may lead to infertility.^{41, 42} Difficulties conceiving may strain relationships and cause stress to both mother and father. Furthermore, postpartum mental health in the three years following birth is likely to be poorer in mothers under 20 years.³⁹

Reproductive ill-health incurs financial costs to the individual and to the state. For example, unplanned pregnancies leading to maternity may have long-term costs to local authority housing, education, and social care.⁴³ Teenage pregnancies may, in some cases, be costly to both mother and child with regards to earning potential and future employment.⁴³ Terminating a pregnancy has direct costs to the NHS: in 2010, approximately £143m was spent on abortions.⁴⁴

In contrast, publicly-funded contraception to prevent unintended pregnancy is extremely cost-effective and is one of the highest value public health interventions. While NHS and local authority spending on contraception totalled £246.1m in 2016, new analyses in England suggest that every £1 invested in contraception saves these public services £4.64 over a four year period, and £9.00 over 10 years.³⁸ Benefits include savings that result from avoiding unwanted pregnancies, including healthcare costs (for example birth costs, abortion costs, miscarriage costs and ongoing child health care costs) and non-healthcare costs (such as education costs, welfare costs, children in care costs). Good reproductive health therefore not only is essential contributor to good overall health and wellbeing, but also yields savings for public services.

In the UK, women spend approximately 30 years of life avoiding unwanted pregnancy and therefore requiring contraceptives.^{40, 45} The median age of first heterosexual intercourse is considered to be 16 for both men and women,⁴⁶ though national estimates suggest almost one-third of young people have had sex before this age.⁴⁷ Most information pertaining to reproductive health for young people is provided by relationships and sex education (RSE) lessons, parents, and health professionals,¹⁰ however, there are notable issues in awareness of free and available reproductive health services among young people. A 2016 survey of school-aged children in Lambeth, Southwark, and Lewisham (LSL) revealed only 20% of young people reported knowing where to get free condoms⁴⁸⁻⁵⁰ and STI rates in young people are higher in LSL than the regional and national average, and than in other age groups. This suggests a missed opportunity to embed discussions of contraception when treating young people with STIs and to promote good overall sexual and reproductive health (SRH).

Unfortunately, challenges remain in ensuring equality in knowledge of contraceptive options and access to preferred methods. The rate of under-18 conception is consistently higher across LSL compared to London and England,⁵¹ which represents an unmet need in contraception care as well as a failure to comprehensively tackle the wider determinants of teenage pregnancy. Moreover, this suggests a lack of awareness of or confidence in accessing other more effective methods of contraception. Long acting reversible contraceptives (LARC), in contrast to user-dependent methods ((UDM) e.g. condoms, oral contraceptives (OC)), do not depend on daily concordance and have been proven more clinically effective than OC at only one year of use.⁵² Despite these benefits, uptake remains low in the UK at about 12% of women aged 16-49, compared to 25% for OC and 25% for male condoms.⁵³ In Lambeth and Lewisham, the rates of GP-prescribed LARC have remained relatively stable since 2011.⁵¹ In Southwark, the rate has decreased to 7.5 per 1000 women, the fifth-lowest rate among London boroughs.⁵¹ This suggests that barriers remain in communicating the benefits of LARC or in ensuring that women of reproductive age have easy access to the full range of contraception, including LARC.

RSE in schools provides an opportunity to reach young people at risk for becoming pregnant and deliver messages around contraception and reproductive health. These should be accurate and aligned with information from healthcare professionals. Advice relating to contraception should be culturally appropriate, non-judgemental, and given according to the needs of each individual.⁴⁷ An example of best practice is highlighted in Shropshire County Council, who invested in their RSE curriculum to tackle high levels of teenage pregnancy. Collaboration was achieved between school nurses, parents, and school staff in order to train teachers to deliver targeted, evidence-based messages on reproductive choices and challenges.³⁹

Pharmacies play a vital role in offering accessible SRH services, in particular to young people who may feel uncomfortable visiting their GP or a sexual health clinic. Pharmacies tend to have consistent and long opening hours, allow for relative anonymity, do not require appointments, and are usually more conveniently located than GP surgeries or sexual health clinics.^{47, 54, 55} However, the current model of sexual health provision in pharmacies across LSL is disjointed and is not contributing to improved reproductive health outcomes. LSL has high rates of abortion and repeat abortion, and highly accessed emergency hormonal contraception (EHC) services at pharmacies. In Lambeth and Southwark, 80% of women accessing EHC declared previous use and, in Southwark, 50% of these had used EHC in the past 6 months. Under the current model of provision, most pharmacies are unable to provide on-going contraception alongside EHC and must refer to GP or sexual health clinics. This fragments the patient pathway and increases the risk of unmet contraceptive need and unintended pregnancy. In response, sexual health provision in pharmacies across the three boroughs is being reshaped to most effectively support women seeking contraceptives and reproductive and advice.

Online offers of contraception may also be a way of improving access. The Southwark- and Lambeth-based online service SH:24 has been delivering online OC since March 2017 as part of a pilot scheme, providing free OC to local women. The service has also begun an offer of paid OC for women not living in Lambeth and Southwark, which has proven extremely popular. While private supply of contraceptives is not suitable for everyone, the observed demand has demonstrated it is an acceptable way of improving access for a subset of the population.

Finally, school- or community-based drop-in clinics can be an effective method of reaching young people and improving their access to SRH services. Bristol City Council successfully established a network of drop-in clinics at secondary schools, run by a sexual health nurse

and youth worker. They were able to reach nearly two-thirds of the population of young people; 5,000 pupils attended a drop-in service in one year to discuss healthy relationships, contraception, and sexual health.³⁹

Contraceptives such as condoms should also be made available in non-traditional settings, for example at leisure centres and libraries, to improve access for young people. The pan-London condom distribution scheme Come Correct is delivered by Brook across LSL and provides free condoms and sexual health information to young people under 25 who hold a 'c-card'. C-card schemes for condom distribution were recently evaluated nationally and found to be successful in engaging young people.⁵⁶ High numbers of repeat users compared to new registrations suggest the scheme was popular and acceptable.⁵⁶ In LSL, there has been an increase in c-card registrations and in repeat users, compared to 2016.⁵⁷ These schemes are particularly important in reaching young men, who are less likely to visit GP or specialist sexual health clinics for contraceptives and may otherwise miss out on SRH advice.¹⁰

The reproductive health of both men and women may be affected by some STIs. HPV is of particular concern for its ability to cause cancer of the cervix, vulva, vagina, penis and anus. While not all types of HPV cause cancer, an estimated 90% of cases of anal cancer relate to HPV infection.⁴² and, of the approximate 3,100 cases of cervical cancer reported each year in the UK, nearly all are related to viral infection.⁴¹ In 2011-2013, Lambeth had the highest rate of cervical cancer registrations of all London boroughs.⁵¹ Sexually active individuals should be reminded of the importance of condoms in reducing the risk of contracting HPV (and other STIs) through intercourse.⁴¹ Since 2008, a vaccine against the two most common cancer-related types of HPV has been available free of charge to girls aged 12-18 through the NHS.⁵⁸ At present, the NHS does not offer the vaccine to young men, despite the relationship between HPV and male cancers.⁵⁸ However, in April 2018, Public Health England introduced a nationwide HPV vaccination programme for men who have sex with men aged 45 or younger, as this group is likely to receive little indirect protection from female vaccination.⁵⁹ All women aged 25 or over, irrespective of vaccination status, are invited for cervical screening through the NHS Cervical Screening Programme.⁶⁰ The programme aims to identify abnormal cervical cells early to prevent the development of cancer. Most treatment for cervical cancer will result in infertility.⁶⁰

Some unintended pregnancies, regardless of the age of the mother, will become wanted; however, a proportion will result in termination. Access to safe and legal abortion care, free from harassment, has a critical role in protecting the reproductive health of women who choose to end a pregnancy. Since our previous strategy, access to high quality abortion services has improved; however, inequalities persist across LSL in terminations of pregnancy (TOP). The TOP rate per 1,000 population is consistently higher among Black African and Black Caribbean populations in the three boroughs, reaching over 50 per 1,000 population in some areas.⁶¹ LSL should seek to address the underlying drivers of these inequalities, for example cultural preferences for barrier methods of contraception.⁶²

After delivery or between pregnancies is an often unrecognised period during which women require effective contraception.^{63, 64} Short inter-pregnancy periods increase a woman's risk of complications in the subsequent pregnancy, including preterm birth, low birthweight and stillbirth,^{65, 66} and thus present a critical time to intervene. Furthermore, during pregnancy, women are frequently in contact with healthcare professionals and are therefore accessible to information about, and supply of contraception. This is especially important for vulnerable women who are at high risk for future unintended pregnancy (i.e. young women, women who have had previous children removed).⁶⁷ National guidelines recommend that professionals providing care to pregnant women be able to offer their chosen method of contraception following pregnancy or termination, or facilitate access to these services.⁶⁷ Female and male

sterilisation should be included among the range of available methods of contraception discussed within the context of a patient's individual circumstances.⁶⁸ Support for effective, appropriate contraception should continue for as long as a patient is sexually active, extending through menopause and into old-age.

Good reproductive health is thus reflective of a comprehensive, whole-system approach to reproductive wellbeing that offers support from adolescence through to old-age. At any reproductive stage, individuals should understand the range of contraceptive methods available to them and be aware of how best to access them.⁶⁹ Likewise, services need to be arranged to facilitate easy access to the full range of reproductive health services. As people move through life, their personal circumstances should continue to be at the centre of the discussion of preferred contraceptives, ensuring they continue to enjoy safe and healthy sexual relations.

HIGH QUALITY AND INNOVATIVE STI TESTING AND TREATMENT

Sexually transmitted infections (STIs) facilitate the transmission of HIV, cause a number of cancers and contribute to poor sexual and reproductive health and overall wellbeing.^{70,71} The sequelae of untreated STIs include infertility, ectopic pregnancy, and harmful impacts on mental health and sexual relationships.^{52,72,73} Furthermore, STIs are a significant contributor to health inequalities, which in turn increase a person's risk of poor sexual health and limit their access to prevention, testing and treatment; STIs remain one of the most common acute conditions. A total of 422,147 new diagnoses of STIs were reported for England in 2017, of which 48% were chlamydia, 14% genital warts, and 11% gonorrhoea.^{70,71} The overall number of new STI diagnoses in 2017 was similar to that of the previous year, however, there have been notable differences in the trends of particular infections.^{70,71} Syphilis and gonorrhoea diagnosis rates increased by about 20% relative to 2016, there was a 7% relative decrease in genital warts, while chlamydia incidence remained stable.⁷¹

Lambeth, Southwark and Lewisham (LSL) have historically had some of the highest national rates for STIs. In 2017, Lambeth had the highest rate of new STI diagnoses in England in 2017, followed by Southwark in third, with Lewisham 11th.^{51,74} This partly reflects local provision of modern and accessible STI testing and treatment services but also our young, ethnically diverse, and mobile populations.

To reduce inequalities, we need to improve the sexual and reproductive health (SRH) of key groups including young people, men who have sex with men (MSM), and Black and minority ethnic groups (BAME).⁴⁰ Lambeth, Southwark, and Lewisham residents are predominantly young, with a larger proportion of the population aged 25-34 years.^{51,75} We are also more ethnically diverse than England: approximately one quarter of LSL residents are from a Black ethnic background. Furthermore, Lambeth and Southwark have the second and third largest lesbian, gay, and bisexual communities in England.⁷⁴ We therefore have a large population at higher risk of poor sexual health.

Tackling the burden of STI requires both disease-specific interventions as well as wider intervention at several levels as detailed in national guidance.⁴⁰ At the population level, it is integral to build an honest and open culture and reduce sexual health stigma, while at the community level it involves ensuring adequate access to contraception such as through condom distribution schemes as well as access to testing and treatment of STIs in a variety of settings, especially for high risk groups.⁴⁰ Screening for common STIs like chlamydia should be offered routinely and opportunistically to young people. Protecting people against reinfection through having timely and effective treatment, and appropriate and effective partner notification pathways in place is crucial. Incorporation of education and access to correct and timely information is important plan and can be achieved through use of evidence-based online services and websites such as "Sexwise",⁴⁰ but importantly, starting early through effective delivery of RSE in schools.

Correct and consistent condom use remains the principal intervention for preventing STIs and reducing transmission. The pan-London condom distribution scheme Come Correct is delivered by Brook across LSL and provides free condoms and sexual health information to young people under 25 who hold a 'C-card'. C-card schemes for condom distribution were recently evaluated nationally and found to be successful in engaging young people.^{56,77,78} High numbers of repeat users compared to new registrations suggest the scheme was popular and acceptable. In LSL, there has been an increase in C-card registrations and in repeat users, compared to 2016. These schemes are particularly important in reaching young men, who are less likely to visit GP or specialist sexual health clinics for contraceptives and may

otherwise miss out on SRH advice. Further work needs to be done, however, to engage BAME in these distribution schemes given contraceptive usage in general is lower in this population.⁶²

Part of the success in managing to maintain such services through a financially challenging period has been through introduction of innovative methods of access. This is most apparent in web-based access to STI testing and treatment. A randomised trial conducted in Lambeth and Southwark in 2014-15 found that e-STI testing delivered through SH:24 increased uptake of STI testing across all groups including those at highest risk.⁷⁹ An added advantage of this method is that traditional structural and social barriers to STI testing may be overcome through online service delivery and home-testing.⁸⁰ Service innovations to improve STI treatment rates once diagnosis is confirmed via e-STI testing continue to be active areas of research.⁷⁹ Self-testing online services have since been extended across London (now 'Sexual Health London') with the aim of freeing capacity at SRH clinics by targeting asymptomatic patients, ensuring those most in need of a face-to-face intervention receive one.

A diverse range of pathogens can be sexually transmitted and, while complications vary widely, all contribute to the burden of poor health.⁴⁰ Five STIs from the bulk of diagnoses seen both across England and in LSL: chlamydia, gonorrhoea, syphilis, genital warts, and genital herpes.⁷⁴ Several others such as shigella, hepatitis, lymphogranuloma venereum (LGV), trichomoniasis and molluscum contagiosum (MC) form a much smaller percentage of overall STI burden.^{71, 79}

Chlamydia remains the most common STI diagnosed across England and LSL. In 2017, 9,000 cases were diagnosed in LSL with reported rates in Lambeth and Southwark over double that of London and triple that of England.^{51, 74} Untreated chlamydia can lead to several gynaecological and urological complications such as pelvic inflammatory disease and epididymitis.⁸¹ The chlamydia detection rate in 15-24 year olds is an important indicator of good sexual health.⁷² All three boroughs in LSL have met and exceed the recommended rate of 2,300 per 100,000 people. Young people remain at greatest risk of chlamydia and annual opportunistic screening of sexually active people aged 15-24 years is recommended.⁸² Chlamydia testing should be offered in a range of settings to increase opportunistic testing, including primary care, online, outreach and termination of pregnancy services, however, a decrease of around 8% in testing was observed between 2016-17 nationally.⁷¹ This represents a continued decline that has only been somewhat compensated for by increases in the provision of online SRH services.^{51, 83}

Rates of gonorrhoea diagnosis have risen sharply from 2016 to 2017 nationally and locally. This is particularly concerning alongside the increasing prevalence of azithromycin- and recently, ceftriaxone-resistant gonorrhoea.^{84, 85} Gonorrhoea was the second most prevalent STI in LSL in 2017, with diagnosis rates 4-8 times greater in Lambeth (654 per 100,000), Southwark (565), and Lewisham (302) compared to England (79). Men in general have higher rates of diagnosis across all ages. In LSL, gonorrhoea remains concentrated in certain groups, particularly MSM and BAME.^{51, 74} Similarly to chlamydia, frequent gonorrhoea testing allows for timely diagnosis, treatment, prevention of serious complications, and onward transmission through case and partner management.⁸⁵

A syphilis outbreak was declared in 2017. Nationally, a total 7,137 cases of syphilis were reported in 2017, of which just under 1,000 were diagnosed in LSL residents.^{71, 74} The disease can remain latent and asymptomatic for many years before manifesting with dermatological, neurological and cardiovascular symptoms.⁸⁶ Rates of syphilis diagnosis in Lambeth and Southwark were higher than in London in 2017, while rates in Lewisham were similar to England. Nearly all (98%) of cases in LSL were in men with those aged 35-44 most affected.⁵¹ Syphilis is also most common among individuals who are at higher risk of other STIs, such as

HIV.⁸⁷ The highest number of cases of syphilis in over half a century were recorded in 2017 and, in response, PHE is developing an action plan to help address these rising rates especially among vulnerable groups.⁴⁰ This may require greater national coordination of efforts as well as innovative approaches such as targeted social media messaging to raise awareness of outbreaks when they occur.⁸⁸ Screening HIV-positive men and MSM for syphilis every three months has also been demonstrated to improve detection.⁸⁷

Cases of genital warts continue to decline with a 90% decrease reported since 2009 nationally.⁵¹ This decline has been mirrored in LSL though rates are still higher than the national average. The rate of diagnosis in Lambeth and Southwark (219 and 209 per 100,000 respectively) in 2017 was double that reported for England.⁷⁴ The introduction of a school-based HPV vaccine for girls is believed to have been the key driver in this reduction.⁷³ This success has instigated a roll out of the vaccine in MSM population to tackle increasing rates in this group.⁷¹

The incidence of genital herpes (HSV) has remained relatively stable nationally and in LSL. New diagnosis rates in London were 54 per 100,000 compared to Lambeth, Southwark and Lewisham respectively (148, 124 and 105 per 100,000). It remains the only STI which is more prevalent in women in LSL.⁷⁴ Many genital herpes infections are asymptomatic, however, they can cause severe systemic disease in neonates and facilitate HIV transmission.⁸⁹ Routine testing for genital HSV is not recommended unless symptomatic or in targeted groups where partners are affected or multiple partners are involved.^{90, 91}

Several other less prevalent, high-risk STIs are also treated through SRH services across LSL hence preventative strategies here are also important.⁴⁰ Viral hepatitis remains high on the public health agenda with the commitment from PHE to the WHO Strategy on elimination of hepatitis C as a major public health threat by 2030.⁹² Rates of hepatitis B reported in LSL are also higher than the London average with an incidence of 2.54 per 100,000 compared with 1.7 per 100,000 in London.⁵¹ Males and MSM in particular have been disproportionately affected. In addition, hepatitis A immunisation recommendations have been updated following the ongoing outbreak primarily affecting MSM in England: to opportunistically vaccinate all MSM attending SRH clinics without previous evidence of vaccination for hepatitis A and B, and to educate around preventative activities and condom distribution.^{93, 94}

Lymphogranuloma venereum cases peaked in 2014 but have been declining since. Of LGV diagnoses made in England in 2016, 91.7% were among MSM, 73.4% lived in London and 67.5% were HIV-positive. Clinicians are advised to always consider LGV testing and to maintain high suspicion in these high-risk groups.⁹⁵

Shigella has been traditionally associated with travel to lower income countries where sanitation is poor. However, since 2009, case numbers in England (particularly in MSM) have increased dramatically. Work undertaken by PHE in London highlighted that education and understanding of shigella remain low despite attempts for engagement through social media campaigns, posters and through sexual health clinics. Although cases among men have fallen in recent years, SRH clinics and health protection teams must continue to provide advice to SRH professionals on how to prevent spread and protect themselves.⁹⁶

Molluscum contagiosum and trichomoniasis together encompassed over 100 new diagnoses in LSL in 2017 although they are less clinically severe infections (with the exception of infections in those with late-stage HIV).⁹⁷ BASHH recommends that all individuals presenting with molluscum contagiosum should be given a full STI screen.⁹⁷ Trichomoniasis is associated with reproductive morbidity and increased rates of HIV transmission hence prompt treatment and contact tracing are recommended on diagnosis.⁹⁸

Several vulnerable groups are disproportionately affected by STIs – young people, MSM, and Black communities. Young people aged 15-24 years still experience the highest diagnosis rates of most STIs.⁴⁰ Historically, young women have had higher rates of genital warts however this has seen a significant decline with the introduction of a UK school-based HPV vaccine.⁷³ Relationships and sex education (RSE) in schools provides an opportunity to educate children and young people early in life about safer sex, types of contraception and local support services, in order to prevent the transmission of STIs. However recent work has revealed that nearly a third of schools lack good RSE and updates in government guidance are now needed (in anticipation of statutory RSE being introduced in September 2020), with consultation work underway.¹¹ A Cochrane review in 2016 revealed that too much RSE provision placed emphasis on abstinence or delayed sexual initiation rather than provision of information about contraceptives, for example.⁹⁹ School-based surveys in LSL have reinforced these results, demonstrating poor knowledge amongst young people about where to obtain free condoms. This is reflected in rates showing that LSL young people experience STIs more than the London and England average. This suggests a missed opportunity to embed discussions of effective methods of contraception (and where to obtain them) and safer sex when educating children and young people as part of RSE to promote good overall sexual and reproductive health.⁵⁶

MSM bear the burden of many types of STIs, with the main challenges among MSM being the large relative increases in gonorrhoea (21%), chlamydia (17%) and syphilis (17%) observed nationally in 2017 compared to 2016, and mirrored in LSL.⁵¹ Several behaviours likely explain these trends including increased condomless intercourse, multi-partner sex facilitated by geosocial networking applications, and a rise in 'chemsex'. This may also be partly explained by an increasing availability of HIV pre-exposure prophylaxis (PrEP). While PrEP has dramatically changed the landscape of HIV prevention, recent literature on coincident outcomes have suggested PrEP use may be associated with a reduction in the use of condoms and an increase in STI acquisition.¹⁰⁰ Research in England via the Impact trial continues. The national extension of targeted MSM HPV vaccination is expected to help reduce the incidence of genital warts and HPV-related cancers, though a lag is expected before full benefit is observed.⁷¹

With regards to ethnicity, the highest rates of STI diagnoses are among Black Caribbean and Black 'other' groups. Rates of STIs across England are highest in urban areas – especially in London – reflecting areas of higher deprivation. We know that Black communities are more likely to live in the more deprived areas of our boroughs.¹⁰¹ Interventions and services should be informed by the opinions and experiences of BAME groups to ensure services are attractive and sensitive to the needs of specific communities.^{75, 102} Engagement with faith communities and leaders in creative ways has also been shown to yield better participation in SRH services.⁷⁵

Trends in STI diagnoses therefore highlight several areas for concern both nationally and in LSL, especially with regards to drug-resistant gonorrhoea, rising rates of syphilis, and an apparent increase in condomless sex. For LSL, strategies are needed that increase STI testing, aid targeted condom distribution services and use of condoms, and provide effective access to treatment. This is most crucial in those groups who are at greatest risk of STI acquisition. Engaging 'hard to reach' groups, especially in an environment of austerity, will require continued innovative approaches and testing methods informed by those communities to ensure appropriate reach of services.

LIVING WELL WITH HIV

HIV remains a national and regional priority, particularly in Lambeth, Southwark and Lewisham (LSL) where diagnosed HIV prevalence rates are among the highest in the country; Lambeth has the highest rate of HIV diagnosis in England. These high diagnosed HIV rates are, in many ways, an indicator of the success of policy and action, but also a reflection of our communities. With knowledge of positive HIV status and access to effective treatment, the mortality rate of people with HIV is now comparable to the rest of the population.¹⁰³ As a result, HIV has transitioned away from the life-threatening illness it once was and into a long-term condition that must be managed alongside traditional age-related illness. Health and social care practitioners must adapt their thinking to mirror the evolution of this disease and to appropriately support and manage comorbidities in people living with HIV (PLHIV) in a non-discriminatory way.

In 2014, UNAIDS set out an ambitious treatment target for HIV globally: that by 2020, 90% of all people living with HIV would know their HIV status, 90% of all people with a diagnosed HIV infection would be on treatment (antiretroviral therapy (ART)), and that 90% of all people on treatment would be virally suppressed.¹⁰⁴ These aims are supported by current communications and campaigns around HIV: that 'undetectable = untransmittable'. In 2016, London achieved and surpassed these 90-90-90 targets: 90% of Londoners with HIV were diagnosed, 97% were on treatment, and 97% of those receiving ART were virally suppressed.¹⁰⁵

In January of 2018, London signed up to the Fast-Track Cities (FTC) Initiative, an international pledge to accelerate local responses to HIV and AIDS, including reaching the 90-90-90 goal.¹⁰⁶ As a testament to our commitment, London has set a more ambitious target to reach 0-0-0: 'zero HIV-related stigma and discrimination, zero new HIV infections, and zero preventable deaths from HIV-related causes'. London has also pledged to improve the health, quality of life and wellbeing of people living with HIV across the capital. Regionally, LSL contributes to and hosts the pan-London prevention programme 'Do It London', which provides far-reaching campaigns, free condom distribution, outreach and rapid HIV testing services. Furthermore, the Elton John AIDS Foundation (EJAF) has invested £2 million into primary care and community groups in LSL to increase HIV testing and support people diagnosed with HIV to engage in care.

HIV elimination is also a national objective. Public Health England's (PHE) strategic action plan 'Health promotion for sexual and reproductive health and HIV (2016-2019)' aims to decrease HIV incidence in populations most at risk of infection and to reduce the rate of late and undiagnosed HIV.⁴³ They also encourage adapting combination approaches to prevention. These involve deploying a set of behavioural, biomedical and structural approaches tailored to local such as levels of infrastructure, local culture as well as populations most affected by HIV. In the UK and particularly London, we have made considerable efforts to encourage condom use, promote expanded HIV testing and diagnosis (including self-sampling), and ensure prompt treatment and the use of pre-exposure prophylaxis (PrEP).

Both the private market and the national PrEP trial (the Impact trial) have revealed acceptability and demand for PrEP – particularly amongst men who have sex with men (MSM). The advent and accessibility of PrEP is a turning point for HIV, affording the freedom to engage in sex with an HIV positive partner safely and without fear or distress. Widespread acceptance and use of PrEP also works to combat the stigma once associated with HIV by reducing the marginalisation of those living with the virus.

These accomplishments are laudable, however, inequalities remain across LSL from HIV testing uptake to treatment and engagement in care. Anyone can contract HIV but people from some groups or parts of the world are more likely to be affected. Locally, the highest HIV diagnosis rates are seen in those aged 35-64, men of White ethnicity and women of Black African ethnicity.⁷⁴ Sex between men accounts for more than half of the new HIV cases in LSL each year. The number of new HIV diagnoses in MSM fell for the first time since the beginning of the HIV epidemic, likely driven by increased private use of PrEP and frequent testing. This decreasing trend has not been seen across all populations, however. New diagnoses in heterosexual women and Black African men remain proportionately high. In the UK and internationally, engagement of other at-risk groups including women, BAME communities, and trans people in the uptake of PrEP as a method of HIV prevention in trials has been much poorer than MSM, and more specific work to engage these groups will be required in a future commissioned PrEP service.

HIV testing, including frequent testing among those most at risk of HIV continues to be one of the most important interventions to identify current HIV infection and prevent onward transmission. Providing access to, and encouraging frequent testing has the potential to reduce the number of people unaware of HIV infection, the time with which people live with undiagnosed infection, and provides the opportunity for prompt HIV treatment. ART is now so effective that those who are treated and have an undetectable viral load (<200copies) have levels of virus that are untransmittable, even if having sex without condoms. Despite our local demographics and high prevalence of HIV, LSL testing coverage has consistently trended below the regional average.⁵¹ This is a strong indicator to us as sexual health commissioners that more must be done to ensure those most at risk of HIV are receiving prompt testing and treatment.

In December 2015, PHE launched a national self-testing service funded by local authorities that allows users to order free HIV test kits online. This provides an accessible, easy-to-use alternative to traditional testing and help to empower individuals to take control of their sexual health. This service has been particularly successful at engaging MSM, which has decreased the attributable HIV testing in sexual health clinics and may in turn be partially responsible for the proportional rise in new diagnoses in women and Black African men.

Our concerted efforts to increase testing, timely diagnosis, and treatment have helped to improve the life chances of those who contract HIV and over time, fewer people in LSL are receiving a late HIV diagnosis. Nonetheless, in all LSL boroughs in 2014-16 more than 25% (target) of people diagnosed with HIV received a late diagnosis.⁷⁴ Late diagnosis is highest in Lewisham where almost 40% of people received a late HIV diagnosis in 2014-2016, closely followed by Southwark. Across LSL in 2016, certain groups had a higher proportion of people with late diagnosis: those aged 50-64 (53%), Black African ethnicity (49%) and Other ethnicity (46%), those whose exposure to HIV was through heterosexual contact (59%), and women (55%).⁷⁴ These data afford us insight into groups who would benefit from outreach programmes and targeted prevention and testing. Late diagnosis is the most important predictor of morbidity and premature mortality among people with HIV and increases the risk of HIV transmission; it is therefore a critical target for reduction in our strategy.

Effective, timely treatment allows PLHIV to lead long and largely unencumbered lives. However, stigma and discrimination remain primary barriers to engagement across the course of HIV. A national survey of perceived stigma was undertaken by Stigma Index UK in 2015/16.¹⁰⁷ In London, while almost all (94%) participants reported someone in their social circle was aware of their HIV status, those of Black and other minority ethnicities were less likely to have disclosed their status.¹⁰⁷ Among those who reported feeling stigmatised, sexual rejection was the most common cause of concern. The majority (59%) of patients who had

disclosed their HIV status to their GP felt well supported, however, 13% reported having avoided seeing the GP when required. These experiences were broadly similar to that of PLHIV in the UK overall.¹⁰⁷

Education and campaigns aimed at young people and the general public may help to normalise HIV and reduce the marginalisation of those affected. Stigma and discrimination have also been suggested to influence adherence to ART.¹⁰⁸ A large systematic review of retention in care among adult PLHIV¹⁰⁹ found that substance use, physical comorbidities (e.g. hepatitis C infection), and certain demographics were less likely to remain engaged in care. Key demographics identified as risk factors for becoming lost to care included being from an ethnic minority group. Sexual health professionals must recognise these added risk factors and, where possible, programmes and services should be designed to best support and engage these groups. A synthesis of qualitative evidence suggests that shifting the responsibility of holistic care and support away from clinicians onto lay workers or peer counsellors may nurture a positive outlook and increase retention in care.¹⁰⁸

As PLHIV generally continue to live longer and age, it is critical that our services evolve to meet the complex needs of this population. The mental wellbeing of PLHIV is associated with adherence to treatment and overall quality of life.¹¹⁰ Unfortunately, PLHIV are more likely to experience depression and anxiety, which may negatively impact treatment outcomes.¹¹⁰⁻¹¹⁴ Mental health and wellbeing should be considered and supporting throughout the life course of PLHIV. As PLHIV age, they may also be affected by physical comorbidities. These may be routine age-related illnesses, however, certain conditions may be exacerbated by HIV infection and treatment, and vice-versa.¹¹⁵ In terms of STIs specifically, in Lambeth and Southwark in 2017, 90% of syphilis cases were in people who identified as gay; this was slightly lower in Lewisham (78%).⁷⁴ Genital sores caused by syphilis make it easier to transmit and acquire HIV infection sexually. Across London, half of MSM cases of syphilis also have HIV.⁷⁴ This is concerning as co-infection with HIV increases the risk of central nervous system complications. PLHIV are also most affected by lymphogranuloma venereum (LGV), a type of chlamydia that infects the lymph node. In LSL, 67.5% of LGV diagnoses in 2017 were in HIV-positive MSM. Finally, tuberculosis (TB) is one of the most common co-infections with HIV,¹¹⁶ with PLHIV being at 16-27 times greater risk of developing TB than those without HIV infection.¹¹⁷ Alongside these particular conditions, as PLHIV age, like the rest of the population they may develop common age-related illnesses such as cardiovascular disease and dementia.¹¹⁸⁻¹²⁰ It is therefore essential that HIV care evolves to include a wide range of professionals that effectively manage HIV as a long-term condition, acknowledge and support the social care needs and wellbeing of PLHIV, and are prepared to recognise and treat as routine communicable and non-communicable diseases.

Acquiring, living with, and ageing with HIV affects a significant proportion of LSL residents. While significant achievements have been made in reducing the incidence of HIV and improving the quality of life of those living with HIV, approaches must remain agile to address the changing landscape of HIV support. Specialist HIV services and primary care must work together to deliver holistic, person-centred care, managing HIV alongside with other chronic and acute health conditions. Strengthening our combined prevention approaches, promoting timely testing and treatment, and improving our understanding of the social aspects of HIV will support PLHIV in LSL to access the services and care they need to live a long, healthy and fulfilling life.

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Agenda Item 7

HEALTH AND WELLBEING BOARD			
Report Title	Update on NHS Long Term Plan		
Contributors	Lewisham Clinical Commissioning Group Managing Director	Item No.	7
Class	Part 1	Date: 7 March 2019	
Strategic Context	The report provides an update on the NHS Long Term Plan		

1. Purpose

- 1.1 This report provides members of the Health and Wellbeing Board with an update on the NHS Long Term Plan.

2. Recommendation

- 2.1 Members of the Health and Wellbeing Board are asked to note the presentation that will be received at the meeting.

3. Policy Context

- 3.1 In June 2018, the Prime Minister made a commitment that the Government would provide more funding for the NHS for each of the next five years, with an average increase of 3.4% a year.
- 3.2 In return, the NHS was asked to come together to develop a long term plan for the future of the service, detailing our ambitions for improvement over the next decade, and our plans to meet them over the five years of the funding settlement. That plan has now been published.

4. Summary of plan

- 4.1 Working groups - made up of local and national NHS and local government leaders, clinical experts and representatives from patient groups and charities – were formed to focus on specific areas where the NHS could improve over the next ten years.
- 4.2 The working groups have developed a range of specific ideas and ambitions for how the NHS can improve over the next decade covering all three life stages:
- Making sure everyone gets the best start in life
 - Developing world-class care for major health problems
 - Supporting people to age well

4.3 To ensure that the NHS can deliver the ambitious improvements for patients, the NHS Long Term Plan also sets out actions to overcome the challenges that the NHS faces, such as staff shortages and growing demand for services by:

- Doing things differently
- Preventing illness and tackling health inequalities
- Backing our workforce
- Making better use of data and digital technology
- Getting the most out of taxpayer's investment in the NHS

5. Financial implications

5.1 The Long Term Plan has been developed in response to central government commitments for NHS funding over the next five years. The plan identifies national funding commitments, for instance in mental health and primary and community care. Sustainability and Transformation Partnership (STP) areas are required to develop local plans for 2019/20 and for five years that set out how the Long Term Plan ambitions will be delivered.

6. Legal implications

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

7. Crime and Disorder Implications

7.1 There are no specific crime and disorder implications arising from this report.

8. Equalities Implications

8.1 The Long Term Plan has identified tackling health inequalities as a priority area, in particular to focus on those communities and groups impacted by smoking, drinking problems and Type 2 diabetes.

9. Environmental Implications

9.1 There are no specific environmental implications arising from this report.

If there are any queries on this report please contact Charles Malcolm-Smith, Deputy Director (Strategy & OD), Lewisham CCG, e-mail charles.malcolm-smith@nhs.net

Lewisham Health & Wellbeing Board

NHS Long-Term Plan



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Background

In June 2018, the Prime Minister made a commitment that the Government would provide more funding for the NHS for each of the next five years, with an average increase of 3.4% a year.

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In return, the NHS was asked to come together to develop a long term plan for the future of the service, detailing our ambitions for improvement over the next decade, and our plans to meet them over the five years of the funding settlement.

That plan has now been published.

How the NHS Long Term Plan was developed



200

distinct engagement events, 150 of which were over August and September

500

direct submissions by letter or email

Working groups – made up of local and national NHS and local government leaders, clinical experts and **representatives from patient groups and charities** – were formed to focus on specific areas where the NHS could improve over the next ten years.

2000+

submissions via the online form

3.5M

Individual or organisational members represented through submissions

They then engaged extensively with stakeholders to come up with and test practical ideas which could be included in a plan.

5427

readers of blogs about the [long term plan](#)

21,788

views of the online discussion guide webpage

Over Autumn, working group members organised or attended over **200 events** to hear a wide range of different views, and received over **2,500 submissions** from individuals and groups representing the opinions and interests of **3.5 million people**.



What the NHS Long Term Plan will deliver for patients

The working groups have developed a range of specific ideas and ambitions for how the NHS can improve over the next decade, covering all three life stages:

- Making sure everyone gets the best start in life
- Delivering world-class care for major health problems
- Supporting people to age well

Making sure everyone gets the best start in life...

...including:

- reducing stillbirths and mother and child deaths during birth by 50%
- ensuring most women can benefit from continuity of carer through and beyond their pregnancy, targeted towards those who will benefit most
- providing extra support for expectant mothers at risk of premature birth
- expanding support for perinatal mental health conditions
- taking further action on childhood obesity
- increasing funding for children and young people's mental health
- bringing down waiting times for autism assessments
- providing the right care for children with a learning disability
- delivering the best treatments available for children with cancer, including CAR-T and proton beam therapy.

Delivering world-class care for major health problems...

...including:

- preventing 150,000 heart attacks, strokes and dementia cases
- providing education and exercise programmes to tens of thousands more patients with heart problems, preventing up to 14,000 premature deaths
- saving 55,000 more lives a year by diagnosing more cancers early
- investing in spotting and treating lung conditions early to prevent 80,000 stays in hospital
- spending at least £2.3bn more a year on mental health care
- helping 380,000 more people get therapy for depression and anxiety by 2023/24
- delivering community-based physical and mental care for 370,000 people with severe mental illness a year by 2023/24.

Supporting people to age well...

...including:

- increasing funding for primary and community care by at least £4.5bn
- bringing together different professionals to coordinate care better
- helping more people to live independently at home for longer
- developing more rapid community response teams to prevent unnecessary hospital spells, and speed up discharges home.
- upgrading NHS staff support to people living in care homes.
- improving the recognition of carers and support they receive
- making further progress on care for people with dementia
- giving more people more say about the care they receive and where they receive it, particularly towards the end of their lives.

Delivering the ambitions of the NHS Long Term Plan

To ensure that the NHS can achieve the ambitious improvements for patients, the NHS Long Term Plan also sets out actions to overcome the challenges that the NHS faces, such as staff shortages and growing demand for services, by:

1. Doing things differently
2. Preventing illness and tackling health inequalities
3. Backing our workforce
4. Making better use of data and digital technology
5. Getting the most out of taxpayers' investment in the NHS



1. Doing things differently

The NHS will:

- give people more control over their own health and the care they receive,
- encourage more collaboration between GPs and their teams and community services, as 'primary care networks', to increase the services they can provide jointly;
- place an increasing focus on NHS organisations working with each other and their local partners, as 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities.

2. Preventing illness and tackling health inequalities

The NHS will:

- increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.

3. Backing our workforce

The NHS will:

- continue to increase the NHS workforce, training and recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships.
- take steps to make the NHS a better place to work, so fewer staff leave and more feel able to make better use of their skills and experience for patients.

4. Making better use of data and digital technology

The NHS will:

- provide more convenient access to services and health information for patients, with the new NHS App as a digital ‘front door’;
- provide better access to digital tools and patient records for staff, and;
- improve the planning and delivery of services through the greater use of analysis of patient and population data.



5. Getting the most out of taxpayers' investment in the NHS

The NHS will:

- continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered;
- make better use of the NHS' combined buying power to get commonly-used products for cheaper, and;
- reduce spend on administration.

What happens next

Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) now need to develop and implement their own strategies for the next five years.

These strategies will set out how they intend to take the ambitions that the NHS Long Term Plan details, and work together to turn them into local action to improve services and the health and wellbeing of the communities they serve – building on the work they have already been doing.



January 2019
Publication of the NHS
Long Term Plan



By April 2019
Publication of local
plans for 2019/20



By Autumn 2019
Publication of local
five-year plans

London

- Prioritising what to do at capital city level
- Looking at health inequalities at source (where do the people who have most admissions live?)
- Using evidence based care
- Recognising that telling people what to do might not work

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A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England



Developing the vision for health and care in London

South East London
Clinical Strategy Workshop

Dr Vin Diwakar
Regional Medical Director
January 2019



SUPPORTED BY
MAYOR OF LONDON

London's NHS organisations include all of London's CCGs, NHS England and Health Education England

SE London

For each Clinical Leadership Group and Enabler and at neighbourhood, place and system level

- What is new?
- What is a re-announcement?
- What is a change to an existing priority or plan?
- What is not mentioned?
- What is funded?

Response due by the autumn:

- Plan production
- Financial modelling
- Engagement process
- Communications

Agenda Item 8

HEALTH AND WELLBEING BOARD			
Report Title	Lewisham Suicide Prevention Strategy 2019-21		
Contributors	Director of Public Health, London Borough of Lewisham	Item No.	8a
Class	Part 1	Date	7 March 2019

1. Purpose

- 1.1 To provide members of the Health and Wellbeing Board with the draft content of the Lewisham Suicide Prevention Strategy 2019-21.

2. Recommendation/s

Members of the Health and Wellbeing Board are recommended to:

- 2.1 Note the draft content of the Suicide Prevention Strategy and direct as required any further analysis or commentary.

3. Policy Context

- 3.1 In March 2016 the Five Year Forward View for Mental Health was published which set out the ambition that the number of people taking their own lives nationally would be reduced by 10% by 2020/21 compared to 2016/17 levels. The document also set out the following national recommendations in terms of suicide prevention:

- The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, contributing to a 10 per cent reduction in suicide nationally.
- These plans should set out targeted actions in line with the National Suicide Prevention Strategy and new evidence around suicide, and include a strong focus on primary care, alcohol and drug misuse.
- Each plan should demonstrate how areas will implement evidence-based preventative interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within their population, drawing on localised real time data.
- Local suicide prevention plans should also agree indicative targets and trajectories for the reduction in suicides, to support transparency and monitoring locally over the period.

4. Background

4.1 In line with the recommendation from the Five Year Forward View, a suicide prevention plan has been developed for Lewisham. The Public Health England (PHE) 'Local Suicide Prevention Planning: A Practice Resource' guidance was used in the development of this strategy.

4.2 Development of the strategy has involved the following stages:

- Establishment of a multi-agency stakeholder group

The Lewisham Suicide Prevention Strategy Group was set up in January 2017 to develop and implement the suicide prevention strategy for Lewisham.

- Completion of a Suicide Audit

A refresh of a previous local suicide audit was performed in February 2017. This audit refresh was performed using data from the Primary Care Mortality Database to examine all deaths recorded as suicides in Lewisham between 2012 and 2016 (calendar years). Deaths recorded as having 'open verdicts' were also included in the audit since deaths due to suicide are defined as deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent. This data formed the basis of the strategy/plan development.

- Drafting of the suicide prevention strategy and action plan

The key priorities areas of the national strategy were used to form the framework for actions in this strategy. In addition to using local data to inform these actions, the Lewisham multi-agency group convened several stakeholder events to gain important local views on what would be important to incorporate into the local strategy.

5. Lewisham Suicide Prevention Strategy 2019-21

5.1 The vision of the strategy is to be a borough that becomes safer from the risk of suicide. The main aims of the strategy are as follows:

- To contribute to a national 10% reduction in the suicide rate by 2021
- To provide better support for those affected by suicide in Lewisham
- To raise awareness of suicide prevention in Lewisham among the frontline workforce and wider community

5.2 The priority areas for action in the strategy mirror those of the national strategy and are as follows:

- Reduce the risk of suicide in key high-risk groups

The high risk groups identified by the audit and consultation events include:

- Young men (those between the ages of 25 and 44 years)
- Those who misuse drugs and/or alcohol
- Pregnant women

The main actions in this priority area include: promoting suicide prevention training to services that are targeted at those in these high risk groups e.g. substance misuse services, midwives and health visitors; supporting work on dual diagnosis in the borough; and reducing stigma around talking about mental health in men through initiatives such as the Lewisham Time to Change Hub and Downham Men's Group collaborative project on mental health with Lewisham HealthWatch.

- Tailor approaches to improve mental health in specific groups

Children and young people have been chosen as the specific group to target for this area of the strategy, as a means of prevention/early intervention. The actions in this priority area involve building on the initiatives and services already in place for children and young people in Lewisham and ensuring that they align with the proposals included in the government Green Paper on improving the mental health of children and young people.

- Provide better information and support to those bereaved or affected by suicide

There are currently no dedicated support groups for those affected or bereaved by suicide in Lewisham. The strategy group will work to support the co-ordination of a local group and will also work to ensure that existing resources and groups across London are appropriately signposted to by those who might be first responders to a suicide in the borough.

- Support the media in delivering sensitive approaches to suicide and suicidal behaviour

Collaborative work with South East London (SEL) boroughs and the Samaritans will support this priority area of the strategy, through engagement with local media outlets to influence more sensitive reporting around suicides taking place across the SEL geography. A collaborative approach has been sought for this action area due a number of local media outlets in SEL having shared ownership. SEL boroughs will also work with Thrive LDN on this area to influence media outlets that operate across London.

- Support research, data collection and monitoring

A joint approach with SEL boroughs and Thrive London will be sought for this priority area to work with Coroners to develop both local and London-wide data sharing agreements to support a local annual suicide audit for Lewisham. Data and intelligence from local Child Death Overview panels (CDOP), Drug and Alcohol-Related Death panels and serious incident reporting from secondary care could also be collated in order to provide the most up to date data on suicides to incorporate into local suicide audits.

An action plan and monitoring/evaluation framework have also been developed for the strategy to support its implementation.

6. Financial implications

- 6.1 NHS England have not released any specific funding to support the Lewisham suicide prevention strategy. Resources and expertise to implement the strategy will be sought from Thrive London. The work described in the Strategy will be carried out within the existing budgets of the Council and partner organisations.

7. Legal implications

- 7.1 There are no specific legal implications of this strategy.

8. Crime and Disorder Implications

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

9. Equalities Implications

- 9.1 The suicide audit performed to inform the strategy made use of available data on the protected characteristics (age, gender, country of birth as a proxy for ethnicity) of those who have completed by suicide in Lewisham between 2012 and 2016. The main inequalities identified from the audit were in relation to age and gender, with men between the ages of 24 and 45 years being at highest risk of completing suicide in the borough. These findings were fed into the development of actions for the main priority areas of the strategy.

10. Environmental Implications

- 10.1 There are no Environmental Implications from this report.

11. Conclusion

- 11.1 A suicide prevention plan has been developed for Lewisham to cover the 2019-2021 time period and aims to make the borough safer from the risk of suicide and contribute to a national 10% reduction in the rate of suicide by 2021.

If there are any queries on this report please contact Catherine Mbema, Public Health, Lewisham Council, on 0208 314 3927, or by email at: ***Catherine.mbema@lewisham.gov.uk***



LEWISHAM SUICIDE PREVENTION STRATEGY

2019-2021

Contents

1. Introduction and National Context
2. Local Strategy Development
3. Deaths by Suicide in Lewisham
4. Strategic Aims
5. Priority Areas for Action
6. Monitoring and Evaluation
7. Governance
8. Action Plan

Appendices

1. Introduction and National Context

National Strategy

In 2012, the government produced a cross-party strategy focusing on suicide prevention, 'Preventing suicide in England: A cross-government outcomes strategy to save lives', which focuses on preventing suicide through a public health approach and establishes the case for locally developed multiagency strategies and action plans.¹

The national strategy had two specific ambitions and the following six priority areas for action:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

Since the publication of the strategy, two progress reports have been published which have led to the addition of an additional priority area for action around 'reducing rates of self-harm as a key indicator of risk of suicide'.^{2,3}

National Suicide Statistics

The most recent national data has shown that³:

- The suicide rate in England fell slightly in 2015, though the rate remains high in comparison to the last 10 years.
- The suicide rate in mental health patients has reduced
- The suicide rate in men has fallen for two years and this fall is found most clearly in middle-aged men whose risk has been highlighted in the National Strategy.
- The highest rates are still found in men in their 40s and 50s and it remains the leading cause of death in young men
- The suicide rate in women has risen, though the male rate is still three times higher

Five-Year Forward View for Mental Health

In March 2016 the *Five Year Forward View for Mental Health*⁴ was published which endorsed the vision of Future in Mind⁵ and set out the ambition that the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels. The document also set out the following national recommendations in terms of suicide prevention⁴:

- The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, contributing to a 10 per cent reduction in suicide nationally.
- These plans should set out targeted actions in line with the National Suicide Prevention Strategy and new evidence around suicide, and include a strong focus on primary care, alcohol and drug misuse.
- Each plan should demonstrate how areas will implement evidence-based preventative interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within their population, drawing on localised real time data.
- Local suicide prevention plans should also agree indicative targets and trajectories for the reduction in suicides, to support transparency and monitoring locally over the period.

Future in Mind 2015

In March 2015, NHS England published 'Future in Mind'⁵ as part of a national drive to improve capacity and capability in the delivery of mental health services for children. This report provides a broad set of recommendations across five key themes:

- Promoting resilience, prevention and early intervention
- Improving access to effective support
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

The national and local drive to transform mental health services for children and young people across these key areas is evident across the country. Locally plans are in place across all areas to highlight and reflect, progress and further ambitions within the Child Adolescent and Mental Health Services Transformation Programme.

2. Local Strategy Development

The Public Health England (PHE) 'Local Suicide Prevention Planning: A Practice Resource' guidance⁶ was used in the development of this strategy, alongside information from one of the PHE Suicide Prevention Masterclass held in London in March 2017. The PHE guidance document outlines the following three steps in local plan development as recommended by the All-Party Parliamentary Group on Suicide and Self-harm Prevention, which were followed in the development of this plan (see Figure 1):

- Establish a multi-agency stakeholder group

The Lewisham Suicide Prevention Strategy Group was set up in January 2017 to develop and implement a suicide prevention strategy for Lewisham. The terms of reference (including membership) for the group can be seen in Appendix 1.

- Complete a Suicide Audit

A refresh of a previous local suicide audit was performed in February 2017. This audit refresh was performed using data from the Primary Care Mortality Database to examine all deaths recorded as suicides in Lewisham between 2012 and 2016 (calendar years). Deaths recorded as having 'open verdicts' were also included in the audit since deaths due to suicide are defined as deaths given an underlying cause of intentional self-harm or injury/poisoning of *undetermined intent*. This data formed the basis of the strategy/plan development.

- Develop a suicide prevention strategy and/or action plan that is based on the national strategy and the local data

The key priorities areas of the national strategy were used to form the framework for actions in this strategy. In addition to using local data to inform these actions, the Lewisham multi-agency group convened several stakeholder events to gain important local views on what would be important to incorporate into the local strategy. Summaries and feedback from these events can be found in Appendix 2.

Figure 1: Strategy Development Process



3. Deaths by suicide in Lewisham

Both national and local data sources were used to gain an understanding of local population need in relation to suicide in order to inform the development of the local strategy.

National Data

Between 2013 and 15, Lewisham had a 3-year average suicide rate of 7.4/100,000 (ref), which was significantly lower than the London and England averages for that period (Table 1).

Table 1: Age standardised mortality rate from suicide, per 100,000 population, 2013-15

	Total	Male	Female
Lewisham	7.4	9.6	Insufficient data
London	8.6	13.4	4.1
England	10.1	15.8	4.7

(Source: Office for National Statistics)

In terms of the years of life lost to suicide, Lewisham had a 3-year average total of 25.8 per 100,000 years of life lost to suicide between 2013 and 2015 (Table 2).

Table 1. Age standardised years of life lost from suicide, per 10,000 population, 2013-15

	Total	Male	Female
Lewisham	25.8	37	14.7
London	23	35.4	10.7
England	31.9	50.2	13.7

(Source: Office for National Statistics)

Local Suicide Audit

To gain further understanding of local population needs in relation to suicide and to inform the local strategy, the Lewisham Public Health team performed a refreshed suicide audit. The audit examined anonymised data extracted from the Primary Care Mortality Database (PCMD) for the time period January 2012 - December 2016. This included data on cause of death, age, gender, place of death and country of origin.

The following main findings were concluded from the audit:

- In Lewisham, the largest number of suicides during the time period examined was among those aged between 24-45 years (53% of all suicides). This differs from what is seen nationally, where those aged between 45 and 55 have the highest suicide rate. This finding may reflect the relatively younger population in Lewisham compared to England overall since the audit results have not been standardised.
- Three times as many men died as result of suicide in Lewisham in this time period compared to women. This reflects trends seen across the country.
- The most common method of suicide in Lewisham was hanging (66% of all suicides) during this period for both men and women.
- Opiate overdose made up a quarter of all non-violent suicides during this period in Lewisham.
- In terms of place of birth, the majority of suicide deaths in Lewisham were in those born in the UK (68%). Ethnicity data is not available from the PCMD, therefore place of birth can be used a proxy measure for ethnicity although will only closely correlate with ethnicity for first generation immigrants.

Data definitions and constraints

- It is important to note that in the UK (and therefore national statistics) suicide is defined as deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent. This means that the Coroner's review does not have to result in a verdict of suicide; open verdicts are still considered suicides.
- The PCMD is limited in the nature of the data that it can provide around suicide deaths to inform local action. Information concerning ethnicity, socio-economic status, employment, previous mental health diagnoses, previous contact with primary care or mental health services and other contextual factors can only be gained from records held by our local Coroner.
- We do not currently receive any additional data from the Coroner concerning deaths by suicide. Cross-borough approaches are currently being explored to obtain a minimum Coroner dataset for South-East London public health teams concerning suicides and drug/alcohol-related deaths.

4. Strategic Aims

Strategic Vision

To be a borough that becomes safer from the risk of suicide

Main Strategic Aims

To contribute to a national 10% reduction in the suicide rate by 2021

To provide better support for those affected by suicide in Lewisham

To raise awareness of suicide prevention in Lewisham among the frontline workforce and wider community

The main aims of this strategy closely reflect those of the national suicide prevention strategy¹.

The main objectives of the national strategy are to achieve¹:

- **a reduction in the suicide rate in the general population in England; and**
- **better support for those bereaved or affected by suicide.**

The main areas for action in the national strategy are to:

- **reduce the risk of suicide in key high-risk groups**
- **tailor approaches to improve mental health in specific groups**
- **reduce access to the means of suicide**
- **provide better information and support to those bereaved or affected by suicide**
- **support the media in delivering sensitive approaches to suicide and suicidal behaviour**
- **support research, data collection and monitoring**

They also reflect the ambitions set out in the Five Year Forward View for Mental Health as mentioned above.

The main long-term areas for action in this strategy will follow the main action areas of the national strategy, however the national 'reduce access to the means of suicide' action area will not be an immediate area of focus in this strategy. We will, however, aim to incorporate this action area into future iterations of the strategy.

5. Priority Areas for Action and Programmes of Work

A. Action Areas

National and local data, evidence and stakeholder input has been used to determine which specific actions are outlined under each main action area.

5.1 Reduce the risk of suicide in key high-risk groups

Why is this important for Lewisham?

There are a number of population groups that have been identified as being at higher risk of suicide than the overall Lewisham population:

- Young men (aged between 24-45 years)
- Those who misuse drugs and/or alcohol
- Pregnant women

It is critical that we take specific action and support targeted interventions to reduce the risk of suicide in these groups.

Main issues

Young men

Between 2012 and 2016, 53% of deaths by suicide in Lewisham occurred in men aged between 24 and 45 years. This is a slightly younger age group than that seen nationally (men aged between 45-59 years have the highest rates of suicide in England), which may reflect the younger population of Lewisham as noted earlier. Further data and exploratory work is required to understand more about deaths by suicide in this group, however evidence-based approaches and examples good practice will be examined as part of this strategy to take some steps towards reducing the risk of suicide in young men.

Those who misuse drugs and/or alcohol

There is a clear overlap between drug and alcohol related deaths and suicide. Eighty per cent of those in treatment for alcohol use conditions and nearly seventy per cent of people in drug treatment are thought to have co-existing mental health problems³. In 2014, the proportion of drug misuse deaths that were due to suicide (defined as intentional self-poisoning or poisoning of undetermined intent) in England was 28% and 11% in men and women respectively³.

At the Lewisham Drug and Alcohol-related Deaths (DARD) panel this overlap has become increasingly apparent. At the stakeholder workshop those working in the local substance

misuse services also highlighted the need for specific training around how to respond to service users in an acute mental health crisis expressing suicidal ideation.

Pregnant women

National evidence shows that approximately 20% of women experience a mental health condition during pregnancy and the first 12 months after childbirth, with suicide being the second most common cause of death for women during this period. In Lewisham, 33% of suicide deaths in women occur between the age of 24-45. Further investigation is required to understand what proportion of these occur within the perinatal period.

Those who self-harm

Previous episodes of self-harm have been identified as the strongest predictor of suicide⁶. In Lewisham, the (age-standardised) rate of emergency hospital admissions due to intentional self-harm⁷ is lower than the England average, and has seen a declining trend since 2013. However, local data on presentations/attendances at emergency services for episodes of self-harm is not routinely reported.

What is already happening?

Mental Health First Aid Training

Adult and youth mental health first aid training is currently available for all frontline workers and volunteers in Lewisham. This includes those who support young men, women in the perinatal period, children and young people, and those who misuse drugs and/or alcohol.

Perinatal Mental Health

A programme of work has been in place aimed at early identification of and support to women experiencing perinatal ill health in line with national initiatives such as 1001 Critical Days⁸. The Lewisham Maternity Voices Partnership (MVP) has led on the co-production of the, 'It's ok not to feel ok' on-line webpage⁹. Commissioners and the MVP have also worked together to commission a 2-year programme called 'Mindful Mums' run by Bromley and Lewisham MIND. This is a programme in which trained peer supporters with lived experience of mental ill health, facilitate a 6-week programme for pregnant and new mothers aimed at improving mental health and wellbeing.

Specialist perinatal mental health posts in midwifery and health visiting are also in place aimed at better staff training and ensuring there is a clear care pathway aimed at prevention and early identification of perinatal illness.

Dr Serena Patel, Public Health GP trainee has undertaken a Perinatal Joint Strategic Needs Analysis (JSNA), which is now publicly available and being implemented¹⁰.

What further action can be taken?

Paternal Mental Health

The above JSNA will inform future plans for improving perinatal mental health and suicide prevention. The JSNA findings indicate that there are gaps in knowledge and support services to new fathers with mental health issues and this is likely to be an area of work warranting more detailed analysis in the future. There is also scope to do more on suicide prevention through existing commissioned services for fathers e.g. The Working with men pilot for young fathers up to the age of 25 years.

Suicide Prevention Training

To ensure that front-line staff working with high-risk groups are confident in the recognition, assessment and management of risk in relation to suicide, appropriate suicide prevention training should be delivered to priority workforce areas. This would include non-clinical frontline staff, such as those in the housing department, benefits office, and job centres.

Comprehensive and concise guidance on how to ask, how to safety plan and what next for all front line staff including healthcare workers, Jobcentre Plus staff, drug and alcohol services and supported people services could also be included within this training. Work with the criminal justice system would also ensure that those in points of transition are effectively identified and supported. More emphasis needs to be placed on suicide prevention when going through the gate i.e. greater liaison with community mental health teams and more established release planning (primary care, accommodation, employment, signposting and appointments to support agencies such as drug and alcohol agencies, family support, finance and debt advice).

Dual Diagnosis

The National Institute for Health and Care Excellence (NICE) is currently reviewing guidance for people with coexisting severe mental illness and substance misuse, which aims to improve care pathways for this group. It is important for Lewisham to review these guidelines when published in September 2019 to provide coordinated services that address the wider health and social care needs as well as other issues such as employment and housing. Mental health and substance misuse commissioners have started to meet to further develop effective pathways for those with dual diagnosis in Lewisham.

Public Mental Health awareness particularly for young men

Resources from national campaigns targeting stigma and discrimination around mental health, such as the 'Time to Change' campaign, in addition to those focusing on mental health in men can be used locally to raise awareness of mental health in young men.

Lewisham has become one of a number of organic Time to Change hubs, enabling resource and training from the national campaign to be received locally to plan and develop activities to address stigma and discrimination for those with mental ill health. The mental health of young men could be an area of focus within the work of the Hub.

A new partnership initiative between Quo Vadis Trust, Community Connections and HealthWatch has established a men's mental health support group that meets on a monthly basis. Learning from this group will be used to inform the possibility of further men's mental health groups being established in Lewisham.

Improving local data and support for those who present to services with self-harm

There is a need for clearer data on self-harm presentations to emergency services in Lewisham, particularly in children and young people. There is also a need to standardise the information given to those presenting and their families. A strand of work is being developed to ensure that standardised materials are distributed to those affected by self-harm presenting to Lewisham A&E. Data reporting on self-harm will also be included in the annual suicide audit mentioned in priority action area number 6.

5.2 Tailor approaches to improve mental health in specific groups

Mental health of children and young people

Why is this important for Lewisham

There has been universal acknowledgment in policy over the past ten years of the challenges faced by children and young people in developing resilience and psychological wellbeing. For those children and young people with diagnosable mental health problems and their parents/carers and the agencies that support them, the challenges are greater. A number of disorders are persistent and will continue into adult life unless properly treated. It is known that 50% of lifetime mental illness (except dementia) begins by the age of 14 and 75% by age 18. Young people who are not in education, employment or training report particularly low levels of happiness and self-esteem.

Main issues

There is a strong case to improve the current provision of health services for young people. A challenge for commissioners and providers is how services for young people are configured and provided. There is evidence that the complex and overlapping needs of young people and the challenges in identifying the early signs of risk factors, are not well served by an all too often silo approach to services and professionals working with young people.

No one service alone will be able to meet their needs. There is a duty of cooperation placed on commissioners and services to work together to the benefit of children and young people. The multi-agency nature of CAMHS will require a multi-agency approach to commissioning is required. Changes in one agency or one part of the system can affect demand and delivery in another. This interdependency can create risks if not properly considered but also brings with it the possibility of agencies working together to meet the needs of the populations they serve and to achieve wider system efficiencies. Services should work together in integrated ways to ensure appropriate communication and transitions.

What is already happening?

Lewisham's Children and Young People Plan (CYPP) 2015-18 affirms how partner agencies will work together to improve outcomes and improve the life-chances of young people in the borough. It also emphasises the commitment to joint commissioning with the purpose to achieve better value for money and ensure resources are aligned to achieve the greatest impact. The four priorities listed within the CYPP are: Build Resilience; Be Healthy and Active; Stay Safe; and Raise Achievement and Attainment, of which mental health and wellbeing are recognised across all.

'Lewisham's Children and Young People's - Mental Health and Emotional Wellbeing Strategy' works hand in hand with the CYPP and supported by Child and Adolescent Mental Health Services (CAMHS) Transformation funding, a considerable amount of work has been undertaken over recent years, to improve the mental health and wellbeing of Lewisham children and young people. Stakeholders, including children, young people and their parents have worked together to develop a shared vision and common language, to be understood by all.

“Our children and young people will be emotionally resilient, knowing when and where to go for help and support when faced with challenges and adversities as they arise. Those that require mental health support are able to access this, where and when they need it.

Our parents/carers and young people’s workforce will be equipped to identify and respond to low levels of emotional well-being amongst our young people.”

The NHS Lewisham CCG Local Transformation Plan (LTP) was finalised at the end of 2015 and in December 2015 CCGs were advised of rising baseline funding for the next five years. Plans have now been in place since that time and there is continued expectation for CCGs to refresh plans annually to reflect local progress and further ambitions based on the increasing financial envelop and the Mental Health Implementation Plan.

NHS Lewisham CCG and stakeholders have developed an approach to delivering accessible, efficient and evidence based mental health services across the borough. Partners are working together to manage financial pressures across the system, integrating services where possible to ensure future sustainability.

Local Provision

Information below has been separated across specialist, targeted and universal provision to demonstrate the range of support services that are available to Lewisham children, families and schools, to ensure that the right mental health and wellbeing support is available, at the right time.

Specialist Provision

Specialist child and adolescent mental health services (CAMHS) is available in Lewisham to support children and young people up to the age of 18, where significant mental health concerns have been raised. Over the last 12 months, a service transformation programme and waiting list initiative have been implemented to improve access. Data has shown that overall CAMHS Referral to Assessment waiting times have improved significantly over the last 6 months.

Targeted Support

For children and young people displaying lower levels of needs, the Young People’s Health and Wellbeing Service is available to those aged 10 – 19 (up to 25 where there is a disability). The service employs a dedicated team of clinically trained wellbeing practitioners and integrates physical and mental wellbeing (providing a parity of esteem between the two) and responds to the three main risk factors to poor health and wellbeing: sexual health; mental health; and substance misuse, to provide holistic, youth-centred care. The hub-and-spoke model provides an outreach service to reach young people in schools and other settings such as youth centres, together with a central hub that can be accessed in a face to face capacity, as well as online counselling (available in the evenings and weekends) and via a text-messaging service.

There are also a range of services available to support the mental and emotional health of younger children. The Children’s Wellbeing Practitioner (CWP) Programme provides support to children with low level emotional health concerns, such as anxiety and depression. This is a national programme designed to increase capacity by training a new sub-service of practitioners to deliver support to children, young people and parents/carers who wouldn’t

normally meet the CAMHS threshold. Over the course of a year, CWPs are trained to offer brief, focused evidence-based interventions in the form of low intensity support and guided self-help to young people.

In additional schools are also able buy in different types of therapy support, such as educational psychology and speech and language services and a number (currently eight) commission 'Place2Be', a school based counselling and drop-in service originally established with support from the local authority.

The Pre-School Learning Alliance provides support for conduct and behaviour issues in partnership with local CAMHS and 'Place2Be', and are providing face to face and group work with parents and children aged 3-11 years.

For older children (11-18) with conduct and behaviour concerns, the Lewisham Functional Family Team, provided through the Youth Offending Service offers intensive outreach family therapy for young people and their families where the young person has persistent and significant conduct problems at home, school or in the community.

For Children Looked After (CLA), a new multi-disciplinary team, including a family therapist and a clinical psychologist has been established within the Virtual School for CLA, to provide support for lower level mental health issues to enhance education outcomes for CLA. The Lewisham Virtual School promotes and supports the educational attainment and progress of children and young people in care from Nursery to 18 years old, through effective collaboration with schools, social care, and other agencies.

Universal Provision

In partnership with voluntary sector organisations, a number of Lewisham primary and secondary schools have been supported to implement the Academic Resilience Approach. Some specialist support has been given to schools to undertake a needs assessment, workforce development programme, coaching, leadership support with action planning and implementation and finally reviewing impact.

Through the Young People's Health and Wellbeing Service (YPHWBS), universal emotional health support is offered across schools and youth settings, with a particular focus on supporting vulnerable children when transitioning from primary to secondary school. The service also offers a universal and targeted Universal Schools Safety Programme (USSP), across Year 7 year groups in all Lewisham secondary schools, the programme will cover sexual health, mental health, substance misuse and general health and wellbeing. Kooth, the online counselling platform, is also a partner in the delivery of the YPHWBS.

The Public Health team offer free training to all frontline CYP staff in Lewisham including schools. This training includes a Youth Mental Health First Aid training (jointly funded by public health and the CCG) and a Young Person's toolkit training (managing emotional and mental distress). Past attendees include mainstream and SEN teaching staff.

What further action can be taken?

A Government Green Paper ('Transforming Children & Young People's Mental Health Provision') was published in December 2017¹¹, which had a large focus on earlier intervention and prevention, especially in schools & colleges. Key proposals within the paper include:

- Creating a new mental health workforce of community-based mental health support teams
- Encouraging every school and college to appoint a designated lead for mental health
- Piloting a new four-week waiting time for NHS children & young people's mental health services in some areas

The proposals within the paper present an opportunity to work with schools in a co-ordinated way and to bridge a gap for children and young people with a low level of mental health need. A specific offer of youth mental health first aid training available to all Lewisham schools has been developed ahead of the implementation of the Green Paper proposals. This will work towards achieving a baseline level of mental health awareness among key school staff members in Lewisham. This offer will seek to complement the existing USSP and freely available online secondary school resources provided by the Samaritans.

5.3 Provide better information and support to those bereaved or affected by suicide

Why is this important for Lewisham?

When someone dies by suicide, the shock is profound and widely felt – by families, friends, colleagues and professionals. They describe profound distress, guilt, searching for explanations and stigma. They may struggle with work or relationships. They may develop their own mental health problems. They may themselves feel suicidal.

Support after suicide, called postvention is therefore an essential part of public health. Research suggests there is a substantial unmet need for support with survey data suggesting that two thirds of people in the UK receiving no formal support after being affected by suicide. We have no local data for Lewisham but there is no reason to believe the findings would be different. It is important to note that different people want different types of support (e.g. individual counselling, group peer support etc.).

Postvention forms a core part of our local suicide prevention strategy and will require close collaboration between all agencies in Lewisham.

What is already happening?

There are currently no specific support groups for those bereaved or affected by suicide in Lewisham, although people can access the groups organised by Survivors of Bereavement by Suicide and Cruse.

There are a number of online resources and a key document is ‘Help is at Hand’, jointly produced by PHE and the National Suicide Prevention Alliance¹².

What further action can be taken?

The Strategy Group consider that the opportunity to co-ordinate a support group in Lewisham for those affected by suicide should be explored.

The Group consider that the Help is at Hand resource should be distributed as soon as possible after a death that could be suicide to those most closely affected. This would ideally be done as a routine procedure by the Metropolitan Police and work will be done to explore how this might take place locally. However the resource should be available more widely for those not in direct contact with the emergency services and should be available in primary and secondary care as well as in community organisations.

Support groups for those affected by suicide exist in other London boroughs that can be accessed by Lewisham residents, which are summarised in Appendix 3 below.

5.4 Support the media in delivering sensitive approaches to suicide and suicidal behaviour

Main issues

Over the past few decades there has been significant research into media coverage of suicide and how it can affect behaviour. The research shows that, when the media has applied caution in the reporting of suicide, there have been positive outcomes, potentially reducing the number of deaths.

This academic research has been conducted mainly around 'mainstream' media, including television and print newspapers, but there is growing interest among researchers to investigate the possible influence

What is already happening?

The South East London (SEL) STP Mental Health Prevention subgroup, covering the 6 boroughs in the SEL STP area are planning a collaborative approach to engaging with local media outlets to influence more sensitive reporting around suicides taking place across the SEL geography. A collaborative approach has been sought for this action area due a number of local media outlets in SEL having shared ownership.

What further action can be taken?

The Samaritans have published guidance around sensitive reporting of suicides in the media. South East London boroughs can work with the Samaritans to ensure that the content of this guidance is accessible and communicated to media outlets operating across SEL. SEL boroughs can also work with Thrive LDN on this area to influence media outlets that operate across London.

5.5 Support research, data collection and monitoring

Why is this important for Lewisham?

The analysis of available data on deaths by suicide through conducting a regular audit is recognised both locally and nationally as being a critical element of suicide prevention efforts. The main source of data used in Lewisham suicide audits is from Primary Care Mortality files and summary data from Public Health England. This data is limited in what can be ascertained about deaths by suicide locally, so additional sources of local data are required to support suicide prevention efforts.

Main issues

Lack of Coroner Data

The inner South London Coroner that serves Lewisham does not currently share data on suicides as part of the suicide audit process. Reviewing data from local coroners' records as part of the audit process can provide retrospective insights into the circumstances of deaths by suicide. These insights can play an important part in guiding local suicide prevention efforts.

Need for Real time data

There is no current real-time data collection process for suicides in Lewisham. Real-time data 'enables public health teams and/or multi-agency suicide prevention groups to consider and agree if interventions are required after a death has occurred where the circumstances suggest suicide in advance of the coroners' conclusion'⁶. This information can 'provide the means to offer timely support to people who have been bereaved or affected by a suspected suicide and to respond quickly to emerging patterns that could indicate clusters, increasing trends or new methods of death'⁶.

What is already happening?

South East London boroughs that share a Coroner – Lambeth, Southwark, Lewisham and Greenwich – have started to meet with the local Coroner to agree a minimum dataset from the Coroner's records concerning deaths by suicide in the four boroughs. Thrive LDN have also started to work with the Coroner to support the development of a London-wide data sharing agreement.

What further action can be taken?

Collaborative Annual suicide Audit

A local suicide audit could be performed on an annual basis with the potential for this being part of a SEL audit performed at a similar frequency. Data and intelligence from local Child

Death Overview Panels (CDOP), DARD panels and serious incident reporting from secondary care could also be collated in order to provide the most up to date data on suicides to incorporate into the audit.

B. Main Programmes of Work

The Lewisham multi-agency group made a decision to identify the main streams of work arising from the areas for action identified. These areas of work are summarised in Figure 2 below.

Figure 2: Main work streams

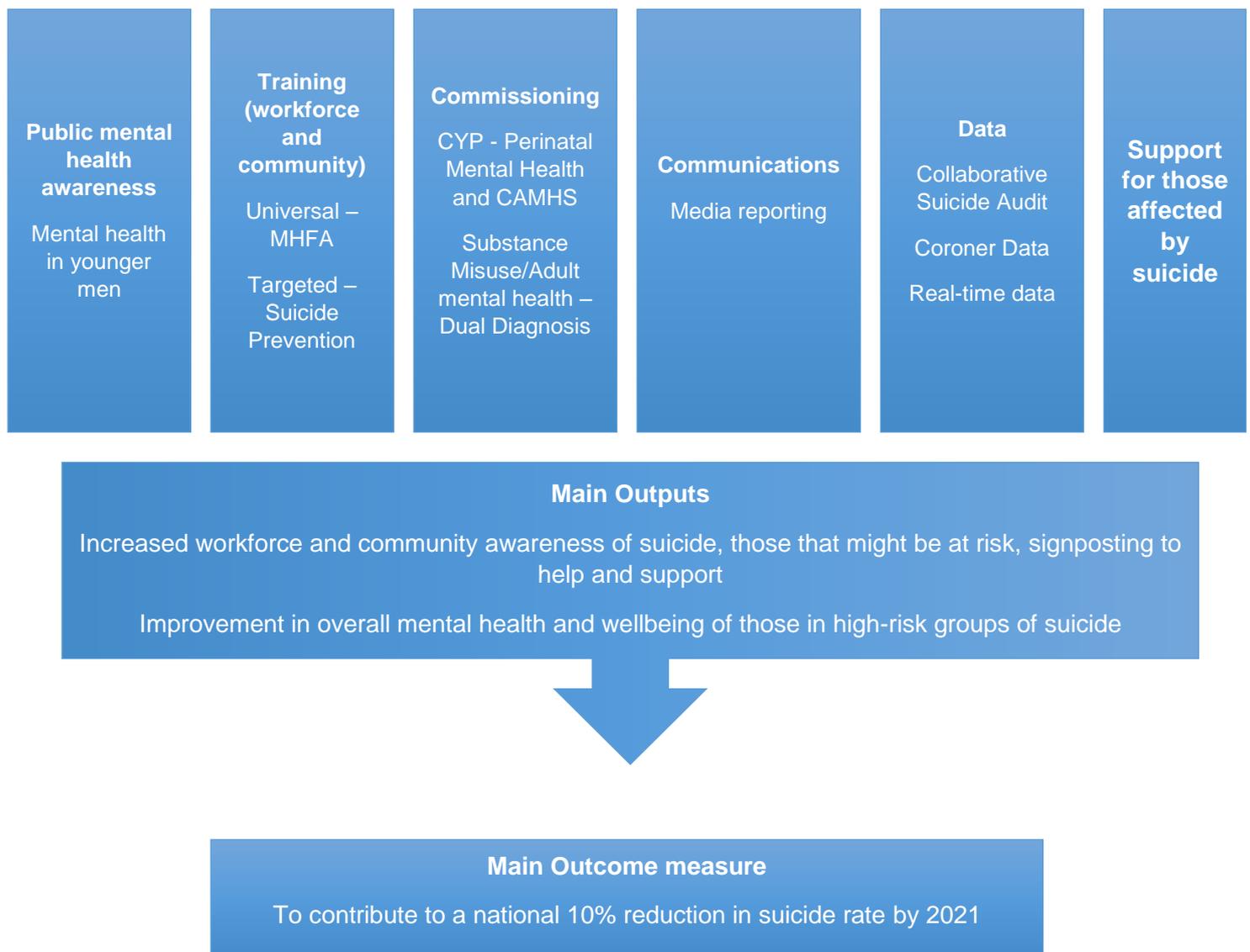


6. Monitoring and Evaluation

The main measure that will be used to monitor the achievement of the national ambition to reduce deaths by suicides by 2021 is the three-year rolling average age-standardised suicide rate per 100,000 population.

In this local strategy the same metric (three year rolling average age-standardised suicide rate) will be used to monitor the main strategic aim of contributing to a 10% reduction in the national suicide rate by 2021. Since this is a 3-year rolling average with a 2-year time lag in data reporting, monitoring for the length of this strategy will continue on until 2023 to capture the 3-year rolling average for 2019-21.

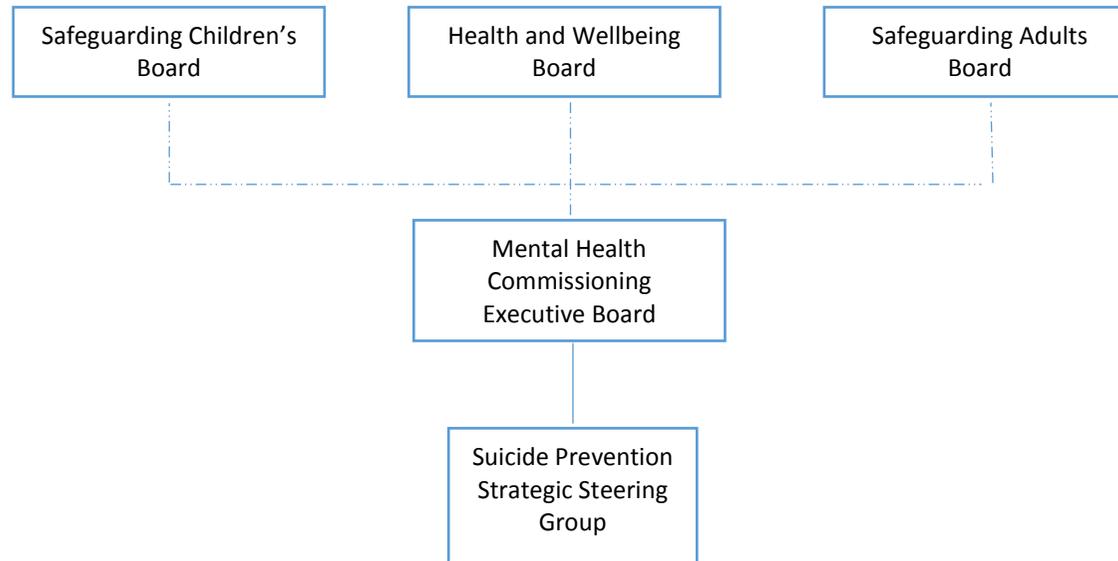
The following monitoring and evaluation framework will be used to capture the process and output measures that will be captured to achieve the overarching aim of reducing deaths by suicide by 2021:



7. Governance

The Lewisham Suicide Prevention Strategic Steering Group, which is a multi-agency partnership is the main planning meeting which brings together Lewisham CCG and Local Authority mental health commissioning team, Public Health and partners, with the aim to address and achieve the government's agenda in the reduction of suicide in our local area as outlined in the Mental Health Five Year Forward View.

The Chair of the Lewisham Suicide Prevention Strategic Steering Group is a sitting member of the Lewisham Mental Health Executive Board, which provide strategic influence over mental health commissioning decisions across Lewisham NHS, Primary and Secondary care, Public Health, children's services and adult social care and the third sectors organisation.



The Suicide Prevention Strategic Steering Group will take a work programme management approach in the delivery of the work streams highlighted in the Multi-agency Action Plan. It will also provide quarterly updates to the Mental Health Commissioning Executive Board who would be responsible for the management of the outcome for this group.

8. Action Plan

The following action plan outlines the main strategic areas for action and the lead partners, timescales and progress for achievement of actions. This action plan will be used to implement and monitor progress for the lifetime of the strategy.

Area for action	Standard/ Description of intervention	Standard/ Description of intervention	Lead (Responsibility) and Key Partners	Level (local/SEL/London region)	Timescale	Status (RAG)
1. Reduce the risk of suicide in high risk groups						
1.1 Young men (aged 25-44 years)						
a.	Suicide Prevention Training	To explore how training can be commissioned for frontline staff or in community settings that support young men e.g. job centre plus staff, faith leaders, sports clubs, police, housing providers and primary care.	Public Health/Joint Commissioners/Primary Care Commissioning	Local	To be determined	Not started
b.	Public Mental Health and Wellbeing strategy	Develop a strand of work within the public mental health and wellbeing strategy group around young men's mental health	Public Health/Joint Mental Health Commissioners	Local	Ongoing	In progress
c.	Support national campaigns focusing on the mental health of young men locally e.g. Time to Change, Rethink Mental Illness and Campaign Against Living Miserably (CALM)	Lewisham Time to Change Organic Hub implementation	Public Health/Joint Mental Health Commissioners	Local	March 2018 – August 2019	In progress
d.	Adult Mental Health First Aid training	Mental Health Workforce training to also include invitations to pharmacy	Public Health /Joint Mental	Local	Ongoing	In progress

Area for action	Standard/ Description of intervention	Standard/ Description of intervention	Lead (Responsibility) and Key Partners	Level (local/SEL/London region)	Timescale	Status (RAG)
		and appropriate workforce areas in contact with high risk population groups	Health Commissioners			
e.	Working with Men Pilot	Pilot Project for young men/fathers up to 25 years of age	CYP Joint Commissioning	Local	Ongoing	In progress
f.	Quo Vadis Trust Men's Mental Health Group/HealthWatch Project	To support mental health men's group and use learning to support the development of further groups	Quo Vadis Trust /HealthWatch/Community Connections	Local	Ongoing	In progress
1.2 Parents in the perinatal period						
a.	Suicide Prevention Training	To be explore how training can be delivered to be frontline staff or in settings that support parents in the perinatal period e.g. midwives, health visitors	Public Health/Joint Commissioners/CCG/Maternity Commissioner	Local	To be determined	Not started
b.	Perinatal Mental Health JSNA	To support the implementation of the recommendations of the perinatal mental health JSNA	Public Health/Maternity joint commissioner	Local	Ongoing	In progress
1.3 Those who misuse drugs and alcohol						
a.	Suicide Prevention Training	To explore how Suicide Prevention Training can be commissioned for staff at local substance misuse services (YPHWBS, PCRS and CGL)	Public Health/Substance Misuse Commissioners	Local		Not started
b.	Dual diagnosis work	To progress commissioning discussions around dual diagnosis services in Lewisham	LA (Joint mental health and substance misuse commissioners)/S LAM	Local	Ongoing	In progress

Area for action	Standard/ Description of intervention	Standard/ Description of intervention	Lead (Responsibility) and Key Partners	Level (local/SEL/London region)	Timescale	Status (RAG)
c.	Adult Mental Health First aid training	Training to be delivered to substance misuse staff in Lewisham	Public Health	Local/Sector	Ongoing	In progress
1.4 Those who self-harm						
a.	Support for those who Self-harm	NICE guidance for management of self-harm in A&E through SLAM Core 24 model	Joint Commissioning Teams/SLAM	Local	Ongoing	In progress
b.	Support for those who Self-harm	Development of a provider (SLAM) strand of work across 4 boroughs to address self-harm in young people	SLAM/Public Health Lambeth, Southwark, Lewisham and Croydon	SEL	Ongoing	In progress
c.	Support for those who Self-harm	Improving reporting of local data on presentations of self-harm in Lewisham	SLAM/PH/Joint Mental Health Commissioning team	Local	To be determined	Not started
d.	Support for those who Self-harm	Improving information provision to those who present with self-harm to A&E	Child Death Overview Panel/CAMHS	Local	Ongoing	In progress
2. Tailor approaches to improve mental health in specific groups						
2.1 Children and Young People						
a.	CAMHS Transformation refresh	The NHS Lewisham CCG Local Transformation Plan (LTP) was finalised in December 2015 and there is an expectation for CCGs to refresh plans to reflect local progress and further ambitions based on the increasing financial envelop and the Mental	CYP Joint Commissioning	Local	Ongoing	Completed

Area for action	Standard/ Description of intervention	Standard/ Description of intervention	Lead (Responsibility) and Key Partners	Level (local/SEL/London region)	Timescale	Status (RAG)
		Health Implementation Plan				
b.	Youth Mental Health First Aid training	To continue to deliver youth mental health first aid training and to develop bespoke schools offer	CYP Joint Commissioning/Public Health	Local	Autumn 2018-Spring 2019	In progress
e.	Children's Safeguarding Board	To work with the LSCB to: a) incorporate suicide prevention into safeguarding training for children and young person's settings b) Consider reviewing the risk assessment process for children and young people at risk of suicide in school settings c) Co-ordinate mental health awareness training for school staff/pupils	LSCB/Children's Social Care	Local	Ongoing	In progress
f.	Young People's Health and Wellbeing Service	Universal Schools Safety Programme delivered by YPHWBS/Youth First to include mental health component for Year 7 students in school and Year 8 + in non-school settings	CYP Joint Commissioning/C OMPASS/Youth First	Local	Ongoing	In progress
g.	Samaritans free online secondary school resources	Public Health to work with the local Samaritans lead to promote this training to Lewisham schools	Samaritans / Public Health	Local	To be determined	Not started

Area for action	Standard/ Description of intervention	Standard/ Description of intervention	Lead (Responsibility) and Key Partners	Level (local/SEL/London region)	Timescale	Status (RAG)
3. Provide better information and support to those bereaved or affected by suicide						
3.1 Provision of more comprehensive local support for those bereaved or affected by suicide						
a.	Map existing support groups for those affected by suicide in London that can be accessed by Lewisham residents	Perform mapping exercise to ensure signposting to available services for those affected by suicide in Lewisham	Public Health/Joint Mental Health Commissioning Team/London SOBs/SEL STP Public Mental Health Group	Local/Sector	To be determined	Not started
b.	Dissemination of existing resources/guidance for those affected by suicide	Use existing borough-wide communication channels to signpost to or disseminate existing resources for those affected by suicide	CCG/LA/VCS/Communications teams (CCG/LBL)/Metropolitan Police	Local/SEL	To be determined	Not started
4. Support the media in delivering sensitive approaches to suicide and suicidal behaviour						
4.1 Communications training for SEL news outlets						
a.	Samaritans communications training	To work with the Samaritans and other SEL boroughs to deliver communications training to news outlets and local council communications teams	Samaritans/SEL Public Mental Health Group	Sector-wide	To be determined	Not started
5. Support research, data collection and monitoring						
5.1 Local Suicide Audit						
a.	Annual Suicide Audit	i) A local suicide audit will be performed on an annual basis with the potential for this being part of a SEL audit performed at a similar frequency. ii) To work with local CDOP and	Public Health/SEL Public Mental Health Group/SEL Public Health Intelligence Group	Local/Sector-wide	To be determined	Not started

Area for action	Standard/ Description of intervention	Standard/ Description of intervention	Lead (Responsibility) and Key Partners	Level (local/SEL/London region)	Timescale	Status (RAG)
		DARD panels to collate most up to date data on suicides to incorporate into the audit. iii) To aim to incorporate UHL and SLAM serious incident reports involving suicides in the audit				
b.	Coroner Data	Work with other SEL boroughs that share a Coroner with Lewisham to develop a minimum dataset template that the Coroner is willing to share for the purposes of completing suicide audits	Public Health/SEL Public Mental Health Group/SEL Public Health Intelligence Group	Sector-wide	Ongoing	In progress
c.	Real-time Data	To explore the gathering of real-time data with the police and local road safety teams who attend deaths by suicide	Metropolitan Police/LBL Road Safety/Public Health	Local	To be determined	Not started
d.	Implement monitoring and evaluation framework for the strategy	To use a robust monitoring and evaluation framework to measure success of the strategy	Public Health	Local	To be determined	Not started

Appendix 1

TERMS OF REFERENCE

NHS Lewisham Clinical Commissioning Group

London Borough of Lewisham

Suicide Prevention Strategic Steering Group

Our aim is to contribute to a 10% reduction in the national rate of suicide by 2021 and to improve the care given to residents of Lewisham who are affected by suicide.

1. Introduction

Lewisham Suicide Prevention Strategic Steering Group is the main multi-agency stakeholder-planning group that supports the continuous development and improvement of the local Suicide Prevention Strategy and integrated Suicide Prevention Plan.

2. Purpose

The Suicide Prevention Strategic Steering Group will support and inform the development of a local strategy and integrated action plan to reduce the rate of suicide and self-harm in Lewisham.

It is therefore the role of the group to facilitate joint working within the partnership and provide a forum for discuss and implement solutions for the reduction of suicide in Lewisham

3. Areas of Focus

- To develop and agree a multi-agency suicide prevention strategy and action plan
- To monitor the implementation of the suicide prevention strategy
- To review and update the strategy as appropriate
- To commission and develop specific projects and initiatives to meet the aims of the suicide prevention strategy over and above routine MH commissioning by CCGs
- Support the formulation of a strategic vision for adult mental health services within Lewisham
- Oversee the steering mechanisms for best practice developments in service user involvement.
- To analyse an annual statistical and intelligence update
- To publicise on-going work and recent developments
- To facilitate partnership working between organisations represented on the Steering Group
- To influence the work of all agencies and individuals who could help prevent suicide and self-harm

4. Meeting Schedule

The Suicide Prevention Strategic Steering group will meet bimonthly

5. Accountability

The Suicide Prevention Strategic Steering Group will report to the Mental Health Executive Commissioning Group. Attendance to which is required to support the implementation of the strategic vision of mental health Joint Commissioning in Lewisham.

6. Committee Membership

Members of the group include colleagues from Mental Health Joint Commissioning, Public Health, GPs, London Borough of Lewisham and South London & Maudsley NHS Foundation Trust, Service Users, Carers and Voluntary Sector providers

The Chair of the CCG is an ex-officio member of all the CCG's committees and sub groups with full voting rights.

Representation	Attendee/Role
GP	Jim Sikorski (Chair)
NHS Lewisham & London Borough of Lewisham	Kenneth Gregory Keith Stewart (Minute taker) Caroline Hurst
London Borough of Lewisham	Gary Connors
Public Health Lewisham	Catherine Mbema Pauline Cross
Lewisham Police	Liz Delves
Bromley and Lewisham Mind	Ben Taylor
South London & Maudsley NHS Foundation Trust	Alice Ashby Victoria Morgan Rosalind Ramsay Omer Moghraby
Maytree	Natalie Howarth
Samaritans	Precious Jeffers
London Ambulance Service	Conal Percy Iris Mtero
Community Connections Service User/Consultants Representation	Trevor Pybus
Service User/Consultants Representation	Beverley Weston
Health Watch	Marzena Zoladz

7. Role & Responsibility

Role of the Chair

The Chair's role is to support the Joint Commissioning team in building strong relationships with the members of the group, ensuring that their views and concerns are represented at these meetings. .

The term of office for the chair and members

The terms of office for the Chair, is initially two years with the option for further three years if agreed by the members.

Members with the agreement of the Chair can co-opt members from other organisations that support the strategic vision and implementation of the strategy and integrated action plan.

Support to the Group

The Joint Mental Health Commissioning team will provide administrative support to Suicide Prevention Strategic Steering group meetings and work with the Chair to:

- Schedule meeting
- Take minutes, notes of each meeting
- Providing presentations and reports in a timely manner.

8. Quorum Rules and Responsibilities of Members

A minimum of four representatives from the list below is required for the meeting to be quorate

- Chair
- Service User
- Bereaved Family Member
- Police
- London Ambulance Service
- Joint Commissioning Team
- SLaM Representative
- Voluntary Sector Representative

9. Subgroups

The Suicide Prevention Strategic Steering Group is authorised to establish sub-committees and working groups as required to deliver its aim and priorities as identified in this terms of reference

10. Reporting Arrangements

The Suicide Prevention Strategic Steering Group will provide a regular report(s) of its meetings to Mental Health Executive Commissioning Group

11. Review

Terms of Reference will be reviewed annually.

Resources and support

The committee will be supported by an Associate Director of the CCG, who will be responsible for:

- overseeing of Suicide Prevention Strategic Group agendas, minimising the duplication of discussion and decision-making
- bringing together in accessible form, the reports and information necessary to support the discussion and decision-making
- producing and distributing minutes within seven days of meetings
- tracking progress on actions, identifying and rectifying any lapses in communication.

Meeting dates will be agreed on an annual basis and will not be changed without the permission of the chair.

Papers for the meeting will be distributed no less than seven days before the meeting.

Any exceptions to this will require written notification to the chair, and subsequent agreement on distribution arrangements.

Version Control

Version:	Date	Changes made
0.1	20 th June 2017	KS Initial Draft
0.2	21 st June 2017	KS

Appendix 2

Comments from the Evaluation Form

Below comments and feedback from the Suicide Prevention event that was held in Lewisham Civic Suite on 11th May 2017

- Should be longer at least a full day
- Prior to any workshop on this subject; the facilitators should be given script, something like “keep yourself safe if you are affected by anything said today”, with information where someone could get support immediately or later on. Just a few lines and where to go for help.
- The workshop needs to be less “presenting” and more interactive. Maybe whizz through the facts first and use the experts in the room.
- Good Event and well organised. Interesting network
- Could have lasted longer, especially the times for the workshops
- Good Opportunity to share information
- Wishing more community group could have attended.
- What will happen after this meeting?
- Who will be invited to sit on the Preventing Suicide Steering Group?
- Will there be culturally specific group, looking at the percentage of people in these groups whom commit suicide?

Venue

- The space was not ideal (three workshops in one room), but the facilitators did their best
- There was some difficulty with noise from other workshops
- Rooms were too hot and it was difficult to concentrate
- If this event takes place again it maybe an idea to have dividers in the main room
- It could have been longer and allowed us the opportunity to participate in more workshops
- Room not great due to sound carrying, maybe allow a little more time, otherwise excellent!

Other comments and suggestions

- Names on the table for the Chair and Summary Panel – if you weren't in that workshop you didn't know who the facilitator was
- Lewisham needs to keep promoting what it is doing well (there is a lot).
- Publish contacts detail and share with attendees
- The Lewisham Safeguarding Children's Board (LSCB) have a website and are aiming be a central point for information across the borough for children, YP, parents, carers, professionals and community. www.safeguardinglewisham.org.uk
- Most of voluntary organisation, groups, etc. have “passed” – not supported by the council. They (we) are talking about isolation and non-involvement – WHY!!
- A police officer or rescue worker from a key suicide area like Beachy Head in Sussex would bring great insight to front line experience

Any suggestions, topics or activities related to Suicide Prevention for future meetings?

Training

- GP Training
- Mandatory training for public sector workers on basic of suicide first aid
- Improved publicity of services offering support in Lewisham
- More refresher courses and networking

Publicity

- Mental Health Promotion Strategy
- How to better communicate
- People bring leaflets and information from their organisation
- Letting people know that they haven't got to have a particular "problem" to be involved in what is going on
- More focus on collaboration of resources in the local area. Both for services and for referring health care professionals
- Promotional / focus groups to target GP surgeries

Networking

- Market Place – ask delegates to contribute; bring a summary of what they are doing in their organisation, sharing information and knowledge
- Aim at maximising expertise – what do we have in the borough.
- How can we make Mental Health everyone's business!
- Keep it going! Networking is really important. Lots of attenders want to make a difference and develop strategy

Additional Groups

- Maternal Suicide – learning that the cause of death in the first year following birth could be linked to suicide – not mentioned at all
- Some future involvement from suicide survivors not just relatives of people who have completed suicide
- Talking to those who are suicidal – the could assist in developing a guide/myths/best outcomes/practice
- It would be nice to hear more from people who work in this area on a daily basis (like doctors, psychiatrist...) to share their experience and give examples.

General Comments

- Expand confidentiality boundaries, central information point with up to date leaflets online and GP's, library's, Lewisham Website
- At the event most of the people were professionals, however it would have been good to have a percentage of the general public invited
- I feel that it is by events such as this one that we can all learn and hopefully make a major difference in turning people of all ages and creeds away from this tragic epidemic which is sweeping our society
- How do we take support for those in crisis away from traditional health settings, out into a more community/non-threatening setting

Notes from the Suicide Prevention Workshop

On the 20th October a workshop was held to support the development of the Mental Health and Wellbeing Suicide Prevention Strategy and Action Plan. The attendees split into two groups and were asked a range of questions about the current situation around Suicide Prevention and the direction of travel to enable the group to produce a strategy and action plan

The notes from the two groups were collated and captured below.

Priority Groups/Priority areas of Work

- Prescribed and over the counter medication
- There was a discussion around how to raise awareness of this issue, including the interaction with alcohol.
- There was a comment about the Increase in the use of Tramadol which is the 4th highest costly medication for the CCG spend (in year spend)
- There was a discussion around how over the counter medication may interact negatively with other medication
- The suggestion was that Training/awareness raising with GP's/Pharmacists, Pain Clinic and other front line clinicians
- Another area for development in the data and information form the Coroner's Office (e.g. toxicology reports) to a better understanding of why people commit suicide.
- The Police are developing an information pack to provide family members and the public after attendance of a Suicide. The Police require support in the development of the pack with information of what is available locally.
- The Police will have two Mental Health Liaison Officers in each borough from 2018
- Need to work closer with our statutory partners that see individual's that do not access health provision, i.e. DWP
- Network of Refugees/ Migrants network

Communication

- Who do we need to communicate with around the Strategy?
- Education – Schools and Colleges
- Police Family Liaison Officers-- Mental Health relates to 75% of Police calls
- Paeds Commissioners – we have a thriving younger population – Who is working with them – what knowledge do they have – What info is there in schools/Colleges i.e. self-harm
- CAMHS Crisis provision is increasing – including on-line services
- Need to pull together available information about services – focusing on Prevention, support, etc. So not to end up in Secondary Care and or A&E
- Need to monitor A&E attendance by young people and Priority groups
- Another area that needs to be included is our local hospital as there is limited information that is shared and the Hospital Coding needs to be accurately inputted
- Job Centre Plus – provides support and enhanced support with community partners for individual with a mental health issue
- Develop a Central Portal that could make links to Samaritans and other group websites
- Make available Paper copies of information and website
- Lewisham Life (long leading time)
- Look at other Council (Brent, Tower Hamlets, etc.) and other Media (Samaritans)

Mantra

- Job Centre Plus/ DWP - Make every interventions count
- Safeguarding is everybody's problem

Training

Training is expensive and we need to acknowledge that. We also need to advertise and promote the training programmes

What is available?

- Determine what's available -1st action and if the information is up to date
- Mental Health First Aid – Public Health - Introduce first awareness training to raise confidence
- 'Future learn' – website
- Online Clips to watch – need to investigate
- Time To Talk – in Croydon is there one in Lewisham?
- 'Help is at Hand'?
- Samaritans – media training
- Maytree – Training
- Mental Health FX – Website
- One Housing Group – has Mandatory Training, Mental Health Clinics, informal support,

What do we need?

- Suicide Prevention Training/Evaluation
- Training people to be Champions and then those Champions can train others i.e. Peer to peer training (similar to dementia friends)
- Develop solid network of Knowledge
- Mandatory training – SLAM provide training for staff we should look at what is being delivered
- Children services – plus organisations commissioned to deliver intervention to Children and young people i.e. COMPASS
- Include Counselling and Peer Support
- To engage local people with experience of Suicide support

Who require the trainings?

- Support for Survivors
- Post ventions –impact on families; impact on staff what support is available
- A&E
- Job Centre Plus
- Mosque and churches
- Youth Events
- NHS Front line services
- Crisis Resolution HTT
- Faith leaders
- Care homes
- Frontline staff
- Community pharmacist

Potential partners for delivery?

- PHE
- Re brand PHE first aid mental health training
- Could MIND help with this? - Consider the MIND training 'Speak up, Speak out
- Police information pack
- Lewisham Bereavement Group – not specifically looking at Suicide - Can we approach them again?
- Greenwich CRUSE Bereavement Group
- Samaritans
- Job Centre Plus/DWP – Training

Who do we need to Gain Commitment from?

- Local CCG
- Health and Wellbeing Board
- Safeguarding Boards
- Safer Neighbourhood Boards
- Samaritans

Campaigns

- Samaritans - Press Manager
- Suicide Prevention Day – Communication and Publicity
- World Mental Health Day
- Time To Talk
- Thrive London

Appendix 3: Support for those affected by suicide

Survivors of Bereavement by Suicide Support Groups

1) London

Contact Information

- Phone: (10am - 10pm) David on 0208 675 5862
- Email: sobslondon@gmail.com

London, UK

2) Orpington, Kent

Contact Information

- Phone: Sandra on 07519 105 354
- Email: sobs.orpington@gmail.com

Orpington, UK

3) Surrey

Contact Information

- Phone: Ann on 0785 142 0526

Cheam, Sutton, UK

4) London North

Contact Information

- Phone: 07934 976 253
- Email: northlondon.sobs@gmail.com

London Borough of Haringey, UK

Cruse Bereavement Care - Greenwich Area

St Luke's Hall Westmount Road, Eltham, SE9 1JB

<http://www.greenwichcruse.co.uk/>

020 8850 0505

One to One Support, Pre-bereavement Support, Telephone Support and Home Visits,
Bereaved by Suicide Group, Family Support Group

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HEALTH AND WELLBEING BOARD			
Report Title	Lewisham CCG Annual Report 2018/19		
Contributors	Charles Malcolm-Smith, Deputy Director (Strategy & OD), Lewisham CCG	Item No.	8b
Class	Part 1	Date: 7 March 2019	
Strategic Context	The report provides an update on Lewisham CCG's annual report and accounts for 2018/19		

1. Purpose

This report provides members of the Health and Wellbeing Board with an update on the CCG's annual report and accounts for 2018/19. A requirement of the Health & Social Care Act 2012 is that the annual report includes the CCG's contribution to local plans and strategies and that the Board is included in this regard in the preparation of the annual report.

2. Recommendation

Members of the Health and Wellbeing Board are asked to:

Note the deadline for the CCG Annual Report and accounts for 2018/19 and its outline content areas that will include a performance analysis, including its relationship with the Board and contribution to local plans and strategies

3. Policy Context

Lewisham CCG is required to publish, as a single document, an annual report and accounts. NHS England will incorporate this into their consolidated accounts which, in turn, form part of the Department of Health's consolidated accounts incorporating all its arm's length bodies.

NHS England has communicated a structure for the annual report and accounts as per the Department of Health manual for accounts, which provides guidance on preparing and completing annual report and accounts. By 29th May the CCG must submit full audited and signed annual report and accounts, as approved in accordance with the CCG scheme of delegation and signed and dated by the accountable office and appointed auditors.

4. Summary of report

The overall structure of the report will cover:

- I. Performance report
 - a. An overview
 - b. A performance analysis
- II. Accountability report
 - a. Corporate governance report
 - b. Remuneration and staff report
- III. Financial statements

The performance report overview will provide a short summary of the organisation from the CCG Accountable Officer , i.e. its purpose, key risks to the achievement of its objectives and how it has performed during the year. While the analysis will report on the most important performance measures and provide longer term trend analysis where appropriate. Key measures to typically report on include financial performance, the CCG assurance framework, Better Care Fund metrics, outcome framework and any local indicators (quality, patient safety etc), and NHS Constitution standards.

The CCG's positive relationship with the Health & Wellbeing Board and other local partners, and contribution to the delivery of local strategies and priorities will be integral to the report, for instance the work of the Lewisham Health & Care Partners (LHCP) and adult integration programme in the development of the whole system model of care. This has been reflected in the contribution to the planning and delivery of the BAME mental health summit and the review of the outcomes from that summit, the frailty summit in July, the LHCP partnership event 'Working together for a healthier Lewisham' held in October, as well as contributing to the sub-group of the board that leads on the development of the Joint Strategic Needs Assessment (JSNA) topic areas and reports. Comments and feedback from members of the Board on the CCG's contributions to these areas, and others, are welcomed.

The draft report and accounts will be subject to review by NHS England and CCG audit committee and auditors. The final report will be available to the Board.

5. Financial implications

The annual report and accounts will include the CCG's financial position and main areas of expenditure.

6. Legal implications

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 the area.

7. Crime and Disorder Implications

There are no specific crime and disorder implications arising from this report.

8. Equalities Implications

The report will include an explanation of how the CCG has discharged its duty to reduce inequalities under section 14T of the health and social care act 2012. This will involve assessing how effectively we have discharged our duty to have regard to the need to reduce inequalities, acting in consultation with the Health& Wellbeing board.

9. Environmental Implications

The annual report includes a sustainable development update, including, travel energy use and carbon footprint.

Background Documents

The Department of Health manual for accounts can be found [here](#)

If there are any queries on this report please contact Charles Malcolm-Smith, Deputy Director (Strategy & OD), Lewisham CCG, e-mail charles.malcolm-smith@nhs.net

HEALTH AND WELLBEING BOARD			
Report Title	Health and Wellbeing Board Performance Dashboard Exceptions Report		
Contributors	Director of Public Health	Item No.	8c
Class	Part 1	Date:	7 March 2019
Strategic Context	Please see body of report		

1. Purpose

This report provides members of the Health and Wellbeing Board with an update on performance against its agreed priorities within the Health & Wellbeing Strategy.

2. Recommendations

Members of the Health and Wellbeing Board are recommended to note performance as measured by health and care indicators set out in the attached dashboard at Appendix A.

3. Strategic Context

- 3.1 The Health and Social Care Act 2012 established Health and Wellbeing Boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. The activity of the Health and Wellbeing Board is focused 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 the priority outcome in Shaping our Future 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 The Health and Social Care Act 2012 placed a duty on local authorities and their partner clinical commissioning groups to prepare and publish joint health and wellbeing strategies to meet needs identified in their joint strategic needs assessments (JSNAs). JSNAs then inform Health and Wellbeing Strategies. Lewisham’s Health and Wellbeing Strategy was published in 2013.
- 3.4 The Health and Social Care Act also required Health and Wellbeing Boards 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.

4. Background

- 4.1 In response to the request from members of the Board, the Director of Public Health has worked alongside colleagues within Adult Social Care, Children’s Services and the Clinical Commissioning Group (CCG) to produce a dashboard of indicators which would assist members in monitoring health and wellbeing improvements across Lewisham and the effectiveness of the integrated adult care programme.

- 4.2 The dashboard also includes a number of indicators (including those on low birth weight, immunisation and excess weight) that are also included in the 'Be Healthy' priority of the Children and Young People's Partnership Plan.

5. Health and Wellbeing Board Performance Dashboard Update

- 5.1 The dashboard is based on metrics drawn from the Quality and Outcomes (Primary Care), Public Health, NHS and Better Care Fund Frameworks. These metrics have been selected to assist members in their assessment of the impact and success of the plans and activities in relation to the Health and Wellbeing Strategy.

- 5.2 Updated indicators since the previous period of data availability are commented on below. Where performance has deteriorated, commentary on actions being taken to improve the position has been provided.

5.3 Overarching Indicators of Health & Wellbeing

The latest data for **premature mortality from Cardio-vascular disease** has improved and is now considered similar to the England rate. There has been an almost constant downwards trend since 2000. **Low Birth weight of all babies** has remained stable, and is in line with England.

Female life expectancy at birth has increased and is now significantly higher than the national average. However **male life expectancy at birth** has fractionally decreased and is now statistically lower than the national average. A similar trend was seen in Southwark, Greenwich and Hackney.

5.5 Priority Objective 1: Achieving a Healthy Weight

Lewisham remains in line with the national average for **adult excess weight**.

Regarding excess weight in children, Reception year performance has improved and Lewisham rates for obesity and excess weight are now significantly lower than England and London, and compared to similar boroughs. This is a notable success however it should be qualified that the participation rate was lower than in previous years, 87% in Reception and 89% in Year 6, slightly below the target coverage of 90%. For Year 6 children there was a small increase in obesity rates but an overall reduction in excess weight. As in previous years the proportion of obese children in Year 6 was more than double that of Reception year children, similar to the national results.

In addition the revised GP Personal Medical Services contracts between the CCG and GPs now require practices to record the BMI centile of children who attend for their pre-school booster vaccination (3-5 year olds), offering brief intervention and/or referral to local specialist services as required. This will have a beneficial impact on these indicators in future years.

Maternal excess weight increases the risk of poor pregnancy outcomes and is a risk factor for childhood obesity. There has been a slight decrease in the rate over the last two years reflecting the national picture. Overall, around half of women at their booking appointment are overweight or obese. Lewisham **breastfeeding rates at 6-8 weeks** continue to exceed target, with rates amongst the highest in England.

5.6 Priority Objective 2: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years

The **Under 75 cancer mortality rate** has decreased, however it remains significantly higher than England. This difference continues to be largely due to male cancer mortality, with lung and bowel cancer deaths increasing. Nationally there has been a general trend of decline over the past 10 years.

Both **breast and bowel cancer screening** have seen marginal improvements, yet remain below the national average and targets. **Cervical cancer screening** has reduced and is below the national average.

Following the publication of a Cancer focused Joint Strategic Needs Assessment in 2017, a number of actions have been taken with the aim of improving cancer outcomes. A task and finish group was set up to develop a NHS Lewisham CCG Cancer Plan (2018-19). Public Health was a member of this group and has undertaken specific action around reducing inequalities which include: Commissioning community based Cancer Research UK (CRUK) training (which reached the Voluntary and Community Sector and others) to provide information and increase confidence around having conversations about cancer including taking up preventative measures such as breast and bowel screening. A specific bursary-funded workshop for community members was awarded to Lewisham by CRUK this year. This workshop was held in December 2018 and was well attended, with positive feedback and evaluation. Work is also starting with MacMillan Cancer Support in 2019 to develop a number of community cancer champions from community members that attended the bursary-funded workshop.

5.7 Priority Objective 3: Improving Immunisation Uptake

The most recent data on **over 65 flu immunisation uptake** is stable, but remains below the England average and the national target (75%). Work is in progress with GPs in Lewisham to improve uptake of flu vaccination for all eligible groups by sharing learning from practices with higher levels of vaccination uptake. Promotion of the 65+ flu jab has also been included in key council publications.

The **HPV vaccine uptake** rate has improved but remains below the London and England averages and target level (80.0%). Work is being coordinated between Public Health, Joint Commissioning, the School Health Service and NHS England to ensure continued improvement. **Uptake of the second dose of measles, mumps and rubella vaccine** has also improved and is above the London average but needs to improve to reach to the England average and hit the target (91.1%) and achieve herd immunity. Public Health continue to work on the MMR pathway, which includes steps to improve information systems. Public Health is also in dialogue with NHS England to improve promotion of the MMR vaccination to all Lewisham residents. For all childhood vaccinations opportunistic immunisation of children is done whenever they present within the health service.

5.8 Priority Objective 4: Reducing Alcohol Harm

Alcohol related admissions have fallen again and remain significantly below the England average.

5.9 Priority Objective 5: Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking

Smoking prevalence decreased compared to the previous reporting period and is now in-line with London and England. **The self-report rate for smoking quitters per 100,000 population** is also currently in-line with London and England.

Smoking status at time of delivery has increased marginally but remains significantly below the national average.

5.10 Priority Objective 6: Improving mental health and wellbeing

Prevalence of Serious Mental Health Conditions has remained stable but is significantly higher than the England average. Prevalence is similar to neighbouring boroughs. **Prevalence of depression** has increased slightly, yet remains significantly lower than the national average. Improving Access to Physiological Therapies performance service data continues to improve.

BAME mental health is an area that the Health and Wellbeing Board are focussing on. Furthermore the 2017 Annual Public Health Report focused on Mental Health. The aim of the report was to provide user-friendly information about the levels of mental health and wellbeing in Lewisham, including information about risk and protective factors. The content in summary:

- Providing real-life stories from Lewisham residents across the course of life about living with and through mental ill health.
- Providing information on the strategies, initiatives and interventions being delivered in Lewisham that aim to promote mental wellbeing and prevent mental ill health.
- Providing information about where residents can seek help if concerned about their mental ill health to ensure that mental ill health is identified and treated at the earliest possible opportunity.

5.11 Priority Objective 7: Improving sexual health

The rate of **chlamydia diagnoses per 100,000 young people aged 15-24 years** has decreased but is above the national average. This performance should be seen in context of the proportion of young people now screened for chlamydia. In 2017, 25% of people aged 15-24 were screened, in 2015 it was 50% of the same population. The **legal abortion** rate has remained stable but is significantly higher than the London and England average. **Teenage conceptions** have decreased and are in-line with England.

People presenting with HIV at a late stage of infection has increased but remains in-line with the national average. Lewisham are currently working with the Elton John Aids Foundation to increase HIV testing both in hospital and primary care. Furthermore the Lambeth, Southwark and Lewisham (LSL) Sexual Health Strategy has identified late diagnosis of HIV as a critical target. In producing the strategy it was found that certain groups had a higher proportion of people with late diagnosis. This insight means that the same groups will be increasingly targeted for screening.

5.12 Priority 8 (Delaying and reducing the need for long term care and support) & Priority 9 (Reducing the number of emergency admissions for people with long-term conditions)

Within Lewisham's wider integration framework, health and care partners have continued to focus on these priority areas. The Better Care Fund metrics remain the

overarching measures by which progress and performance against these priority areas has been measured. The four national metrics are:

- Non elective admissions
- Admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care (DTC)

As at December 2018, performance was on track to meet target in all four measures. Full year (2018-19) figures will be available in summer 2019. These metrics continue to be monitored by health and care partners, both by individual organisations and jointly through the BCF.

6. Financial implications

There are no specific financial implications arising from this report. A range of activity designed to improve performance against these indicators is funded from the Public Health budget using the ring fenced Public Health Grant. This expenditure is reviewed regularly and reallocation to address indicators with poor performance is possible.

7. Legal implications

The statutory requirement to have a Health and Wellbeing Strategy is set out above.

8. Crime and Disorder Implications

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

9. Equalities Implications

There are no specific equalities implications arising from this report or its recommendations, but the dashboard highlights those areas where health inequalities exist in Lewisham and can be monitored.

10. Environmental Implications

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

11. Summary and Conclusion

Challenges remain around a number of indicators. Cancer screening and immunisations are key areas to improve.

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, Health Intelligence Manager, Public Health, Community Services Directorate, Lewisham Council, on 020 8314 7990 or by email patricia.duffy@lewisham.gov.uk

Appendix A - Health and Wellbeing Board Performance Metrics - January 2019

Updated indicators are in bold										
	Frequency	Latest Period of Availability	Previous Available Period (Lewisham)	Latest Available Period (Lewisham)	London	England	England Benchmark	Direction from Previous Period	Data Source	
Overarching Indicators										
1a	Life Expectancy at Birth (Male)(yrs)	Annual	2015-2017	79.1	79	80.5	79.6	similar	↓	ONS
1b	Life Expectancy at Birth (Female)(yrs)	Annual	2015-2017	83.3	83.7	84.3	83.1	similar	↑	ONS
2	Under 75 mortality rate from CVD (DSR)	Annual	2015-2017	82.2	80.7	73.2	72.5	similar	↓	PHOF 4.04i
3	Low Birth Weight of all babies (%)	Annual	2016	7.1	7.3	7.6	7.3	similar	↑	P00455/CHIMAT Profile 2015
4	Number of practitioners trained in Making Every Contact Count (behaviour change training)	Quarterly	Q1 2018/19	90	27	-	-	-	-	Lewisham Public Health
Priority Objective 1: Achieving a Healthy Weight										
5	Excess weight in Adults (%)	Annual	2016/17	57.9	57.8	55.2	61.3	similar	↓	PHOF 2.12
6a	Excess weight in Children - Reception Year (%)	Annual	2017/18	22.2	17.6	21.8	22.4	sig lower	↓	PHOF 2.06i
6b	Excess Weight in Children - Year 6 (%)	Annual	2017/18	39.0	37.9	37.7	34.3	sig high	↓	PHOF 2.06ii
7	Maternal Excess Weight at <13 weeks gestation(%)	Quarterly	Q2 2018/19	50.7	45.7	-	-	-	↓	Lewisham & Greenwich Trust Data
8	Breastfeeding Prevalence 6-8 weeks (%)	Quarterly	Q2 2018/19	79.4	79.3	-	46.4	sig higher	↓	NHS ENGLAND
Priority Objective 2: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years										
9a	Cancer screening coverage - breast cancer (%)	Annual	2018	67.8	69.3	69.3	74.9	sig lower	↑	PHOF 2.20i
9b	Cancer screening coverage - cervical cancer(%)	Annual	2018	69.1	68.4	64.7	71.4	sig lower	↓	PHOF 2.20ii
9c	Cancer screening coverage - bowel cancer (%)	Annual	2018	46.7	47.0	50.2	59	sig lower	↑	PHOF 2.20iii
10	Early diagnosis of cancer (%)	Annual	2016	50.2	52.4	51.9	52.6	similar	↑	PHOF 2.19 – experimental statistics
11	Conversion of Two Week Wait Referrals to Cancer Diagnosis (%)	Annual	2016/17	4.2	4.3*	5.3*	7.6*	sig lower	↑	PHE Fingertips Cancer Services Portal
12	Under 75 mortality from all cancers (DSR)	Annual	2015-2017	149.4	146.7	123.6	134.6	sig high	↓	NHSIC - P00381/ PHOF 4.05i
Priority Objective 3: Improving Immunisation Uptake										
13	Uptake of the second dose of Measles Mumps and Rubella Vaccine (MMR2) at five years of age (%)	Quarterly	Q2 2018/19	83.5	85.3	74.8	86.4	similar	↑	COVER Programme
14	HPV Vaccine Update (All Doses) %	Annual	2017/18	75.5	79.5	81.0	83.1	sig lower	↑	Public Health England - via www.gov.uk
15	Uptake of Influenza vaccine in persons 65+ years of age %	Annual	2017/18	67.5	67.4	66.9	72.6	sig lower	↓	PHOF 3.03xiv
Priority Objective 4: Reducing Alcohol Harm										
16	Alcohol related admissions (ASR per 100,000 pop)	Annual	2017/18	526	537	533	632	sig lower	↑	PHOF 2.18
Priority Objective 5 : Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking										
17	Smoking Prevalence in adults (18+) - current smokers (APS)(%)	Annual	2017	21.2	15.5	14.6	14.9	similar	↓	PHOF 2.14
18	4 week smoking quitters (crude rate per 100,000)	Annual	2017/18	2,203	2,329	2075	2,070	similar	↑	Smoking Quitters
19	Smoking status at time of delivery (%)	Annual	2017/18	4.8	5.4	5.0	10.8	sig lower	↑	PHE Tobacco Profiles
Priority Objective 6: Improving Mental Health and Wellbeing										
20	Prevalence of Serious Mental Illness (%)	Annual	2017/18	1.31	1.33	1.11	0.94	sig high	↔	Quality Outcomes Framework
21	Prevalence of Depression 18+ (%)	Annual	2017/18	7.0	8.2	7.1	9.9	sig lower	↑	Quality Outcomes Framework
22	Improving Access to Physiological Therapies (IAPT) referrals entering treatment (%)	Annual	To Nov 2018	15.3	20.0	-	-	-	↑	SLaM
23	Proportion of those accessing IAPT who moved to recovery (%)	Annual	To Nov 2018	48.0	49.0	-	-	-	↑	SLaM
Priority Objective 7: Improving Sexual Health										
24	Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24 (crude rate)	Annual	2017	4,735	2,573	2,199	1882	sig higher	↓	PHOF 3.02i/3.02ii (NCSP & CTAD)
25	People presenting with HIV at a late stage of infection (%)	Annual	2015-2017	37.3	39.6	35.2	41.1	similar	↑	PHOF 3.04
26	Legal Abortion rate for all ages (crude rate per 1000 women aged 15-44 yrs)	Annual	2017	23.1	23.1	19.8	16.5	sig high	↔	ONS Abortion Stats
27	Teenage conceptions (Rate per 1,000 15-17 Yr olds)	Annual	2016	23.4	22.1	17.1	18.8	similar	↓	PHOF 2.04
Better Care Fund Metrics										
28	The proportion of those aged 65+ who received reablement services after hospital discharge	Annual	2017/18	2.3	4.0	3.8	2.9	-	↑	Better Care Fund, NHS England
29	Residential Admissions Rate (per 100,000 65+ population)	Annual	2017/18	687.4	541.2	406.2	585.6	-	↓	Better Care Fund, NHS England
30	Average daily rate of delayed transfers of care (per 100,000 population aged 18+)	Annual	2017/18	7.3	5.7	-	12.4	-	↓	Better Care Fund, NHS England
31	Non-Elective Admissions (per 100,000 population)	Annual	2017/18	-	-	-	-	-	-	Better Care Fund, NHS England

Key

sig high -significantly higher than England; sig low - significantly lower than England
 similar - statistically similar to England
 DSR - Directly Standardised Rates
 ASR - Age Standardised Rates
 ISR - Indirectly standardised Rates
 PHOF - Public Health Outcome Framework

	Latest period highlighted
	Statistically Better than England
	Statistically Similar to England
	Statistically Worse than England
	Blank where no statistical comparison could be made

Arrows Indicate up or down performance of current year /qtr from previous yr/qtr

Links to Source with their abbreviations

<http://www.phoutcomes.info/>
<http://www.phoutcomes.info/profile/sexualhealth>
<https://www.indicators.ic.nhs.uk/webview/>
<http://www.hscic.gov.uk/qof>
<http://ascf.hscic.gov.uk/>
<http://www.productivity.nhs.uk/>
<https://www.nhscomparators.nhs.uk/NHSComparators/HomePage.aspx>

Public Health Outcomes Framework (PHOF)
 Public Health England Sexual Health Profiles
 NHS Indicator Portal (NHSIC) by Health and Social Care Information Centre (HSCIC)
 Quality and Outcomes Framework (QOF) by HSCIC
 Adult and Social Care Outcomes Framework (ASCOF)
 NHS Better Care Better Value Indicators
 NHS Comparators by HSCIC

* Data Quality Issue has been reported with this indicator, interpret with caution